

Health and Social Care Board and Public Health Agency

Annual Quality Report 2014/2015

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Chief Executives' foreword

This is the second *Annual Quality Report* of the Health and Social Care Board (HSCB) and PHA (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 sets out actions we have taken 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 has been structured around the core Quality 2020 themes: **Transforming the culture, Strengthening the workforce, Measuring improvements, Raising the standards and Integrating the care.**

The HSCB and PHA remain committed to creating a modern and sustainable health and social care system which meets the changing needs of our population. The DHSSPS has announced a review of commissioning and we are currently undertaking our own stocktake as part of our continual drive for improvement and excellence against a background of increasing demands and a challenging financial position. The DHSSPS also announced a review of health and administrative structures with a key focus on the roles and relationships between the regional organisations, aimed at ensuring effective and efficient commissioning and delivery of services.

These reviews together with the recommendations arising from the Sir Liam Donaldson report *The Right Time, The Right Place* will provide a valuable opportunity for us to refocus and strengthen commissioning as we drive forward the reform programme at scale and pace and in partnership with health and social care professionals working across primary, secondary and community care and the statutory, voluntary and community sectors.

There is, however, no room for complacency. Therefore the HSCB and PHA will continue their 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.

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.

What is Quality 2020?

Quality 2020 is a 10 year strategy to protect and improve the quality of health and social care in Northern Ireland. 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*”.

Quality 2020’s five strategic goals are:

- Transforming the culture;
- Strengthening the workforce;
- Measuring the improvement;
- Raising the standards;
- Integrating the care.

To achieve these goals in 2014/15, the Quality 2020 implementation team have been working in a number of task groups. Each task group is led by key senior stakeholders from across the HSC family and a number of key outcomes have been achieved during 2014/15. These outcomes have been detailed throughout this report.

Next steps

In the incoming year the work of the task groups will continue to expand and evolve as they move into new phases of development and delivery.



Theme one:

Transforming the culture

It is widely agreed that the culture of an organisation is an indication of the quality of its output. The HSCB and PHA recognise that, in order for the quality of care and services to be of the highest level, the culture of the organisation must be open, honest, transparent and, above all, client focussed. The HSCB and PHA senior management are committed to ensuring that any negative behaviours or attitudes will be dealt with and not accepted as common practice. Both organisations will continue to promote and encourage partnerships between staff, patients, clients and carers to support the decision making process.

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

Regional serious adverse incident review sub-group

The regional serious adverse incident review sub-group (RSAIRSG) 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 RSAIRSG 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.

SAI professional groups

During 2014/15 a pilot was undertaken in relation to the process followed by designated review officers when reviewing SAI investigation reports. The pilot involved the following programmes of care (POC):

- paediatrics and child health;
- mental health (including prison health);
- acute.

A number of designated responsible officers (DROs) from each of the above groups have met on a monthly basis to review SAI investigation reports in order to close and/or identify any issue that requires consideration by the RSAIRSG. Consideration to extending this process to other POCs will be reviewed during 2015/16.

During the reporting period the Chairs of the RSAIRSG conducted a round of meetings with each of the HSCT governance leads to discuss issues relating to the procedure for the reporting and follow-up of SAIs – this included the more recent inclusion of the process for engaging with service user/family and carers.

Regional governance leads group

The regional governance leads group meets on a quarterly basis. Membership includes a range of relevant HSC managers and professionals from across the six HSCTs, the HSCB and PHA who engage in open discussion and debate on relevant HSC governance issues. The group is chaired by the HSCB governance manager.

Regional complaints sub-group

The regional complaints sub-group (RCSG) is chaired by the HSCB complaints and litigation manager and membership comprises professional representatives from the HSCB, the PHA and Patient Client Council (PCC).

Since the implementation of 'Complaints in HSC' in 2009, the number of complaints received by HSCTs and FPS each year has increased from just under 5,000 in 2009 to approximately 7,400 in 2014/15. The top three categories of complaint remain: staff attitude/behaviour, treatment and care, and the quality of communication/information provided to patients and relatives.

The RCSG reviews complaints information received from HSCTs and family practitioner services, as well as complaints received by the HSCB and PHA. Areas of concern, patterns, trends and information from complaints is shared with established professional groups to ensure that issues of complaint inform key areas of work in relation to the quality of patient experience and safety, including thematic reviews and strategy and policy development including the food and nutrition strategy, falls strategy, development of pathways for bereavement from stillbirths, transforming your palliative and end of life care programme, miscarriages and neonatal deaths.

This RCSG considers whether there is any regional learning and/or makes recommendation(s) to QSE on suggested courses of action as a result of an individual complaint or pattern/trend.

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: Breakdown of all category 1 alerts and status as of 31 March 2015

Alert type	Alert status		Overall No. of alerts
	Closed	Open	
DHSSPS safety and quality alerts/circulars	176	8	184
RQIA reports and independent inquiries	19	29	48
NCEPOD report and other confidential enquiries	4	13	17
National patient safety alerting system alerts (NPSAs)	19	1	20
Learning letters	28	2	30
Reminder letters	1	3	4
Safety or quality related professional letters	10	0	10
GAIN reports	3	2	5
Total	260	58	318

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

- Development of an agreed regional service model and management of multiple pregnancies, including adherence to NICE Guidance CG129 multiple pregnancy;
- Continue to work through the Critical Care Network NI (CCaNNI) to standardise pre-operative risk assessment in response to the NCEPOD report *Knowing the risk*. An audit was carried out by CCaNNI of all high-risk patients having general, urology or orthopaedic surgery in Northern Ireland between 10-14 February 2014;
- Development and issue of a poster to raise awareness about the prescribing characteristics and properties of the newer oral anticoagulant agents;

- Development of an implementation plan in relation to the NCEPOD report *Managing the Flow* for the recommendations that are applicable to Northern Ireland;
- A regional approach to the use of National Early Warning Scores (NEWS) through the Safety Forum. A re-audit was undertaken to review HSCT compliance of the roll out of NEWS. The Safety Forum continues to work with HSCTs on quality improvement in this area.

Table 2: Audit results (2014-2015) headline results

The main results from each HSCT from cycle 1 and 2 are summarised in Table 1.

Please note that in 2014, Data from Trust E was unable to be analysed alongside other data.

Trust	% Compliance with NEWS Chart		% NEWS charts with some form of "trigger reset"		% Observations recorded according to policy		% Correct grade of doctor assessing patient	
	2014	2015	2014	2015	2014	2015	2014	2015
A	72	82	19	9	35	45	35	52
B	74	79	5	16	40	81	50	75
C	47	87	5	10	27	88	58	88
D	90	86	13	13	95	94	95	71
E	-	91	-	17	-	90	-	90
Overall % (A-D inclusive)	71	84	11	12	49	77	60	72
Overall % (A-E inclusive)	-	85	-	13	-	80	-	75

Review of 2014 and 2015 templates for Trust D identified an error of measurement. Please note the revised result for 2014 (underlined in Table 1).

- Worked with HSCTs to ensure policies/procedures are in place for the digital removal of faeces that reflect Royal College of Nursing guidelines;
- Continued with work through the Medicines Safety Sub-group to ensure a regional approach to preventing fatalities from medication loading doses. Regional HSCT clinical pharmacy leads led on the work associated with this. Each HSCT carried out a risk assessment and has a list of critical medicines. Each HSCT's outputs have been shared with all HSCTs to allow a standard regional approach to this issue, but it is recognised that it will be an ongoing area of work.

- Worked with HSCTs to ensure standard operating procedures and arrangements for managing beta blockers are reviewed and updated as necessary. In response to the issue of a safety and quality learning letter *Dispensing beta blockers - selection errors*, assurances were sought from all HSCTs that they had reviewed their arrangements for the management of beta blockers, taking into account the learning and recommendations that were included in the letter. Assurances have now been provided by all HSCTs that the actions have been completed.
- The serious adverse incident learning letter *Safe use of Intravenous Magnesium Sulphate LL/ SAI/2013/023 (AS)* recommended that there should be a regional approach to obtaining pre-prepared magnesium sulphate. To date the regional medicines governance team has worked with their respective HSCT colleagues to obtain regional agreement on the strengths and volumes needed to determine suitable pre-prepared products and potential suppliers have been identified. Work is underway by each HSCT to determine the financial impact of their introduction.
- Worked with HSCTs to ensure adherence to guidance on minimising the transmission of CJD and vCJD; ensured protocols are in place for risk assessing patients preoperatively for CJD and notifying other staff of a patient's CJD 'at-risk' status; and ensured audits of compliance with CJD risk assessments in relevant specialties are undertaken;
- Worked with HSCTs to ensure amendments to HSCT protocols and emergency department escalation plans in relation to the management of head injury;
- The competency framework document (to reduce the risk of hyponatraemia when administering intravenous infusions to children) updated to take account of recent revisions to the regional IV fluid prescription charts, fluid balance charts and associated training packages for adults and children.
- Shared and confirmed adoption of good practice by all HSCTs in relation to the discharge planning and recording of legal status under the *The Mental Health (Northern Ireland) Order 1986*;
- Worked with HSCTs to ensure they review and as necessary update processes for managing patients who require buccal midazolam products and that plans are in place to review all patients currently receiving buccal midazolam;
- Ensured that emergency call arrangements in maternity units are the functional equivalent of a crash call system and that training is provided to new and existing staff, and tested and rehearsed regularly;
- Worked with HSCTs to ensure systems are reviewed and updated to check the integrity and sterility of instruments/packs prior to use to minimise the risk of individual error;
- Shared Neonatal Network Northern Ireland guidance to support the implementation in Northern Ireland of *NICE CG 149: Antibiotics for early onset neonatal sepsis*;

Implementing the findings of national audits

National audits are designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions. Their purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care.

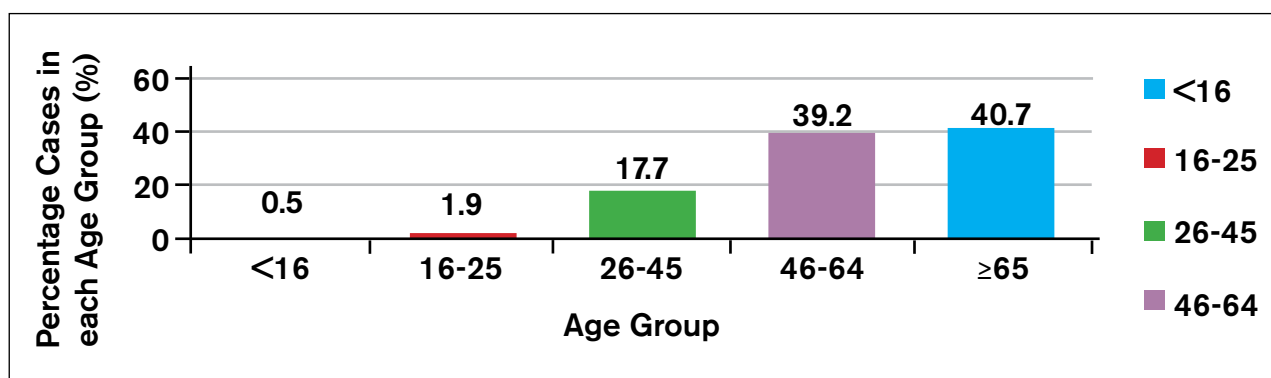
The purpose of a confidential enquiry is to detect areas of deficiency in clinical practice and devise recommendations to resolve them. Enquiries can also make suggestions for future research programmes. Most confidential enquiries to date (at both national and local level) are related to investigating deaths, to establish whether anything could have been done to prevent the deaths through better clinical care.

Most national clinical audits have been developed because they are in an area of healthcare that is highly important and where it is felt that national results are essential to improve practice and standards. In all cases they form part of a broader approach to improve quality and are backed by the relevant Royal College. They also usually have the support and engagement of the relevant national voluntary organisation which represents patient interests

National Audits collect a large volume of data about local service delivery and achievement of compliance with standards, and about attainment of outcomes. These audits are undertaken in various clinical specialties for the purposes of improving service quality, monitoring need and assessing new processes and interventions. Data are collected by clinical departments in each trust and submitted directly to the organisation responsible for the audit. This data are then analysed, interpreted and reflected back to the services as well as being presented in national publications.

Northern Ireland participates in a number of national clinical audits to benchmark performance of local services with those in other countries in the UK. An important step in improving the quality of services is to implement the recommendations and findings from audits locally. As a result, national audits can be drivers for quality improvement. The two examples below illustrate how this has been done in Northern Ireland.

Figure 1: % aSAH Cases by Age Northern Ireland 2010/11 - 2012/13



Source: Patient Administration System (PAS). Individual patients admitted as an emergency with ICD 10 Codes: I60.0/I60.1/I60.2/I60.3/I60.4/I60.5/I60.6/I60.7/I60.8/I60.9 as primary and secondary diagnoses (up to secondary diagnosis 5), by age group.

Improving the care of people who suffer an aneurysmal subarachnoid haemorrhage

Subarachnoid haemorrhage (bleeding into the subarachnoid space in the brain) has a number of causes, but a bleed caused by rupture of an aneurysm (a swelling in the wall of an artery) accounts for more than 8 out of 10 cases.

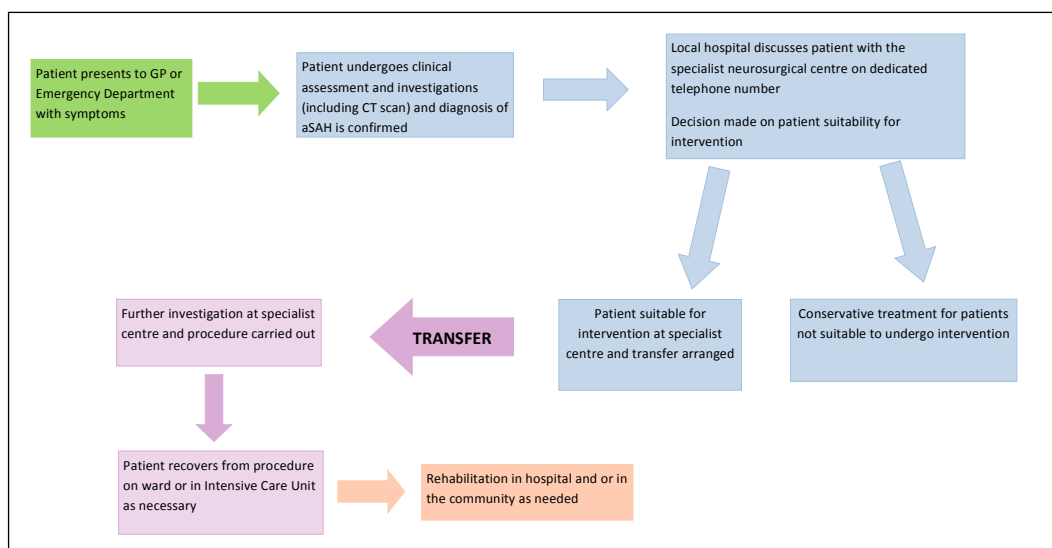
Aneurysmal subarachnoid haemorrhage (aSAH) occurs at a relatively young age compared with other forms of stroke: half of the patients are under the age of 60 years. People are frequently left with disability and rehabilitation is often required. The main treatment aim is to control the aneurysm to prevent it bleeding again, which may be performed by placing a coil into the aneurysm, or less often by clipping the aneurysm. Most patients are treated with coils by neuroradiologists, which is a less invasive procedure than surgical clipping.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report *Managing the flow?* published in 2013, reviewed the care of 427 cases of aSAH in the United Kingdom between July and November 2011. The review team looked at the care these patients received and made recommendations about how care for people suffering aSAH might be improved. One of the main issues the team identified was that a delay at any stage in the patient journey can have a negative effect on outcomes, and should be reduced and avoided where possible.

The PHA convened a multidisciplinary group to review the recommendations in the report and consider how the findings could be applied to Northern Ireland. Overall, it was agreed that care in Northern Ireland was already in line with some of the recommendations from the report, but that there were areas for improvement.

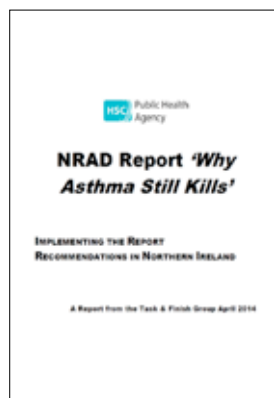
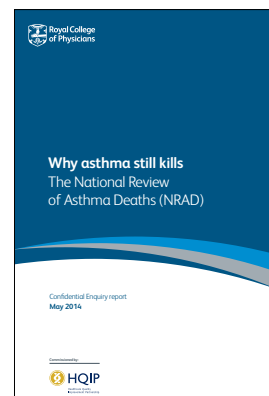
The group developed a care pathway, which describes the steps a patient with this condition will move through in their diagnosis and treatment. This process generated consensus on key steps including investigation, and communication between the specialist centre and referring hospitals. It is hoped that this care pathway will reduce delays in the patient journey and will be used by all HSCTs. Additional changes to services are required to meet the recommendations of NCEPOD. These will be taken forward with the HSCB.

Figure 2: Northern Ireland care pathway for patients with aneurysmal subarachnoid haemorrhage (simplified)



Improving the care of people who suffer from asthma

Asthma is a common, multifactorial and often chronic (long-term) respiratory illness that can result in episodic or persistent symptoms and in episodes of suddenly worsening wheezing (asthma attacks, or exacerbations) that can prove fatal. The underlying pathological process resulting in the features of asthma vary between individuals. Hence, each person's asthma has different characteristics and patterns of triggers and their response to treatment may also vary. People with asthma also experience uncontrolled episodes or attacks that too can vary between and within individuals.



In order to ensure that people with asthma are free from symptoms and attacks and are able to lead a normal, active life, each patient should have their asthma triggers identified and treatment tailored to their needs.

The National Review of Asthma Deaths (NRAD) Confidential Enquiry *Why asthma still kills* was published in May 2014. The primary aim of the NRAD was to understand the circumstances surrounding asthma deaths in the UK in order to identify avoidable factors and make recommendations to improve care and reduce the number of deaths.

