Health and Social Care Board and Public Health Agency

Annual Quality Report
2013/2014

Health and Social Care Board

Public Health Agency

QUALITY 2020

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Chief Executives' foreword

Welcome to the first *Annual Quality Report* of the Health and Social Care Board (HSCB) and Public Health Agency (PHA).

Annual quality reports are a recommendation of the Department of Health, Social Services and Public Safety's (DHSSPS) *Quality 2020: a 10 year strategy to protect and improve quality in Health and Social Care in Northern Ireland*.

The HSCB and PHA want patients, carers and their families to feel confident about the quality of health and social care services in Northern Ireland. This report demonstrates what we have done to achieve this in the last year. It also highlights the broad range of work that we routinely undertake and reaffirms our commitment to **safety, effectiveness** and **patient and client focus**.

This report (and indeed our work) has been structured around these three core themes, as high-quality care can only be achieved when all three are present.

Safety

Recently there have been high-profile reports published with important lessons for health and social care in Northern Ireland: *The Francis Report* (which detailed failings of care at the Mid Staffordshire NHS Foundation Trust), *The Keogh Review* (which examined hospitals with high mortality) and *The Berwick Report* (regarding patient safety in the NHS).

These reports have provided stark evidence of the importance of ensuring that those delivering and commissioning care continually strive to provide the very best care possible while protecting patients from harm. Where they have concerns, they must feel able to speak up.

During 2013 the HSCB and PHA provided evidence to the Inquiry into Hyponatraemia Related Deaths (IHRD). When published, the final report will be reviewed by both organisations.

Effectiveness

Throughout 2013/14 there has been a sustained focus on developing and implementing services for at-risk members of the community, such as people living with dementia, and improving informed choice for screening services.

There has also been a reduction in healthcare-associated infections (HCAIs), specifically a reduction in *Clostridium difficile* and meticillin-resistant *Staphylococcus aureus* (MRSA) rates, which are now at an all-time low.

Patient and client focus

The HSCB and PHA have made a significant investment in the **10,000 Voices** initiative, which has provided an opportunity for patients, carers and their families to share their experiences.

More than 3,000 people have taken the time to do this, influencing the delivery, design and improvement of services. By focusing on things that really matter to patients we have seen improvements in patient and staff communication.

There is, however, no room for complacency. Therefore the HSCB and PHA will continue our efforts to ensure and improve good practice, and to address areas of concern.

The coming years will present a very challenging financial environment, but it is essential that efforts to improve the quality of care are maintained.

In order to build on the previous year's work, we have selected a number of new priorities and objectives for 2014/15, with a theme of **improving public health and reducing preventable harm**. We feel that this is fundamental to ensuring that our patients receive high-quality care.

Finally, we would like to thank all the staff for their continuing efforts over the past year to improve the quality of our services. There will always be areas for improvement and we will continue to aim for the highest quality in the care we provide and put our patients at the heart of everything we do.
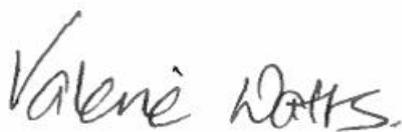
Mrs Valerie Watts
Chief Executive
Health and Social Care Board

Dr Eddie Rooney
Chief Executive
Public Health Agency

What is Quality 2020?

Quality 2020 is a ten year strategy to protect and improve the quality of health and social care in Northern Ireland. It was developed by the DHSSPS with involvement from both service users and HSC staff.

The strategy defines three core elements of **quality**:

Safety
Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Effectiveness
The degree to which each patient and client receives the right care (according to evidence-based assessment), at the right time, in the right place, with the best outcome.

Patient and client focus
All patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The aim of *Quality 2020* is for the HSC "**to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care**".

The strategy sets five goals to be achieved by 2020:

Transforming the culture
This means fostering a culture that embraces change, innovation and new thinking.

Strengthening the workforce
It is vital that the people who work in health and social care (including volunteers and carers) are equipped with the skills and knowledge they need.

Measuring the improvement
To confirm that improvement is taking place, the service needs more reliable and accurate means of measuring, valuing and reporting on improvement and outcomes.

Raising the standards
The service requires a coherent framework of robust and meaningful standards against which performance can be assessed.

Integrating the care
Patient care should cross all geographic and professional boundaries to benefit patients, clients and families.

How we measure and report on our work

The HSCB and PHA have established two joint strategic groups to monitor and report on **safety, effectiveness and patient client focus**: The quality, safety and experience group and the safety and quality alerts (SQA) team.

Quality, safety and experience group

The quality, safety and experience group (QSE) was established in November 2013 to oversee all issues relating to **safety, effectiveness and patient client focus** within the HSCB and PHA. This group allows senior staff to share information, approve policy and identify areas of concern.

The group meets monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals.

An overview of the QSE governance and assurance structure is outlined in Appendix 1.

The serious adverse incident review sub-group and regional complaints sub-group report to and support the work of the QSE.

Serious adverse incident review sub-group

The serious adverse incident review sub group (SAIRSG) provides assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow-up of **serious adverse incidents** arising during the course of the business of an HSC organisation or commissioned service.

The SAIRSG also has responsibility (in conjunction with the QSE and SQA team) to ensure that trends, examples of best practice and learning are identified and disseminated in a timely manner.

The group is co-chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience.

Regional complaints sub-group

The regional complaints sub-group meets monthly to consider complaints arising from regional HSC services. The group makes key recommendations for action and agrees issues to be referred to the QSE.

The group is chaired by the HSCB Complaints/Litigation Manager.

Safety and quality alerts team

The safety and quality alerts (SQA) team was formed in April 2012 to coordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA and other organisations.

This team meets fortnightly and is chaired by the PHA Medical Director/Director of Public Health. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

Table 1: Category 1 alerts or equivalent correspondence reviewed by the SQA team from 1 April 2013 to 31 March 2014.

Category 1	Status of alert/report		Total
	Completed	Ongoing	
Safety and quality alerts/circulars	45	3	**48**
Learning letters	6	4	**10**
RQIA reports	5	3	**8**
GAIN reports	3	0	**3**
DHSSPS independent reviews	1	0	**1**
Total	**60**	**10**	**70**

Last year the SQA team oversaw a number of key quality improvements, including:

• a regional competency assessment framework for the safe administration of intravenous fluids to reduce the risk of hyponatraemia;

• preliminary work on an e-learning module on fluid management and hyponatraemia;

• a regional approach to preventing fatalities from medication loading devices;

• a regional passport and leaflets to support the safer administration of insulin;

• a regional training programme for nurses on the safer administration of insulin;

• work to improve appropriate resuscitation practice for patients at end-of-life;

- refinement of patient selection criteria for maternity units that do not fully meet the standard for resident anaesthetic, paediatric and obstetric medical staff;

- work through the Northern Ireland Critical Care Network to standardise pre-operative risk assessment;

- a review of compliance with roll-out of national early warning scores;

- work to implement the recommendations of the Regulation and Quality Improvement Authority (RQIA) report on hospitals at night;

- development of a joint HSCB/PHA action plan in response to the *Memorandum of Understanding: Investigating patient or client safety incidents (unexpected death or serious untoward harm)*;

- publication of the *Learning Matters* newsletter to complement existing methods of sharing learning from incidents, reviews, complaints and patient experience;

- introduction of a system to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented.

- review of prescribing data from August – October 2013 from all GP practices to identify instances of oral ketoconazole prescribing;

- awareness raising of new SMS messaging service for air pollution to the Business Services Organisation (BSO), HSCB and PHA.

Governance and audit committees

Both the HSCB and PHA maintain statutory governance committees:

HSCB governance committee

The HSCB governance committee is made up of four non-executive directors (one with a professional nursing background) with an integrated understanding of risks across the organisation.

In addition, the HSCB senior management team attends all meetings of the governance committee.

The governance committee provides a broad range of assurances to the board of directors including:

- management of corporate risk;
- quality, safety and standards in health and social care;
- social care delegated statutory functions, controls assurance and internal control;
- serious adverse incident management;
- complaints management;
- litigation management;
- maintenance of the reputation, image and integrity of the HSCB;
- professional regulation;
- information governance.

The governance committee also receives briefings on case management reviews as well as reports from professional leads.

Once approved, minutes of governance committee meetings are brought to the attention of the full board of directors at the subsequent public meeting.

PHA governance and audit committee

The purpose of the PHA governance and audit committee (GAC) is to assure the PHA board and accounting officer of the effectiveness of the PHA's system of internal control.

The GAC has an integrated governance role encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by risk management systems.

The GAC meets at least quarterly and comprises four or more non-executive directors supported by the PHA Director of Operations, the HSCB Director of Finance, the BSO Head of Internal Audit, and their respective staff.

Links with key partners

The HSCB and PHA work in partnership with statutory and professional bodies to support and improve professional standards and clinical practice.

Northern Ireland Medical and Dental Training Agency

The Northern Ireland Medical and Dental Training Agency (NIMDTA) commissions, promotes and oversees postgraduate medical and dental education and training throughout Northern Ireland. In June 2012 the HSCB and PHA established a timetable of quarterly meetings between commissioners and NIMDTA. The purpose of the meetings is threefold:

- **To discuss the allocation of medical and dental training placements and the recruitment of trainees.**

  This means commissioners are aware when there are recruitment issues that might lead to service pressures within a particular HSCT or speciality, and can work to resolve or manage them.

  Commissioners also discuss how service pressures or plans might impact on placements so that training remains aligned with current and future service needs. For example, following discussions with NIMDTA about ongoing service pressures within haematology, there is now greater rotation of haematology trainees through cancer units to encourage greater take-up of haematology posts.

- **To ensure that clinical governance concerns raised through NIMDTA visits to HSCTs are appropriately escalated to the HSCB and PHA.**
  Commissioners work with NIMDTA and HSCTs to respond to and manage clinical governance concerns at the earliest opportunity. From 2014, a report summarising issues and resulting actions will be taken through the HSCB governance committee annually.

- **To provide an opportunity to share skills and resources with a view to enhancing the quality of training.**
  Examples of this include shared inequalities e-learning resources, communication skills training and the introduction of a regional email account for all trainee doctors and dentists in Northern Ireland.

Regulation and Quality Improvement Authority

The PHA meets quarterly with the Regulation and Quality Improvement Authority (RQIA) and agrees the work programme for service reviews. A point of contact for each review (an 'affiliate') is appointed.

The reports issued by RQIA are processed through the SQA team. Eight RQIA reports were taken through this process last year.

Professional meetings with HSCTs

The directors of medicine, nursing and social services from the HSCB, PHA and HSCTs meet quarterly with their professional colleagues from health and social care providers to address quality concerns. The DHSSPS senior professional officers also meet regularly with their professional colleagues.

Accountability meetings with DHSSPS

There are biannual accountability meetings between the DHSSPS and the HSCB, PHA and HSCTs to provide assurance on the delivery of the agreed commissioning plan.

The HSCB and PHA also meet bimonthly with HSCTs to assure performance and address quality.

Governance arrangements for primary care

There are four healthcare services provided to patients and clients through primary care: general medical, pharmaceutical, ophthalmic and dental.

The HSCB Directorate of Integrated Care is responsible for commissioning these services and has established governance arrangements to ensure primary care is safe, effective and patient client focused.

General medical services

General practitioners (GPs) are responsible for the provision of general medical services to their registered practice population. The role of general practice is to treat acute and chronic illnesses and to provide preventative care and health education to patients.

The HSCB undertakes a range of contractual and governance activities with GPs, including the management and reporting arrangements of adverse incidents and serious adverse incidents.

- **Contract review and visit process**
  All GP practices are visited on a three year cycle, at which a detailed contract review is undertaken. There are also visits each year to the 10% of practices with the lowest performance in clinical outcomes. Practice visits perform a quality-improvement role and an inspection function.

- **Clinical governance review**
  The GMS contract requires general practices to have an effective system of clinical governance.

  A comprehensive clinical governance framework for primary care has been developed over the past five years and is now the agreed regional framework for GMS clinical governance.

  By the end of each year each practice must submit the following documentation to the HSCB:

  - governance record describing work undertaken in the previous year;

  - annual practice governance declaration signed by the clinical governance lead.

- **Continuing professional development**

  Education is a key part of the HSCB relationship with practices and through education programmes and protected learning afternoons, each locality has hosted specific training events. These allow staff to discuss practice performance and plan service improvements. Courses are organised by integrated care staff in response to changing clinical priorities and contractual and statutory requirements.

- **Management of performance concerns**

HSCB Reference Committee

The role of the HSCB Reference Committee is to ensure that the highest quality of health and social care is maintained in Northern Ireland. Primarily this is achieved by monitoring the professional standards of family care practitioners – GPs, dentists, pharmacists and opticians, considering complaints and feedback about any relevant matters, and referring any such cases for further investigation. Depending on the nature of each case subsequent investigation can involve the HSCB, other agencies or relevant professional bodies such as the General Dental Council, the General Medical Council, the General Ophthalmic Council or the Pharmaceutical Society of Northern Ireland. The work of the committee is supported by professional officers and their staff.

The committee has established processes to ensure that any cases coming before it are considered in a fair and confidential manner and, with HSCB professional leads, regularly reviews the operation of these processes to ensure they are fit for purpose. Occasionally concerns over relevant strategic issues are raised with the HSCB.

Cases that can require consideration by the reference committee can relate to:

- failings in professional standards
- serious adverse incidents involving a practitioner, particularly when an incident puts the public at risk
- matters referred by the police, the Coroner, or other legal entities

In overall terms, the committee remains of the view that the quality of care and clinical standards provided by family practitioners across Northern Ireland remains of a very high standard. Any such failings remain as rare events, and the committee acknowledges that much work continues to maintain and develop standards. This process is being actively pursued with the input and assistance of practitioners and their representative organisations.

Regional professional panel

The regional professional panel, which is an advisory body to the HSCB, manages concerns about the safety of patients posed by the performance of a practitioner. The panel makes recommendations to the HSCB on whether there needs to be any restriction or suspension placed on a practitioner's practice. In such cases referral is made to the HSCB reference committee which considers serious disciplinary matters relating to family health service practitioners.

Management of the Northern Ireland primary medical performers list

A doctor is required to be listed as a primary medical services performer in order to treat patients in primary care. *The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004* introduced the Northern Ireland primary medical performers list (NI PMPL) on 1 April 2004. The HSCB is responsible for the admission of doctors to the NI PMPL and for their removal from the list, subject to strictly defined criteria.

The *Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010*

The medical profession regulations came into operation on 1 October 2010 and require each designated body to nominate or appoint a responsible officer (RO).

The HSCB RO is responsible for the evaluation of the fitness to practise of every medical practitioner who has a prescribed connection with the HSCB, including the revalidation of practitioners.

The estimated number of practitioners to be revalidated each year are:

2013–14 Year one: 93
2014–15 Year two: 607
2015–16 Year three: 601

To support the HSCB RO in making robust revalidation statements to the General Medical Council, a process has been developed to consider any issues flagged by the RO that might impact on a revalidation statement (see page 72).

Pharmaceutical services

The most common primary care medical service is the prescribing of medication. Community pharmacies are responsible for dispensing and advising on these medicines and providing advice on a range of wider health issues. Currently there are 535 community pharmacies across Northern Ireland.

HSCB staff work closely with community pharmacies to ensure that appropriate governance arrangements are in place and that the services they provide are consistently delivered to a high standard.

A system has been developed around the management of adverse incidents and complaints that occur in community pharmacies, and work on the governance arrangements for the full range of services that are provided in community pharmacies is ongoing.

General ophthalmic services

In Northern Ireland, eyecare services within primary care are delivered by 266 providers (practices) of general ophthalmic services. Over 400 ophthalmic professionals are responsible for sight testing and ophthalmic dispensing in optometry practices.

Developing eyecare partnerships, improving the commissioning and provision of eyecare services in Northern Ireland is the policy document that has facilitated recent developments in integrated eyecare provision, including the establishment of enhanced eyecare provision by optometrists for the triage, treatment and management of certain eye conditions.

The HSCB ensures the quality of general ophthalmic services using a variety of methods:

- **Ophthalmic checking clinics**
  Ophthalmic checking clinics assure the quality of provision of general ophthalmic services. Patients are invited to attend a meeting to have their optical appliance checked and verified and to provide views on the service they received.

- **Annual quality assurance (QA) returns**
  Opticians are expected to send to the HSCB for review an annual summary of: complaints; adverse incidents; business continuity planning; and notification of the receipt and implementation of regulations and guidance.

- **Governance reviews of clinical records**
  HSCB advisers review the clinical records of patients during optometry practice visits and then follow up any issues that are identified.

Dental services

There are currently 380 dental surgeries in Northern Ireland with 1056 dentists working in them. These are mostly practices where general dental care and treatment is provided. A small number deliver specialist dental care and treatment, particularly orthodontics and oral surgery.

Quality of care provided by dental practitioners is monitored through the Referral Dental Service (RDS). This was historically the responsibility of the DHSSPS and transferred to the HSCB in 2010.

The RDS examines a sample of patients post-treatment for all practitioners. Patients are called to clinics to be examined by dental advisers and their record cards are also examined. The subsequent reports comment on the quality of treatment provided and in addition contribute to financial assurances and the overall probity process.

Each practitioner is now also issued with an analysis of the records review and the examination reports.

- **Dental prescribing**
  General dental practitioners prescribe medications as listed in the *Dental Practitioners'*

Formulary. Controlled drug prescribing is monitored on a monthly basis by a dental adviser with support from a pharmacy adviser. To date, correspondence with practitioners has resulted in identification of two serious adverse incidents and a referral to the Counter Fraud Unit of BSO.

- **The Regulation and Quality Improvement Authority (RQIA)**
  Establishments providing any private dental care or treatment are subject to the *Independent Health Care Regulations (Northern Ireland) 2005* and must be registered with the Regulation and Quality Improvement Authority (RQIA). This organisation has overall responsibility for assessing and reporting on the quality and safety of those services and for encouraging improvements.