A number of important recommendations for improvement in asthma care have been identified though this review. To facilitate the implementation of these recommendations in Northern Ireland, a Regional Respiratory Forum NRAD subgroup led by the PHA was established. The subgroup worked closely with relevant stakeholders and developed a detailed implementation plan including the development of local asthma pathways, guidance, templates and education resources.

The subgroup first established the current baseline practice in both children and adult services across HSCTs against the NRAD recommendations. It was agreed that care in Northern Ireland was already in line with the recommendations from the report, but that there were areas for improvement. The subgroup then compiled a local action plan and reviewed the Asthma Key Performance Indicators in the Revised Respiratory Service Framework to facilitate and measure the local implemented actions. The implementation plan built on the key themes and priorities already promoted by the Respiratory Forum including 'smoking cessation, responsible respiratory prescribing and prioritising and empowering self-management. The action plan covers the complete patient pathway from prevention to diagnosis and management of difficult to treat asthma. Additional resources will be required in both paed's and adult services to support the implementation process. The identification of funding streams and allocation of resources is currently under consideration within the HSCB.

Reducing the risk of hyponatraemia when administering intravenous infusions to children

In order to harmonise practice and to ensure training is consistent across HSCTs, the Chief Medical Officer asked the PHA to form a task and finish group to provide advice, support and share regional learning across HSCTs in Northern Ireland. This group had representation from

the PHA and a number of nominated representatives from the five of the six Northern Ireland HSCTs.

During 2014/15 the PHA worked with HSCT colleagues and other internal and external stakeholders to update the 'Competency Framework' document (to reduce the risk of hyponatraemia when administering intravenous infusions to children) to take account of recent revisions to the regional IV fluid prescription charts, fluid balance charts and associated training packages for adults and children.

The framework has been developed to ensure consistency of approach in the implementation of RQIA recommendations across HSCTs in the following areas:

- The development of a competency assessment tool on the administration of intravenous fluids;
- Training and assessment of staff in the administration of intravenous fluids to children.

A central repository for HSC resources relating to hyponatraemia is now hosted on the PHA website at www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/nursing/central-repository-hsc-resources-relating

Next steps

- Implementation of a regional e-learning module for assessment of competency;
- Development of regional guidelines on the use of paediatric IV fluids.

Serious adverse incidents

The management of serious adverse incidents (SAIs)

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.

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 current SAI procedure will be reviewed in light of the recommendations made within the Donaldson Report, *The Right Time, The Right Place*, after the consultation process on the report has been completed.

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, and in line with DHSSPS communication, the HSCB and PHA have worked with the Patient and Client Council, RQIA and HSCT governance leads to develop guidance for HSC organisations when involving service users/families throughout the relevant stages of the SAI process (issued in February 2015).

The purpose of the guidance is to ensure that communication with service users/families/carers, following on SAI, is undertaken in an open, transparent, informed, consistent and timely manner, thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. The guidance should be read in conjunction with the revised SAI procedure in order to ensure the engagement process is closely aligned to the required timescales, documentation, investigation levels etc. A leaflet was also developed to provide information for patients/families on the process.

Table 3: Serious adverse incident activity 1 April 2014 – 31 March 2015

The HSCB received **801 SAI notifications** from across the HSC for the above period, of which 13 were subsequently de-escalated/withdrawn and four transferred. The table below provides an overview of all SAIs reported by organisation and programme of care (POC) for 2014/15.

Organisation	2014/15												
	SAI Notifications Received	SAI De-escalated/withdrawn	SAI Transferred	Total SAIs excluding De-escalated & Transferred SAIs	POC 1	POC 2	POC 3	POC 4	POC 5	POC 6	POC 7	POC 9	POC NA
BHSCT	185	1	3	181	46	99	3	1	22	10	0	0	4
BSO	5	0	0	5	0	0	0	0	0	0	0	0	5
HSCB	2	0	0	2	0	2	0	0	0	0	0	0	0
NHSCT	189	5	0	184	46	17	12	55	38	6	2	2	11
NIAS	4	0	0	4	2	2	0	0	0	0	0	0	0
PCARE	25	2	0	23	0	1	0	0	0	0	0	20	4
PHA	2	1	0	1	0	0	0	0	2	0	0	0	0
SEHSCT	120	0	0	119	26	15	7	2	67	0	0	0	3
SHSCT	159	1	1	157	37	21	5	58	35	0	1	0	2
WHSCT	110	3	0	107	41	28	4	12	21	1	0	0	3
Totals	801	13	4	783	198	185	31	128	185	17	3	22	32

Key

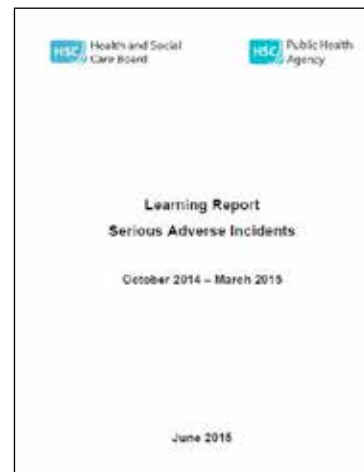
- POC1 Acute services
- POC2 Maternity and child health
- POC3 Family and childcare (inc CAMHS)
- POC4 Elderly
- POC5 Mental health
- POC6 Learning disability
- POC7 Physical disability and sensory impairment
- POC8 Health promotion and disease prevention
- OC9 Primary health and adult community (includes GPs)
- POCNA POC - Corporate business / Other

Learning from SAIs

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;
- Reminder of good practice letters;
- Newsletters;
- Thematic reviews;
- Training;
- Audits, guidelines and resources.



Learning letters/reminder of good practice letters

Last year the following learning letters and reminder letters of good practice were issued:

Table 4: Learning letters

Learning letters	Date published	Open/closed to SQA
LL/SAI/2014/ (AS&PHC) - Systems to check the integrity and sterility of packs or instruments prior to use	01/10/14	Closed
LL/SAI/2015/030 (MCH) - Emergency Call Arrangements in Obstetric Units	12/01/15	Closed

Table 5: Reminder letters of good practice

Reminder letters of good practice	Date published	Open/closed to SQA
SQR/SAI/2015/001 (CAHMS, MH and LD) - Discharge Planning and Recording Legal Status under the Mental Health Order	14/01/2015	Closed
SQR/SAI/2015/002 (AS and MCH) - Avoidance, recognition and management of anaphylaxis	03/02/2015	Open
SQR/SAI/2015/003 (AS and MCH) - Residual anaesthetic drugs in cannulae and intravenous lines	13/03//2015	Open
SQR/SAI/2015/004 (MCH) - Reduced Fetal Movements	16/03/2015	Open

Newsletters

A number of newsletters have been developed to share learning from Complaints, SAIs and AIs with the HSC. These include:

- Learning matters
- 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 review has been completed and issued during 2014/15:

- Thematic review of mental health SAIs relating to patient suicides.

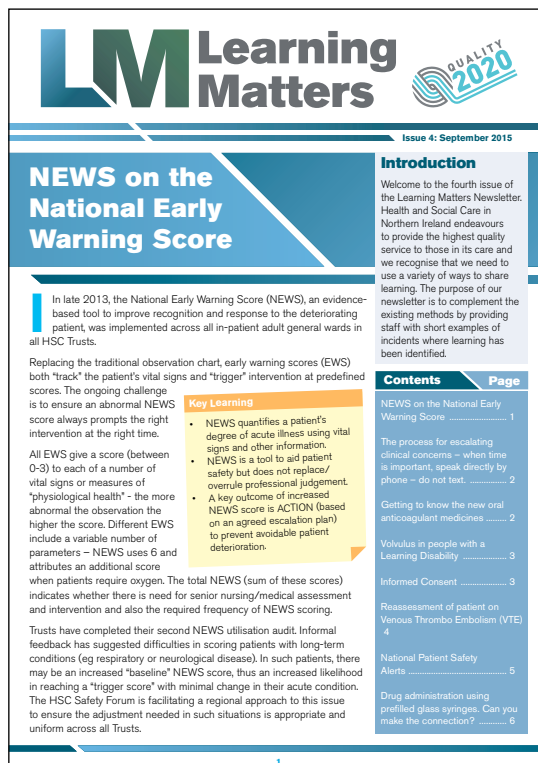
Other thematic reviews approved by QSE to be undertaken during 2014/15 are:

- Thematic review of independent sector SAIs;
- Thematic review of adverse incidents relating to the prescribing, supply and administration of insulin.

Governance arrangements in primary care

The Directorate of Integrated Care comprises four contractor services - **Medical, Dental, Ophthalmic** and **Community Pharmacy** - who provide primary care to patients in Northern Ireland. The Directorate continues to drive and improve quality, safety and service delivery for patients during 2014-15 within each contractor service.

All contractors are independent organisations and operate within the framework of their own regulatory and professional codes of conduct.



General medical services (GMS)

There were 350 GP practices in Northern Ireland in 2014-2015. GPs play a key role in ensuring that health service provision in Northern Ireland is effective and efficient. GPs provide:

- The main point of entry to the healthcare system;
- Person-centred, ongoing care covering whole episodes of ill health;
- Delivery of the majority of care for all but the most uncommon conditions;
- Coordination of care provided by others.



Since the introduction of the 2004 contract, the Directorate of Integrated Care has undertaken a schedule of review practice visits incorporating assessment, support and development to all general medical practices.

Each visit covers the following key contractual areas:

1. Quality and outcomes framework
2. Enhanced service provision
3. Clinical and social care governance
4. Statutory and mandatory contractual requirements

The new GMS contract introduced a range of improvements across the UK. These include:

- improved access to services for patients;
- better management of chronic diseases;
- higher standards of record-keeping;
- a range of nationally agreed enhanced services and the ability to develop local enhanced services in response to local need.

General dental services (GDS)

As of April 2014, there were 380 dental surgeries in Northern Ireland with 1,126 dentists working in them. Most practices offer general dental care and treatment but a small number provide specialist dental services, particularly orthodontics and oral surgery. Quality of care provided by dental practitioners is monitored through the Referral Dental Service (RDS), a small group of dental advisers based within the Directorate.

The dental team in the directorate also works collaboratively with other organisations to undertake a range of monitoring activities which help assure and improve the quality of care that patients receive.



Quality assurance is a vital part of good governance for all primary care professions. Under GDS terms of service, all dentists are required to work under a quality assurance scheme and every practice must submit a declaration to the HSCB by June each year, providing details of the scheme and listing any improvements that have been made to working arrangements.

In order to provide all relevant practice governance information for the year in a single document, annual quality assurance declarations now contain sections on practice complaints and adverse incidents. Previously this information was supposed to be sent to the HSCB by dental practices as and when these issues arose but reporting levels were lower than expected.

In the 2014/15 year the quality assurance returns from practices also included:

- a declaration on the handling, management and use of controlled drugs;
- a declaration as to the receipt and implementation of the content of alerts;
- a memoranda of dental services;
- a business continuity plan for dental practices.

To assist practices in the fulfilment of business continuity planning the HSCB produced guidance and a template which practices may find useful in addressing the issue of business continuity planning.

In the 2014/15 year declarations were also included relating to:

- General Dental Council standards for the dental team;
- Training in medical emergencies;
- IV sedation.

The HSCB developed a reporting system to collate, analyse and report on all of the component parts of the quality assurance returns from each practice carrying out health service dentistry in Northern Ireland. This was implemented through local HSCB offices.

General ophthalmic services (GOS)

Optometrists are an integral part of the system-wide approach to improving care provision, being ideally placed to deliver essential information to patients about eye care - not only in relation to their specific eye care needs, but also on the broader, but equally important, public health messages.



Optometrists can provide advice to patients about lifestyle choices and nutrition which can help reduce the risk of eye disease and visual impairment. Many eye diseases have preventable components – AMD, ocular surface disease and diabetic eye disease - and in their day-to-day engagement with patients, optometrists are well placed to **“make every contact count”** and educate patients on the importance of good diet, physical exercise, UV protection and smoking cessation.

In 2014/15 there were 265 optometry practices in Northern Ireland with approximately 570 optometrists providing or assisting in the provision of General Ophthalmic Services (GOS). The ophthalmic services provided in these practices under the NHS are eye examinations, spectacle and contact lens fitting and local enhanced eye services. The latter services relate to additional or ‘enhanced’ care, outside general ophthalmic services, for certain patients who present with an ophthalmic problem which requires additional investigation. The HSCB optometry team monitor the activity and quality of eye care services on an ongoing basis and undertake checks which seek feedback from patients on the quality of eye care services. The HSCB is actively working with service users and other organisations to develop better patient-centred eye care services.

In 2014/15 the annual quality assurance process for optometry practices included the following assurances:

- Declaration in respect of complaints and adverse incidents;
- Declaration in respect of receipt and implementation of Memoranda of Ophthalmic Services, HSCB Optometric Guidance and safety and quality guidance and alerts;
- A business continuity plan for optometry practices. To assist practices in the fulfilment of business continuity planning the HSCB produced guidance/information and a template for practices which could be adopted for their individual practice business continuity planning;
- Information in respect of Independent Prescribing Optometrists working in the Optometry practice.

The HSCB continues to undertake clinical audit checks which provide information on the quality of service provision. The HSCB has developed an optometry database held by the Directorate of Integrated Care which draws together information on statutory ophthalmic listing, quality assurance and local enhanced service provision for all optometric contractors. This will be utilised as a central point of reference for HSCB staff involved in governance, probity, and enhanced service provision.

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.

Collaborative working

The HSC Safety Forum provides leadership in transforming the culture through collaborative working with HSCTs and organisations to bring about sustainable improvements in safety and quality. During 2014-15 the HSC Safety Forum led on a number of quality improvement collaboratives including:



Paediatrics

The paediatric collaborative aims to facilitate the provision of high quality, safe care to ensure the best outcomes for children in Northern Ireland. The collaborative has worked on improving both multi-professional communication and communication between parents and staff. Teams have used structured tools such as SBAR (Situation, Background, Assessment, and Recommendation) and introduced safety briefings and enhanced handovers. The collaborative has worked with parent representatives to co-design a parent/child safety poster *You know your child best*. This poster is aimed at empowering parents to take a partnership role in ensuring their child has a safe hospital experience.

Maternity

In line with the challenges and the ambitions of the NI Maternity Strategy, the HSC Safety Forum established a maternity quality improvement breakthrough collaborative. All HSCTs, commissioners and the DHSSPS actively contribute to the collaborative.

An advisory group to the collaborative, chaired by a frontline senior obstetrician, guides the strategy and direction of the collaborative. Learning sessions provide focused events at which frontline teams share learning, best practice and develop a plan for further actions focused on improving quality and safety for mothers and babies. Teams test and implement changes in their own settings and collect local data to measure whether or not improvement is occurring. In 2015/16 the collaborative plans to expand its work to include a care bundle for the reduction of stillbirths.

Primary care

A primary care collaborative was established in 2014. A number of practices participated and received training in basic quality improvement skills. The focus in year one was on diabetes care and optimising implementation and monitoring of a care bundle for diabetes care. A diabetes nudge chart was developed to assist with personalised diabetes care for patients.

In partnership with NIMDTA, a symposium was held on quality improvement in general practice in September 2014. This brought together those in leadership roles within training and appraisal for general practice in Northern Ireland to shape and develop a shared vision for quality improvement in the local health service.

In September 2014 a web-based resource for the management of lower tract symptoms (LUTs) for men was made available (www.luts4gp.org). This was developed using quality improvement principles and the involvement of primary and secondary care clinicians. The aim of this resource is to demonstrate what better care looks like for LUTs in general practice and to raise awareness of quality improvement in the wider GP community.

Nursing homes

The Nursing Home Quality and Safety Improvement Collaborative, established in 2012, expanded in 2014 from 12 members to 18 members.

A falls prevention toolkit has been made available across Northern Ireland and one very large group of nursing homes has spread the intervention to over 60% of its homes and plans to extend this to the entire group.

Improvement is now aligned to the ROIA Inspection Themes and in 2014-15, nursing homes are applying QI methodology to improving nutrition and preventing pressure ulcers. In 2015-16 the focus will be on palliative and end of life care.

Mental health

The mental health improvement collaborative, established in April 2014, has progressed and secured full engagement with all HSCTs. Improvements being developed and tested include; a mental health safety plan and health passport; better management of out-of-hours crisis presentations; monitoring of patients' physical health especially those on antipsychotic medication; cessation of smoking and weight reduction within a supported living environment.

Review of Allied Health Professions (AHP) support for children/young people with statements of special educational needs

The PHA is leading on a review of AHP support for children with statements of special educational needs (SEN) in special and mainstream schools.

The ultimate aim of this child-centred review is to agree a proposed regional model and implementation plan in order to best meet the AHP assessed needs of these children. The proposed model should represent value for money, ensure the most effective use of resources and ensure that the AHP assessed needs of children with statements of SEN are met, irrespective of where they live and what school they attend.

The project board is chaired by the Chief Executive of the PHA and is responsible for the overall management of the project. A professional stakeholder reference group has also been developed with representation from relevant health and education professionals in order to ensure that professional opinion informs the process and to help facilitate the implementation of the review.

There has been significant stakeholder engagement and data collection in order to hear views and establish the current levels and models of AHP support for children with statements of SEN. Common themes have been identified and principles have been agreed. These common themes will be integral to the proposed regional model. Many of these themes aim to strengthen the culture of partnership working. Within the professional stakeholder reference group, communication guidelines and operating principles are being agreed between AHPs and teachers. The aim of these is to help improve outcomes for children by strengthening collaborative working and is one example of how this work is transforming the culture.

Key themes also include the need for strengthening joint working with parents and children; the need to make the most effective and efficient use of current resources and the need for regional consistency in relation to services so that the child's needs are met, regardless of where they live or go to school.

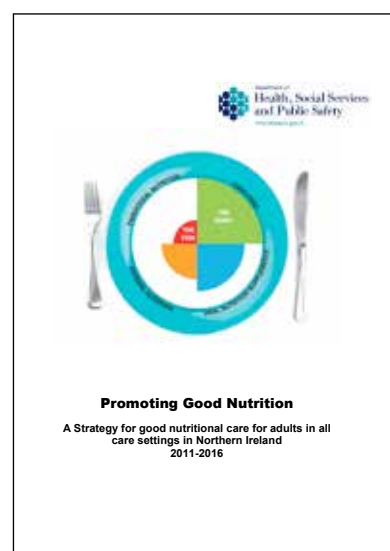
Promoting good nutrition

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:

under nutrition – when you don't get enough nutrients;

over nutrition – when you get more nutrients than you need.

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



of the strategy is overseen by the promoting good nutrition steering group, chaired by the Director of Nursing, BHSCT. Most people at risk of malnutrition or who are malnourished have their needs met by the 'food first' approach, a smaller number require oral nutrition supplements, fewer still need enteral (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.

Cost of malnutrition:

- £13 billion 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.

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

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

There have been key pieces of work which aim to improve the nutrition of our population.



The PHA has worked with HSCTs and the DHSSPS to develop and agree a Key Performance Indicator (KPI) as part of the Regional KPI nursing group. This will identify the percentage of patients who have nutritional screening undertaken within 24 hours of admission to hospital across all HSCTs.

In 2014/15, the HSCB and PHA developed and implemented a pilot service which saw the establishment of the medicines management dietetic team. The team consists of registered dietitians and these staff have provided sessions within a number of GP practices to assess the nutritional needs of adult patients receiving nutritional supplements registered with GP practices.

To date 115 GP practices across the region have availed of the initiative. 2633 patients have been offered an appointment for nutritional assessment and advice with the medicines management dietitian. As part of the assessment the dietitian calculates a nutritional screening score to identify the individual's current nutritional status. Subsequently a nutritional care plan is developed with the patient, which outlines recommendations and dietary goals. The recommendations within the plan are designed to improve or maintain the nutritional status of individual patients and are agreed with the GP. In total, 92% of patients surveyed reported comparable or improved wellbeing.

The PHA in partnership with dietitians, ROIA and relevant health professionals recently updated the nutritional guidelines and menu checklist for nursing and residential homes which were published in March 2014. Since then the PHA has been working with dietitians to develop awareness and training sessions for relevant care home providers and caterers. This training includes:

- Residential and nursing home awareness training (to include nurse manager and one other nurse/care assistant).
- Catering staff training (to include head cook and nursing home manager). Training will provide practical advice on menu planning, snack provision and food fortification. It includes practical skills training on texture modification and food fortification.

In total the training will be offered to 720 care home staff and caterers. It is envisaged that this training will be required in 2015/16 as well.

Strengthening families - family support hub

A family support hub is a multi-agency network of statutory, community and voluntary organisations that either provide early intervention services or work with families who need early intervention services. The network accepts referrals of families who need early intervention family support and uses their knowledge of local service providers and the family support database to signpost families with specific needs to appropriate services. The hub concept is based on the idea that early intervention services can be delivered more effectively if existing providers are encouraged to work more closely together and form a supportive network. The family support hubs offer a new way of enabling cultural change through:

- Promoting partnership working between families, children, professionals and community agencies;
- Creating a collaborative family support network which improves the coordination of family support services across community, voluntary and statutory providers;
- Improved understanding of local needs.

- More effective allocation of resources achieved through pooling resources/expertise and matching these with the needs of families.
- Development of consistent early intervention approaches which strengthen personal, family and social reliance.
- Improved access to flexible family supports, reducing the need for families to navigate/negotiate their way around complex systems.

Across Northern Ireland 15 hubs are fully developed and nine more are in the process of being developed and established.

From a recent evaluation of family support hubs, hub partners report a:

- 90% increased focus on early intervention;
- 83% increased use of all the resources;
- 48% increased demand on their own agency;
- 90% increased identification of service gaps;
- 75% reduced likelihood of duplication;
- 58% increased demand services to work collaboratively;
- 92% enhanced knowledge and understanding of others' roles;
- 91% increased knowledge of what is available in the area;
- 90% improved information sharing , communication and trust;
- 91% increased cooperation.

Between April – December 2014 **1,896** families were referred to family support hubs and out of these **1,822** were accepted and signposted.

Key reasons for referral included: emotional and behavioural difficulty support for post-primary school children, emotional and behavioural difficulty support for primary school children, parenting programmes/parenting support, emotional and behavioural difficulty support for parents, adult mental health issues, financial support, child care support, emotional and behavioural difficulty support for pre-school children.

Providing intensive family support services

Commissioning of an intensive family support service was piloted in the Belfast HSCT as part of a cross five government department investment initiative. This was an innovative response to providing an effective service for families presenting with complex/highly complex needs, often inter-generational. Year one of the pilot has been completed and initial outcomes with families engaged in the project showed very positive changes and improvements in family lives as viewed by both families and the statutory agencies and professionals involved. Rigorous systems are in place to capture outcomes and user experience. The HSCB has also commissioned a further external evaluation which will run until September 2016. Report cards are submitted to Project Board on a quarterly basis which is available for 2014/15.

Protecting adults at risk: improving the safety of adults at risk of harm and adults in need of protection

Recognising the importance of all agencies involved in adult safeguarding working in an integrated and co-ordinated way to improve the safety of adults at risk of harm and in need of protection, an Information Sharing Agreement (ISA) for the Northern Ireland Adult Safeguarding Partnership (NIASP) was developed. This agreement enables agencies to share appropriate information and improve partnership working.

The ISA has resulted in improved levels of communication between organisations and facilitated the harmonisation of procedures across health, social care and law enforcement agencies. In doing so, it has ensured a more timely response to adults at risk and has greatly improved the quality of decision-making.

Transforming cancer follow-up

Transforming cancer follow-up (TCFU) programme has been a partnership between the HSCB and PHA in partnership with Macmillan Cancer Support and the five HSCTs to implement risk stratified models of cancer follow-up.

The programme's aims for post-treatment follow-up for the two regional tumour sites - breast and prostate cancer were to:

- Improve the patient experience and promote health and wellbeing;
- Enhance communication and coordination of care;
- Maximise use of resources.

Despite this being a large and complex change process, significant progress has been made and this has been due to the collegiate, collaborative and resilient approach from professionals at all levels across organisations and sectors engaging with the programme. A final evaluation report produced recently by PriceWaterhouseCoopers details the progress and an achievement worthy of particular note is that 58% of women with a new breast cancer are now on the self-directed

pathway. Learning from the programme has been harnessed with extensive pathway redesign taking place in other cancer tumour groups.

Quality 2020 Task 6 ward level review of the quality of clinical and social care

The leads for this task group have carried out a literature review around random safety audits and a weekly ward level review of patient experience and quality clinical care toolkit has been developed and tested.

A report has been collated to provide an overview of both the regional and local work that has been initiated and implemented between July 2014 and March 2015 throughout each of the HSCTs in relation to safety, quality and patient experience, in order to demonstrate that safety and quality is a key priority when delivering health and social care and provide a platform for sharing information throughout Northern Ireland. The report gives a brief summary of the quality, safety and patient experience initiatives that are progressing both regionally and within HSCTs and is available on the DHSSPS website.

Managed clinical networks

Northern Ireland pathology network

The Northern Ireland pathology network has enabled HSC laboratory services across the region to work in a more joined up manner and provides a single umbrella under which regional laboratory service activities can be planned and facilitated in partnership with stakeholders through a regional network board and 10 discipline specific specialty fora.



The network has developed a culture of team working and integration to achieve specific objectives with input from five HSCTs, the Northern Ireland Blood Transfusion Service, the HSCB, PHA, primary and secondary care services, universities, Northern Ireland HSC Research, DHSSPS, the Patient and Client Council and the Royal College of Pathologists.

Key achievements during 2014/15

- Successfully ensured that HSC laboratories participate in recognised benchmarking to demonstrate equity of performance alongside other parts of the UK. All Northern Ireland HSC laboratories now participate in the Keele University Benchmarking Scheme (KUBS) which includes measures of workload, staffing, productivity and finance data.
- Initiated a process to explore Northern Ireland's engagement in the UK 100,000 Genomes Project.
- Developed a single agreed process for the introduction of new commissioned molecular diagnostic tests.

- Coordinated the development of a business case which has ensured the Regional Paediatric Pathology service workforce was appropriately matched to the workload requirement.
- In partnership with primary care representatives and gastroenterologists, a business case for the introduction of H-Pylori Testing for adults with dyspepsia in the primary care setting was developed by the network and has recently been approved by commissioners.
- Biochemistry specialty forum has standardised a number of high volume tests and profiles across the region including U&E, lipid, and liver.
- Microbiology and virology specialty forum has implemented a change to all Group B Streptococcus (GBS) test request forms to indicate whether a woman is pregnant, which has critical implications for the safe treatment and care of pregnant women, and implemented a standard laboratory reporting format for positive GBS results.
- Microbiology and virology specialty forum has agreed a regional standard turnaround time of 72 hours for a Teicoplanin test to assist clinical service users.
- Implemented a regional electronic alert designed to help in the effective management of acute kidney injury (AKI). Laboratory test reports relevant to AKI that are viewed on the Northern Ireland Electronic Care Record will include a link to AKI clinical guidelines.
- Supported the successful establishment of a regional familial hypercholesterolaemia (FH) cascade screening service, which has resulted in an increase in the detection rate, with 28.7% of the estimated FH population now identified.

Neonatal Network Northern Ireland (NNNI)

In 2013, following inclusion in the 2012/13 HSCB/PHA Commissioning Plan as a recommendation of a 2012 RQIA independent review of incidents of pseudomonas aeruginosa infection in neonatal units in Northern Ireland, the Neonatal Network NI (NNNI) was formally established as a managed clinical network.



In 2014 a HSCB/PHA review of neonatal services commenced with the aim of informing the commissioning of safe and sustainable neonatal services in Northern Ireland. Supported by the network the review will focus on:

- A. Developing an optimum service model for the provision and location of neonatal cots in Northern Ireland.
- B. Outlining the neonatal workforce required for the provision of a high quality, sustainable neonatal service.
- C. Developing a service specification for neonatal services across all levels of care.
- D. Identifying priorities for action/implementation by the Neonatal Network as a result of the review.

The review is expected to complete in 2015 with a service model for the future of neonatal services in Northern Ireland.

Key achievements during 2014/15:

1. The NNNI has worked collaboratively to achieve consistency in care and drive quality improvement within the network and beyond with a family centred approach. By hosting quarterly quality improvement events focusing on key network priorities, using a PDSA cycle approach, wider network and interfacing service engagement is achieved to raise standards and outcomes for patients and families. This approach has and continues to promote consistency and communication across the network and beyond reaching regional agreement, eg the development of a Neonatal Network guidance to support the early onset of sepsis (EoS) across neonatal care. Furthermore a cohesive network culture enables the effective management of network cot capacity at times of significant challenge via the facilitation of weekly regional network teleconferences reducing the risk of out of region transfers.
2. The ongoing neonatal service review has assessed national evidence supporting multi-disciplinary team working to secure positive outcomes for staff and families and in hand with a neonatal workforce analysis will identify requirements to strengthen the neonatal workforce and raise outcomes in specific areas/professions/grades.
3. The network has provided peer and professional support through continuous engagement and collaborative working to the wider network through attendance and involvement in service improvement events and projects. Outputs from these projects has secured increased regional consistency in service delivery in areas of infection control, neonatal transfer and prescribing and is currently working on a regional multi-professional basis on infection control agreement in relation to the testing, transfer and isolation of neonates.
4. The network's priorities are influenced by parental feedback on the neonatal care pathway and its engagement with Tiny Life, SANDS and other user representatives is key to this. This has been achieved through the development and implementation of a regional parental discharge questionnaire in 2014 across all units. This together with parental focus groups has provided positive feedback for staff and families while identifying key areas within and beyond neonatal for improvement to drive up quality and consistency in parental experience.
5. With a PDSA cycle approach to key issues audit measure the quality improvement in areas targeted by the network with focus in 2015 on improving the repatriation of neonates across the network, measuring the impact of neonatal pressures on interfacing services (Post Natal Wards) and currently focusing on improving breast feeding rates in neonatal units across Northern Ireland.
6. The network have utilised time specific task and finish groups to progress the work plan to improve consistency and drive up quality across the region in service delivery, eg working with paediatricians, obstetricians, and user representatives across Northern Ireland to improve the in utero transfer process for patients and staff through the provision of regional guidance for staff in the form of a counselling leaflet for parents to ensure consistency in information and support informed decision making.

Critical Care Network in Northern Ireland (CCaNNI)

The Critical Care Network in Northern Ireland (CCaNNI) was established in March 2007 to improve access, experience and outcome for patients with potential or actual need for critical care. This is achieved by providing a service that is high quality, coordinated, timely and unrestricted by traditional clinical or organisational boundaries.



There are currently 11 units in the Network, including paediatric critical care services, treating more than 5,000 critical care patients a year.

Key achievements during 2014/15:

- Developed a suite of reports which inform clinical practice and assist organisational and clinical decisions on activity and resources.
- Key role in collecting, monitoring and reporting incidents of influenza within critical care, which form the basis of a local and national report.
- Undertake quarterly regional patient flow exercises in adult and cardiac surgical intensive care, together with an ongoing collection of data from PICU. Units/HSCTs are supplied with individual reports.
- Undertook workforce analysis to identify issues within critical care and in particular the consultant medical workforce.
- Facilitating the regional medical workforce survey on behalf of DHSSPS Regional Workforce Planning Group in conjunction with PHA.
- Developed and delivered a lead assessor study day in support of mentors to the critical care course.
- Continue to develop regional policies and guidelines.
- Standardised definitions within critical care.
- Review of discharge and admission policy / transfer guidelines / central venous catheterisation guidelines.
- Implementation and roll out of regional dedicated Critical Care Transfer (CCT) Trolleys, standardising practice across 14 sites and five HSCTs and in partnership with NIAS.
- Developed a suite of SOP in support of the CCT Trolley roll out.
- Provide training in support of the CCT Trolley both locally and regionally.

- Collect, review and report on all critical care transfer within Northern Ireland and all air transfer outside Northern Ireland.

Paediatric networks in Northern Ireland

The Royal Belfast Hospital for Sick Children is the major children's hospital in Northern Ireland and has provision for 84 beds, providing a comprehensive range of regional specialist services, as well as acute care to children within the Greater Belfast area.

The HSCB, PHA, Belfast HSCT and DHSSPS are committed to maintaining specialist paediatric services in Northern Ireland within a high quality, safe and sustainable framework of care.

The strategic intention for specialist paediatric services is, where it is safe and sustainable to do so, offer as much specialist care as possible within Northern Ireland. This may not always be possible and other options may need explored including the establishment of clinical networks with tertiary centres either in GB or ROI, optimising the use of specialist interest areas of paediatricians across Northern Ireland, securing 'in reach' from larger providers, and/or commissioning some service elements outside Northern Ireland.

In 2012 a paediatric network manager was appointed to work within the Royal Belfast Hospital for Sick Children (RBHSC) at BHSC to lead the establishment of both informal and formal clinical networks across specialist service areas, provide leadership for change, develop and maintain effective relationships with internal and external stakeholders and actively engage key stakeholders in service delivery.

In line with this, three main objectives were set:

1. formalise selected paediatric networks within Northern Ireland;
2. formalise networks with other UK-based tertiary and quaternary services;
3. improve the patient and family experience for families that require access to very specialist care not available in Northern Ireland.

(1) Formalise selected paediatric networks in Northern Ireland

In 2014/15 the Northern Ireland paediatric gastroenterology network, the Northern Ireland paediatric epilepsy network and the Northern Ireland paediatric respiratory and allergy network have continued a process of formalisation to build on excellent working and partnership arrangements of clinicians throughout Northern Ireland.

The networks are linked groups of health professionals and organisations from secondary and tertiary care, working in a coordinated manner, unconstrained by existing professional and Trust boundaries, there to support equitable provision of high quality clinically effective care to children residing in Northern Ireland.

Each network has now agreed terms of reference including plans to improve patient and family engagement and annual objectives. Both the Northern Ireland paediatric gastroenterology network and the Northern Ireland paediatric epilepsy network have produced annual reports for the first time. In addition, the networks have continued to deliver a programme of education and training for all interested clinicians at least four times annually.

This year the BHSCT has begun planning to deliver a Northern Ireland paediatric neurodisability and Northern Ireland paediatric endocrine network in 2015/16.

(2) Formalise networks with other UK-based tertiary and quaternary services

In 2014/15 the BHSCT continued to formalise networks with UK providers to provide 'in-reach' services. These include very specialist clinicians coming to Northern Ireland to deliver clinics or operating theatre sessions that would otherwise be unavailable in Northern Ireland. The following specialist in-reach clinics were delivered in 2014/15:

- Urology by Mr Cuckow from Great Ormond Street Hospital for Children NHS Foundation Trust
- Gastroenterology by Mr McKiernan from Birmingham Children's Hospital NHS Foundation Trust
- Metabolic bone by Professor Bishop from Sheffield Children's NHS Foundation Trust
- Metabolic lysosomal storage disorders by Dr Jones from Royal Manchester Children's Hospital NHS Foundation Trust.
- Endocrine by Professor Butler from Great Ormond Street Hospital for Children NHS Foundation Trust.
- Bone marrow transplant failure clinic by Dr Steward – Bristol Royal Hospital for Children NHS Foundation Trust.

This year, the BHSCT has agreement in principle to deliver a specialist in-reach services for spasticity assessment and other services from Alder Hey Children's Hospital NHS Foundation Trust in 2015/16.

In 2014/15 the BHSCT cemented formal arrangements with Great Ormond Street Hospital for delivery of a 24/7 specialist telephone clinical advice service for Northern Ireland paediatricians treating paediatric patients with suspected or confirmed endocrine and metabolic conditions when the consultant team based in RBHSC is unavailable.