  The RQIA gives the HSCB assurance of these practices through a regular programme of inspections.
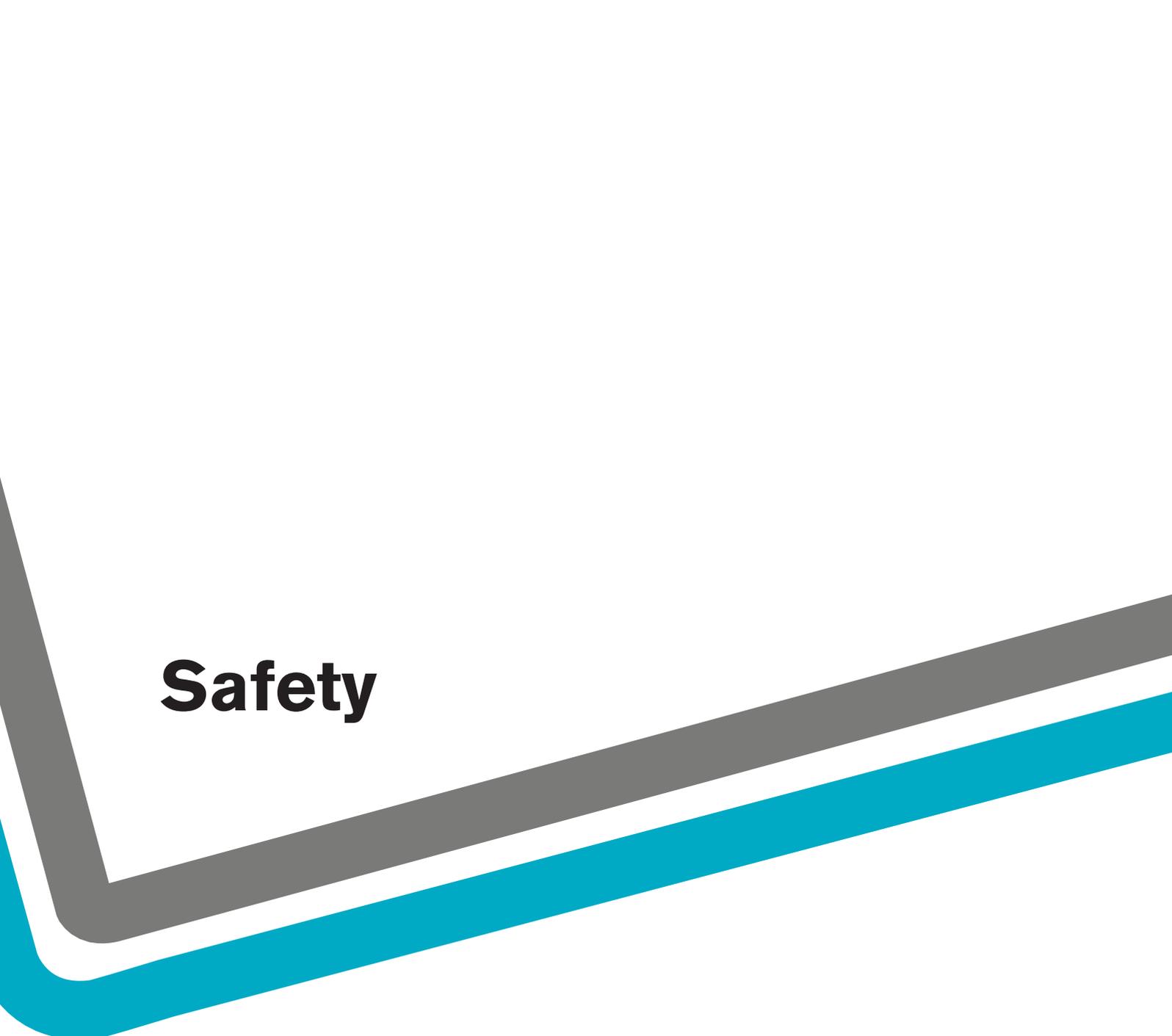
Safety

The management of serious adverse incidents

This section outlines how we follow the procedure for the reporting and follow-up of serious adverse incidents (revised October 2013) (see Appendix 2) and the number of serious adverse incidents (SAIs) reported between 1 April 2013 – 31 March 2014.

The current operational arrangements for managing SAIs reported to the HSCB or PHA are:

- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis.
- Each SAI has a nominated professional who is the designated review officer (DRO).
- Reports, themes and learning are shared with the SAI review sub-group (SAIRSG) and the quality safety and experience (QSE) group to agree actions.
- The safety and quality alerts (SQA) team provide an assurance mechanism for any actions to be taken forward as a result of regional learning.

The aim of the SAI process is to:

- provide a mechanism to share learning, focusing on quality and leading to service improvement for service users;
- provide guidance on the SAI criteria, responsibilities and the process for reporting, investigation, dissemination and implementation of learning arising from SAIs;
- ensure the process works simultaneously with all other statutory and regulatory organisations;
- provide a culture of openness and transparency that encourages the reporting of SAIs;
- ensure trends, best practice and learning are identified, disseminated and implemented in a timely manner, in order to reduce recurrence;
- maintain a high quality of information and documentation within a time-bound process.

Training

During the reporting period, a number of regional training programmes were undertaken to support staff in the implementation of the SAI procedure:

- Regional significant event audit training (December 2013)
- Designated review officer workshop (December 2013)
- Regional root cause analysis training (January/February 2014)

Service user and family involvement in SAIs

The HSCB and PHA SAI procedure makes clear the need for appropriate communication and involvement of service users, relatives and carers.

In addition, the HSCB and PHA are working with the HSCTs, Patient and Client Council (PCC) and RQIA to develop guidance for HSC organisations when involving service users/families throughout the stages of the SAI process. A leaflet is also being developed to provide information for patients/families on the process.

Table 2: Serious adverse incident activity 1 April 2013 – 31 March 2014

The HSCB received **483 SAI notifications** from across the HSC for the above period, of which 23 were subsequently de-escalated and three transferred. The table below provides an overview of all SAIs reported by organisation and programme of care (POC) for 2013/14.

| Organisation | 2013/14 | | | | | | | | | | | | |
	SAI notifications received	SAI de-escalated	SAI transferred	Total SAIs excluding de-escalated and transferred SAIs	POC 1	POC 2	POC 3	POC 4	POC 5	POC 6	POC 7	POC 9	POC NA
BHSCT	105	8	1	96	26	41	3	0	21	2	0	1	2
BSO	1	0	0	1	0	0	0	0	0	0	0	0	1
NHSCT	154	7	0	147	53	12	8	27	34	6	1	1	5
NIAS	3	1	0	2	2	0	0	0	0	0	0	0	0
Primary care	29	2	1	26	0	0	0	0	0	0	0	26	0
SEHSCT	57	2	1	54	11	8	5	4	22	2	1	0	1
SHSCT	75	2	0	73	11	14	1	16	27	1	0	2	1
WHSCT	58	1	0	57	14	9	2	3	24	1	0	0	4
NIBTS	1	0	0	1	1	0	0	0	0	0	0	0	0
Totals	483	23	3	457	118	84	19	50	128	12	2	30	14

Key

POC1	Acute services	POC6	Learning disability
POC2	Maternity and child health	POC7	Physical disability and sensory impairment
POC3	Family and childcare (including CAMHS)	POC8	Health promotion and disease prevention
POC4	Elderly	POC9	Primary health and adult community (includes GPs)
POC5	Mental health	POCNA	Corporate business/other

In addition to SAIs, adverse incidents (AIs) in primary care are reported to the HSCB Directorate of Integrated Care through a variety of methods, including anonymised reporting.

Table 3: Overview of AIs reported during 2013/14

Localities/ areas	General medical	Dental	Pharmaceutical (see below)	Ophthalmic	Multi*	Total
Belfast	17	2	0	0	1	20
Northern	37	3	2	0	0	42
South Eastern	16	0	0	2	0	18
Southern	63	2	0	0	0	65
Western	15	3	0	1	0	19
Blanks**	3	0	0	0	0	3
Total	151	10	2	3	1	167

*Refers to incidents occurring across multiple organisations

**Refers to incidents where the local area cannot be determined

In 2013/14 the adverse incidents reported to the HSCB were categorised as follows:

- Medication incidents (eg prescribing errors, drug specific issues)   47%
- Patient issues (eg records/identification issues)   19%
- Interface incidents between primary and secondary care   13%
- Premises/equipment issues   13%

The majority of pharmaceutical service incidents are not represented on the table above. These incidents are not recorded by locality but either anonymously or as named incidents. There were 395 anonymous incidents recorded in 2013/14:

- Dose/strength wrong or unclear   32%
- Wrong drug   26%
- Wrong quantity   7%
- Other   13%

There were 156 named incidents recorded in 2013/14:

- Dose/strength wrong or unclear   29%
- Wrong drug   21%
- Mismatch between patient and medicine   15%
- Wrong quantity   5%

The key aim of our SAI and AI processes is to reduce the risk of recurrence and improve patient safety by learning from incidents, not only within the reporting organisation, but across the HSC as a whole.

The HSCB and PHA use a variety of mechanisms to share learning in a timely manner for implementation, including:

- Learning letters;
- Newsletters;
- Thematic reviews;
- Training;
- Audits, guidelines and resources.

Learning letters

Last year the following 10 Learning letters were issued:

- Loss of data from the Twinkle paediatric diabetic database managed by BSO ITS (23 May 2013)
- Management of data in community services (17 May 2013)
- Haemolysis during or after haemodialysis (28 June 2013)
- Know the massive haemorrhage protocol (9 July 2013)
- Child centred decision making (13 August 2013)
- Revised communication of patient risk status for CJD (2 September 2013)
- Care planning for adult mental health patients (28 August 2013)
- Safe use of intravenous (IV) magnesium sulphate (9 September 2013)
- Safe management of lower bowel dysfunction including digital rectal examination (DRE) and digital removal of faeces (DRF) (16 December 2013)
- Head injury in patients on Warfarin – treat as a medical emergency (8 January 2014)

Newsletters

A number of newsletters have been developed to share learning from SAIs and AIs. These include:

- Learning matters (see Appendix 3)
- Optometric practice
- Medicines safety matters
- Prescribing matters
- General practice
- Medicines management

Thematic reviews

Thematic reviews are commissioned by the QSE group to focus on specific areas to identify themes or trends. Recommendations are disseminated across the HSC.

The following thematic reviews were undertaken during 2013/14:
- Patient falls in hospitals
- Failure in referral or follow-up process
- Venous thromboembolism (VTE)

Training

There are various on-going training programmes, especially in the area of medicines safety on a range of subjects to share learning and improve practice for all disciplines.

Audits, guidelines and resources

The HSCB, through the pharmaceutical medicines management team, has developed a number of resources to help healthcare providers review and improve systems and prescribing in their practice. These range from workbooks on developing standard operating procedures, to audits and guidelines, including the Northern Ireland formulary. Existing resources are updated on a regular basis and new resources are developed as required.

Quality improvement plans

The *Francis report* highlights that statistics, benchmarks and action plans are not ends in themselves and should not come before patients and their experiences.

Therefore, while the HSCB and PHA are continuously reviewing performance measurements, our quality improvement plans focus, where possible, on patient-orientated outcomes to demonstrate improvements.

In 2013/14 our quality improvement plans included:
1. Pressure ulcer prevention
2. Falls prevention in hospitals
3. The World Health Organization (WHO) surgical checklist
4. Preventing harm from venous thromboembolism (VTE)
5. Cardiac arrest rates
6. Monitoring and reducing healthcare associated infections

The HSCTs report to the PHA and HSCB quarterly on their progress with each indicator.

Pressure ulcer prevention

Pressure ulcers (often called pressure sores or bed sores) are areas of localised damage to the skin and underlying tissues caused by pressure or friction. Not all pressure ulcers are avoidable, but in the majority of cases they can be prevented by frequently changing a patient's position, using special mattresses or chair cushions and attention to hydration and nutrition.

Skin care bundle (four elements)

Support the surface
Keep moving the patient
Increased moisture management (keep skin dry and well cared for)
Nutrition (ensure patient is well fed and hydrated)

The 'SKIN' care bundle is a powerful tool as it defines and ties best practices together. The bundle also makes the actual process of preventing pressure ulcers visible to all. This minimises variation in care practices. Consistently delivering all elements of the care bundle at every care opportunity will improve the pressure area care that a person receives. This will have impact on improving care outcomes.

Last year the PHA worked closely with HSCTs to implement a pressure ulcer prevention programme within acute hospitals, and have continued to work in partnership with Your Turn, a non-profit organisation, to raise awareness of pressure ulcer prevention in the community. In 2013/14 HSCTs were tasked with spreading the 'SKIN' bundle to 80% of all inpatient areas/wards, ensuring 95% implementation by March 2014. All Trusts have implemented this quality improvement initiative across adult inpatient areas/wards and are focusing on improving compliance with all elements of the bundle.

Figure 1 (below) illustrates that while the indicator required the HSCTs to have spread the SKIN bundle to over 80% of all adult inpatient areas (red line), all HSCTs exceeded this and spread to over 90% of required areas.

Figure 1: Spread of SKIN bundle as of March 2014

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
2013-2014 % Spread	100	98	100	100	100
Target	80	80	80	80	80
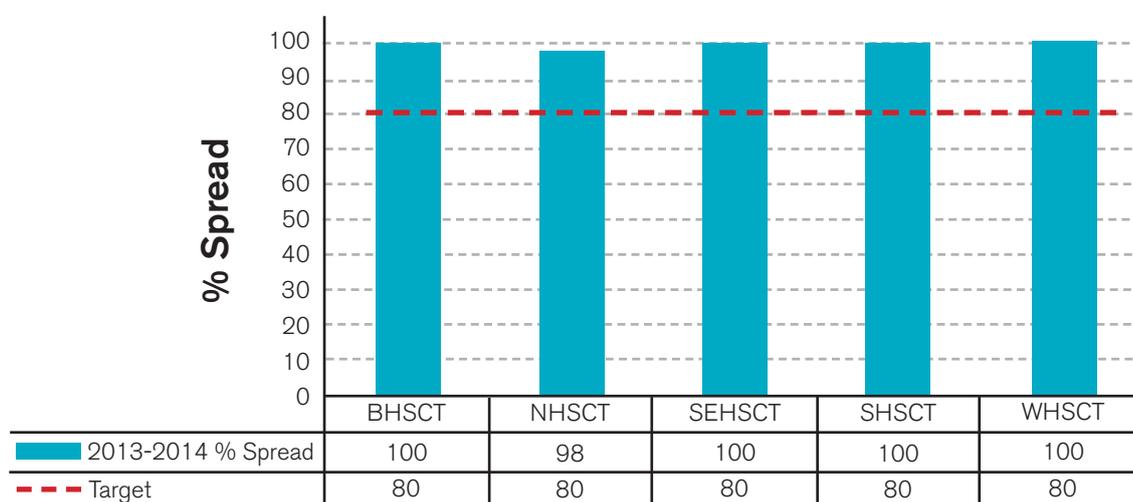
Falls prevention in hospitals

Falls can not only lead to physical injury, they can also have a significant detrimental impact on a person's confidence, increase anxiety and lead to a reduction in mobility, which can have longer lasting effects than the physical injury. The HSCB and PHA are committed to ensuring that the risk of falls in hospitals is minimised.

Falls are among the top five most frequent adverse incidents reported in HSCTs.

To reduce risks it is important to understand why patients fall in hospital and put steps in place to reduce falls and the harm from falls.

We cannot prevent falls without imposing unacceptable restrictions to patients' independence, dignity and privacy. However research has shown that falls can be reduced by 20–30% through assessments and interventions.

The PHA is leading a project to implement The Royal College of Physicians 'Fallsafe' bundle in hospitals in Northern Ireland, which is an evidence-based bundle of interventions shown to reduce falls.

The PHA monitors the HSCT implementation of Part A of the Fallsafe bundle:

- Patient asked about history of falling
- Patient asked about fear of falling
- Urinalysis performed
- Avoidance of prescription of night sedation
- Call bell provided
- Safe footwear
- Mobility status communicated
- Personal items in sight and reach
- No trip or slip hazard

There were approximately 10,250 falls reported last year in health and social care facilities. Of these, 284 resulted in moderate to severe harm such as broken bones.

HSCTs have worked diligently to implement all these elements (see Figure 2). However two elements are proving a challenge: 'patient asked about fear of falling' and 'urinalysis performed' as these factors were not routinely recorded on patient's notes.

The new regional nursing documentation will include routine urinalysis and a question asking patients about a fear of falling, which should significantly improve compliance when introduced.

Figure 2: Fallsafe bundle: HSCT compliance with all of Part A

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
A: Asked about history of falling	93%	95%	67%	95%	98%
A: Asked about fear of falling	25%	51%	67%	95%	98%
A: Urinalysis performed	70%	86%	68%	85%	68%
A: Avoidance of perscription of night sedation	90%	100%	90%	90%	100%
A: Call bell	88%	95%	83%	98%	100%
A: Safe footwear	95%	92%	95%	100%	100%
A: Mobility status communicated	98%	86%	84%	97%	100%
A: Personal items in sight and reach	95%	97%	98%	100%	100%
A: No trip or Slip hazard	98%	92%	98%	100%	100%

World Health Organization safe surgical checklist

The World Health Organization (WHO) has undertaken a number of global and regional initiatives to address surgical safety. The WHO safe surgical checklist is an initiative aimed at increasing surgical safety.

> **The checklist identifies three phases of an operation:**
>
> 1. **Sign in** (before the induction of anaesthesia)
> 2. **Time out** (before the incision of the skin)
> 3. **Sign out** (before patient leaves the operating room)
>
> **A checklist coordinator must confirm that the surgical team have completed the listed tasks before proceeding with the operation.**

In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before proceeding with the operation. By following a few critical steps, health care professionals can minimise the most common and avoidable risks to patients.

Last year each HSCT undertook a number of measures to achieve at least 95% implementation of the checklist across all theatres and day procedure units in Northern Ireland.

Figure 3 (below) shows that all HSCTs have increased their implementation of the WHO surgical checklist. Four HSCTs have achieved 95% or more and the remaining HSCT achieved 92%, with a plan to ensure it is introduced to the remaining areas in the next quarter; these include all procedural areas.

Figure 3: WHO surgical checklist end-of-year compliance

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
2012-2013	77	98	82	99	97
2013-2014	92	100	95	98	98
Target	95	95	95	95	95

Preventing harm from venous thromboembolism (VTE)

Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE).

A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg. If this blood clot becomes mobile in the bloodstream it can travel to the lungs and cause a blockage (PE) that could lead to death.

Some patients are at increased risk of a blood clot, particularly if they are not mobile due to their condition or treatment.

The risk of hospital-acquired VTE can be greatly reduced by risk-assessing patients and, if required, prescribing appropriate treatment.

Evidence suggests that as many as 50% of people in whom a blood clot in the leg is left untreated will go on to develop a blood clot in their lung.
NICE guidlines (CG 144; June 2012)

Last year HSCTs were required to increase implementation of the VTE risk assessment across all inpatient units/wards and, in addition, achieve 95% compliance with appropriate VTE prophylaxis prescribing in all clinical areas.

Figure 4 (overleaf) shows the number of risk assessments completed between April 2012 and March 2014 has increased regionally. HSCTs are committed to implementing the VTE risk assessment to improve the quality of patient outcomes.