Northern Ireland has also strengthened formal links with the Northern Children's Epilepsy Surgery Service (NorCESS), which is a joint service between Alder Hey Children's Hospital NHS Foundation Trust and Royal Manchester Children's Hospital NHS Foundation Trust to deliver an epilepsy surgery and rehabilitation service. This is one of only four designated units in the UK. BHSCT and NorCESS colleagues have visited each other's units and agreed a specific patient pathway for families in Northern Ireland.

(3) Improve the patient and family experience for families that require access to very specialist care not available in Northern Ireland

In 2013, following focus groups involving families that travelled for care outside Northern Ireland, it was identified that the following improvements could be made in this service:

- There should be a single contact point where families can speak to a member of staff for queries related to all travel, accommodation, expenses and care with relation to receiving care outside of Northern Ireland.
- There should be a patient information resource detailing the process for receiving care outside Northern Ireland including travel, accommodation and expenses.
- There should be a patient information resource regarding the specific hospital outside Northern Ireland that the family have been referred to.
- There should be a contact number for this service 24/7.

In October 2014, the paediatric patient experience office began work from RBHSC to manage all arrangements for families that travel outside Northern Ireland for care. The paediatric patient experience office delivers all the service improvements, as requested by families, which are listed above.

In addition, the service is working with colleagues in the Northern Ireland bereavement network and the HSCB to provide an information pack in 2015/16 for families that suffer bereavement when their child receives care outside Northern Ireland. This work includes improving processes and arrangements for families to return home during this very difficult time.

Theme two:

Strengthening the workforce

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 (612 in HSCB and 331 in PHA as of March 2015) throughout Northern Ireland and recognise that their employees are their greatest resource.

The cumulative percentage absence in respect of staff sickness for 2014/15 was 2.81% for the HSCB and 2.55% for the PHA; this was a reduction for both organisations from 2013/14. Sickness absences have an impact on quality and productivity, affect service delivery and are therefore an important factor when measuring an organisation's 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 2014/15, HSCB and PHA staff in each of the four main 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 including alcohol and nutrition advice, information on cycle to work, physiotherapy and staff services. In addition, occupational health nurses carried out cholesterol and blood pressure checks.

Staff information

Information sessions

As part of the HSCB's commitment to supporting staff in their roles and keeping staff informed on developments across the Health and Social Care system, staff information sessions are organised across the HSCB offices on a regular basis. The staff information sessions are led by the HSCB's Chief Executive and Chairman and provide an opportunity for discussion and engagement at a local level. In addition, information relevant to staff is made available on the HSCB staff intranet.

HSCB bulletin

The HSCB produces a regular HSCB magazine which is distributed to all staff across the HSCB and is available on the HSCB intranet site. The magazine aims to keep staff informed and updated on developments across the HSCB and the wider Health and Social Care service. Staff are encouraged to submit articles and to share information with their colleagues.

Internal communications working group

The PHA has established an internal communications working group which reports to the Organisational Workforce Development Group to take forward the development and improvement of internal communication systems within the organisation. During 2014/15 the group led on the development of an internal communications audit which attracted 214 responses – almost two thirds of all PHA staff – underlining the importance of effective internal communication. An action plan has been developed which will address the key findings of the audit and help improve internal communication channels within the PHA.

Active travel

The HSCB and PHA continue to participate in the 'Bike to work' initiative, which helps staff buy new bicycles at a discounted rate and aims to improve rates of physical activity.

The PHA has commissioned Sustrans to run a three-year 'Leading the way with active travel' programme. This programme aims to encourage more staff in Belfast to walk or cycle to work, and is being delivered in PHA, Belfast City Council, BHSC (Royal site), HSCB and BSO. The programme is important in helping shift the norm and encourage greater physical activity. Accredited cycle training was offered to all staff (and the general population) from February – March 2015, to help increase confidence and safety on the road.

The PHA and HSCB have participated in the 'Active Belfast Challenge' (ABC) which encourages people in Belfast workplaces to get more active and travel more sustainably. Through logging journeys, staff can be in with a chance of winning some great prizes. Personal and workplace targets have been set including calories burned, CO2 saved, miles travelled and money saved. All journeys except single person car journeys are included.



Staff health and wellbeing group

The staff health and wellbeing working group (SHWWG) was established in July 2014 under the auspices of the organisational workforce development group (OWDG). The purpose of SHWWG is to act as a focus for the promotion of the health and wellbeing of all staff in the PHA and the work of the group reinforces the PHA's commitment to this goal. The process of working together across all divisions has been important, building understanding and sharing perspectives. The group has recently developed an action plan entitled 'Promoting Health and Wellbeing in the PHA as a Workplace: An Action Plan for the PHA' which recognises the importance of the workplace as a setting to promote health and wellbeing. A regular newsletter is produced to update staff on the progress of initiatives and future developments. During 2014-15 the group led the implementation of a number of initiatives/programmes to assist in promoting health and wellbeing for staff such as:

Lesbian, gay, bisexual and/or transgender forum

A forum for lesbian, gay, bisexual and/or transgender (LGB&T) staff in the PHA, HSCB and wider HSC organisations has been established, providing confidential support for LGB&T staff and students in the health and social care workplace. An e-learning facility has been developed and widely promoted within HSC settings and a website to support LGB&T staff in the HSC has been recently launched. The PHA also hopes to be the first HSC organisation to launch the diversity champion programme in 2015-16 which will build upon existing good practice to promote inclusive work environments. It is hoped that by participating in the programme, the PHA will demonstrate leadership to other HSC organisations that may be encouraged to take part in the programme.

Weight loss programme

In January 2015, a pilot weight loss initiative called the '£ for 1lb' challenge was offered in partnership with Business in the Community with the aim of supporting staff who wanted to lose weight over a 12 week period, with the support of a designated 'champion' and expertise from community dietitians. As part of the challenge, employees pledged a donation to local charities. A total of 69 participants took part in the '£ for 1lb' challenge in January 2015.



My Mood Matters/Living Life to the Full

A range of courses have been made available to staff in the PHA in relation to 'My Mood Matters' and 'Living Life to the Full: Life Skills'; both of which have evaluated very positively. The courses have been offered to each locality and have been well attended in each area.

Physical activity

PHA staff have been encouraged to increase physical activity during the working day by using stairs and on site gym facilities in each PHA site. During 2014/15 the SHWWG also negotiated a concessionary rate for staff who wish to join Pure Gym. A Corporate Code (without an expiry date) has been secured for PHA staff for Pure Gym situated in Adelaide Street, Belfast. The code removes the £25 joining fee.

Professional assurance, revalidation and supervision

The PHA/HSCB has in place an appraisal scheme which all professional staff participate in.

Medical Staff

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 appraisals to progress to revalidation. An appraisal policy has been developed. In 2014/13 medical 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. This was completed successfully in May 2014. 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 work together to support individuals to achieve their maximum potential as well enabling staff to take care of themselves and become more self-aware and skilled in their roles.

Midwifery

The PHA has appointed a Local Supervising Authority Midwifery Officer (LSAMO) to ensure that statutory supervision of all midwives practicing in Northern Ireland is exercised to a satisfactory standard as per legislation (The Nursing and Midwifery Order 2001). The LSAMO ensures the implementation of a system for regulation of the midwifery profession and the development of practice to deliver and maintain adequate professional standards, through supervision of midwives in the HSC, private, independent and prison sectors. The LSAMO provides advice on issues relating to midwifery and the maternity service and contributes to the wider HSC agenda by supporting public health and inter-professional activities at strategic level.

Social care

The social care workforce in Northern Ireland is regulated by the Northern Ireland Social Care Council (NISCC) which works closely with employers across the sector to ensure that workers are appropriately registered and supported to meet the required standards in their conduct, training and practice.

It is an offence for an individual to call themselves a 'social worker' or carry out a social work job role if they are not registered with the NISCC. It is also an offence to employ an unregistered person as a care worker in an adult residential home, nursing home or children's home, or as a manager in a residential care home, day care setting or domiciliary care setting. Social work students are also required to be registered with NISCC.

Registration for social care workers and social workers is granted for three or five years depending on the job role. All registrants must maintain their registration for as long as they are in practice. This includes renewing it at the end of each three/five year registration period.

The NISCC code of practice for employers places a responsibility on employers to manage and supervise staff to promote effective practice and good conduct as well as supporting staff to address any deficiencies in their performance.

Compliance with both regulatory and supervision requirements are monitored by the HSCB through the annual Trust reports on their discharge of delegated statutory functions.

Training for HSCB, PHA and HSC staff

The HSCB and PHA firmly believe that 'Quality training will produce quality staff who, in turn, will produce a quality service'. Through a multi-dimensional approach in terms of interventions, training and support to deliver high quality service, the HSCB and PHA have developed leadership skills at all levels to empower staff to take decisions, improve services and influence change.

Training for staff in the management of SAIs

During 2014/15 the PHA and HSCB commissioned a number of regional training programmes to support PHA and HSCB staff as well as HSCT staff and independent lay persons in the implementation of the SAI procedure. These courses included:

- Regional root cause analysis training (April and May 2014) which provides the tools to support staff when conducting or reviewing an SAI investigation.
- Lay persons training (March 2015).
- Significant event audit training.

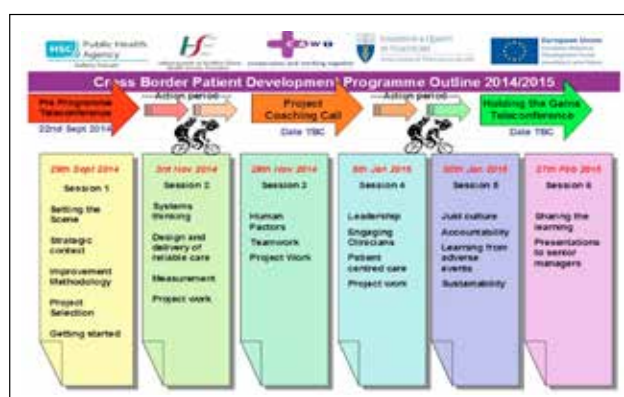
Next steps

- A Regional SAI Learning Workshop is scheduled for 14 April 2015.
- Further Root Cause Analysis Training for DROs and Lay Persons is scheduled for April and May 2015.

Training for staff in the management of complaints

During 2014/15, HSCB complaints staff received training from Hayes Healthcare Consulting in relation to complaints management. This workshop focused on report and letter writing techniques and recognising alternative methods of complaint resolution. The aim of the workshop was to improve the overall experience for complainants and HSCB staff in the handling of complaints.

The HSCB has continued to promote the use of independent lay persons in the local resolution of complaints and they have again been involved in complaints both within FPS and HSC Trusts this year. During 2014/15, their training focused on sharing experiences of cases they have been involved in, on the Serious Adverse Incident Procedure and what their job role would entail if they are involved in this process.



Quality improvement training commissioned by HSC Safety Forum

A key objective of the HSC Safety Forum is building and developing quality improvement capability amongst the HSC workforce in Northern Ireland in all aspects of quality improvement and safety for patients/service users.

As well as contributing a patient safety/improvement element at a number of events and programmes during 2014/15 the Safety Forum has:

- Recruited and funded an additional four safety forum Scottish fellows, who have completed a 10 month high-level training programme on Improvement and Leadership. This brings the total number of Safety Forum Scottish Fellows funded and trained since 2010 to 18.
- Completed cohorts 2 and 3 two of the (CAWT-funded) Cross Border Patient Safety Programme.
- Commissioned and hosted a fourth wave of human factors training for over 40 HSC staff nominated by HSCTs.
- Designed and delivered a patient safety module to senior nursing staff in collaboration with the Royal College of Nursing.
- Facilitated a 12 week module for first year medical students on patient safety.
- Berwick Series – To maintain the momentum for QI learning following the success of the Delivering Safer Care Conference (2014), the HSC Safety Forum, in partnership with the HSC Leadership Centre, designed and hosted an eight session masterclass series inspired by the recommendations of the Berwick Report *A Promise to Learn – a Commitment to Act*.
- Successfully bid for an Improvement & Leadership Fellowship funded by the Northern Ireland Medical and Dental Training Agency (NIMDTA). This post, running from August 2015, will provide the Fellow with Improvement Science and Leadership Training. The Fellow will complete a project to enhance the communication skills of staff working in Health and Social Care.

Lessons from Berwick
A Promise to Learn – A Commitment to Act

A series of events and workshops to help HSC grow as a learning organisation.

Dates for your Diary

Building on the successful Leadership Centre Lessons from Leaders series, the HSC Leadership Centre, working in collaboration with the HSC Safety Forum, Knowledge Exchange, NIMDTA and the HSC is delighted to announce the forthcoming series of events entitled:

Lessons from Berwick
A Promise to Learn – A Commitment to Act

These events have been built around a core theme from Berwick – Delivering Safer Care through growing HSC organisations as learning organisations

Speakers and dates now confirmed

Dr. Kate Oranger (Senior Nurse in Charge)	Thursday 2 nd September
Dr David Vaughan (Deputy Chief Executive)	Friday 3 rd October
Paul Rafferty (National & Local Safety Improvement)	Thursday 12 th November

(A separate flyer with the details of the exact time and venue for each event will follow when available with posters)

Other speakers we hope to have contributing to this series include:
 Darren Rabold (The Change Day)
 Dave Evans, Medical Director, NHS Northampton – Clinical Leadership and T/7 working
 Kevin Sheel – The 2nd Victim and absconding blame

We are currently in discussion with a number of other national leaders who may want to contribute to the Lessons from Berwick, A Promise to Learn – A Commitment to Act series, so more details will follow.

MORE DETAILS WILL FOLLOW SOON BUT WE WANTED YOU TO HAVE AN EARLY OPPORTUNITY TO PUT THESE DATES IN YOUR DIARY

Please get these dates into your diary now.

Dr. Kate Oranger is a Senior Nurse in Charge at the HSC Leadership Centre. She is a wife, daughter, sister, aunt, friend, doctor, patient and a mother. She is trying to look on the bright side of life. She has led the HSC's first national campaign across the HSC which can be used to gather momentum. Come and hear more. Keep details about the Kate Oranger event on 2nd September including venue, start time etc. will issue a short.

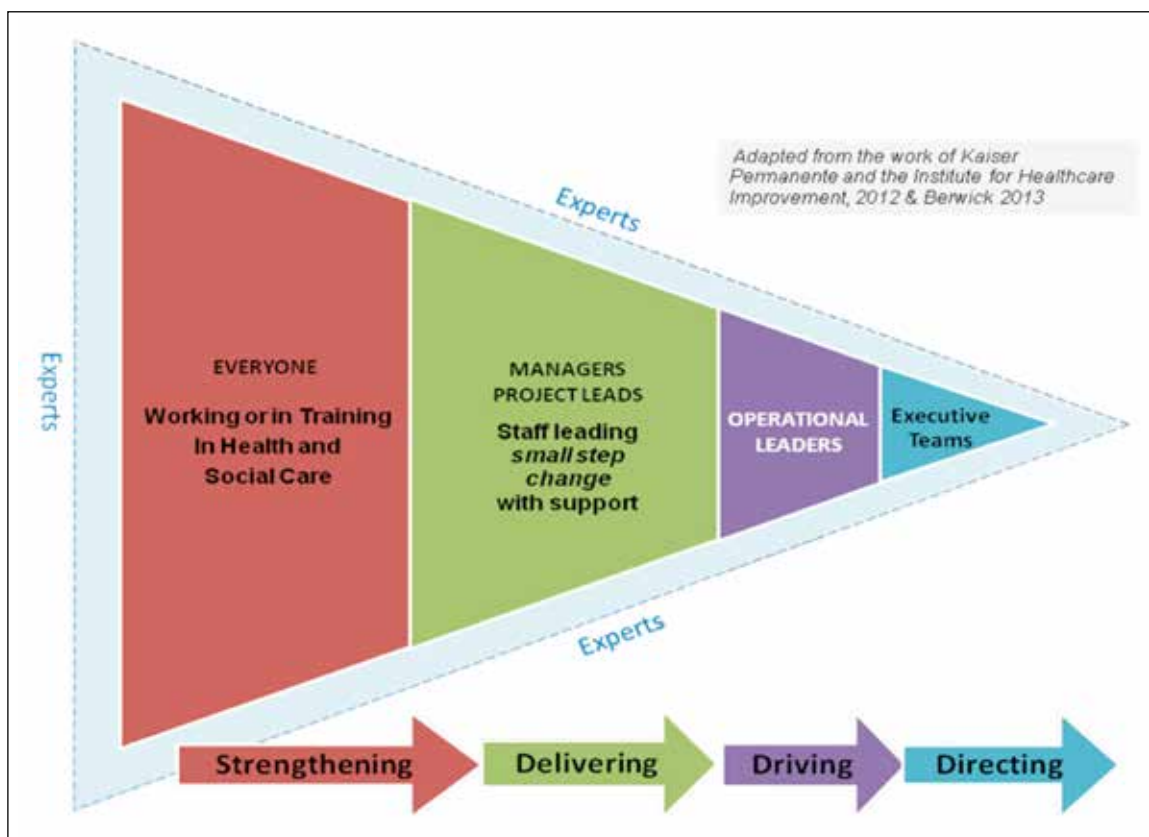
The details around venue and start time for the other confirmed speakers will issue when these details have been finalised. A separate flyer will issue for each event and you will be able to then add to attend or line at the HSC Leadership Centre website or via a specific 'subscribe' button on each flyer.

THE NORTHERN IRELAND CONFEDERATION OF HEALTHCARE MANAGERS

Attributes framework to support leadership in quality improvement and safety

As part of Q2020 Task Group 4, the HSC Safety Forum led a multi-professional group, chaired by the Chief Nursing Officer, in developing this framework. The attributes framework is informed by the principles and values within Quality 2020. It is designed to enable HSC staff to fulfill the requirements of their role and, as a result, put patients and service users where they are entitled – at the centre of care and services.

The framework is designed to assist HSC staff (including those in training) and their organisation in identifying current or future training needs for improving skills and safety. It will also assist providers of education and training in this area to harmonise the approaches used and content of training programmes.