Figure 4: VTE risk assessment end-of-year compliance

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
2012-2013	70	47	72	84	88
2013-2014	82	61	79	82	84
Target	95	95	95	95	95
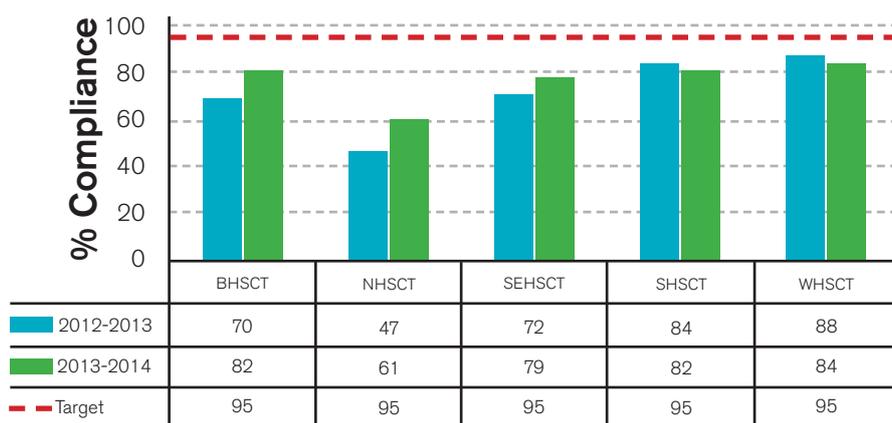
All HSCTs reported 95% or above implementation of VTE prophylaxis prescribing following VTE risk assessment (see Figure 5).

Figure 5: VTE prophylaxis prescribing compliance as of December 2013

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Trusts	95	95	99	95	97
Target	95	95	95	95	95

Cardiac arrest rates

Early recognition and detection of deterioration can reduce the number of cardiac arrests and improve the outcomes for patients.

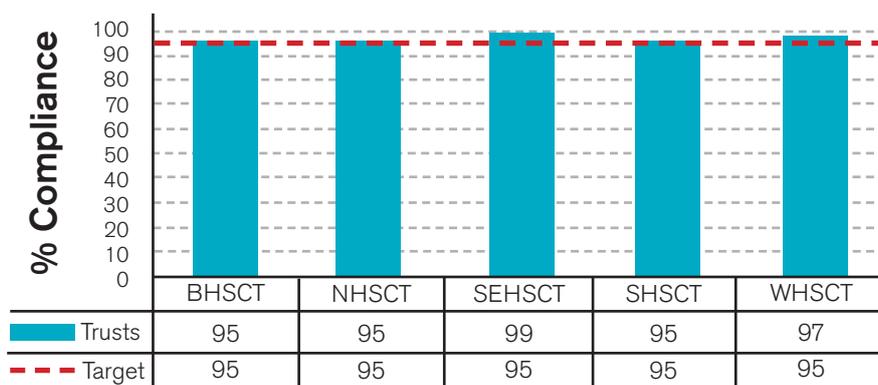The use of tools such as the National Early Warning Score optimises the delivery of safer care as it supports an enhanced level of surveillance and clinical review. It should be used for initial assessment of acute illness and for continuous monitoring of a patient's wellbeing throughout their stay in hospital. Where a patient's condition is identified as deteriorating, prompt escalation to senior staff ensures timely interventions and appropriate clinical care.

Cardiac arrest rates are monitored by the PHA and HSCTs are required to maintain or achieve a 20% reduction from baseline. Baselines were calculated individually for each HSCT based on monthly crash call rate per 1000 deaths and discharges. The target set for each HSCT individually is illustrated by the red bar on the diagram. All HSCTs maintained rates below the target level (see Figure 6).

Figure 6: Reduction in cardiac arrest rate measure at end-of-year

	BHSCT	NBHSCT	SEHSCT	SHSCT	WHSCT
2012-2013	2.48	1.77	1.1	1.44	0.79
2013-2014	1.8	1.3	1.2	1.3	0.8
Target	1.98	2.25	1.3	1.44	2.056
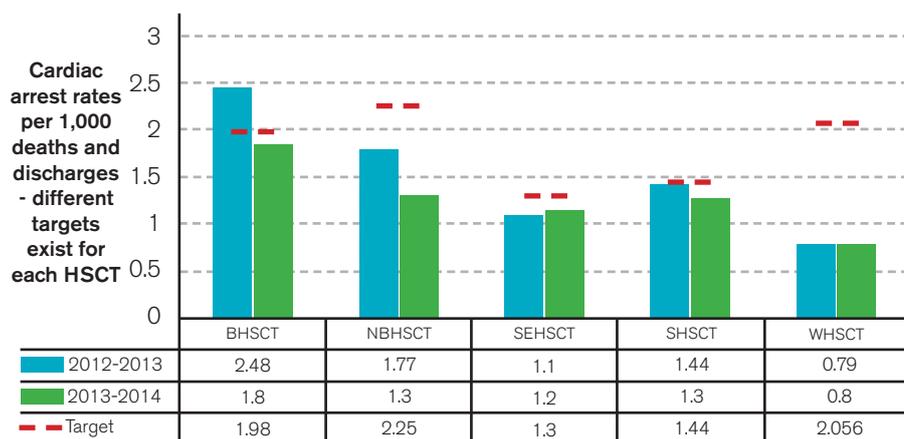
Monitoring and reducing healthcare associated infections

Healthcare associated infections (HCAIs) are an major and preventable cause of death and illness. Older patients and patients with coexisting illness are at increased risk of developing infections either as part of, or as a result of, their healthcare.

The PHA oversees and delivers a number of regional HCAI surveillance programmes in Northern Ireland. Partners across health and social care use the information reported through our regional surveillance programmes to monitor the impact of infection prevention and control programmes and service improvements.

Meticillin-resistant *Staphylococcus aureus* bloodstream infections

The regional rate for Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemias has decreased considerably between 2007/08 and 2013/14. This represents an absolute reduction of almost two thirds, from 221 episodes in 2007/08 to 62 episodes in 2013/14 (71.9% reduction).

Compared to 2012/13, eight fewer MRSA bacteraemias were reported in 2013/14 (11.4% reduction). During 2013/14 the regional ministerial target of 46 MRSA bacteraemias was exceeded by 16 episodes, with one HSCT meeting its individual MRSA reduction target.

Figure 7: Regional MRSA bacteraemia rate per 1,000 occupied bed days 2007/08 to 2013/14
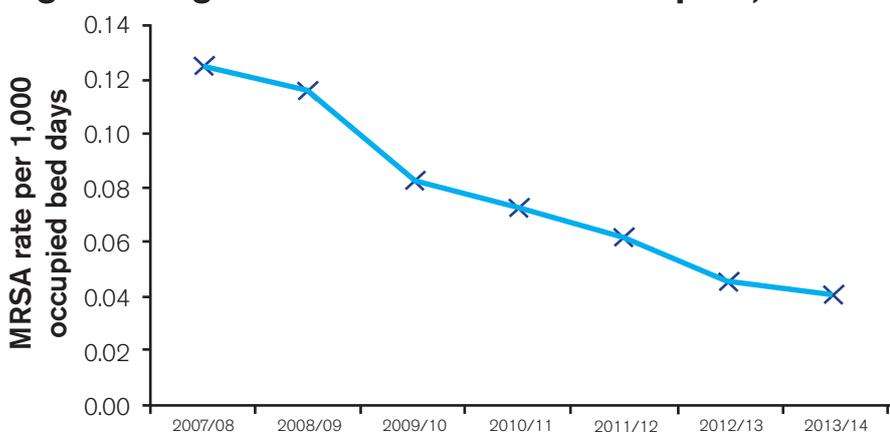
Clostridium difficile infections

The regional rate for *Clostridium difficile* infections (CDI) among hospital inpatients aged two years and over has also decreased considerably between 2008/09 and 2013/14. This represents an absolute reduction of two thirds, from 1,177 episodes in 2007/08 to 310 in 2013/14 (73.7% reduction).

Compared to 2012/13, 101 fewer CDI episodes among inpatients aged two years and over were reported in 2013/14 (24.6% reduction). During 2013/14 the regional ministerial target of 324 CDI episodes among inpatients aged two years and over was achieved with 310 episodes reported from acute hospitals.

Figure 8: Regional CDI rate, in inpatients aged two years and over, per 1,000 occupied bed days, 2008/09 to 2013/14
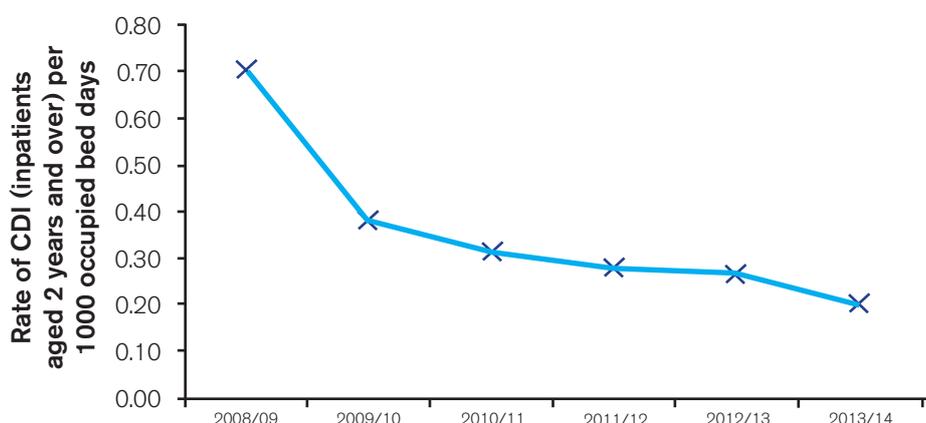
Orthopaedic surgical site infection surveillance

Compliance with orthopaedic surgical site infection (SSI) surveillance is based on the number of surveillance returns received by the PHA with valid orthopaedic procedure and SSI details recorded (reported as part of HSCT quality improvement plans). Compliance with SSI surveillance for orthopaedic procedures exceeded 80% throughout 2013/14.

During 2013/14 the regional SSI rate for orthopaedics was 0.16 per 100 orthopaedic procedures. This represents a considerable reduction from an SSI rate of 0.86 per 100 orthopaedic procedures reported in 2008/09.

Figure 9: Orthopaedic procedures: compliance with SSI surveillance 2013/14

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	13/14
Northern Ireland	81.8	88.4	83.7	78.6	83.1
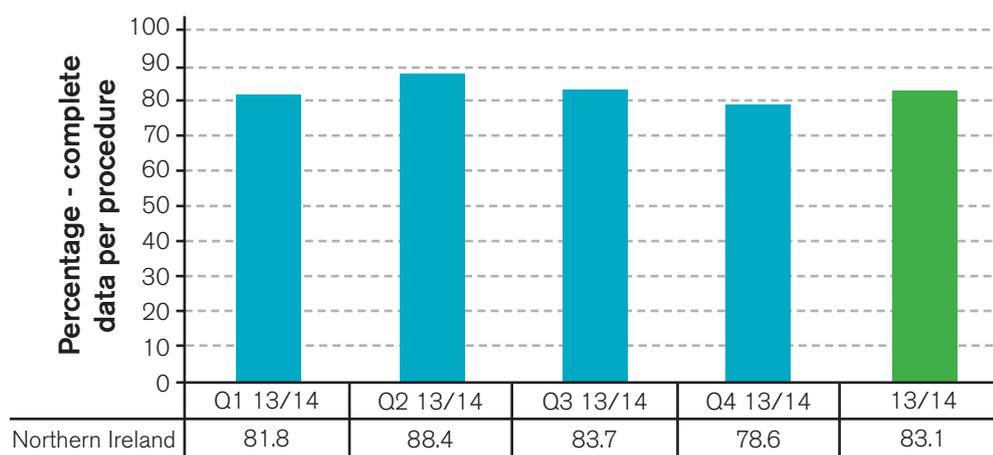
Year and quarter procedure performed
(Paper forms with necessary data per procedure/ excludes
Musgrave Park Hospital where data are submitted electronically)

Figure 10: Orthopaedic procedures: regional SSI rate 2008/09 – 2013/14

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Northern Ireland	0.86	0.85	0.57	0.35	0.25	0.16

Y-axis: Surgical site infection rate per 100 orthopaedic procedures

Year procedure performed and SSI rate
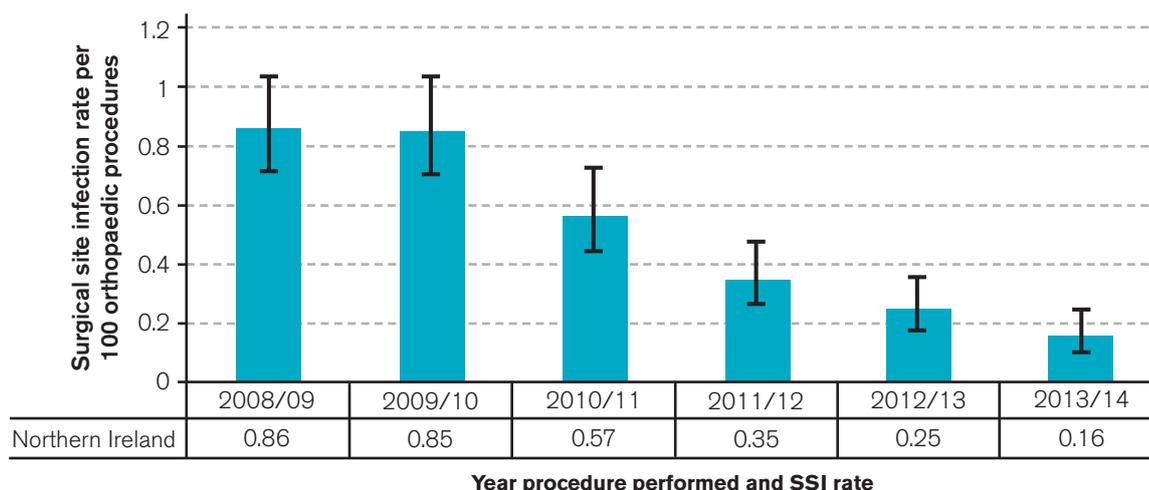
Caesarean-section SSI surveillance

Compliance for Caesarean-section (C-section) SSI surveillance is based on the number of C-section procedures reported to the PHA compared to the number performed. Compliance in C-section SSI surveillance has increased from 44% in 2008/09 to 80% in 2013/14. For three of four quarters in 2013/14 compliance with SSI surveillance for C-sections exceeded 80%.

During 2013/14 the regional SSI rate for C-sections was 8.2 per 100 C-section procedures. This represents a reduction from an SSI rate of 15.6 per 100 C-section procedures reported in 2008/09.

Figure 11: Caesarean sections: compliance with SSI surveillance 2013/14
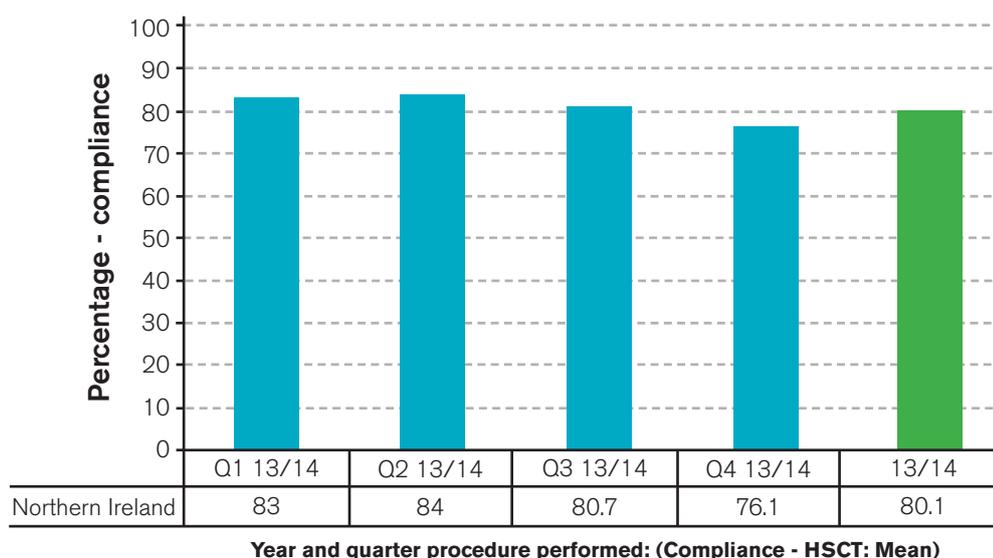
	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	13/14
Northern Ireland	83	84	80.7	76.1	80.1

Y-axis: Percentage - compliance

Year and quarter procedure performed: (Compliance - HSCT: Mean)

Figure 12: Caesarean sections: regional SSI rate 2008/09 – 2013/14

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Northern Ireland	15.6	13.2	11.5	10.8	9.8	8.2

Year procedure performed and SSI rate
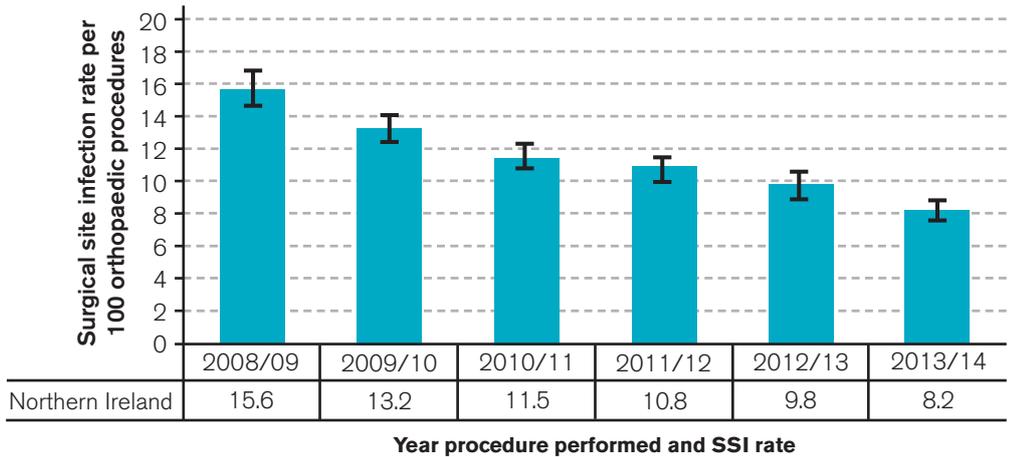
Device-associated infection surveillance

The device-associated infection (DAI) surveillance programme monitors three infections associated with invasive medical devices, an identified risk for HCAI, among patients receiving care in all critical care units in acute hospitals in Northern Ireland. This paperless surveillance programme is delivered through electronic data capture and sharing.

Ventilator associated pneumoniae

The regional ventilator associated pneumoniae (VAPs) rate for March 2014 was 0.73 per 1,000 ventilator days. This represents a slight reduction in the regional 12-month rolling average VAP rate from 0.95 per 1,000 ventilator days in April 2013. VAP rate = (number of VAP/number of ventilator days) x1,000.

Figure 13: Regional VAP rate April 2013 to March 2014
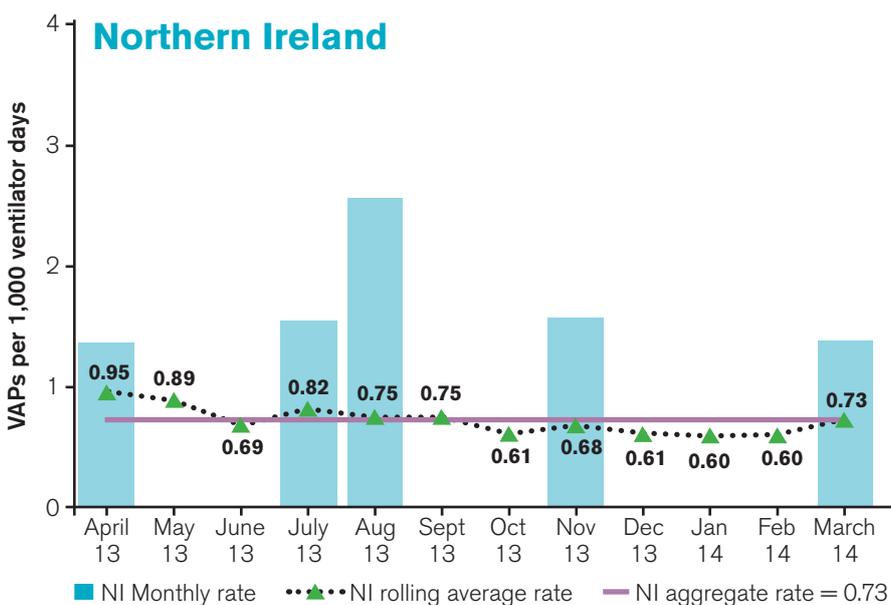
Central line associated infections

The regional central line associated infections (CLABSIs) rate for March 2014 was 0.27 per 1,000 central venous catheter days. This represents a slight reduction in the regional 12-month rolling average CLABSI rate from 0.38 per 1,000 central venous catheter days in April 2013. CLABSI rate = (Number of CLABSI / Number of central venous catheter days) x1,000.

Figure 14: Regional CLABSI rate April 2013 to March 2014
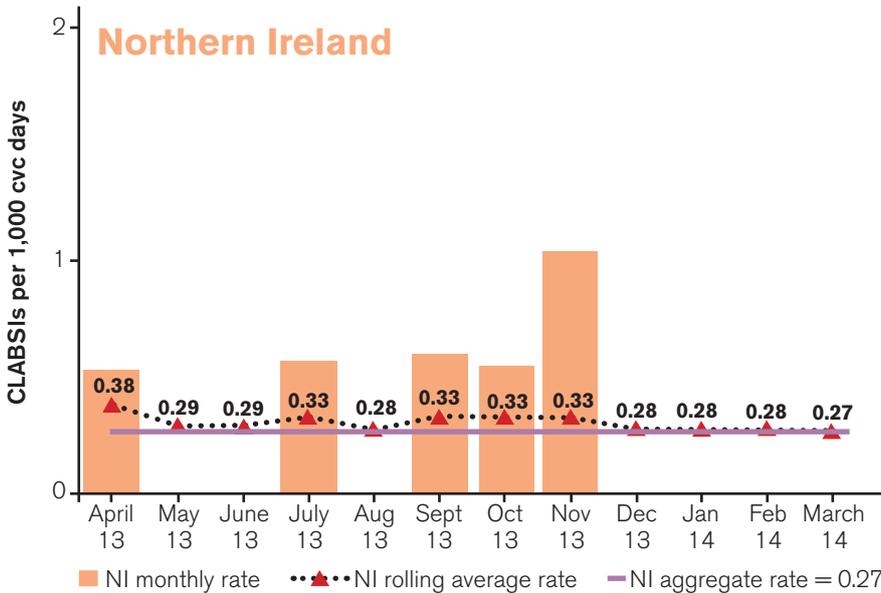
Catheter associated urinary tract infections

The regional catheter associated urinary tract infections (CAUTI) rate for March 2014 was 0.49 per 1,000 urinary catheter days. This represents a slight increase in the regional 12-month rolling average CAUTI rate from 0.14 per 1,000 ventilator days in April 2013.

CAUTI rate = (number of CAUTI / number of urinary catheter days) x1,000.
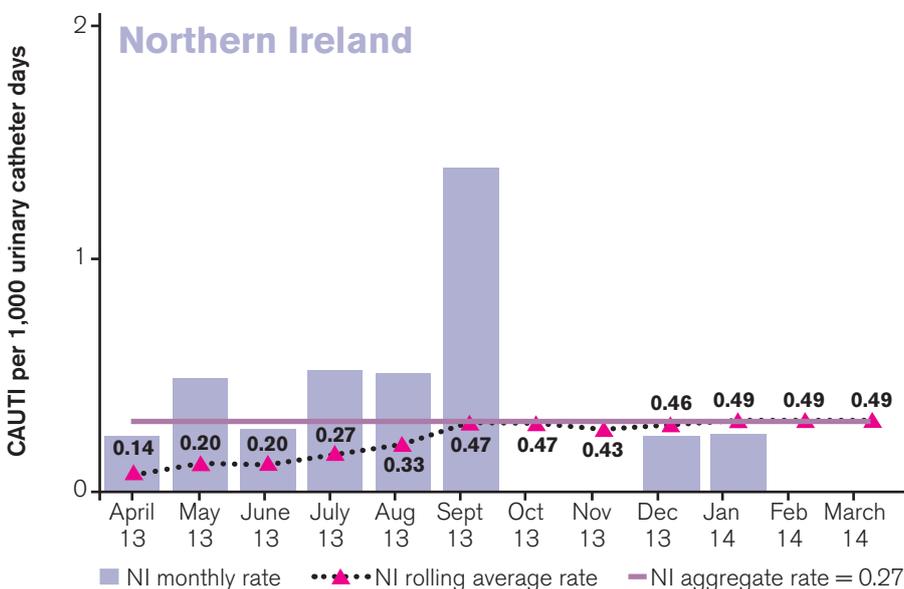
Figure 15: Regional CAUTI rate April 2013 to March 2014

HSC Safety Forum

The HSC Safety Forum provides leadership in quality improvement and patient safety. Achievements in 2013/14 include:

- organising Delivering Safer Care 2014, the largest conference supporting safety and quality improvement ever held in Ireland;
- leading the development of an Attributes framework for quality improvement and leadership as part of Quality 2020;
- providing (or contributing to) training for HSC staff in improvement science, human factors and change management.

The forum leads quality improvement collaboratives involving key staff from all HSCTs in:

- scheduled care;
- unscheduled care;
- maternity;
- paediatrics;
- mental health;
- nursing homes;
- primary care.

The highlights of our collaborative programme include:

Emergency department

The Emergency department (ED) improvement collaborative has worked with all EDs on the care of patients with life-threatening infection (severe sepsis) and those suffering from (acute) stroke.

Management of severe sepsis

Following 12 months of engagement and improvement though the collaborative, by mid-2013, Northern Ireland exceeded the College of Emergency Medicine standards on early management of severe sepsis. A point in time audit, conducted by all HSCTs in spring 2014, demonstrated that this improvement had been maintained.

Figure 16-21: Sepsis run charts

Observations recorded

Blood cultures taken

High flow 02

IV fluids

Antibiotics within one hour

Serum lactate
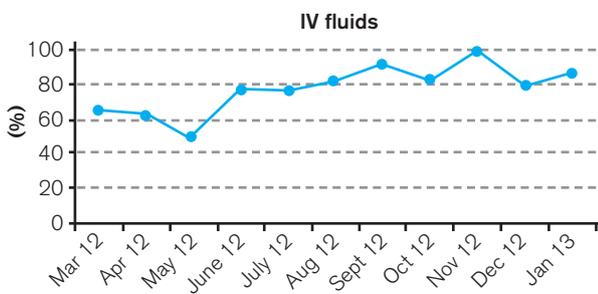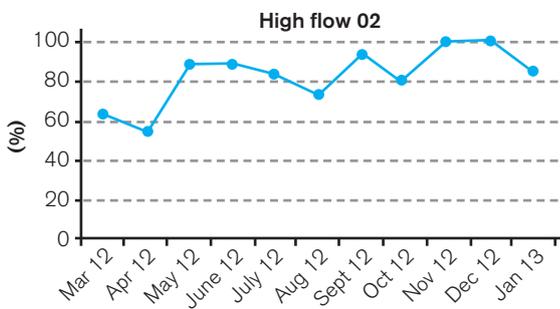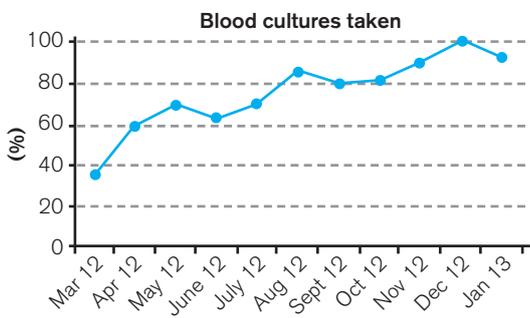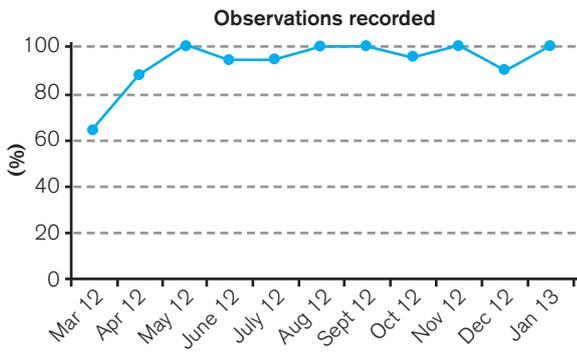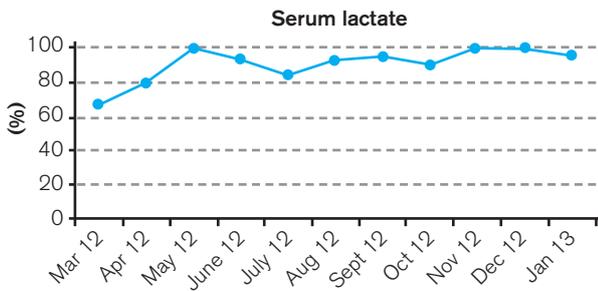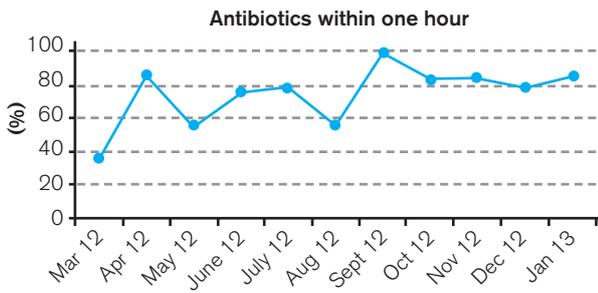
Stroke thrombolysis

Time is of the essence in the management of acute stroke and the collaborative aim was to ensure patients have a completed CT scan of the brain within 45 minutes of arrival in ED. The chart below, showing time to completed CT scan, is an example from a single HSCT showing the effectiveness of this quality improvement intervention and how the goal was achieved. This work was conducted as part of a cross border patient safety training programme, facilitated by the forum and partners and funded by Cooperation and Working Together (CaWT).

Figure 22: Time to CT scan in suspected stroke
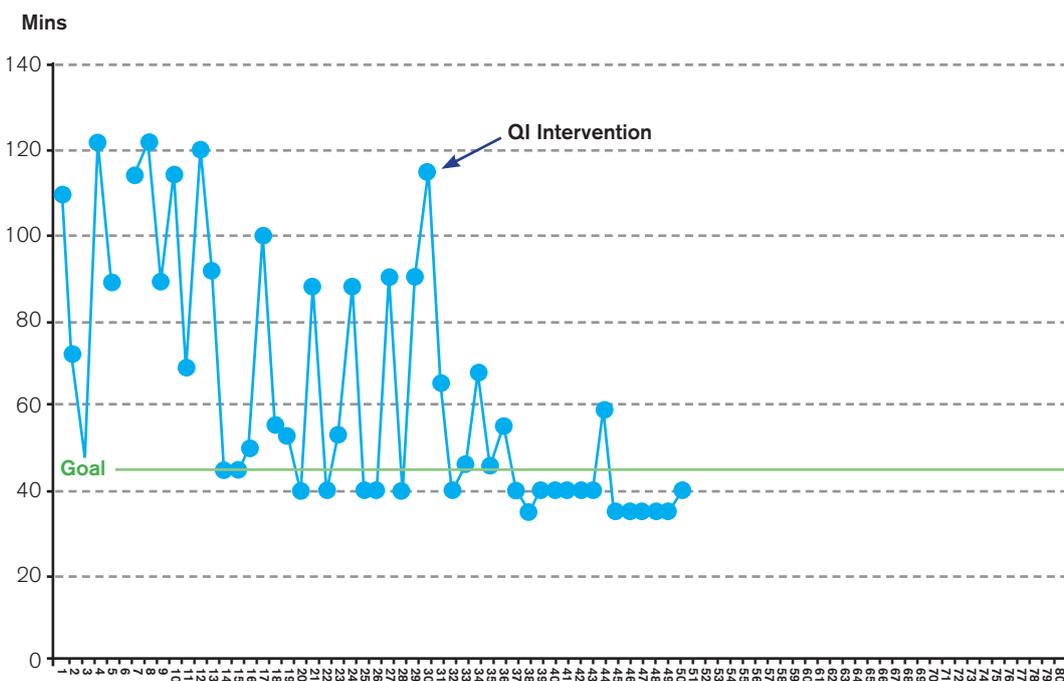
The ED collaborative has also begun work on the College of Emergency Medicine Safer Care Checklist and the development of a regional ambulance handover proforma.

Paediatrics

The HSC Safety Forum paediatric improvement collaborative has worked on:

- Improved communication – improving structured handovers, safety briefs and use of professional communication tools such as SBAR and IPASS.
- Early detection and rescue of children whose condition is deteriorating – this includes piloting the use of age-adjusted regional paediatric early warning scores and escalation protocols, and also evaluating intervention models used in other healthcare systems such as 'safety huddles' and 'watchers' to improve overall situational awareness.
- Improved arrangements to enhance medication safety for high-risk drugs.
- Medication safety in paediatrics and reducing prescription error.

Maternity care

The stated aim of the maternity improvement collaborative is to provide high quality, safe maternity care and ensure the best outcomes for women and babies. The work of the collaborative is aligned to the *Northern Ireland Maternity Strategy* and includes the promotion of normalising birth and birth choice plans using improved data from NIMATS system. Recent improvements from this collaborative have included:

- regional intrapartum and antenatal CTG evaluation stickers;
- regional in-utero transfer proforma;
- regional obstetric early warning score/escalation protocols for early pregnancy antenatal and postnatal care. An audit of this work is currently underway.
- regional vaginal examination sticker (12 month pilot).

Mental health

The mental health improvement collaborative was established in early 2014 and has agreement that HSCT teams will work on two areas of improvement:

- crisis prevention and management;
- improving the physical health needs of mental health patients.

National early warning score

As part of its leadership role, the HSC Safety Forum has led the regional implementation of the National early warning score (NEWS), including appropriate escalation arrangements to improve care of the deteriorating patient, in all HSCTs. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating HSCTs to clearly define their expectations regarding intervention when NEWS is abnormal.

NEWS was implemented across all HSCTs by November 2013 and its use has since been audited. Further work is on-going on improving the usefulness of NEWS in patients with long-term conditions.

Nursing homes

The nursing home improvement collaborative, set up in 2012, has continued its work. The first focus of improvement was on falls prevention and in 2013 the collaborative achieved a reduction in falls (rate/1000 bed days) of 25%. The falls prevention toolkit developed during this work has been made available to all nursing homes. During 2014, an additional seven nursing homes joined the collaborative and currently 18 homes are working on improving nutrition and the prevention of pressure ulcers which aligns with current RQIA inspection themes.

The graph below, based on data from one of the participating nursing homes in the collaborative, shows the effectiveness of using a quality improvement approach to implementing a falls prevention strategy.

Figure 23: Falls rate per 1000 bed days (within one of the participating nursing homes)

Falls rate per 1000 bed days

Nursing Home Collaborative commences
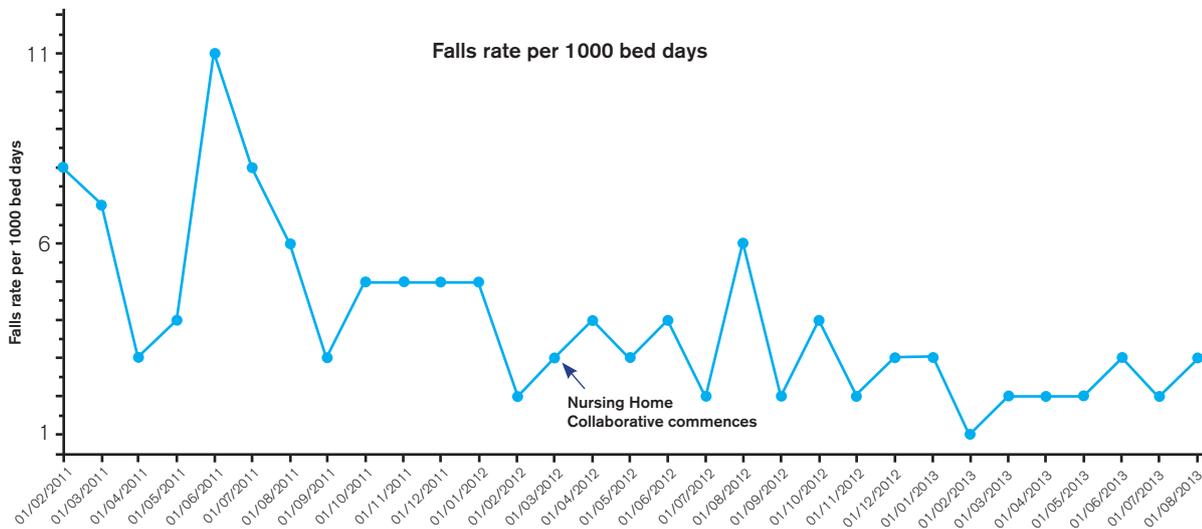
Safe nursing levels

The people of Northern Ireland are rightly demanding that they and their relatives are cared for by a workforce that has sufficient nurses with the right skills to ensure the delivery of a compassionate, safe, effective and person-centred service.

Delivering care: A framework for nursing and midwifery workforce planning to support person-centred care in Northern Ireland is the first in a series that will address a variety of settings across hospital and community care. It will provide all staff, but particularly nurses, in front line practice, management and commissioning with a toolkit which will assist workforce planning processes and support constructive conversations about nurse staffing levels in Trusts.