Professional accountancy qualification

The HSCB Finance Directorate encourages the development of its staff through promoting the achievement of a professional accountancy qualification. In addition to passing examinations, students must also demonstrate they have gained the necessary work experience to fulfil the competency requirements. This is facilitated within the directorate by line managers and mentors.

In 2014/15, six staff passed their final stage of accountancy exams or have been admitted to their professional body, with a further three achieving success at their stage of study.

This enhances the financial skills and technical competence of the Finance Department, equipping them to manage the financial challenge the HSCB faces.

Protecting adults at risk: training for voluntary and independent sector in adult safeguarding

Given the high levels of care and support delivered to adults through the voluntary, independent and faith sectors, it is vital that staff in those sectors are able to prevent, identify and deal appropriately with issues of abuse of adults. Volunteer Now were commissioned to provide training to volunteers and employees. As result, 1,155 people have received training and accreditation in safeguarding. This has significantly improved the quality of life for adults at risk of harm or in need of protection.

In addition the HSCB have commissioned the recruitment of eight dedicated nursing staff to act as Investigating Officers in each HSCT area. These staff bring expertise in complex adult safeguarding investigations. This has resulted in:

- improved responses to adult safeguarding concerns in clinical settings;
- improved safety for service users.



Deliver better outcomes in mental health care

The HSCB developed a new *Working Together Learning Together Framework*. This framework provides HSCTs with guidance on those NICE approved therapies which should underpin continuing professional development for those professionals working in mental health services. The *Working Together Learning Together Framework* ensures a coherent and evidence based approach is adopted across all HSCTs and ensures service users receive care in line with best available

evidence. The HSCB has invested £300,000 annually and this has resulted in over 100 staff being trained in both modular and specialist psychological therapies programmes.

eLearning assessment tool

The HSCB/PHA have commissioned an eLearning Assessment Tool to assist with the ongoing assessment of health and social care staff across Northern Ireland. The objectives of the initiative are:

- To improve the standard of care given to patients through better training and skills assessment tools based on Northern Ireland content.
- To test the feasibility and effect of eLearning tools in improving healthcare professional skills in interpretation of a) X-rays and b) CTGs.
- To inform the value of taking forward future phases, including eLearning modules in other areas, and the development of a system to support a HSC eLearning system more widely.

There are three workstreams to test the objectives and each involves different groups of clinicians. Each workstream will evaluate different aspects of the eLearning Assessment Tool. The workstreams are:

- **plain film reporting** – assessment of competency for radiology trainees.
- **plain film reporting** – assessment of competency for emergency mMedicine doctors
- **CTG interpretation** – competency assessment for obstetricians and midwives.

The concept is being developed with Experior, a Belfast based ICT company, supported by Dr Tom Lynch, radiologist, providing clinical expertise. The approach centres around the Experior app containing considerable numbers of digital images, for example plain films and CTGs, which each have a clear statement of pathology if not normal or no abnormality detected. These images and reports can be configured into a test module or series of modules for an individual.

Staff in all HSCTs have taken part in the plain film interpretation in the spring of 2015, with the CTG phase going ahead as planned over the summer of 2015. An evaluation report to the project board is planned by December 2015.

Advanced communications skills training (ACST)

The Cancer Control Programme (2006), and DHSSPS Framework for Cancer Prevention *Treatment and Care* (2010) recognise the need for health and social care professionals to be skilled in communicating effectively and sensitively with people. The model utilised in Northern Ireland is a quality assured course, designed and led by Dr Susie Wilkinson. It includes a variety of experiential learning approaches. Evaluation has shown it to change behaviours and enhance communication between professional and patients. To date, almost 500 staff have been trained. Agreement was secured through NICaN Board that ACST will be devolved from January 2015 to become the responsibility of HSCTs and approved partner organisations and significant progress has been made. Clinical Education Centre (CEC) have agreed to provide one course per HSCT / per year through their service level agreements which would bolster the HSCTs provision. Oversight of the ACST quality assurance function is the remit of the Regional Advanced Communications Facilitators Forum through the PHA Nurse Consultant (Cancer & Palliative), NICaN and Macmillan. A cadre of facilitators across HSCTs has been established (14 completed training, 8 still in training). Facilitators are trained through a planned programme, supported on an informal basis by the National Co-Leads (from WHSCT and CEC).

Quality 2020 Task 5 minimum mandatory training

In 2014 the leads for nursing across the HSC completed a scoping exercise on the eLearning minimum mandatory training content for nursing. The leads for social care have also been working on taking a similar piece of work forward for social care staff. The Q2020 steering group agreed that this work would move forward in 2015 to now include all training (face to face, eLearning). A scoping exercise is being carried out that will give a baseline of minimum mandatory training that will be expected within each HSCT for nursing and social care staff.

Quality 2020 Task 13 WHO curriculum on patient safety in undergraduate training

This was a new task for 2014/15 and the work of this group has been led by NIMDTA (Northern Ireland Medical and Dental Training Association) and is focused on establishing a common Patient Safety Curriculum for Health and Social Care.

In September 2014 this task group held a workshop with key training providers from undergraduate and post graduate bodies. An action plan has been developed to:

- Document the components of the patient safety curriculum which are included in undergraduate and postgraduate teaching/training programmes and identify the gaps (for nursing, pharmacy, medicine).
- Identify/create examples of patient safety interventions through HSCT Governance Leads. Staff with the skills to support undergraduate/postgraduate education/training providers to deliver patient safety curriculum.
- Gather local anonymised examples of patient safety interventions in each category through HSCT Governance Leads with HSCT permission.

Quality 2020 Task 14 harmonising logistics

This was a new task for 2014/15 and has been led by Queens Centre for Public Health. The aim of the 'harmonising logistics' task group is to examine the variations that junior doctors face when moving between HSCTs. The main objectives are:

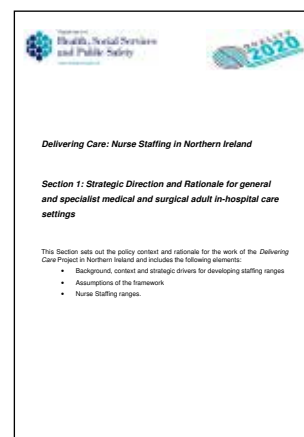
- Identify the core variations that junior doctors face when moving in and between HSCTs.
- Meet with junior doctors to gather information on variation.
- Develop strategies to minimise variations.

During 2014 a number of workshops were carried out with F2 Doctors at NIMDTA to facilitate discussion around the issues that they would face when moving within and between HSCTs in Northern Ireland. Approximately 150 F2 Doctors took part in the focus groups and provided their views. Some of the variations that were noted by the F2 Doctors were around induction, protocols, equipment and hospital at night handover. All the information gathered from these workshops was collated and has been drawn into an action plan for going forward in 2015.

'Delivering Care' nurse staffing in Northern Ireland

'Delivering Care' nurse staffing in Northern Ireland is the outcome of a commission undertaken by the PHA Executive Director of Nursing with the support of NIPEC from the DHSSPS Chief Nursing Officer and approved by the Minister of Health for Northern Ireland in 2014.

The implementation of the delivering care workforce projects is led by the PHA and HSCB.



The aim of the Delivering Care project is to support the provision of quality care which is safe and effective in hospital and community settings.

The outcome of the project will see the delivery of a robust framework to determine nurse staffing ranges for the nursing and midwifery workforce in a range of specialities across the nursing and midwifery workforce in Northern Ireland.

- Phase one: acute medical and surgical units in each of the HSCTs.
- Phase two: emergency departments.
- Phase three: district nursing.
- Phase four: health visiting.

The workplan to date has included a number of engagement events and meetings with HSC organisations and staff.

In addition a process is underway to scope and test the implications of implementing the recommendations set out in Delivering Care as they relate to the specific phases of the project.

Progress to March 2015

1. To date a number of meetings have been held with HSCB and PHA staff to agree the matrix and metrics of information to be included for each phase of the project including KPIs.
2. The summary information on the current position against the agreed normative range within each HSCT has been developed for phase 1 and is ongoing for the other phases. This process has been discussed and agreed with HSC organisations.
3. The implementation plans for phase 1 from each HSCT are now in place. A monitoring process has been agreed following the financial allocation for the requirements for phase 1. This process is ongoing with the DHSSPS/HSCB/PHA and HSCTs to ensure the targets set for the implementation of phase 1 are completed by March 2016.

Surveillance of surgical site infections – refresher training

In June 2014, the PHA delivered refresher training on surveillance of surgical site infections (SSI) for HSCT staff with responsibility for identification, management and reporting of SSIs occurring in their services. In total 66 multi-disciplinary staff from a variety of surgical and infection services across all HSCTs participated in this training. A number of independent sector healthcare providers also participated. The aims of the training were to:

- Update front line colleagues on the methodology used to identify and gather information on SSIs occurring in post-operative patients.
- Enable colleagues to understand and become familiar with changes to definitions and protocols underpinning our regional SSI programmes.

- Enable colleagues to see and access the PHA's web-based results portal, which is used to facilitate timely reporting of SSI rates and comparison of infection rates across and between services and sites.



Particular emphasis was placed on small-group working during this training, with participants availing of the opportunity to work through case studies aimed at increasing understanding of surveillance definitions and their application in the clinical context. The concluding session was used to introduce HSC colleagues to future changes in our regional approach to SSI surveillance and inform them of our intention to move to electronic data capturing and reporting.

HSC staff influenza vaccine uptake rates March 2015

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 uptake 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 winter 2014/15 and for the previous year for comparison purposes.

Table 6: Occupational health seasonal flu vaccine data 1 October to 31 March 2015

	Belfast HSC	South Eastern HSC	Northern HSC	Southern HSC	Western HSC	Northern HSC
HSC frontline staff population	14141	6411	7240	7414	5462	40668
Frontline staff receiving vaccine 1 October to 31 March	3201	1550	2177	1346	909	9183
Uptake rate frontline staff 1 October to 31 March 2015	22.6%	24.2%	30.1%	18.2%	16.6%	22.6%
Uptake rate frontline staff 1 October to 31 March 2014	27.2%	19.0%	30.7%	17.6%	22.6%	24.0%
HSC other staff population	5891	4970	4153	4128	4215	23357
HSC other staff receiving vaccine 1 October to 31 March 2015	1208	810	1047	859	726	4650
Uptake rate other staff 1 October to 31 March 2015	20.5%	16.3%	28.0%	20.8%	17.2%	19.9%
Uptake rate other staff 1 October to 31 March 2014	22.8%	22.6%	28.0%	25.1%	21.7%	24.0%

Theme three:

Measuring improvements

The HSCB and PHA appreciate that gathering information and examining data is important in identifying the performance of an area of work. However, in doing so it also recognises that it is vital that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. During 2014/15 the HSCB and PHA have continued to promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively. The HSCB and PHA have worked with HSCTs and other HSC bodies to provide support to improve outcome measurements in a range of quality improvement initiatives.

Performance against standards and targets

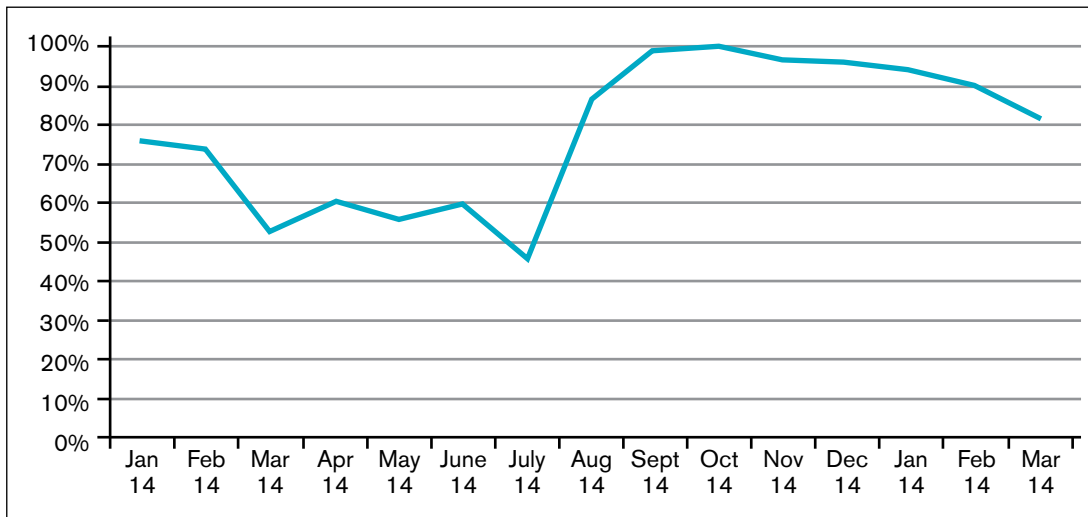
On an annual basis the Health Minister sets out Commissioning Plan Direction (CPD) targets and standards which represent particular areas of focus for the coming year. The Minister's vision for the integrated Health and Social Care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment care and support. Performance against these standards and targets is reported on monthly basis to the public HSCB meeting. During 2014/15 a number of these areas have represented a significant performance challenge and the HSCB and PHA have worked closely with HSCTs to improve performance by using accredited improvement techniques and ensuring that best practice resulting in high performance in some HSCTs is shared and implemented in others. Examples of this work are outlined below.

Cancer

Between January and July 2014 the percentage of urgent breast cancer referrals seen within 14 days deteriorated steeply. In order to address this issue, the HSCB worked closely with all HSCTs to apply the models of best practice that exist within Northern Ireland across all HSCTs to ensure a consistent approach to delivery of the 14 day standard. This included ensuring that existing triple assessment capacity was maximised through using the most appropriate pathways for routine and review patients and in the implementation of effective triage practice in line with good practice. Additional clinics were also undertaken and recurrent investment has been put in place in South Eastern and Northern HSCTs.

As a result of this collaboration, performance has significantly improved since August 2014 and while it has declined slightly in the latter part of the year, this is primarily in one HSCT. Actions to address this have been agreed and performance is expected to improve during the first quarter of 2015/16.

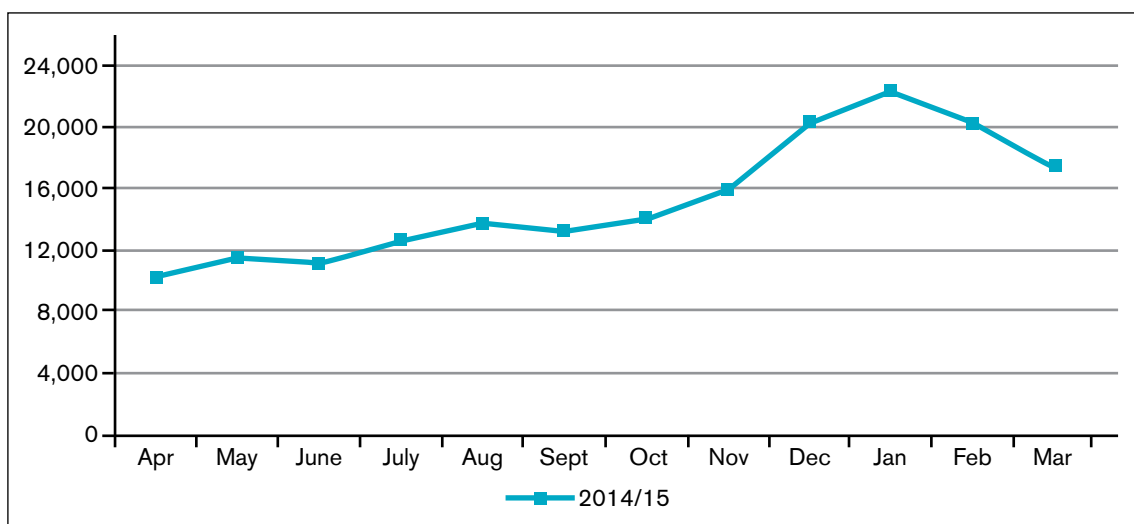
Figure 3: % of patients seen within 14 days of an urgent referral for breast cancer



Diagnostics

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the HSCB has prioritised the allocation of the limited funding available for elective care in the latter part of 2014/15 for diagnostics. As a result, the length of time patients have waited for a diagnostic test has improved during the final quarter of 2014/15. At the end of March 2015, 17,807 patients were waiting longer than nine weeks and it is expected that waiting times will improve further during 2015/16. Furthermore, the HSCB has undertaken a range of service improvement work with HSCTs to understand the demand and capacity across key diagnostic modalities and plans are in place to enhance and expand the current capacity resulting in improved diagnostic waiting times for patients.

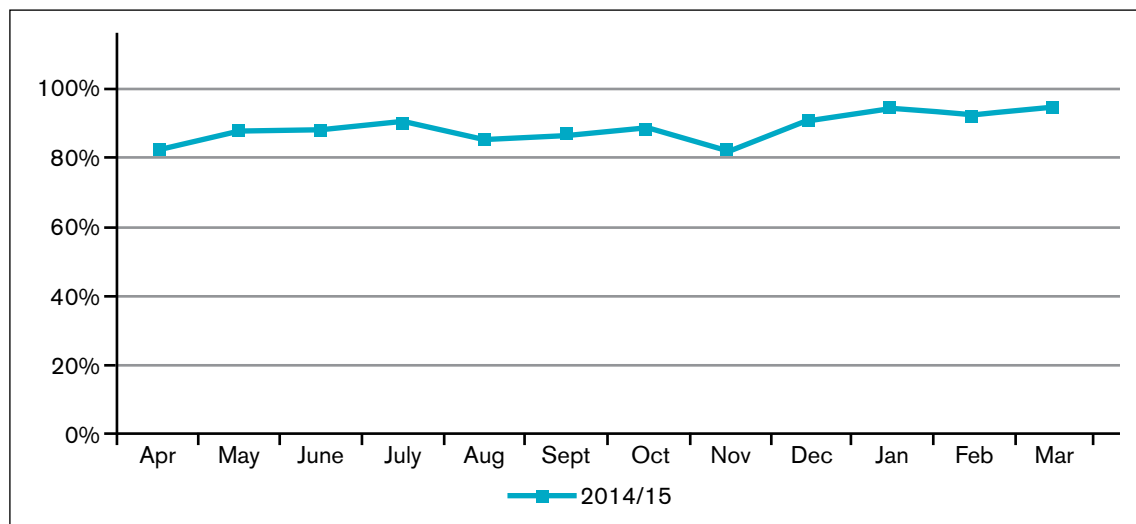
Figure 4: Diagnostics waiting times



Hip fractures

Regionally during 2014/15, 89% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (CPD standard: 95%). This represents an improved position from 2013/14 when 86% of patients were treated within 48 hours. It should be noted that significant improvements were made in the latter part of 2014/15 and this position is expected to further improve in 2015/16.

Figure 5: Percentage of patients receiving treatment for hip fractures within 48 hours



Furthermore, to improve the quality of access for the residents in the Newry and Mourne area of the Southern LCG, the HSCB has made significant investment in the trauma and orthopaedic team in the Southern HSCT. As a result of this investment, it is expected that from May 2015, all hip fracture patients will be treated locally rather than being transferred to Belfast.

Quality assurance and quality improvements for screening programmes

Screening actively seeks to identify a disease or pre-disease condition in people who are presumed and presume themselves to be healthy. 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.

Population 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 HSCTs 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 eye
- Surveillance screening for women at higher risk of breast cancer

Antenatal and newborn screening programmes:

- Antenatal infection screening
- Newborn bloodspot
- Newborn hearing

QA is an integral part of screening because screening can cause harm as well as good. It helps to maximise benefits and minimise harms. QA aims to monitor, maintain and improve upon set 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 provide advice and recommendations for service improvement. This usually takes the form of a QA committee, coordinating group or regional quality improvement group chaired by a Consultant in Public Health. Examples of QA activity include audit, performance monitoring, quality improvement activities, QA visits, QA follow-up meetings, shared learning and training.

QA visits undertaken by cancer screening programmes in 2014/15

Bowel screening:

- Belfast HSCT September 2014

Cervical screening:

- Southern HSCT May 2014
- Belfast HSCT March 2015

Breast screening (also covering surveillance screening for women at higher risk):

- Northern HSCT November 2014

Screening programme performance

The following tables indicate that for the majority of screening programmes, the standards and targets are being met or exceeded. Work to promote informed choice about population screening programmes has been taken forward at HSCT level and regionally. This work has focused on those groups who find services harder to reach.

Table 7: AAA screening data for 2014/15

Measure	Standard/target/comparative data	Outcome
Uptake (initial)	≥ 60% (acceptable) ≥ 85% (achievable)	83%*
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%

***NB: Episodes for the 14/15 screening cohort do not officially close until the end of June 2015**

Table 8: Diabetic retinopathy data for 2013/14 (most recent data available)

	Total invited	Total attended	
Northern Ireland	71,233	54,613	77%

Table 9: 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 10: Newborn bloodspot screening data 2013/14 (most recent data available)

Measure	Standard/target/comparative data	Outcome
Timely sample collection	95% of first samples taken 5-8 days after birth	98.3%
Timely processing of screen positive samples (PKU, CHT and MCADD only)	100% of positive screening results available and clinical referral initiated within four working days of sample receipt by screening laboratory.	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 – 99.1% CHT – 98.3% MCADD – 99.2% CF – 99.1% SCD – 99.1%

Table 11: Newborn hearing screening data for 2014/15 (quarter 3)

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%	95.7%
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 of age)	99.0%	98.8%

Quality improvement plans

The HSCB and PHA are committed to driving improvements through monitoring a range of indicators which enhance the quality of services.

The Quality Improvement Plans are focused on key priority areas to improve the outcomes for patients/clients. HSCTs report on a number of indicators each quarter to the PHA/HSCB.

Last year the focus was on:

1. Pressure ulcer prevention
2. Falls prevention
3. Preventing harm from VTE
4. Sepsis

Regional 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.

The SKIN Bundle is an evidence-based collection of interventions proven to prevent pressure ulcers. The PHA supports HSCs through The Regional Prevention of Pressure Ulcer Quality Improvement Collaborative to implement SKIN in all hospitals in Northern Ireland. Reliably delivering all elements of the care bundle at every care opportunity will improve the pressure area care that a person receives. This in turn will have an impact on improving care outcomes.



The four elements of the SKIN bundle are:

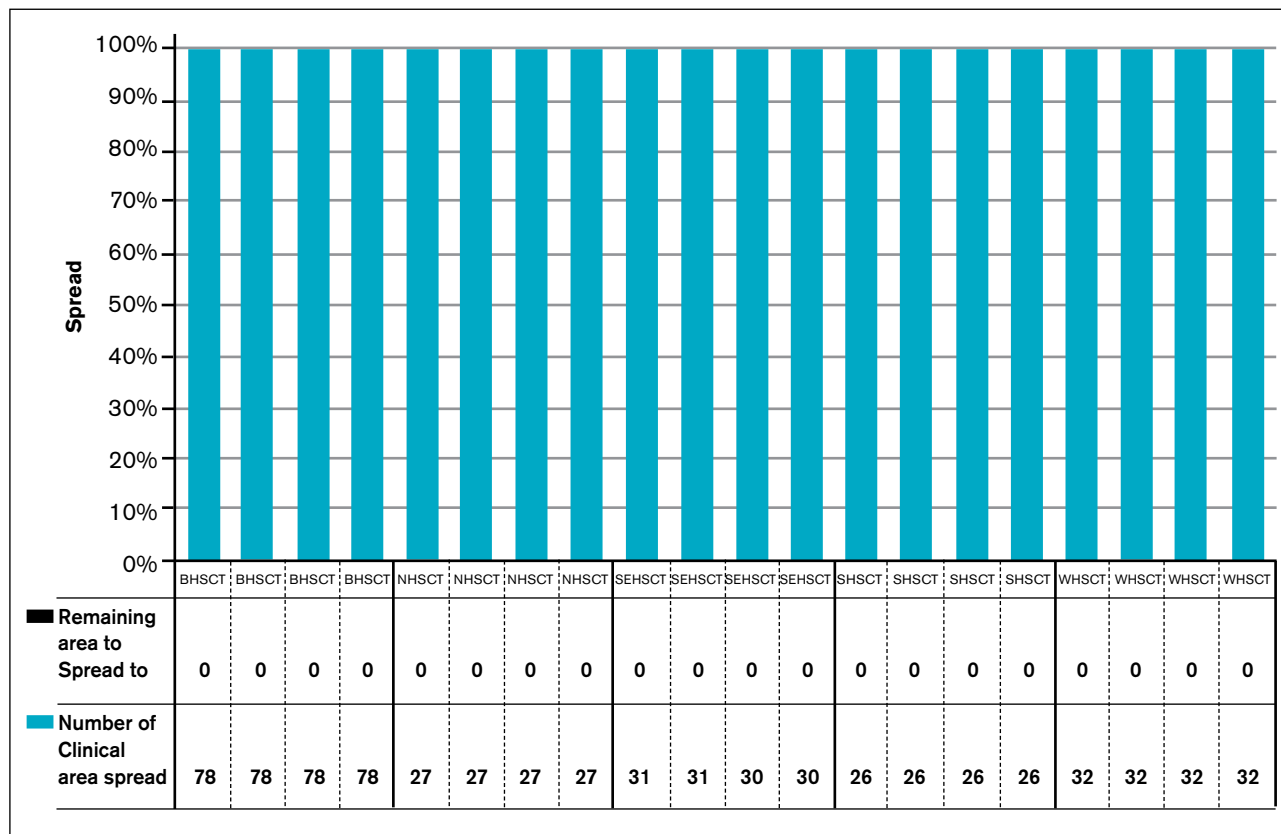
- Surface
- Keep moving
- Incontinence
- Nutrition

During 2014/15 the HSCs were tasked with:

- securing a 10% reduction in pressure ulcers and sustaining spread to all adult inpatient areas/wards.
- monitoring and providing reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days.

A 10% reduction in reported pressure ulcers has not been achieved and an increased number of total pressure ulcers reported regionally has been seen at the end of Q4 2014/15. The initial increase in the incidence of pressure ulcers may be a result of the spread of the SKIN bundle and the resulting expected increase in awareness and reporting.

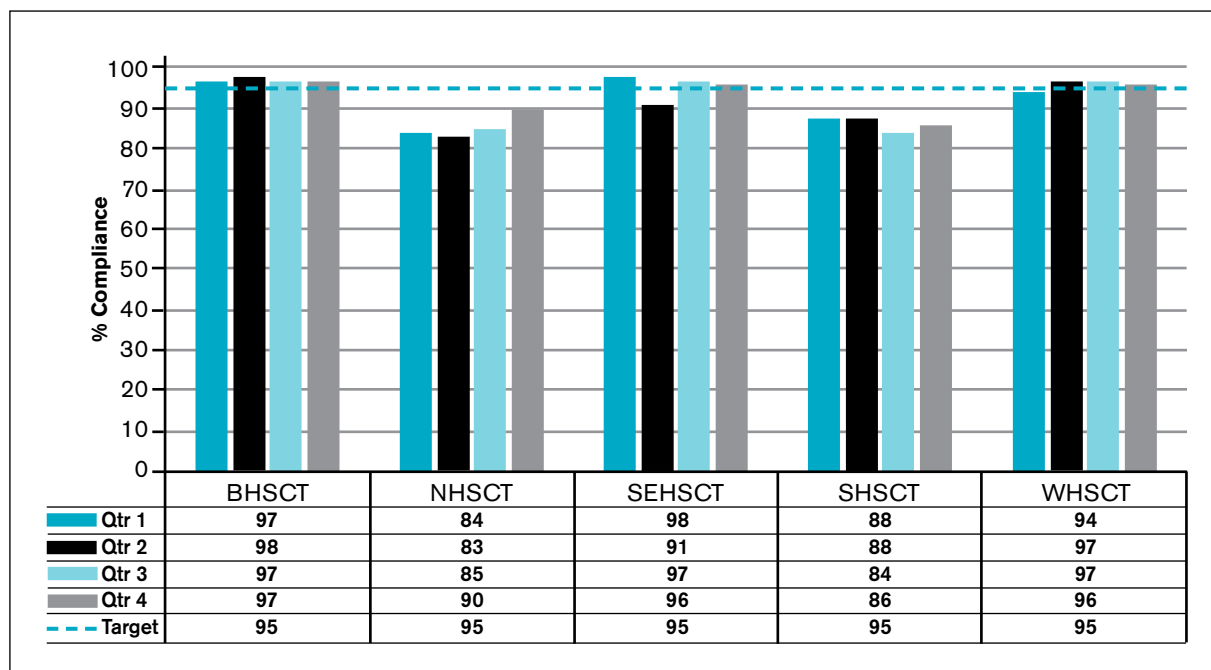
Figure 6: SKIN bundle spread



At the end of Q4 2014/15 the reported regional pressure ulcer incidence rate ranges between 0.3% and 0.6% per 1,000 bed days. There are a number of individual hospital HSCTs in England that report pressure ulcer incidence rates per 1,000 bed days as part of the NHS England open and honest care driving improvement initiative. In February 2015 the reported pressure ulcer incidence rates for these HSCTs range between 0 - 2.12% per 1,000 bed days. It should be noted that direct comparisons with Trusts in England cannot be made due to variations in the way data is collected and different patient cohorts.

At the end of March 2015 all HSCTs had reached 100% compliance with spread/ implementation of the SKIN bundle across all hospital inpatient wards, and the compliance with the SKIN bundle ranges from 86-97% (see Figure 6 and 7).

Figure 7: SKIN bundle compliance



Regional falls prevention

There is evidence that falls are a significant cause of harm to patients in receipt of health and social care in Northern Ireland. Falls are among the top five most frequent adverse incidents reported within HSCTs.

All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy, although research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions.

The PHA leads a project to implement The Royal College of Physicians 'Fallsafe' bundle in hospitals in Northern Ireland. This is an evidence-based bundle of interventions for falls reduction which has been separated into two parts, part A and part B.

Table 12: Fallsafe bundle

Part A	Part B
Asked about a history of falling in the past 12 months	Cognitive screening
Asked about a fear of falling	Lying and standing blood pressure
Urinalysis performed	Full medication review
Call bell in sight and reach	Bedrails risk assessment
Safe footwear on feet	
Personal items within reach	
No slips or trips hazards	

During 2014/15 the HSCTs were tasked with:

- Continuing to improve compliance with elements of 'Fallsafe' bundle parts A and B in identified pilot clinical areas.
- Spread part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the percentage of adult inpatient ward/areas in which the 'Fallsafe' bundle has been implemented.

The process measures that HSCTs will demonstrate improvement in compliance with the nursing elements of the overall Fallsafe bundle (parts A and B). This has provided a challenge for achieving the falls bundle and requires some time to ensure the practice is embedded in the new inpatients area where the bundle has been spread.

All HSCTs demonstrated an increase in spread of the falls bundle

At the end of Q4 2014/15 the reported regional falls rate from falls resulting in moderate to serious harm are 0.11 to 0.37 per 1,000 bed days. There are a number of individual hospital HSCTs in England that report falls resulting in moderate to severe harm rates per 1,000 bed days as part of the NHS England open and honest care driving improvement initiative. In March 2015 the reported moderate to severe harm for falls incidence rates for these HSCTs range between 0 – 0.36% per 1,000 bed days. It should be noted that direct comparisons with Trusts in England cannot be made due to variations in the way data is collected and different patient cohorts.