The framework refers to staffing ranges which are expressed as nursing to bed ratios. There are a number of assumptions which must be considered when understanding how a range is set. These assumptions are:

- assurance of safety, quality and experience – by providing assurance across a number of quality outcomes for people receiving care and treatment that proves either effective workforce planning, or conversely, a need for review of a nursing workforce staff complement;
- planned and unplanned absence allowance – this has been agreed at 24% and refers to periods of anticipated absence from work including annual leave, study leave and sickness;
- skill mix – this refers to the ratio of registered to unregistered nursing staff working within a team in an individual setting. The level of skill mix may vary depending on the setting and on the complexity of the care being delivered;
- management of recruitment – to ensure vacancies are filled promptly to maintain safe and effective care;
- influencing factors – such as ward layout, length of stay or percentage bed occupancy.

Figure 24: Normative staffing range for general and specialist adult hospital medical and surgical care settings
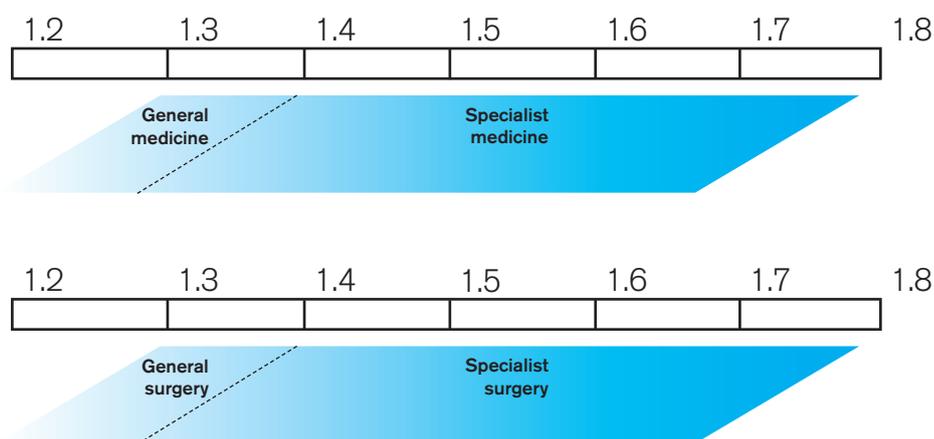
The first phase has targeted general and specialist medicine and surgery.

Figure 24 pictorially represents the range in both specialties eg a general medical ward is defined between 1.3 and 1.4 nurses per bed recognising that a small number may fall below 1.3 to 1.2 and similarly, a small number exist at the higher end of the range at 1.4.

Future phases in the development of normative staffing ranges will include frameworks for emergency departments, district nursing and health visiting.
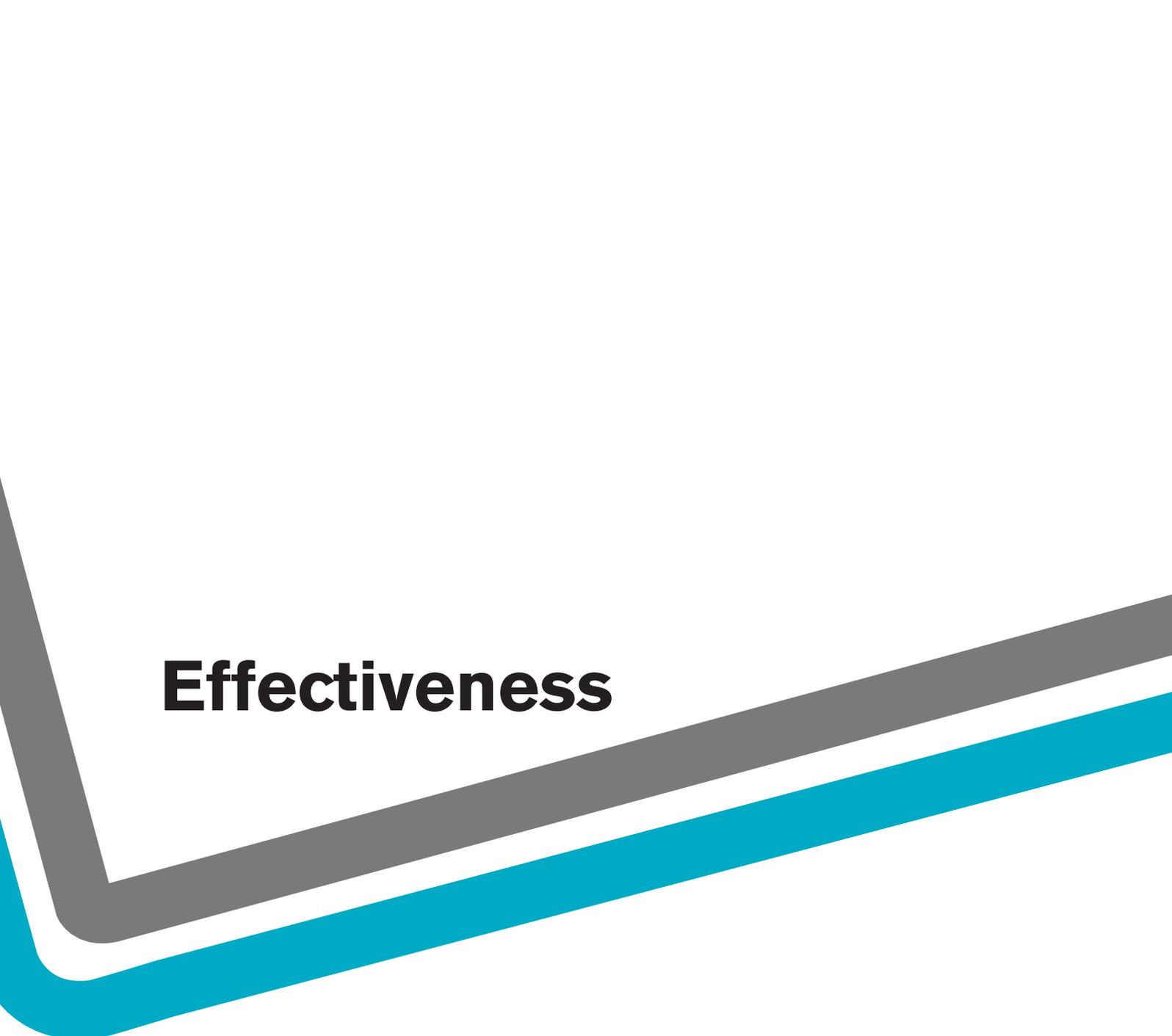
Effectiveness

Performance against targets and standards

Elective care

At the end of March 2014, 69% of patients were waiting less than nine weeks for a first outpatient appointment and 67% of patients were waiting less than 13 weeks for inpatient or daycase treatment (target: 80% by March 2014).

At the end of March 2014, 19,174 patients were waiting longer than the March 2014 target waiting time of 15 weeks for a first outpatient appointment and 4,312 patients were waiting longer than the inpatient/daycase maximum waiting time target of 26 weeks.

Figure 25: Outpatients - number waiting > 15 weeks

Outpatients - number waiting > 15 weeks
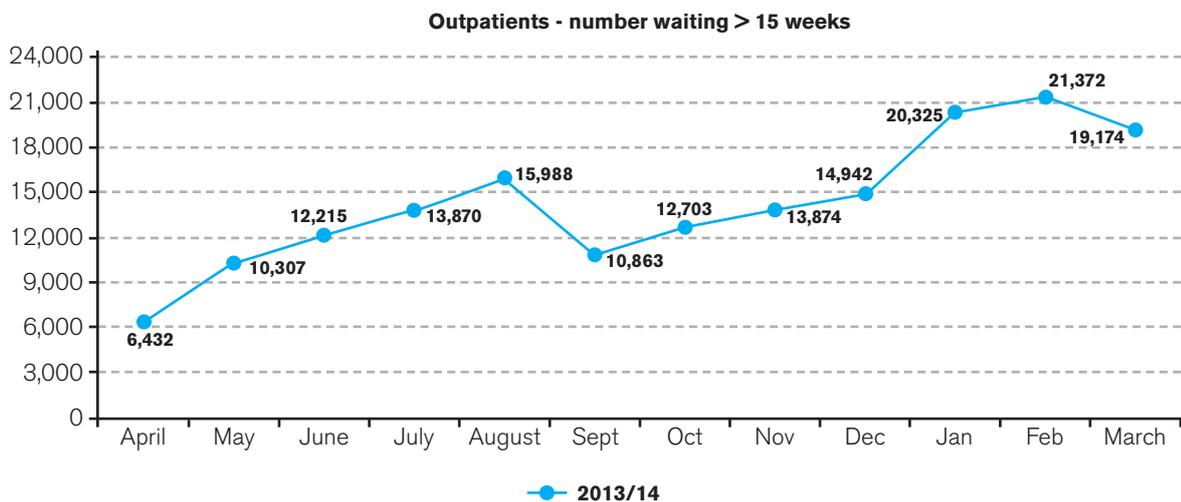
Figure 26: IPDC - number waiting > 26 weeks

IPDC - number waiting > 26 weeks
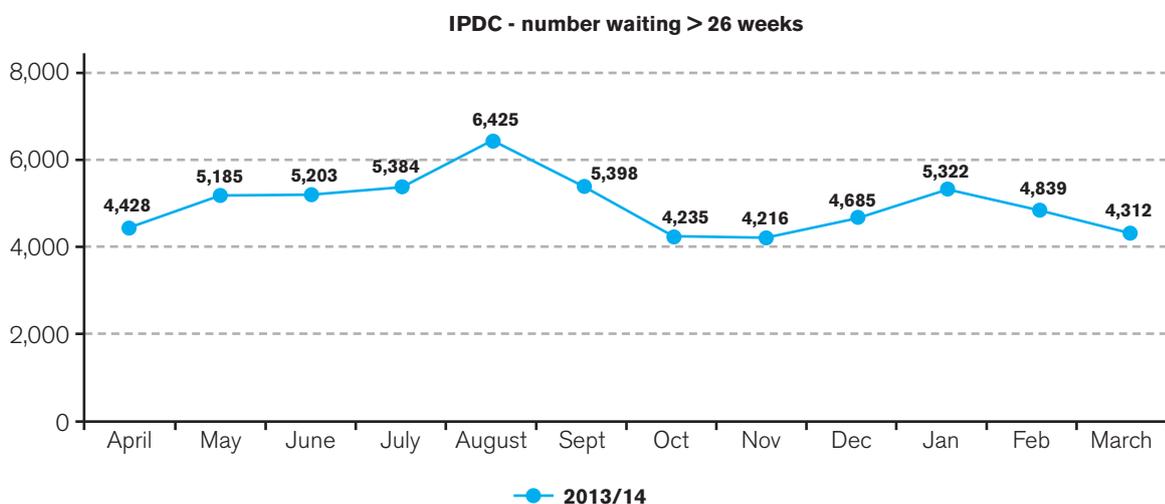
The HSCB will continue to monitor progress in reducing waiting times to improve the quality of services and outcomes for patients.

Diagnostics

Generally during 2013/14, the length of time patients waited for diagnostic tests has improved. Regionally at the end of March 2014, 7,830 patients were waiting longer than nine weeks for a diagnostic test compared to 8,731 at the end of March 2013, a reduction of 901 (10%).

Figure 27: Diagnostics waiting > 9 weeks (imaging and physiological measurement)

**Diagnostics waiting > 9 weeks
(Imaging and physiological measurement)**

Month	2012/13	2013/14
April	8,481	8,829
May	8,965	8,701
June	9,378	8,598
July	10,014	8,823
August	10,199	8,085
Sept	9,950	6,350
Oct	9,337	5,818
Nov	9,509	5,732
Dec	11,158	7,461
Jan	11,203	8,831
Feb	9,524	8,069
March	8,731	7,830
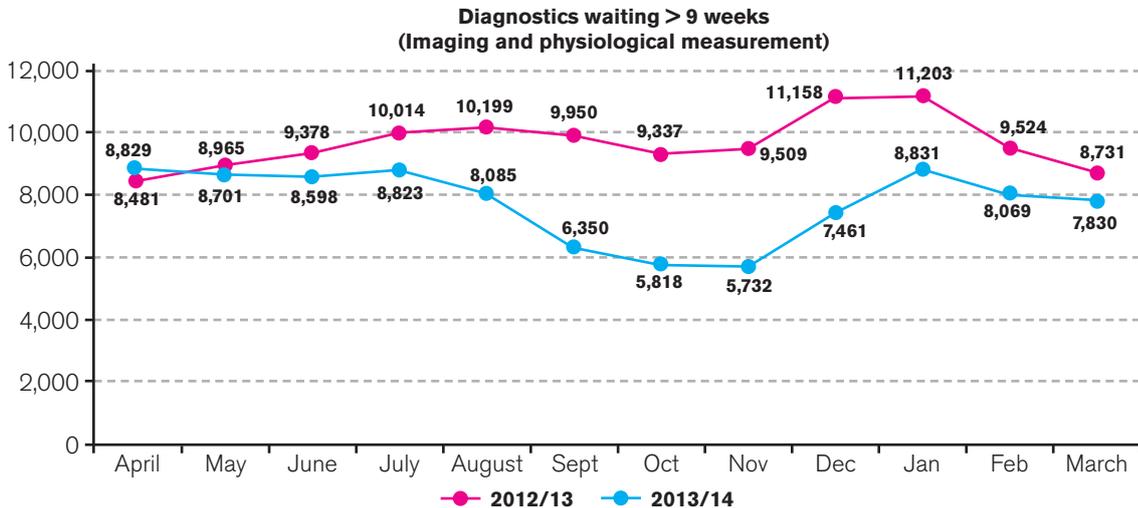
Emergency departments (4 and 12 hour performance standards)

There has been a 44% reduction in the number of patients who have waited longer than 12 hours in emergency departments (ED) during 2013/14 compared to 2012/13 (a total of 3,130 patients waited longer than 12 hours during 2013/14 compared to 5,560 in 2012/13, a reduction of 2,430 patients. Regionally, during 2013/14, the percentage of patients treated and discharged, or admitted within four hours of their arrival in ED, has remained relatively unchanged.

Continuing to reduce the length of time patients wait in ED and improving patient experience will continue to remain a top priority for the HSCB.

Figure 28: ED - number waiting >12 hours

A & E - Number waiting > 12 hours

Month	2012/13	2013/14
April	681	1,003
May	469	299
June	255	245
July	136	195
August	97	150
Sept	294	76
Oct	299	77
Nov	397	82
Dec	579	165
Jan	678	157
Feb	658	271
March	1,017	410
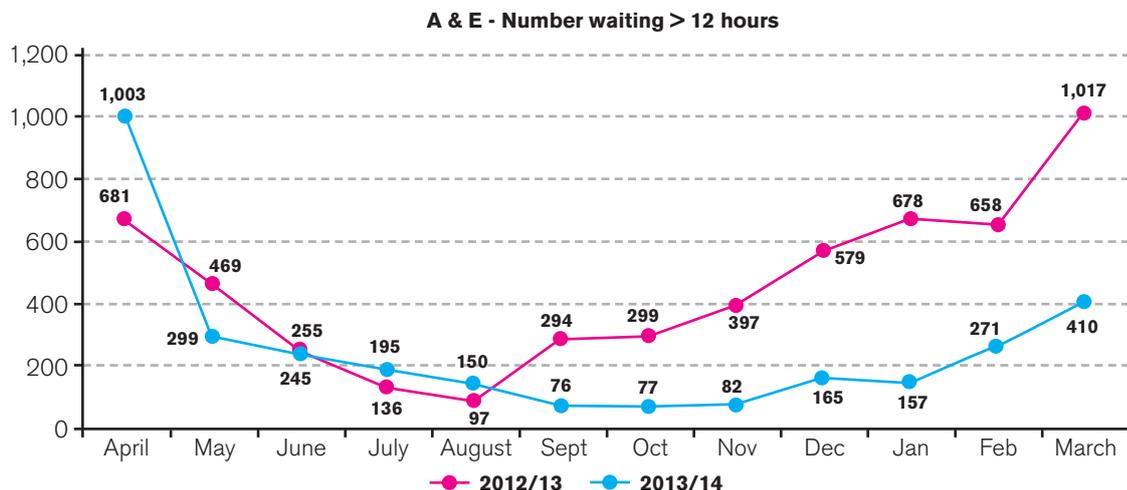
Cancer services

The length of time patients have waited for cancer treatment has remained broadly unchanged. Regionally, 82% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days and 98% of patients diagnosed with cancer received their first definitive treatment within 31 days of a decision to treat.

Improving performance in this important area will continue to be a priority in 2014/15.

Figure 29: Cancer - % treated within 62 days

Cancer - % treated within 62 days
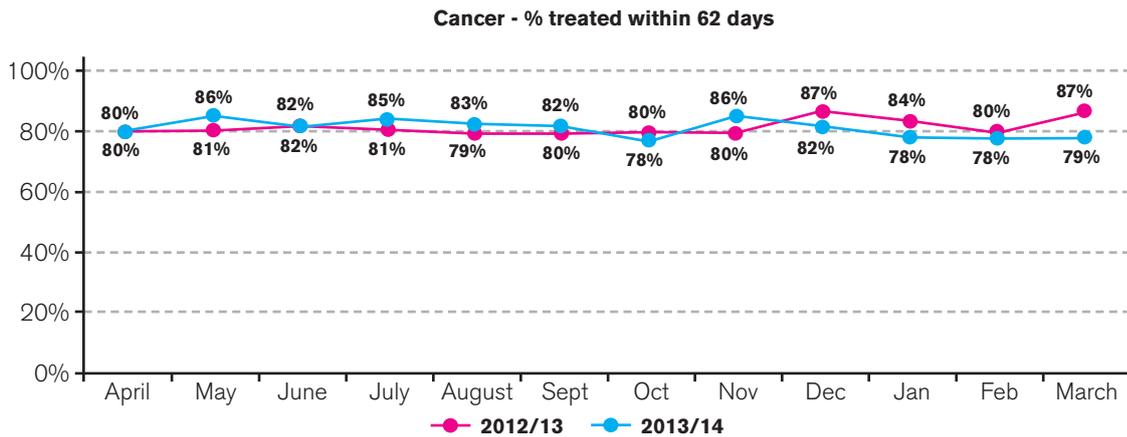
Figure 30: Cancer - % treated within 31 days

Cancer - % treated within 31 days
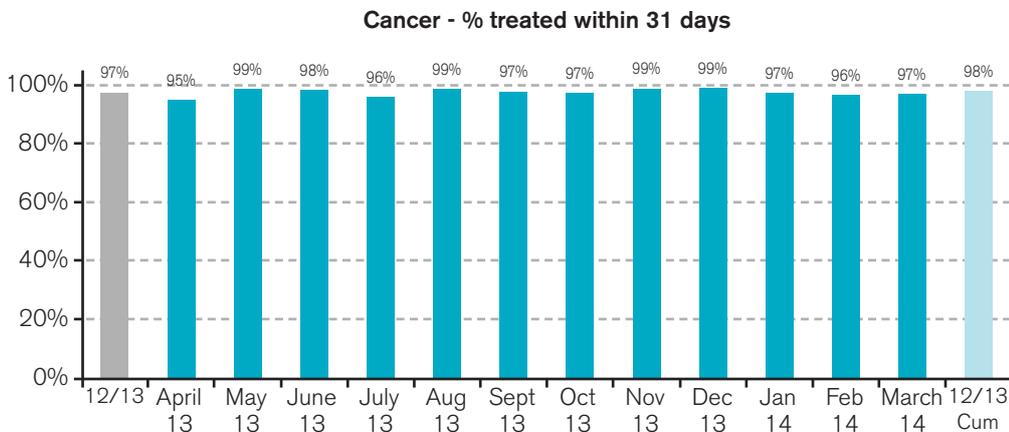
There has been a significant deterioration in the length of time patients have waited to be seen following an urgent referral for breast cancer. Regionally during 2013/14, 84% of urgent breast cancer referrals have been seen within 14 days. In particular, performance has deteriorated significantly in three HSCT areas and is largely as a result of a reported increase in demand. Actions have been put in place and the waiting times for patients will see a significant improvement.

Figure 31: Cancer - % seen within 14 days of an urgent referral for breast cancer

Cancer - % seen within 14 days of an urgent referral for breast cancer
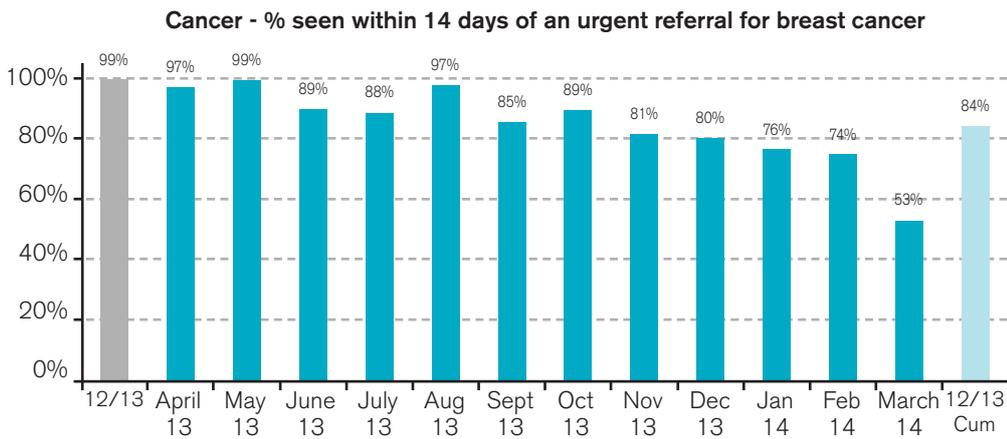
Specialist drugs

There has been an improvement in patient waiting times for specific NICE approved specialist therapies. Regionally at the end of March 2014, no patients were waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis and no patients were waiting longer than three months to commence NICE approved specialist therapies for psoriasis.

Stroke patients

The proportion of patients with confirmed ischaemic stroke who receive thrombolysis has increased in line with the Minister's 10% target.

Figure 32: % Admitted who received thrombolysis

% Admitted who received thrombolysis
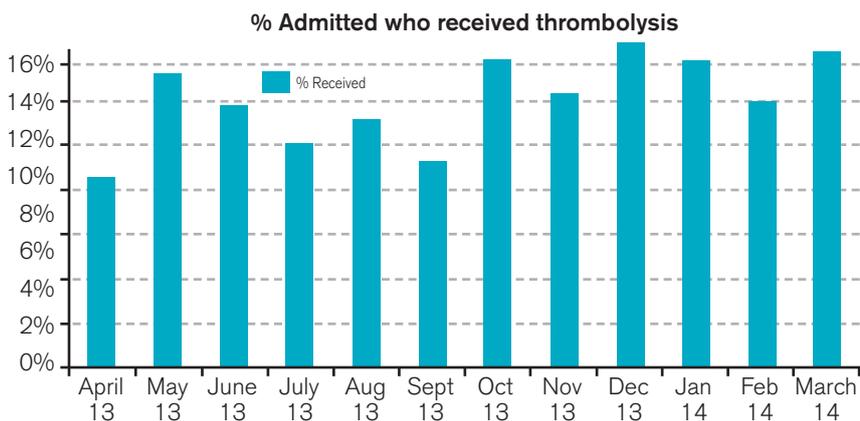
Hip fractures

During 2013/14, 86% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours. While this remains broadly unchanged from the previous year, significant improvements were made in the latter part of the year and improvements are expected to continue.

Figure 33: Fractures - % treated within 48 hours

Fractures - % of NoF 48 hours

Legend: 2012/13, 2013/14
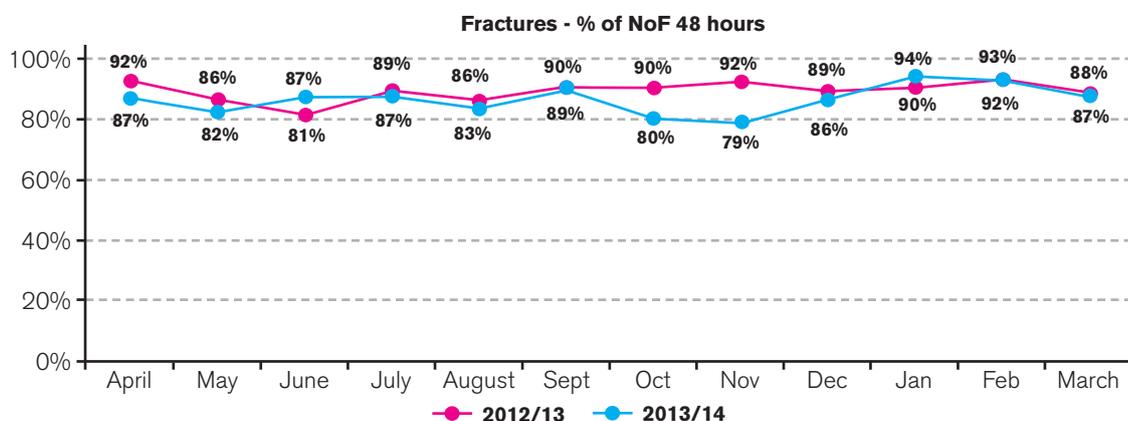
Quality assurance arrangements for screening programmes

Screening programmes aim to identify, from a population of apparently healthy (asymptomatic) people, those individuals who may be at increased risk of a disease or condition. These people can then be offered information, further tests and appropriate treatment to reduce their risk, and or any complications, arising from the disease or condition screened for.

Screening programmes are complex systems of care, often involving a wide range of services, such as call and recall services, highly specialised laboratories and provision of assessment and treatment in HSC Trusts and primary care.

The PHA is responsible for commissioning and for the quality assurance (QA) of the following screening programmes:

Adult screening programmes

- Abdominal aortic aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic retinopathy
- Surveillance screening for women at higher risk of breast cancer

Antenatal and newborn screening programmes:

- Antenatal
- Newborn bloodspot
- Newborn hearing

QA is an integral part of screening because screening can cause harm as well as good and the balance must be tipped in favour of benefits. QA aims to monitor, maintain and improve upon minimum standards of service, performance and quality across all elements of a screening programme.

Each screening programme has a QA structure to ensure standards and quality of service and to provide advice and recommendations for service improvement. This would generally take the form of a QA Committee or Regional Quality Improvement Group supported by specialty specific QA Groups who would be chaired by an appointed regional QA Lead. Each screening programme is then accountable through the PHA to the DHSSPS.

Examples of QA activity include audit, performance monitoring, QA visits, shared learning, training and linking with UK screening programmes.

QA visits undertaken by cancer screening programmes in 2013/14:

Bowel screening – South Eastern HSCT – November 2013

Breast screening – Southern HSCT – May 2013

Screening programme performance

The tables below indicate that for the majority of the screening programmes the standards and targets are being met or exceeded. Work to increase uptake is being taken forward through a number of measures including a media campaign for bowel cancer screening, advance 'teaser' letters for the bowel screening programming in the two LCG areas where uptake was lower and work on the breadth of cancer programmes to improve informed choice to participate in screening. This work has focused on those groups who find services harder to reach.

Each screening area also produces an annual report which is presented to the PHA Board.

Table 4: AAA screening data for 2013/14

Measure	Standard/target/ comparative data	Outcome
Uptake (initial)	≥ 60% (acceptable) ≥ 85% (achievable)	82%
Minimise harm (minimal rupture between detection and referral to vascular specialist)	≥ 3% (acceptable) ≤ 1% (achievable)	0%
Timely intervention (% of subjects with AAA > 5.5cm seen by vascular specialist within eight weeks)	≥ 95% (acceptable) 100% (achievable)	100%

Table 5: Cervical screening data for 2012/13

Measure	Standard/target/comparative data	Outcome
5 year coverage	80% (25-64)	78.04%
Lab turnaround (taken to authorised)	80% within 4 weeks	97%

Table 6: Bowel screening data for 2013/14

Measure	Standard/target/comparative data	Outcome
Uptake	55% in 2012/13 Commissioning directions	53.49% - April - Sep 2013. Based on a six month compliance period.
SSP waiting time	Appointment offered within two weeks of positive test result	All HSCTs are meeting the standard.
Colonoscopy waiting time	Appointment offered within two weeks of SSP appointment	All HSCTs are meeting the standard.

Table 7: Antenatal screening data for 2013/14

Measure	Standard/target/comparative data	Outcome
90% uptake of all four screening tests	NSC IDPS 2010 standards	> 99%

Table 8: Diabetic retinopathy screening data for 2011/12 (most recent data not available)

	Total invited	Total attended	%
Northern Ireland	46715	36193	77%

Table 9: Newborn bloodspot screening data for 2012/13

Measure	Standard / target / comparative data[1]	Outcome (2012/13)
Timely sample collection	95% of first samples taken 5-8 days after birth	98.0%
Timely processing of screen positive samples (PKU, CHT and MCADD only)	100% of positive screening results available and clinical referral initiated within 4 working days of sample receipt by screening laboratory.	Within 3 working days PKU - 100% CHT - 100% MCADD - 100%
Coverage (% of babies, born in and still resident, who have a conclusive test result recorded on CHS by 17 days of age)	Greater than or equal to 95% for all tests	PKU- 99.3% CHT- 98.4% MCADD- 99.3% CF - 99.2% SCD - 99.3%

Table 10: Newborn hearing screening data for 2013 (quarter 2)

Measure	Standard / target / comparative data	Northern Ireland
Coverage by 4 weeks of age (the proportion of babies eligible for newborn hearing screening for whom the screening process is complete.	Minimum 95.0% Achievable 99.5%	95.6%
Coverage by 3 months of age (the proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 3 months corrected age).	99.0%	98.9%

Table 11: Breast screening data for 2012/13

Measure	Standard/target/comparative data	Outcome
Uptake rate	Min Standard >70% Target 80%	73.9% NI
Round length	> 90% first offered appts within 36 months	83.2% NI*
Screen to assessment	> 90% within 3 weeks	90.6% NI

*Failure to meet the round length standard in 2012/13 was due to the Eastern Breast Screening Unit (BHSCT) not meeting the standard in the first two quarters of 2012/13. Round length is now meeting standard.

Promoting good nutrition

Ensuring patients receive the right nutritional care; at the right time; in the right place; with the best outcome.

Malnutrition is a condition that occurs when a person's diet does not contain the right amount of nourishment. It means 'poor nutrition' and can refer to:

• undernutrition – when you don't get enough nutrients;
• overnutrition – when you get more nutrients than you need.

Cost of malnutrition

• **£13billion to the UK in 2007**
• **This is double the amount spent on overweight and obesity**
• **29% of patients admitted to hospital in Northern Ireland are at risk of malnutrition**

The *Promoting Good Nutrition (PGN) Strategy in Northern Ireland* aims to improve the quality of nutritional care of adults who at risk of or who are malnourished.

Most people at risk of malnutrition or who are malnourished have their needs met by 'food first' approach, a smaller number require oral nutrition supplements, fewer still need entera (tube feeding) nutrition and a small minority require parenteral (via vein) nutrition. The 'food first' approach is the term used for general dietary guidance to improve food intake.

It includes approaches such as:

• increasing food frequency;
• modifying food intake;
• fortifying foods to increase the consumption of energy and nutrient-dense foods.

'Food first' advice has been developed to support the implementation of the PGN and is available through the link below:

www.dhsspsni.gov.uk/pgn-must-cs-food-first-leaflet.pdf

To ensure that people on oral nutritional supplements have had access to the correct assessment and education, the HSCB and PHA have worked in together in developing the medicines management dietitian team (MMDT).

This team, along with general practice, identifies and assesses individual adult patients who are prescribed oral nutritional supplements (ONS) but are not under the care of HSCT dietetic services.

Patients will have a dietary assessment undertaken in the clinic, in their own home or in care home by the MMDT. They will provide individualised dietary advice to patients and their carers. The team also provides support and educate to health care professionals in GP practices, care homes and community pharmacies around identification and management of malnutrition.

As of 31March 2014, the MMDT have completed dietetic assessments in 24 practices (484 patients) across the region. In 62% of cases, food fortification was used to meet patients' nutritional requirements and prescriptions for nutritional supplements were stopped with patient's agreement. Changes to the amount and or type of oral nutritional supplements were changed in a further 14% of patients with their agreement.

National Institute for Health and Care Excellence (NICE)

NICE is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It produces different types of guidance, including Technology Appraisals (new drugs, medical treatments and therapies) and Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions)

The HSCB have put in place processes to ensure that all Technology Appraisals and Clinical Guidelines approved by NICE and endorsed by the DHSSPS are implemented within Northern Ireland.

During 2013/14, the HSCB issued 30 Technology Appraisals and 64 Clinical Guidelines for implementation.

More information about the technology appraisals and clinical guidelines that are being implemented can be found at www.hscboard.hscni.net/NICE/

The HSCB produce an annual report which provides greater detail on the roles, processes and timelines associated with the implementation of NICE guidance. The report can also be found on the HSCB NICE webpage.

Social Care Institute for Excellence (SCIE)

SCIE is a leading improvement agency and independent charity that works to improve the quality of care and support for adults and children. It has established a collaborating centre for social care to produce guidance on social care on behalf of NICE. This is a new initiative and so far NICE has published quality standards for the following topics:

- Autism
- Health and wellbeing and looked after children
- Mental wellbeing of older people in care homes
- Supporting people to live well with dementia

Service frameworks

Service frameworks are an important driver in relation to improving quality for the planning, commissioning and delivery of services in Northern Ireland frameworks have been developed for key areas of health and social care. They set out, at a strategic level, the type of service that patients and service users should expect. These frameworks are lined to good practice guidelines and will promote and secure better integration of service delivery across the whole pathway of care, including disease prevention, diagnosis, treatment, rehabilitation and end of life care. The following service frameworks are currently progressing in Northern Ireland.

Mental health

The mental health service framework is helping to reduce variation between mental health services/service models within Northern Ireland – it is therefore helping to ensure that people living with mental health problems get access to the same level of care no matter where they live in Northern Ireland.

Service users told us they wanted services that focused care on supporting recovery and building the resilience of people with mental health problems rather than just treating or managing their symptoms. This has resulted in the development of more 'recovery' based mental health service provision. This is being taken forward regionally through the implementing recovery through organisational change initiative (ImROC).

Learning disability

The service framework for learning disability has been developed over the past 3 years. Service users, carers and families were involved in this development and the standards were widely consulted upon.

The aim of the service framework is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion and reducing inequalities in health and improving quality of care. There are nine standards which encompass inclusion in community life, at home in the community and ageing well.

An estimated 69% of people with a learning disability known to GP practices are receiving an annual health check as a result of the framework.

Older people

The service framework for older people was launched in September 2013 and will cover the three year period from 2014–2017. It aims to improve the health and wellbeing of older people, their carers and families by setting 46 standards in relation to:

- person-centred care;
- safeguarding;
- conditions more common in older people;
- transitions of care.

- health and social wellbeing improvement;
- carers;
- medicines management; and

Cancer

This framework was the strategic driver for the introduction of a screening programme for bowel cancer. It was fully implemented with the age extended to 74 years from April 2013. Early indications are that this is resulting in earlier diagnosis of bowel cancer which will help to improve the outcomes and survival for people who are found to have bowel cancer.

The framework has resulted in the introduction of the Human Papilloma Virus (HPV) immunisation programme for girls aged 12–18 which will reduce the incidence of cervical cancer for future generations of women.

The framework has also resulted in the introduction of new treatments (eg a type of radiotherapy called brachytherapy) and diagnostic test across a number of cancer types which have led to improved diagnosis and treatment.

Anyone with a suspect or confirmed diagnosis of cancer has their care and treatment discussed by a multidisciplinary team. All of these teams work to a common set of standards. These standards ensure that patients get the best possible care no matter where in Northern Ireland they live.

The introduction of the cancer survivorship programme has begun to change how we provide follow up for patients who have survived cancer. We are now moving from a model of follow-up which focused solely on physical symptoms and illness, to one that looks at health and wellbeing. A new regional cancer survivorship website has been set up to allow patients and families to see what support services are available in their area.

Respiratory

In response to patient comments a new oxygen contract was negotiated to procure more portable equipment enabling patients to get out and about more easily. This has resulted in a much better quality of life for those requiring oxygen.

Patients have told us that pulmonary rehabilitation programmes have greatly improved their quality of life and would like them to continue for longer than the 6 week programme. While the evidence supports the six weeks programme we have established a range of 'follow on' exercise and social support groups for people to be supported when the programme finishes. We have also increased access to pulmonary rehabilitation programmes across Northern Ireland.

Cardiovascular

The 2009 framework aimed to increase the number of living kidney donor transplants to 18 per year in Northern Ireland. We have actually achieved 50 per annum. The programme in Northern Ireland is now the most successful of its kind in the United Kingdom. Not only has it transformed the lives of individual patients, but it has also led to a levelling off in demand for hospital dialysis, a service which had previously been growing year on year.

The stroke thrombolysis rate in Northern Ireland now matches the rate in the rest of the UK. Primary percutaneous coronary intervention (PPCI) was established in September 2013 giving people who experience acute coronary artery blockages immediate access to medical intervention.

Children and young people

A draft service framework for children and young people has been developed during 2013/14 by the HSCB and PHA. The framework sets standards aimed at improving birth outcomes; supporting child development across the life course; improving the management of short and long term medical conditions; promoting positive mental health and emotional wellbeing; and improving the care provided to children with disability and children and young people in special circumstances.

The draft framework was submitted to the DHSSPS on the 14 May 2014 and will go out for public consultation before being launched by the Minister for Health. The framework will be implemented over three years.