Figure 8: Fallsafe bundle compliance 2013/14

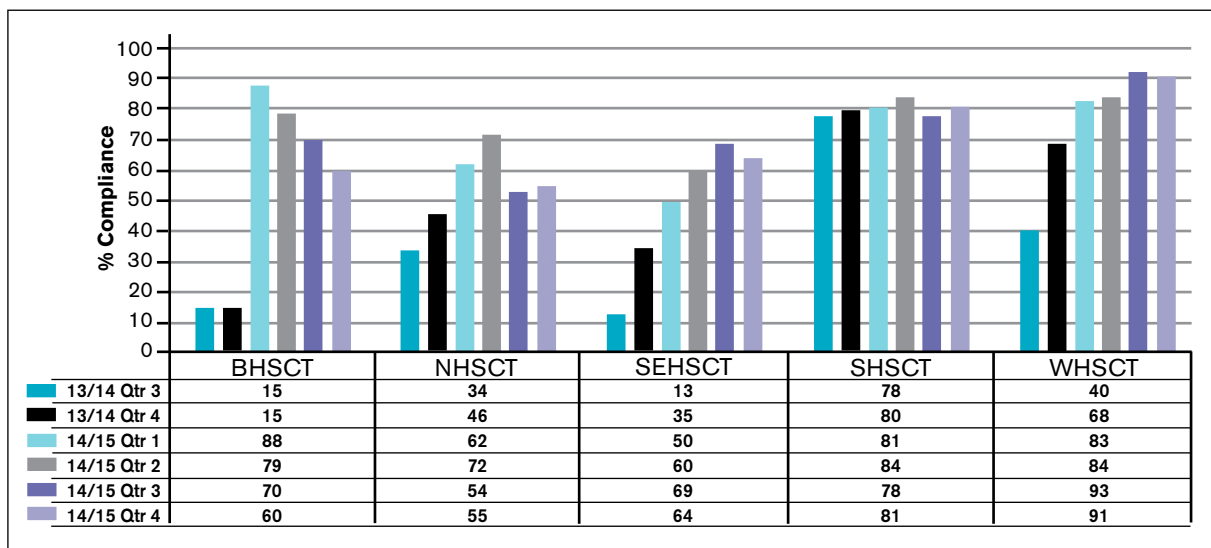


Figure 9: Fallsafe bundle compliance 2015

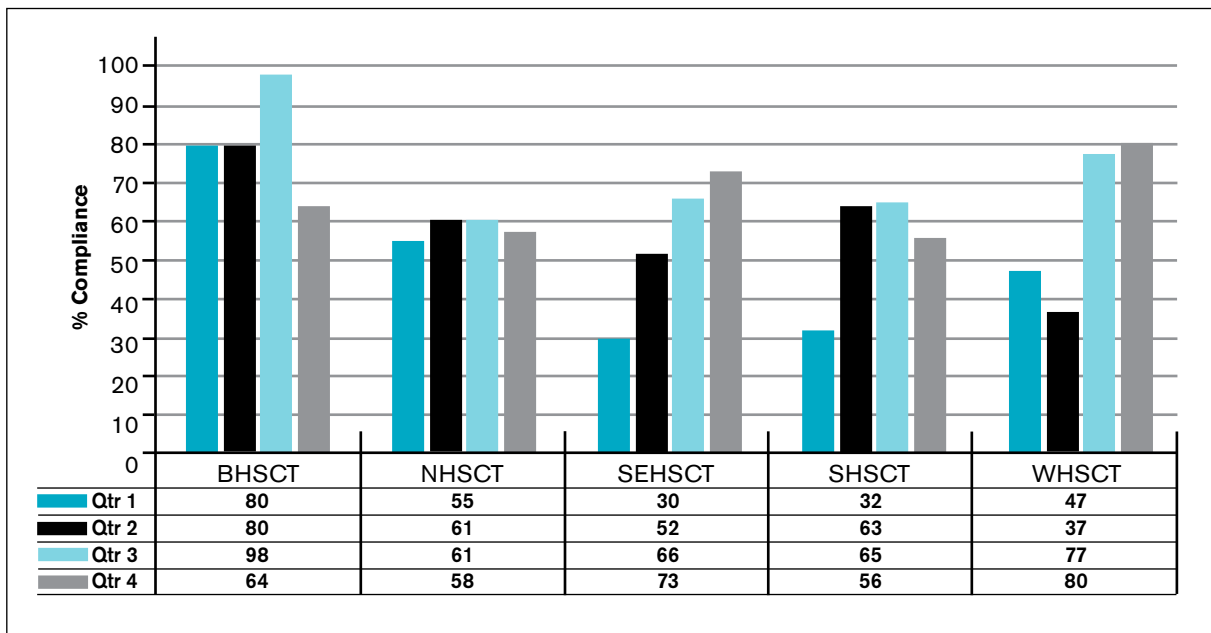
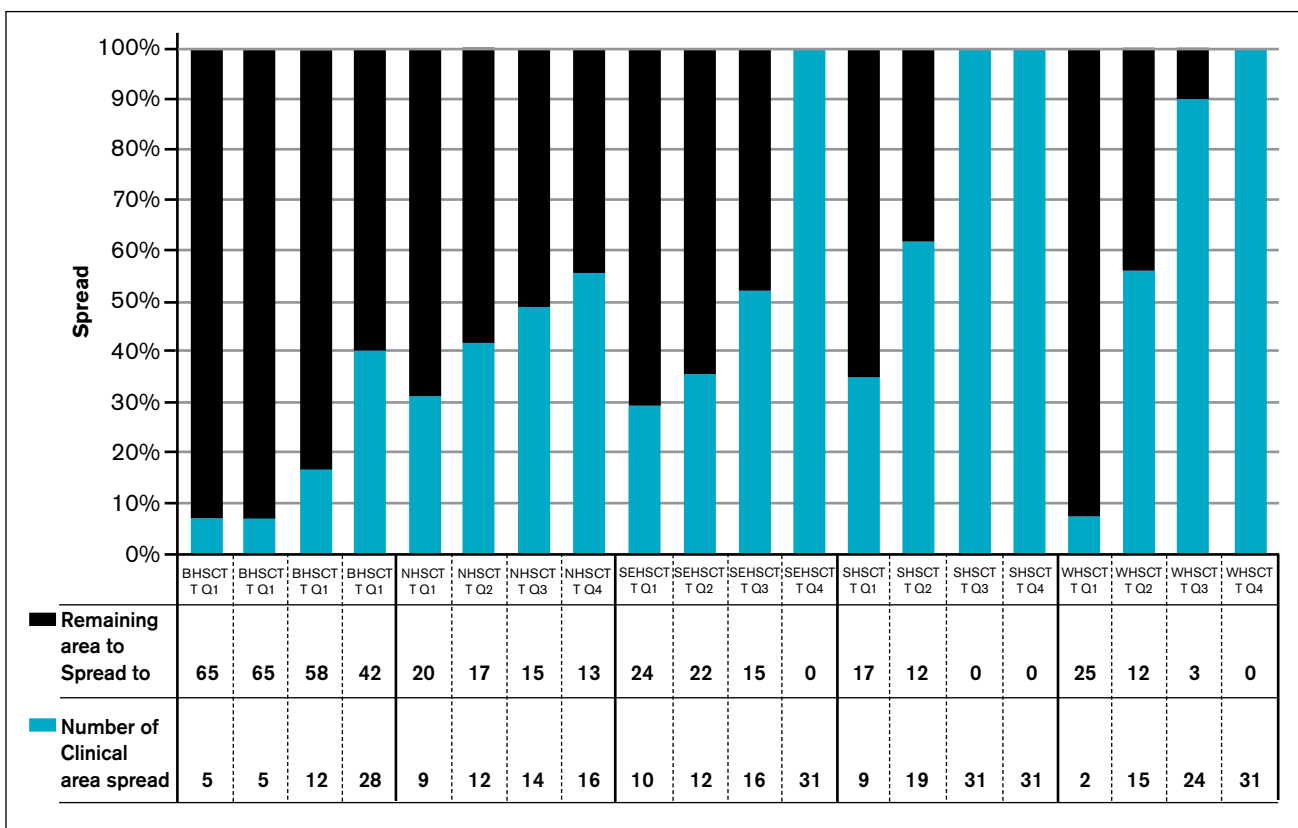


Figure 10: Fallsafe bundle spread



Preventing harm from VTE

Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by the DHSSPS and implemented in Northern Ireland. Assessing the risks of VTE and bleeding is a key priority for implementation of the guidelines.

During 2014/15 the HSCTs were tasked with:

- achieving 95% compliance with VTE risk assessment across all adult inpatient hospital wards by March 2015.

At end March 2015 all HSCTs have reached between 92-100% compliance with spread of the VTE bundle across all hospital inpatient wards, and the compliance with the VTE bundle ranges from 77-88% (see Figure 11 and 12).

Figure 11: VTE bundle compliance

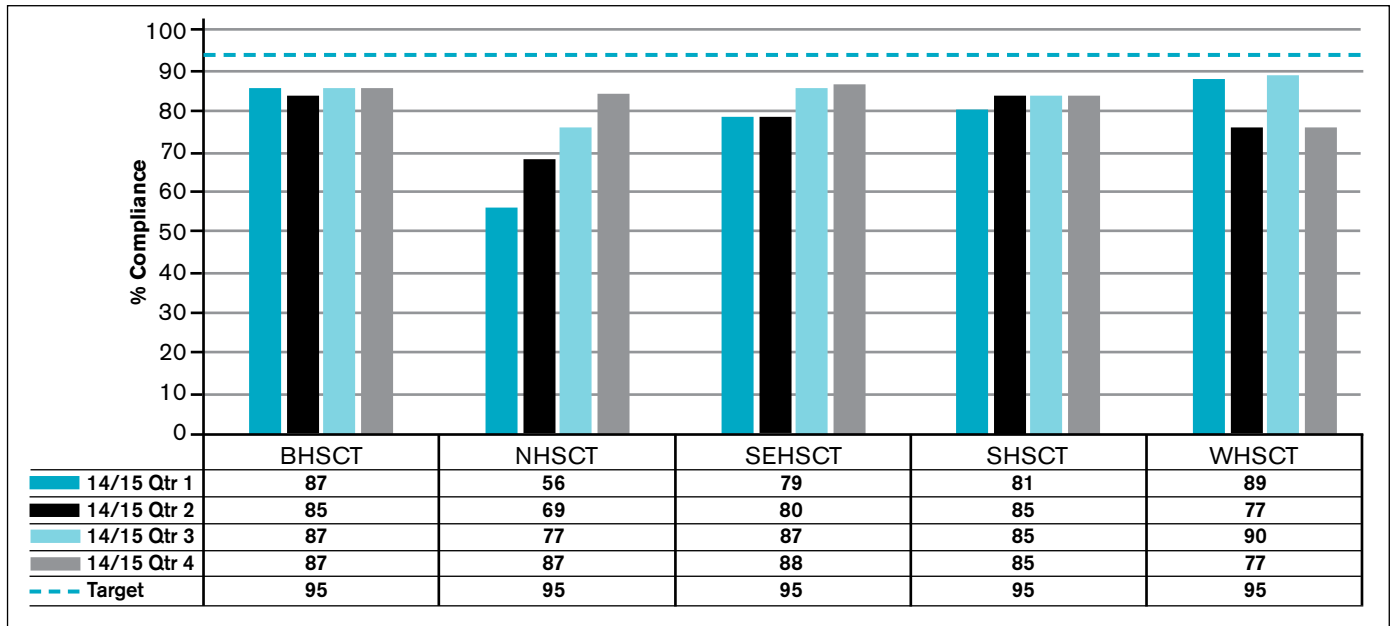
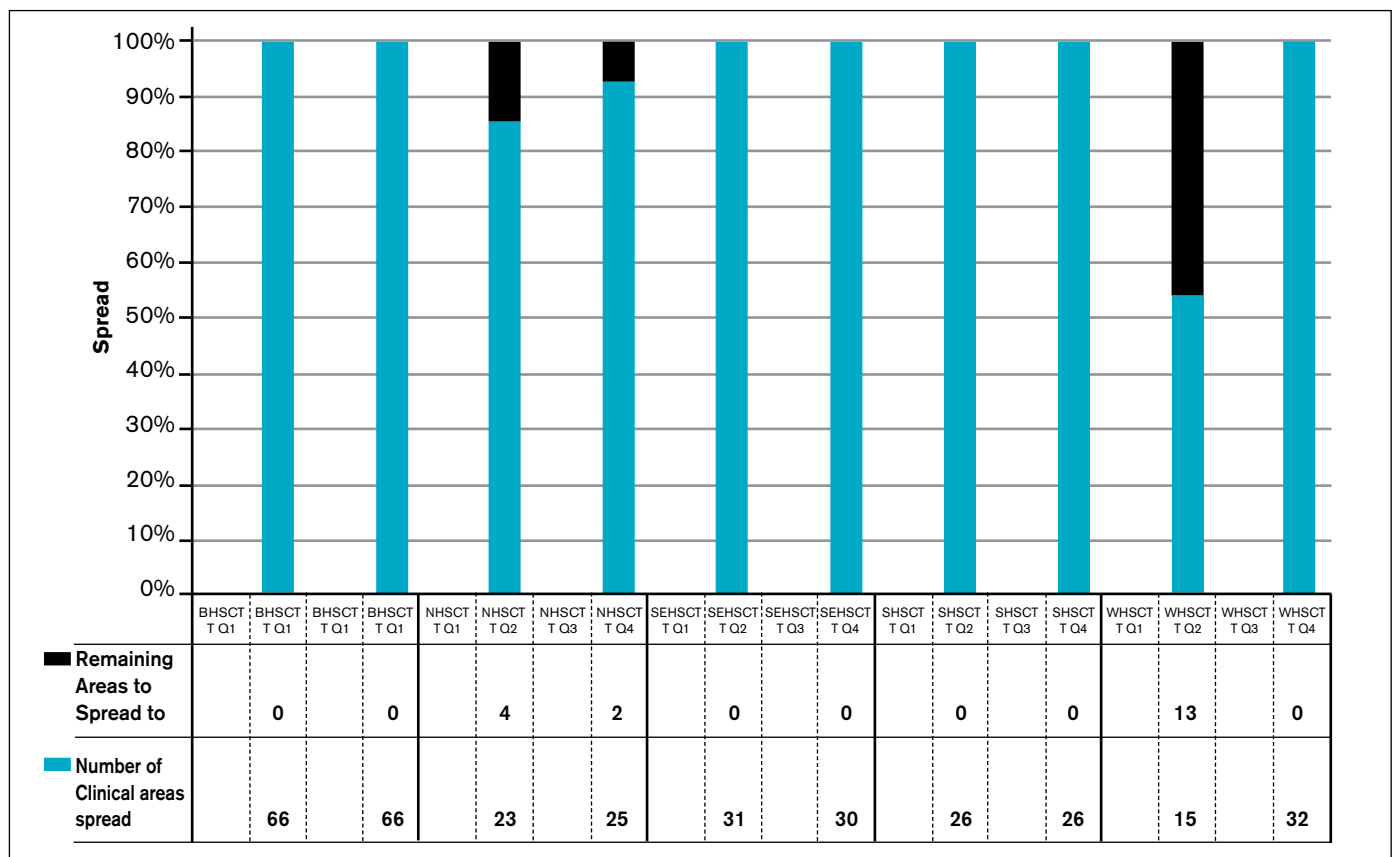


Figure 12: VTE spread



Sepsis6

It is estimated that around 37,000 people die of Sepsis in the UK each year – many of these deaths could be prevented by optimal care. The Sepsis6 are a set of interventions (bundle) which, when delivered promptly by a clinical team, are known to significantly improve outcomes for patients with severe sepsis.

The Sepsis6 intervention, which should be completed within one hour, is as follows:

1. Administer high flow oxygen.
2. Take blood cultures.
3. Give appropriate antibiotics.
4. Give intravenous fluid challenges.
5. Measure serum lactate.
6. Measure accurate hourly urine output:

“Work with HSC Safety Forum to implement and spread quality improvement in the early management of sepsis (eg use of Sepsis6) in medical assessment units (or in other pilot wards by agreement) by March 2015”.

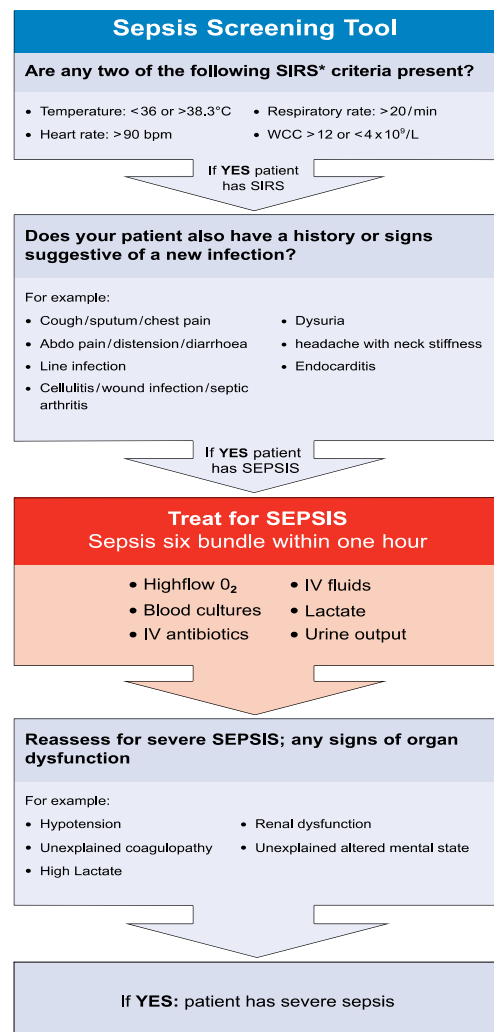
In order to assist HSCTs in implementation of the Sepsis6 Care Bundle, the HSC Safety Forum distributed training and supportive materials prior to hosting a half day workshop on severe Sepsis in October 2014. This included input from HSCT emergency department teams who had already successfully completed similar work. Following the event the following were agreed:

- pilot areas in each HSCT to spread use of the Sepsis6 Care Bundle;
- a strategy to gather baseline information and monthly sampling of compliance.

Since the workshop support, the Safety Forum has, on request, delivered further support via teleconference (x1) and local workshop (x1).

Next steps

1. HSC Safety Forum to discuss with HSCTs the best way to progress this work.
2. If appropriate, Safety Forum will bring HSCT teams together for a further event in Autumn 2015 focused on Sepsis6 Care Bundle implementation.



Measuring improvements from complaints

As outlined previously, The Regional Complaints Sub-Group (RCSG) meets on a monthly basis and is chaired by the HSCB Complaints and Litigation Manager. Membership comprises professional representatives from the HSCB, the PHA and Patient and Client Council (PCC).

Through the work of the RCSG, the following examples of changes implemented as a result of complaints have been highlighted:

Do not resuscitate (DNR)

A number of complaints were received concerning this matter and communication with families in these instances. It was recommended by professionals on the RCSG that a look back exercise was undertaken covering the past year. The resulting information was shared with the Living Matters/ Dying Matters Implementation Group, which undertook work surrounding DNR/CPR and will provide support to families.

Pain relief and nutrition

Following a recommendation to QSE a thematic review of complaints concerning the administration of pain relief and issues relating to nutrition was instigated. This was submitted to QSE in March 2015.

Maternity and gynaecology

A patient was recommended a hysterectomy by her consultant as it was felt that the symptoms she was experiencing could be caused by recurring endometriosis. The surgery took place with a different consultant, however no abnormalities were found. The patient was of childbearing age and felt that the surgery should not have progressed due to lack of clinical requirement.

Upon review of the complaint and HSC Trust response, the RCSG asked the HSCT to provide further detail and to confirm if the consent process had been reviewed in light of this complaint, as indicated. The HSCT provided details of amended stickers introduced for consent forms, which include specific information relating to 'loss of fertility' and 'family must be complete'. However the HSCT has confirmed that it has no current policy document relating to consent for hysterectomies. Following discussion at QSE it was agreed that a short article on consent will be included in the Learning Matters newsletter.

HSCTs, the developed a 'butterfly scheme' with a carer whose mother had dementia. Its purpose is to improve patient safety and wellbeing in hospitals. The scheme enables staff to respond appropriately and positively not only to people who have dementia but also to those with memory impairment or temporary confusion.

In respect of FPS practitioners

A patient was with a GP Practice as a temporary resident when they were placed in a nursing home for a period of respite. The GP Practice obtained a summary of the patient's medication from the family rather than the patients 'parent' GP Practice. As a result of a complaint, the Practice undertook a Significant Event Analysis to ensure that in future, more information is obtained from the 'parent' GP Practice and all acute medication requests are scanned onto the temporary GP records. Thus the GP records will be commensurate with the nursing home records.

Health and Social Care Complaints Awareness Month

Service user feedback has demonstrated that further work is required to promote the visibility and accessibility of the Complaints Process. As part of the continued implementation of the recommendations arising from the Evaluation of 'Complaints in Health and Social Care' and in response to clear messages from service users, the HSCB led on a complaints awareness campaign during June 2014, which was designated as 'Complaints Awareness Month'. A variety of activities were conducted during the month with the dual aims of promoting the existence of the Complaints Procedure and enhancing its accessibility, and, equally importantly, to gauge the views of service users who had made use of this.



A Complaints 'Signposting' leaflet was created to raise and enhance awareness of the public/service users of their right to complain and also to which HSC organisation this should be addressed.

The campaign involved staffing awareness posts in public places across Northern Ireland, distributing the 'Signposting' leaflet and engaging with service users regarding the Complaints Procedure and listening to their experiences of this - both positive and negative. The leaflet was also shared with MLAs, political representatives, the Citizen's Advice Bureau, members of the Pensioners Parliament and provided to libraries and leisure centres across Northern Ireland.

A publicly advertised focus group was also conducted with service users in the Western HSCT area, at which members of the public were again invited to express their views and opinions on the Complaints Procedure, to include: what works well, what does not and how the procedure can be improved.

In addition the first HSC Complaints Learning Event took place in Mossley Mill, Newtownabbey. This will be an annual event and over 90 persons were in attendance on 16 June 2014, with representation from the HSCB, DHSSPS, PHA, PCC, HSCTs, community and voluntary groups, complainants and service users. The aim of the event was to highlight how the complaints procedure has developed and evolved since it was implemented in April 2009 and how it has become integrated into health and social care.