Social care

The HSCB Directorate of Social Care and Children's (DSCC) primary duty is to ensure the social welfare of the population of Northern Ireland. We do this by commissioning social work and social care services which are provided mainly by the HSCTs and are delivered by social workers and social care staff.

Social work and social care services are there to help individuals take control and make choices that enable them to have lives that are comfortable and fulfilled. Social work and social care services place an emphasis on those individuals who require a certain level of extra practical and physical help, and intervention which often has to focus on safeguarding and the protection of health and well-being.

The efforts of those involved in social work and social care can be seen throughout many different communities across the whole of Northern Ireland. As a specialist profession dedicated to effecting social change for the better, social work constantly seeks to address and resolve the challenges faced by vulnerable individuals or those made vulnerable by their social circumstances. As the commissioner of these services, the HSCB is in a constant cycle of reviewing goals and searching for ways to improve the quality of life and achieve the best possible results for the population we serve.

Improving and safeguarding social wellbeing: a strategy for social work in Northern Ireland

The first strategy for social work in Northern Ireland was developed in response to a number of key challenges that threaten to compromise the quality of social work in Northern Ireland, including: growing and changing demand and need; major changes in the health and social care system; resource pressures and the need to make the best use of resources; and high, and at times unrealistic, expectations about social work. To this effect, the social work strategy has identified 10 priorities that will build upon strong foundations to increase the quality of social work across three broad themes: strengthening the capacity of the workforce; improving social work services; and building leadership and trust.

These are encompassed within a framework for social work practice which is illustrated below:

Figure 34: A framework for social work practice

Social work is a skilled profession that works to improve and safeguard the social wellbeing of individuals, families and communities by promoting their independence, supporting their social inclusion and participation in society, empowering them to take control over their lives and helping them to keep safe.

Quality in social care

Identifying and ensuring quality in social work and social care is a complex task. The bedrock of all social work is based on relationships. Effective communication, a non-judgemental approach, building trust and maintaining strong relationships are crucial to enabling change. Social work is therefore practised, whenever possible, in partnership with children, adults, families, communities and other agencies.

Although quality in social work and social care can be difficult to pin down, there are a range of quality measures that can be applied. A key feature of the quality of services is focused on the experience of users, families and experienced staff. Where services are being delivered in partnership the experience of communities will also inform quality. Social care services involve close interaction between the service provider and the user so the central role and relationship between the two become fundamental to any assessment of quality.

Children and young people

The Northern Ireland strategy for children and young people *Our children and young people: Our pledge*, sets out six outcomes for all children. These outcomes inform the work of the HSCB, PHA and the multi-agency children and young people's strategic partnership.

Two of these, 'enjoying learning and achieving' and 'experiencing economic and environmental wellbeing' have informed our focus on the outcomes for care leavers.

Following an investment in employability workers we have been able to sustain the percentage of care leavers in education, training and employment between 75% and 78% over the past five years. This has significant outcomes for our young people.

Figure 35: % of care leavers aged 19 who are in education, training or employment
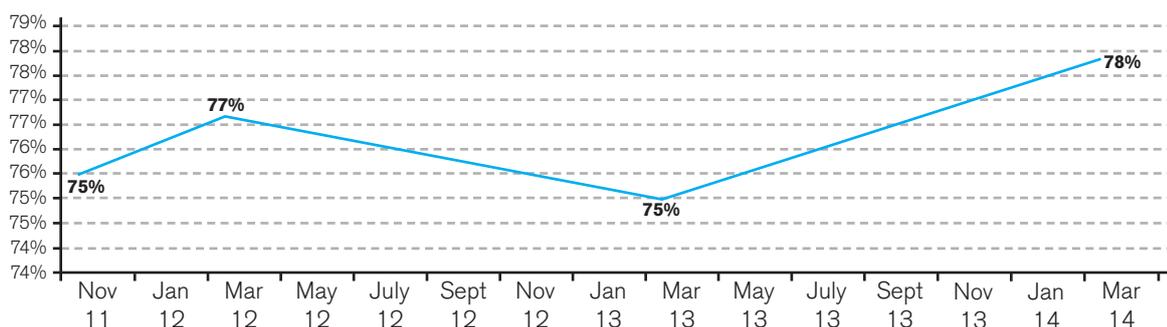
The reason for the majority of care leavers not being in education, training or employment is being unemployed, sick or disabled or pregnant. These care leavers are prioritised in being offered opportunities under the dedicated employability scheme working in each Trust.

Mental health and learning disability

The resettlement of people from long stay hospitals has been a programme supported by the HSCB and PHA to ensure that individuals have the opportunity to live in community settings, thus promoting greater independence and social inclusion.

Table 12: The number of people resettled in community settings

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	Total
Learning disability	39	36	14	27	24	42	74	256
Mental health	7	86	56	38	25	27	29	268
Total	46	122	70	65	49	69	103	524

Since this commenced in 2007 people have started a new life outside a hospital setting.

In addition to achieving this target the HSCB, through the community integration project, has adopted quality of life measures to assess the outcomes for those individuals with learning disability who have been resettled.

These measures are used to ensure that there is improvement in the lives of people being resettled once they are in the community and that the commitments given to the people and their families are realised.

Independent advocacy organisations are involved in completing the measures alongside staff in hospital and community settings for each individual who is undergoing resettlement.

The measures include:

* relationships/friendships;
* choice;
* safety;
* being part of the community.

The Patient Client Council published a report in 2013 on the experiences of people with a learning disability and their families who felt that their lives had improved since leaving hospital and they enjoyed their new surroundings.

Adult services

Since March 2010 the number of people receiving direct payment has increased from 1,678 to 2,482. Direct payments allow people to choose cash payments in lieu of services and as such support greater independence, flexibility and personal choice. By using direct payments, people can develop a package of care that best meets their own individual needs and which gives them greater control over the services they receive. The increasing numbers of people receiving direct payments is welcome and is evidence of the growing awareness and interest in this approach to meeting need. The HSCB is committed to the promotion of direct payments as one of the means by which people can access to the support they need.

Figure 36: Number of people receiving direct payments (all Programmes of Care)
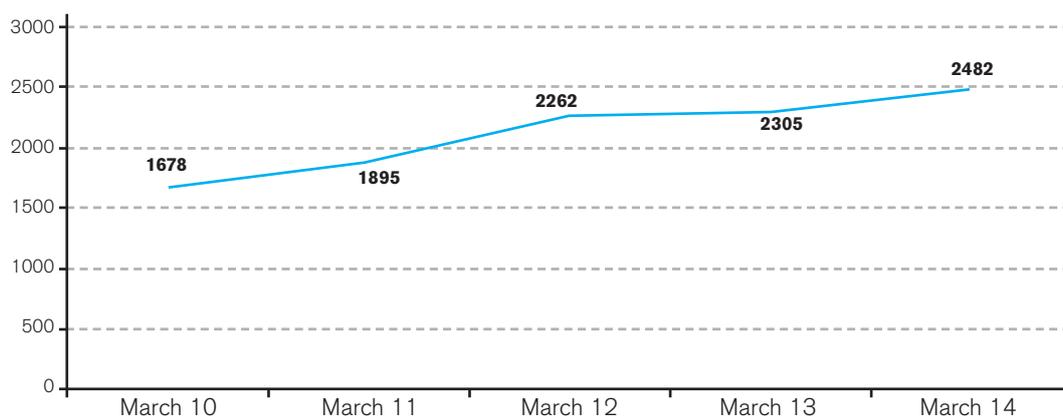
Statutory reporting

Within our comprehensive reporting on delegated statutory functions more emphasis is being placed on areas where the HSCTs are experiencing difficulty in delivering expected services and how these challenges are being addressed. Specific reporting is also required in each Programme of Care describing the actions HSCTs take to adopt a human rights based approach in their service delivery.

Research

To be at the leading edge in the design, commissioning and provision of quality services requires an 'excellence' approach, whereby research, evidence and critical appraisal and reflection are promoted throughout the whole organisation.

With support from senior managers we are putting in place a social work research strategy (2015-2020). This is an ambitious plan which will contribute to the development of a workforce with the capacity and confidence to understand the centrality of research evidence in developing and sustaining quality services. Our social work staff will be supported to develop the skills of applying the knowledge about what works, in what settings and with whom to promote quality.

Supervision

For social workers to be more effective they need to receive good quality supervision. Supervision must enable social workers to build effective professional relationships, develop informed practice, and exercise both professional judgement and discretion in decision-making. For supervision to be effective it needs to combine performance management with a strong reflective element to improve the quality of practice and allow staff to understand the dynamics of their relationships with service users when not simultaneously engaging with them.

All social workers must receive professional supervision and we are currently refining the regional standards for training professional supervisors, and have set new requirements for all POCs which are being rolled out across all HSCTs.

Risk

Accepting that it is difficult to disentangle the providers' influence on the quality of service due to the unique interaction and relationships that exist with the user, we are beginning to look at better ways to understand the quality of the decisions social workers make. The high degree of service diversity means that there are elements of uncertainty in all decision making, and we must accept that sometimes harm will occur, no matter how good the decision making. Often the decision is judged by the outcome, not by the process.

We are taking forward work to develop a systemic approach within decision making that establishes the precepts by which professional risk taking will be judged. This is not to condone poor practice, but to allow us to learn and improve the overall quality of decision making.

Practice learning opportunities

Practice learning opportunities (PLO) are an essential part of preparing students to be eligible to register and work as qualified and accountable social workers.

The regional strategy for practice learning provision in Northern Ireland has a target that every social work student at level 3 will have a PLO with a social work practitioner based on site and every social work student at level 2 will have experience of working alongside other social work practitioners during their PLO. This is based on an evidence base that such proximity to direct social work practice enables students to acquire the required standard of proficiency in practice and prepares them to undertake the full range of professional activities expected of a newly qualified social worker.

Since 2011, each Trust has developed their practice learning provision to ensure this qualitative target is achieved with 100% compliance at both levels.

Table 13: Experience of working alongside other social work practitioners during their PLO.

	Aug 2011 & Jan 2012	Aug 2012 & Jan 2013	Aug 2013 & Jan 2014
BHSCT	98%	100%	100%
NHSCT	100%	100%	100%
SEHSCT	91%	100%	100%
SHSCT	100%	100%	100%
WHSCT	100%	97%	100%

Patient client focus

Complaints and service user feedback

The HSCB is required to monitor how they or those providing care on their behalf deal with and respond to complaints. The HSCB maintains oversight of all complaints received by the Family Practitioner Services (FPS) and HSCTs.

Family Practicioner Services

Table 14: Subject of complaints received by FPS

Subject of complaint	Number received
Clinical diagnosis	9
Clinical treatment	1
Communication	62
Confidentially	3
Date for appointment	1
Failure to follow agreed procedures	1
Other	17
Records	1
Policy and commercial decisions	3
Premises	3
Staff attitude	42
Staff availability	2
Treatment and care	182
Total	**327**

Table 15: Complaints received by Family practitioner services (FPS)

Complaints received by FPS			
Year	Local resolution	Honest broker	Total
2009/10	213	38	251
2010/11	216	86	302
2011/12	212	70	282
2012/13	247	116	363
2013/14	255	72	327

The majority of 'honest broker' complaints each year are regarding general practitioners (57 during 2013/14).

While the total number of complaints received from FPS practices has decreased slightly this year, an increased number of practices approached the Board for advice and assistance in helping them resolve complaints at local level.

The top three subjects of complaint are; staff attitude, communication and treatment and care.

Table 16: Top three subjects of complaints to FPS

Top three subjects of complaints	2009/10	2010/11	2011/12	2012/13	2013/14
Treatment and care	100	122	106	131	182
Staff attitude	71	90	88	93	61
Communication	21	52	53	79	42

Health and social care trusts

A total of 6,836 issues of complaint were received by the six HSCTs during last year. This continues the increasing trend of complaints and compares with 4,733 received in 2009/10, 5,053 in 2010/11, 5,485 in 2011/12 and 5,998 in 2012/13.

Table 17: Top three subjects of complaints to HSCT

Top three subjects of complaints	2009/10	2010/11	2011/12	2012/13	2013/14
Treatment and care	1159	1294	1290	1562	1691
Staff attitude	790	772	857	913	1103
Communication	498	528	726	787	896

Facts and figures

Last year we received the following number of complaints:

• 6836 from HSCTs
• 327 from FPS
• 255 resolved through local resolution
• The Board acted as 'honest broker' on 72 occasions
• 4 resolved by an independent Lay Person
• 9 concerning the HSCB
• 0 concerning the PHA

Learning arising from complaints

The board welcomes and encourages complaints, using feedback to ensure learning and service improvements are made.

Learning arising from complaints has identified:

• the requirement of training programmes regarding the administration of drugs for domiciliary care staff;
• the importance of early recognition of a stroke to ensure patients are assessed quickly for thrombolysis;
• 'promoting positive attitude' has been proposed as a work stream within the Quality 2020 work plan.

Service user feedback

Last year two service user focus groups were held which were aimed at those who had either made complaints since April 2009, or wanted to, but did not. Service users were asked to express their views in relation to the HSC Complaints Procedure, identifying what works well, what does not and how the procedure can be improved.

Feedback collated so far has demonstrated that service users have a lack of awareness of the complaints procedure and what advocacy support is available within the process. A complaints awareness campaign was conducted during June 2014 to ensure that service users are aware of how to make a complaint, what support services are currently available and where they can access additional information.

Next steps

A new complaints leaflet has been designed with clear and concise information, explaining to the public 'how to make a complaint' and to whom. The leaflet will be provided to members of the public at 'complaints awareness posts' which will be scheduled across Northern Ireland in a variety of non-health care facilities. Additional focus groups will be held across Northern Ireland during 2014 as a means of continually receiving service user feedback.

Making the difference

When we are in need of healthcare, we are often at our most vulnerable. Therefore we want to ensure that throughout the entire patient experience people are treated with compassion, dignity and respect.

The PHA lead on the monitoring and implementation of the DHSSPS Patient and Client Experience Standards and a comprehensive programme of work is in place with all six HSCTs to support the implementation of these standards.

Patient and client experiences provide vital information on how services are working for those who use them. Therefore a triangulated approach has been adopted to gather patient and client experiences across a range of settings through questionnaires, patient stories and observation of practice.

DHSSPS patient and client experience standards:

- **Respect**
- **Attitude**
- **Behaviour**
- **Communication**
- **Privacy and dignity**

Following analysis of this information; the PHA identified four key regional priorities for improvement which patients had said would make a difference to their experience:

- Staff introductions
- Interruptions during treatment and care
- Communication and information
- Meals and drinks

HSCTs have identified a range of improvements to address these themes.

1. **Staff introductions** were highlighted in all HSCTs as requiring improvement. The HSCB, PHA and HSCTs have endorsed the 'hello my name is' campaign to highlight the importance of introductions to patients. Plans are in place to officially launch this campaign in 2014.

hello my name is…

This campaign was launched by Dr Kate Granger, a medical registrar from Yorkshire, who has terminal cancer. She noted that staff were so busy caring for patients that they often forgot to introduce themselves before beginning to administer the care and started a campaign to highlight how simple introductions can go a long way to making patients feel at ease and is the first step in providing compassionate care.

2. To further improve communication, all HSCTs have established plans in place to secure **name and designation badges** for frontline staff.

3. Knowing **'who was looking after you'** has continually been identified as being important to the patient/client experience. All HSCTs have developed processes to ensure that the nurse in charge of the ward, on each shift, will undertake to speak to each patient to reflect on their experience.

4. **Meals and drinks** were also highlighted by patients as an area for improvement; all HSCTs have implemented measures to 'protect mealtimes' so that staff are available to provide assistance to patients when required.

During 2014/15 the HSCTs will continue to focus on priorities and provide assurance to the PHA on the implementation. Emerging themes which have been identified locally in order to identify sustain improvement.

10,000 Voices

10,000 Voices is an initiative that was established to give patients, carers and their families the opportunity to share their experience of health services and highlight what was important to them. It is an opportunity for patients to shape the way services are delivered and commissioned; building on the current work on patient and client experience.

Phase one of the initiative began in September 2013 and focused on unscheduled care services (GP out-of-hours service, minor injuries units, emergency departments and the Northern Ireland Ambulance Service).

Phase two commenced in February 2014 and focused on services which are provided for patients in their home.

A survey aimed to gather experiences of nursing and midwifery experiences is currently running alongside phase one and phase two of the project. In addition a bespoke survey has been designed to gather experiences specifically for the Northern Ireland Ambulance Service (NIAS).

Last year, over 3,000 patients, clients and carers took the time to tell us their story.

Examples of actions to date throughout HSCTs include:

- Development of a teaching pack about experience-led commissioning, this has been delivered to student nurses and medical students;
- Improved information for patients while waiting;
- More pillows and blankets made available in EDs;
- Increased cleaning regimes and checks in waiting areas;
- Increased portering and security patrols in ED waiting areas;
- Development of service user group in EDs;
- Review of the management of babies and young children in EDs.

Personal and Public Involvement

We know that Health and Social Care (HSC) services are better quality and more responsive to need when working in genuine partnership with users, carers and communities. In 2009 the HSC Reform Act introduced a new statutory duty of involvement for all the main HSC bodies. This requires them to involve people at a personal and public level in making decisions about service design and delivery.

> **Personal and Public Involvement (PPI)** is about involving and empowering people and communities to give them more confidence and more opportunities to influence the planning, commissioning, delivery and evaluation of services in ways that are relevant and meaningful to them.

In 2009, the Public Health Agency was given lead responsibility for PPI implementation across HSC in Northern Ireland. To date, the PHA PPI Team has focused on:

- **Engaging partners and sharing good practice** – to provide leadership and support to drive forward PPI in Northern Ireland, the PHA established the Regional PPI Forum with representation from all HSC organisations, service users and carers.
- **Developing PPI training** – to support organisations to increase awareness and develop the skills to undertake PPI.
- **Supporting PPI in practice** – investing £300,000 to support PPI projects across Health and Social Care organisations, of which a number have received recognition for good practice. For example the BHSCT, AHP services have worked closely with service users to produce on-line resources to share information with health and social care professionals on choking while eating and drinking. Regionally, the Neonatal Network engaged with service users to strengthen the Network and input into the development of the care pathway.
- **Developing indicative PPI standards for the DHSSPS** - to guide HSC organisations and provide a tool to measure progress on how we are involving people and communities the foundations. A standards workshop was held in November 2013 which brought together HSC organisations, service users and carers to identify the key components for PPI standards.

The HSCB and PHA recognise that PPI is core to the effective and efficient commissioning, delivery and evaluation of Health and Social Care Services. All commissioning teams and local commissioning groups actively consider PPI in all aspects of their work.

There are many examples of good practice:

- Lifeline is a project led by the PHA to provide crisis support to people who are at risk of suicide. Service users and carers have been recruited to sit on the Lifeline clinical and social care governance group contributing to their decision making process.
- Integrated care partnerships (ICPs) - recruitment of service users and carers has been undertaken. A minimum of two service users will be actively involved on the partnership committees and the working groups.

- Promoting the needs of looked after children through the active participation of young people and carers of looked after young people, in the development of a personal health journal called *About Me* which has helped to shape the development of services.

- Northern Ireland Formulary Pharmacy and Medicines Management - The HSCB has run a series of public workshops in relation to medicines. Feedback from service users and carers has shaped the production of a number of patient leaflets aimed at improving medicines safety and compliance and reducing waste: Your Child's Medicines; Medication Reviews; Your Medicines – Your Responsibility (adult); Your Medicines (partners in care).

However, we also acknowledge that there are still areas where we can strengthen what we do and the PHA and HSCB are working together to implement the joint strategy developed in 2012 and increase the capacity of both staff and service users to become involved.

Staff health and wellbeing

The HSCB and PHA are determined to invest in the development of our staff and the creation of a working environment that enables everyone to make their best contribution. The HSCB and PHA employ over 900 staff (590 in HSCB and 320 in PHA) throughout Northern Ireland and recognise that their employees are their greatest resource.

The percentage absence in respect of staff sickness for 2013/14 was 3.36% for the HSCB and 3.56% for the PHA; this was a reduction for both organisations from 2012/13.

Sickness absences have an impact on quality, productivity and affect service delivery and are therefore an important factor when measuring an organisations culture of quality.

The PHA and HSCB have taken a number of steps in order to reduce staff sickness rates and increase productivity by promoting a healthier organisational culture. These include:

Staff health fairs

During 2013/14, HSCB and PHA staff in each of the four main HSCB offices were provided with an opportunity to participate in an annual Health Fair which had been organised by occupational health and human resources, BSO. This provided staff with a range of information on how to improve their health and wellbeing.

There was a wide range of exhibitors and occupational health nurses carried out cholesterol and blood pressure checks.

Over 80% of staff who attended the health fair reported that the health information they received would encourage them to make lifestyle changes such as improving their diet, increased exercise, improved mindfulness.

Health fair exhibitors

- Blood pressure checks
- Cholesterol checks
- Information sessions:
  - an introduction to mindfulness
  - an introduction to self-care at work

- Information on:
  - healthy eating
  - cycle to work scheme
  - drugs and alcohol consumption

- Information from:
  - Care Call
  - Cancer Research
  - physiotherapist
  - LA Fitness
  - Staff Services

The cycle to work scheme

The cycle to work scheme supports the public health strategy by encouraging staff to take physical exercise and the consequential improvement in their health. It also supports environmental improvement for all in Northern Ireland.

Health and Social Care Board

A key theme of the *HSCB Corporate Plan* is to "…maximise the potential of our staff by ensuring that they are skilled, motivated and valued".

The HSCB *Human Resources Strategy* is underpinned by policies and guidance including flexible working policies to enable staff to achieve a work/life balance. The attendance at work protocol has been developed in recognition of the critical contribution that the health and wellbeing of the workforce is to the effective functioning of the organisation.

An occupational health service is available to all staff, which may be accessed through self or managerial referral, and provides professional advice on work-related health and safety and wellbeing issues affecting employees, as well as on fitness for work.

In recognition of the importance of mental and emotional health and wellbeing in the workplace, Carecall, a commercial subsidiary of the Northern Ireland Association for Mental Health, provides a service to all staff and its employee assistance programme includes Freephone 24 hour immediate support as well as structured face-to-face counselling. Staff may also avail of a number of joint wellbeing programmes organised by PHA or BSO.

An annual programme of health and safety training was delivered to HSCB, PHA and BSO staff located in a main HSCB office.

In order to encourage staff to take physical exercise, a small gym is located in 12/22 Linenhall Street for use by HSCB, PHA and BSO staff.

Staff appraisal

The HSCB has implemented an appraisal scheme for staff which provides each individual with: an understanding of their role and contribution to the organisation; identifies specific training and personal development needs of staff which ensures they are able to maximise their contribution to the objectives of the organisation. The scheme also demonstrates the commitment of HSCB to equality and diversity.

Public Health Agency

The PHA launched the **'emphasis on people'** branding during 2013 to support the organisational workforce development programme.

Four key building blocks for development have been identified:

engaging with staff	staff wellbeing	learning and development training	communicating internally

A staff health and wellbeing group is being established under the auspices of the organisational workforce development group (OWDG) in order to enforce the Public Health Agency's commitment to the health and wellbeing of its employees.

In addition to Care Call, occupational health and ongoing line management, a number of initiatives have previously been offered to staff which have focussed on improving mental health and wellbeing, physical activity and nutrition, as well as enhancing communication and working relationships among staff. This has included 'My Mood Matters' and 'Living Life to the Full' – tailored programmes to empower employees to recognise and adapt mood and promote personal resilience; walking and cycling programmes – promoted throughout the year and with particular significance at the time of Giro d'Italia; and the '£ for lb' initiative – a weight loss programme piloted in local offices in PHA and supported by Business in the Community.

Team away days have also provided the opportunity for staff to engage with colleagues and enjoy time away from the office to build team cohesion.

A forum for lesbian, gay, bisexual and transgender (LGB&T) staff has also been established, providing confidential and informal support for LGB&T staff in the HSC workplace. An e-learning facility has been developed and widely promoted within HSC settings; this can be accessed via the following link: http://lgbtelearning.hscni.net/

A draft Terms of Reference has been approved by the Agency Management Team. Membership of the group has been encouraged across directorates, divisions and locations to ensure representation from each area of the PHA. The group will also seek to draw upon good practice and benchmark ideas within other organisations.

The work will encourage two way communication among colleagues in order that they may inform the work of the group and offer appropriate support to staff. The first meeting of the group is aimed to take place by end of July 2014.

Appraisal, revalidation and supervision

The PHA has in place an appraisal scheme which all staff participate in. In addition since December 2012 all medical staff are subject to revalidation through the GMC. The PHA has a responsible officer and deputy who support staff through annual appraisal to progress to revalidation. An appraisal policy is being developed. In 2013 11 staff were put forward to revalidate. The process is ongoing and is in a five year cycle. Doctors in training are also subject to revalidation and an annual review of their progression in training. NIMDTA made a formal visit to assess the quality of the Public Health Training programme and received a very complimentary report in 2013.

In addition regular one-to-one contact offers support and supervision to medical and nursing staff and provides the opportunity through discussion to identify solutions to issues, improve practice and to work together to support individuals to achieve their maximum potential and enabling staff to take care of themselves, become more self-aware and skilled in their roles.

HSC staff influenza vaccine uptake rates March 2014

Seasonal flu vaccine protects against the three most common types of flu each year. Health professionals and other HSC Staff are encouraged to receive the flu vaccination annually. The PHA vaccination programme runs annually from October to March.
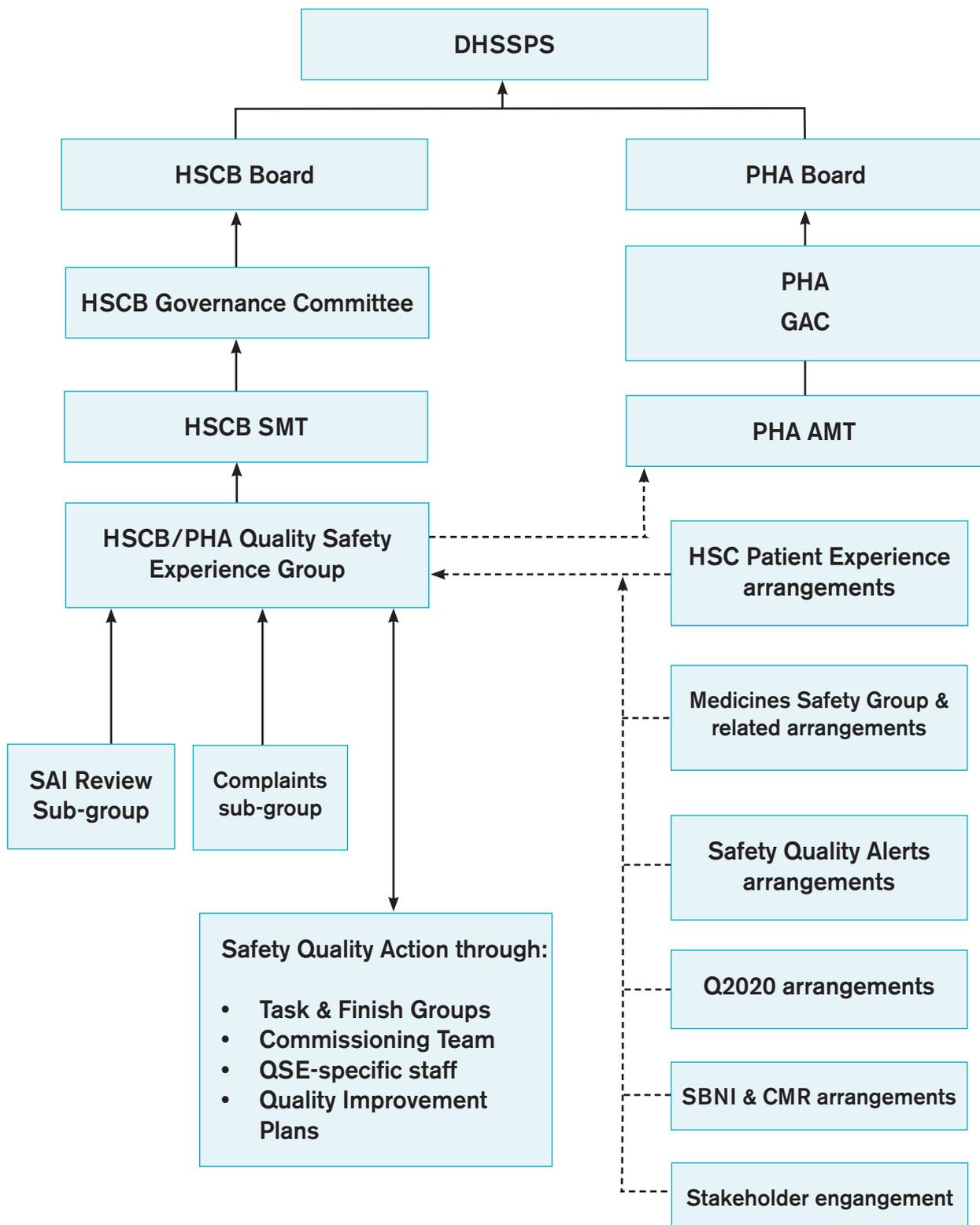
The table on flu vaccine update is divided into 'frontline' and 'other' staff. Frontline staff are those who have direct patient contact and the vaccine is recommended for them for this reason. While it is not specifically recommended for 'other' staff we have nevertheless offered it to all staff for a number of years now for their own protection. Uptake is shown for the winter 2013/14 and for the previous year for comparison purposes and has increased in this period.

Table 18: HSC staff flu vaccine uptake to March 2014

Occupational Health Seasonal flu Vaccine data 1 October 2013 to 31 January 2014	Belfast HSCT	South Eastern HSCT	Northern HSCT	Southern HSCT	Western HSCT	Northern Ireland
HSCT frontline staff Population	**13794**	**7382**	**7240**	**7414**	**5462**	**41292**
Frontline staff receiving vaccine 1 October 2013 to 31 March 2014	3751	1402	2225	1304	1236	9918
Uptake rate frontline staff 1 October 2013 to 31 March 2014	27.2%	19.0%	30.7%	17.6%	22.6%	24.0%
Uptake rate frontline staff 1 October 2012 to 31 March 2013	19.5%	15.5%	26.0%	18.3%	24.2%	20.4%
HSCT other staff population	**6072**	**3655**	**4153**	**4128**	**4215**	**22223**
HSCT other staff receiving vaccine 1 October 2013 to 31 March 2014	1386	826	1162	1038	914	5326
Uptake rate other staff 1 October 2013 to 31 March 2014	22.8%	22.6%	28.0%	25.1%	21.7%	24.0%
Uptake rate other staff 1 October 2012 to 31 March 2013	18.4%	13.6%	27.0%	17.6%	22.2%	19.4%

Appendix 1

Overview of HSCB and PHA quality safety experience internal coordination arrangements

Organisational chart showing:

DHSSPS

- HSCB Board
  - HSCB Governance Committee
    - HSCB SMT
      - HSCB/PHA Quality Safety Experience Group
        - SAI Review Sub-group
        - Complaints sub-group
        - Safety Quality Action through:
          - Task & Finish Groups
          - Commissioning Team
          - QSE-specific staff
          - Quality Improvement Plans
- PHA Board
  - PHA GAC
    - PHA AMT

HSCB/PHA Quality Safety Experience Group connects to:
- HSC Patient Experience arrangements
- Medicines Safety Group & related arrangements
- Safety Quality Alerts arrangements
- Q2020 arrangements
- SBNI & CMR arrangements
- Stakeholder engangement

Appendix 2

Organisations that report more SAIs typically have a better understanding and a more effective safety culture.

In May 2010 the responsibility for the management and follow up of SAIs transferred from the DHSSPS to the HSCB (working jointly with the PHA and collaboratively with RQIA) and a procedure for the reporting and follow up of SAIs was developed.

This procedure was revised in 2013 and fully implemented in April 2014. The 2013 revisions included:

•   An additional criterion for defining an SAI : "Any death of a child in receipt of HSC services (up to the eighteenth birthday)".

•   The reporting of SAIs involving a service user known to or referred to mental health services was reduced from 24 months to 12 months. This timescale is now comparative with England and Scotland.

•   Three levels of investigation were introduced, to reflect the complexity of incidents and to facilitate timely identification of learning.

•   The timescales for conducting investigations were revised in line with the level of investigation to be undertaken. However to date there have been a number of investigation reports that are outstanding beyond their submission date. This was raised during 2013/14 with Trusts at Director level meetings and further steps are being taken to improve the timeliness of these report

LM Learning Matters

QUALITY 2020

Act FAST when Stroke suspected

A residential home contacted the GP out of hours service about one of their residents who had developed arm weakness and slurred speech but who appeared to be getting better. The GP advised the home to wait an hour and if the symptoms persisted to contact the patient's GP.

In this case, the residential home should have dialled 999 and the patient should have gone directly to hospital, or the GP out of hours should have advised the home to dial 999 and send the patient to hospital.

The importance of early recognition of stroke is that it allows patients to be assessed quickly for thrombolysis. Thrombolysis can be given up to 4.5 hours after the onset of an ischaemic stroke which has been confirmed by CT scan. The earlier it is given to suitable patients the better the outcomes (i.e. less disability) for stroke survivors. Currently the thrombolysis rate for ischaemic stroke in Northern Ireland is 12%, but expert opinion used by National Institute for Health and Care Excellence (NICE) suggests that this could be as high as 20% in the next 5 to 10 years.

FACE
HAS THEIR FACE FALLEN ON ONE SIDE? CAN THEY SMILE?

ARMS
CAN THEY RAISE BOTH ARMS AND KEEP THEM THERE?

SPEECH
IS THEIR SPEECH SLURRED?

TIME TO CALL 999
IF YOU SEE ANY SINGLE ONE OF THESE SIGNS

WHEN STROKE STRIKES, ACT F.A.S.T.

Key Learning

The **FAST** campaign describes the common signs of stroke

Facial weakness – can the person smile? Has their mouth or eye dropped?

Arm weakness – can the person raise both arms

Speech problems – can the person speak clearly and understand what you say

Time to call 999 if you see any one of these signs

Introduction

Welcome to the second issue of Learning Matters Newsletter.

Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care and we recognise that we need to use a variety of ways to share learning such as learning letters, alerts and reports. The purpose of our newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.
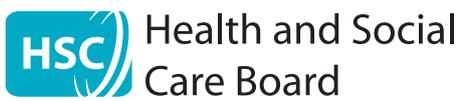
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Appendix 4

Glossary of Terms

AAA	Abdominal Aortic Aneurysm
AMT	Agency Management Team
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
C-Section	Caesarean – Section
CAUTI	Catheter associated urinary tract infections
CLABSA	Central Line associated infections
CNO	Chief Nursing Officer
CDI	Clostridium difficile infections
CHT	Congenital hypothyroidism
CF	Cystic Fibrosis
DVT	Deep vein thrombosis
DHSSPS	Department of Health Social Services and Public Safety
DRO	Designated Review Officer
DAI	Device associated infection
DPH	Director of Public Health
DSCC	Directorate of Social Care and Children
FPS	Family Practitioner Services
GOS	General Ophthalmic Service
GP	General Practitioner
GAC	Governance and Audit Committee
GAIN	Guidance and Audit Implementation Network
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
HCAI	Healthcare associated infections
HSMR	Hospital Standardised Mortality Ratios
HPV	Human Papilloma Virus
IPASS	Illness Severity/Patient Summary/Action List/Situation Awareness & Contingency Planning/Synthesis by Receiver
ImROC	Implementing Recovery through Organisational Change
KPI	Key performance indicator
LGB&T	Lesbian, Gay, Bisexual and Transgender
MMDT	Medicines Management Dietician Team
MCADD	Medium-chain acyl-CoA dehydrogenase deficiency
MRSA	Meticillin resistant Staphylococcus aureus
MDT	Multidisciplinary Team
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS	National Early Warning Scores

NICE	National Institute for Health and Care Excellence
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIAS	Northern Ireland Ambulance Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
OWDG	Organisational Workforce Development Group
OOH	Out of Hours
PCC	Patient and Client Council
PPI	Personal and Public Involvement
PMMT	Pharmacy Medicines Management Team
PKU	Phenylketonuria
PBL	Practice Based Learning
PLO	Practice Learning Opportunities
NIPMPL	Primary Medical Performers List
PGN	Promoting Good Nutrition
PHA	Public Health Agency
PE	Pulmonary embolism
Q2020	Quality 2020 Strategy, 2012
QA	Quality Assurance
QIP	Quality Improvement Plan
QSE	Quality, Safety and Experience Group
RDS	Referral Dental Service
RPP	Regional Professional Panel
RQIA	Regulation and Quality Improvement Authority
RO	Responsible Officer
RPA	Review of Public Administration
RAMI	Risk Adjusted Mortality Indicea
SBNI	Safeguarding Board Northern Ireland
SQAT	Safety and Quality Alerts Team
ScHARR	School of Health and Related Research
SMT	Senior Management Team
SAI	Serious Adverse Incident
SEA	Significant Event Audit
SBAR	Situation Background Assessment Recommendation
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
SSP	Specialist Screening Practioner
SOP	Standard Operating Procedure
SHMI	Summary Hospital Mortality Indicator
SSI	Surgical Site Infection
CHKS	Uk based provider of healthcare analysis
UK	United Kingdom
VTE	Venous Thromboembolism
VAP	Ventilator associated pneumonia
WHSCT	Western Health and Social Care Trust
WHO	World Health Organisation