The keynote speaker for the event was the Director of Nursing at the PHA whose presentation focused on implications of complaints handling arrangements and learning arising from the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust. The audience also heard and reflected on some very powerful messages from a number of service users who were present, who detailed their experience of the complaints arrangements.

Feedback from this event, the service user focus groups, and the monitoring of Trust and FPS complaints has identified that the quality of communication and information provided to patients and families, is at times sub-optimal, which subsequently leads to further upset and distress of service users. It is therefore planned that the second Annual Complaints Learning Event will focus on this theme.

A further two workshops will be organised for 2015/16. These workshops will be targeted at Section 75 groups, to include 'senior' service users and those with a disability. The outcomes from these workshops will help inform the HSCB how the public perceive their experiences of health and social care services, how to improve the complaints process and how to address the reluctance on the part of some service users to raise a complaint, possibly due to fear of impact on their, or relatives ongoing treatment and care.

Measuring improvements in mental health services

Pilot: Testing of an anti-absconding intervention in an acute psychiatric inpatient ward

Unauthorised absence or more commonly referred to as 'absent without leave' (AWOL) from a psychiatric hospital has potentially serious negative consequences for patients including suicide, homicide, self-harm and physical health problems.

The aim of this study, supported by the PHA as part of a regional project, was to evaluate the implementation of the East London and City Mental Health NHS Trust 'Anti-Absconding Work Book' (Bowers et al 2003), as an intervention to reduce patient absconding rates within an acute in-patient mental health ward.

The elements of the intervention include:

- Rule clarity: use of a signing-in and out book
- Identification of those at high risk of absconding
- Targeted nursing time for those at high risk
- Dealing with home worries
- Promotion of controlled access to home
- Promoting contact with family and friends
- Careful breaking of bad news
- Post-incident debriefing
- Multi-disciplinary team (MDT) review following two absconds

The results from this pilot showed a reduction in absconding rates of 70% compared to the baseline audit. As a result Regional Guidelines for the Management of Service Users Absent Without Leave (AWOL) have been developed and include the requirement for all HSCTs to use an evidence based anti-absconding intervention

Special observations

Special observation is a therapeutic nursing intervention with the aim of reducing the factors which contribute to an individual patient's risk to themselves and/or others and promoting recovery.

In October 2011 regional guidance was issued by the PHA and HSCB on the use of observation within mental health inpatient settings and it was agreed that an audit would be carried out following implementation in order to ensure compliance.

All adult acute admission mental health inpatient units in Northern Ireland were included in the audit to assess compliance with the guidelines in relation to continuous observations.

It was agreed with each HSCT that a random sample of five sets of notes from patients on continuous observation per ward per month would be audited. The audit was carried out prospectively from September 2013 until February 2014 inclusive.

Compliance with the guidance in relation to continuous observation was found to be variable within and across HSCTs, with areas of good practice identified as well as significant areas for improvement.

Good practice was noted in the following areas: reason for special observations recorded; recording observation planning on the patient care plan; good evidence was demonstrated that all patients on special observations were receiving some form of therapeutic intervention.

Need for improvement was identified in relation to: patient involvement; review by MDT; duration of observations; qualification of staff involved in observations; overall assessment of outcome.

The following recommendations were issued:

HSCTs should ensure that in all cases:

1. Patients should be involved in the planning of continuous observation, both in understanding the therapeutic need and the level of observation required;
2. Patients should sign the care/management plan;
3. The level of observation should be reviewed daily by the multidisciplinary team;
4. Evaluation of continuous observation should be carried out by the multidisciplinary team in partnership with the patient and the outcome should be recorded on the patient's file/care plan;
5. There should be robust review for those patients on continuous observation for more than 72 hours;
6. The multidisciplinary team must ensure there is an appropriate rationale for commencing a patient on continuous observation in keeping with the guidelines;
7. Consideration should be given to a specific electronic data set for ease of keeping up to date.

Next steps

HSCTs will continue to be monitored in relation to compliance with the guidance.

Using data to measure improvements in primary care

Information about individual patients' care and outcomes is held at GP practice level. The Health and Social Care Board has access to higher level data about patient numbers, payments and outcomes at GP practice level. We use this data to encourage and measure improvement in primary care.

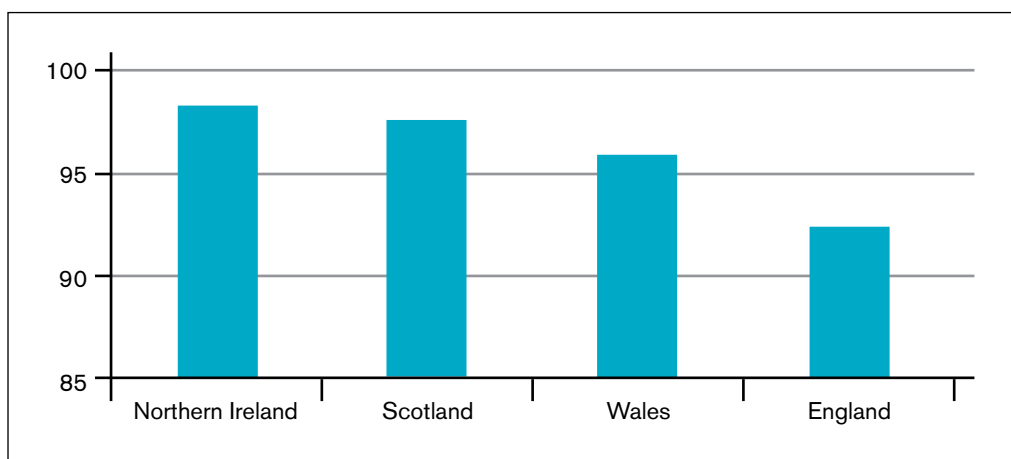
Quality and outcomes framework

There is growing evidence that if people with long-term conditions can be supported to manage their condition, they will have less risk of complications. For example, people with high blood pressure (hypertension) who can keep their blood pressure in a safe range through a combination of lifestyle choices and medication are less likely to have strokes and heart attacks.

Based on this evidence, the Quality and Outcomes Framework (QOF) was introduced for GPs across the UK in 2004 to measure achievement against a range of clinical indicators, with points and payments awarded according to the level of achievement. Although participation is voluntary, all GP practices in Northern Ireland have chosen to participate.

GP practices in Northern Ireland have always achieved high QOF outcomes compared to their colleagues in other countries. The latest UK figures are for 2013/14, but provisional data for 2014/15 indicate GPs in Northern Ireland will again achieve 98% of available points.

Figure 13: GP QOF outcomes



Even though our GPs perform well compared to the rest of the UK, we are still working hard to improve. Within DOIC, the QOF data are further analysed to provide a picture of the overall clinical outcomes for patients with a range of long-term conditions including high blood pressure, diabetes, stroke, asthma, COPD and heart disease.

Each practice is provided with an annual report allowing them to compare each clinical outcome with other practices across Northern Ireland. Medical advisors and practice support staff from the Directorate visit each practice every three years to discuss their achievements and share good practice to improve outcomes.

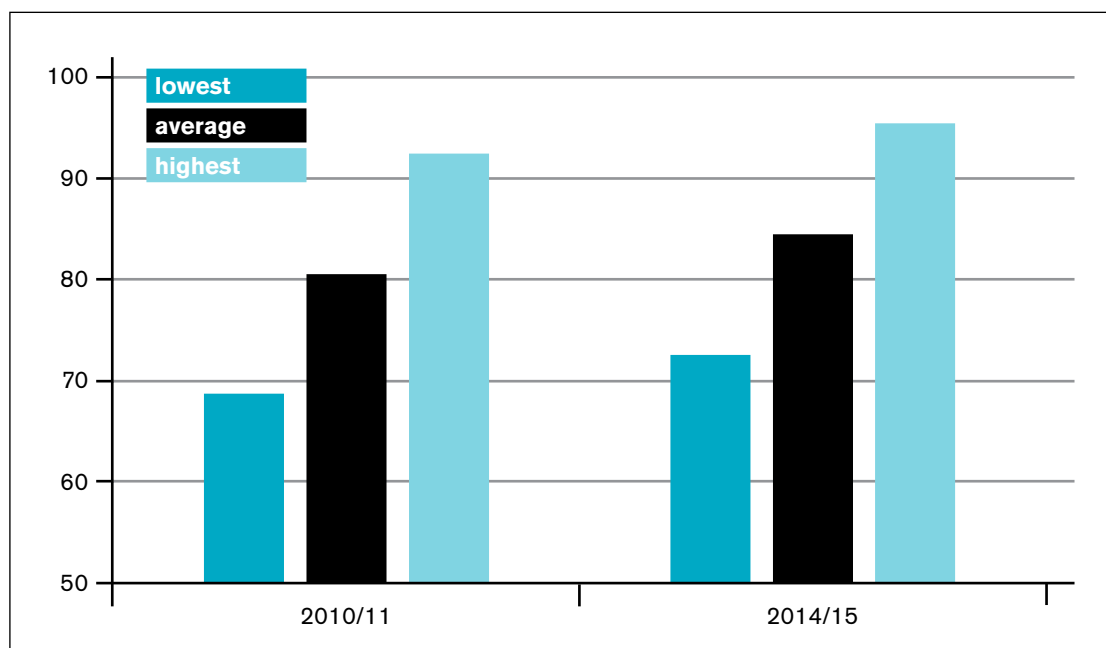
This focus on measurement and improvement by individual GP practices and the Directorate has resulted in gradual improvement in the control of some long-term conditions, for example in April 2015, 25,192 more people had good control of their blood pressure than in April 2011.

It is really important that everyone has the best possible control of their long-term condition, regardless of where they live.

If a practice shows lower than average outcomes for management of several conditions they will have a focused visit by Directorate staff who will agree an action plan with the practice to improve their outcomes. The practice will then have annual visits until their outcomes have significantly improved. This focus helps to reduce any inequality between practices.

The graph below shows practice outcome data for the control of high blood pressure to less than 150/90 (In 2010/11 this was based on QoF indicator BP5 , in 2014/15 this was based on QoF indicator HYP002NI). As well as overall improvement, the lowest performing practices have improved the most, therefore making the difference between lowest and average performance less.

Figure 14: High blood pressure practice outcome data



Cataract referrals

Cataract is one of the main eye conditions referred to hospital for assessment by an eye specialist. Patients are referred to the hospital in most cases by their optometrist. The HSCB has introduced a referral pathway which allows the optometrist to consider in more detail the needs of the patient. It encourages fuller discussion between the patient and the optometrist in the decision about the referral and when is the best time for referral. Patients are assessed on when they are willing and ready to undergo cataract surgery to help their vision and the process from the point of referral to actual surgery is improved.

Next steps

In 2015/16 this pathway will be further helped by the introduction of electronic referrals by optometrists directly into the hospital eye service, providing better communication between those providing the eye care services. This electronic referral will streamline the process, avoid duplication, and contribute to improved patient safety.

Project - Home Oxygen Services

The new contract for the HSCB Home Oxygen Service has now been in place since January 2013 and it is providing long-term oxygen therapy and ambulatory oxygen to over **3,500 patients** in Northern Ireland. A patient requiring long-term oxygen will use their oxygen for more than 16 hours a day and the most cost-effective way to provide the oxygen is a concentrator situated in their home. For patients who need to be able to go out of their home and still use oxygen, there are a variety of devices that can deliver the oxygen but small portable cylinders are most commonly used. The contract delivers **an annual efficiency of £850,000** as a result of competitive pricing and the use of more energy efficient oxygen concentrators that use less electricity.

The contract has enabled patients to:

- Access more flexible equipment to meet their ambulatory oxygen needs.
- Have more freedom to spend time away from their homes by taking their oxygen with them.

Respiratory nurses and physiotherapists will assess the oxygen needs of an individual and their lifestyle and select the most suitable device to meet their needs. The numbers of patients using the newer equipment is currently small but is expected to grow as HSCT clinics for oxygen assessment and review are being set up.

In March 2015:

- 161 patients were using conserver devices with their portable cylinders;
- 61 patients had Homefill systems which allow them to fill their own small cylinders as they need them;
- 37 patients had liquid oxygen systems;
- 100 had portable concentrators;
- 125 had transportable concentrators which are on wheels.

Each system has its own unique features so it is important that the assessment process is used to select the equipment that best meets each individual's needs. This has made a big impact on the lives of individuals who have been able to use their oxygen and still continue with their

hobbies, exercise and social activities which help to maintain positive health and well-being. So far, feedback from patients receiving the service has been very positive:

“The transportable machine is great and now I am able to go and stay with my family overnight and go to the park with my grandchildren.”

Patient, Ballymena

“Oxygen has made a great difference to me. Before I got ambulatory oxygen I did not want to go out because I had no puff. Now I have an oxygen tank and a conserver and I am able to get out and about more and do a little house work, which my husband had to do before. I go to the weekly maintenance classes now after attending pulmonary rehabilitation. My quality of life is much better.”

Patient, Northern HSCT

“Using liquid oxygen has meant that I can go out for longer without worrying if the cylinders are going to run down and how long I am out for. Overall I feel better. I am now able to attend a weekly exercise class in the local leisure centre.”

Patient, South Eastern HSCT

There is also greater integration between the healthcare professionals and BOC, the company that is providing the Home Oxygen Service and, as a result, there has been a greater awareness and reporting of the safety aspects of using home oxygen. The risks of fire with oxygen and smoking have been highlighted and a risk assessment has been developed for use by the healthcare professionals that are prescribing oxygen. The risk of falls from trips involving oxygen tubing has also been identified. During the six month period July to December 2014, there were nine incidents reported in the home oxygen service and of these, two were smoking-related and three involved trips or falls. All of these incidents were investigated and appropriate actions have been taken.

Measuring improvements with healthcare associated infections

Part 1: Device associated infection (DAI) surveillance

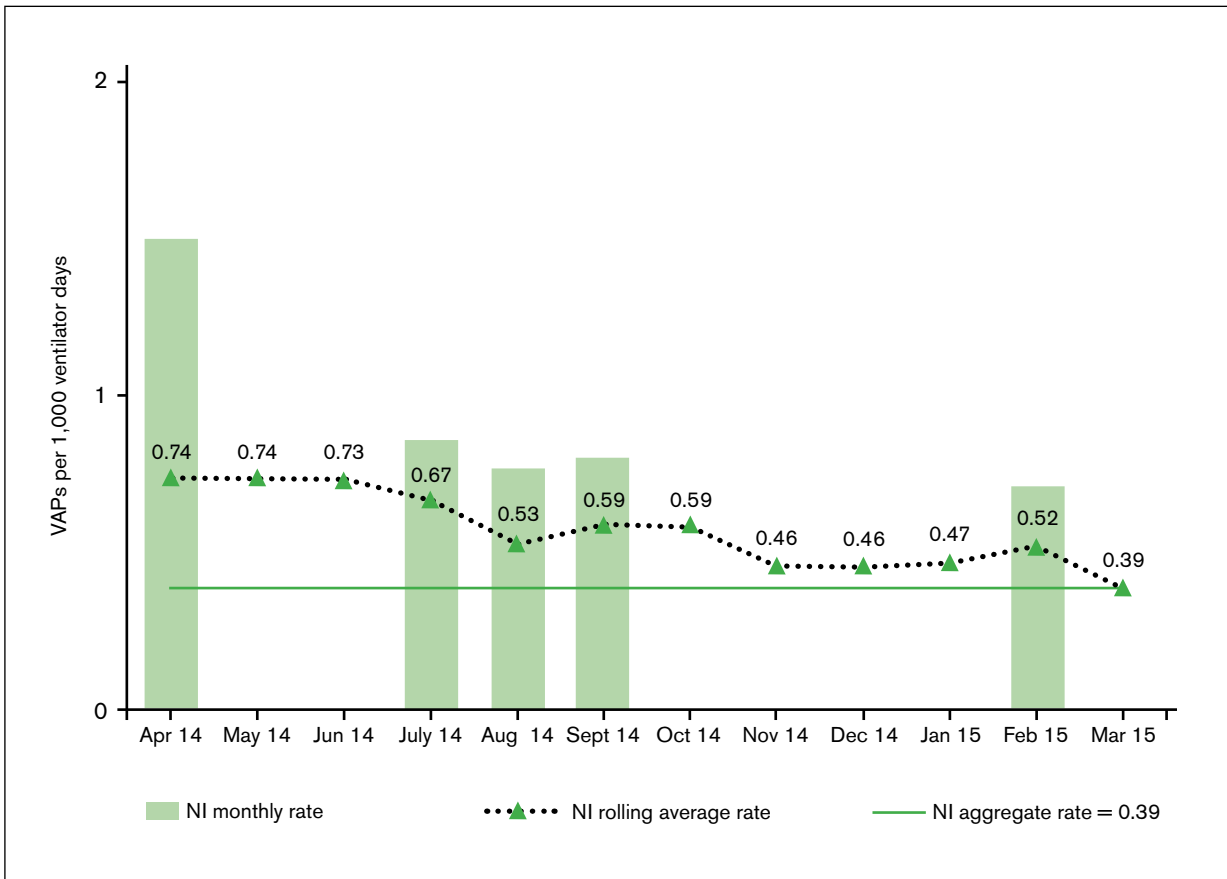
The PHA's regional surveillance programmes monitor three infections associated with invasive medical devices (an identified risk for HCAI) among patients receiving care in all critical care units in acute hospitals in Northern Ireland. This paperless surveillance programme is delivered through electronic data capture and sharing. Outputs from this surveillance programme are used to drive local improvement in critical care units.

Ventilator associated pneumoniae (VAPs)

The regional VAP rate for March 2015 was 0.39 per 1,000 ventilator days. This represents a continuing reduction in the regional 12-month rolling average VAP rate from 0.74 per 1,000 ventilator days in April 2014.

$$\text{VAP rate} = [\text{Number of VAP} / \text{Number of ventilator days}] \times 1,000$$

Figure 15: Regional VAP rate April 2014 to March 2015

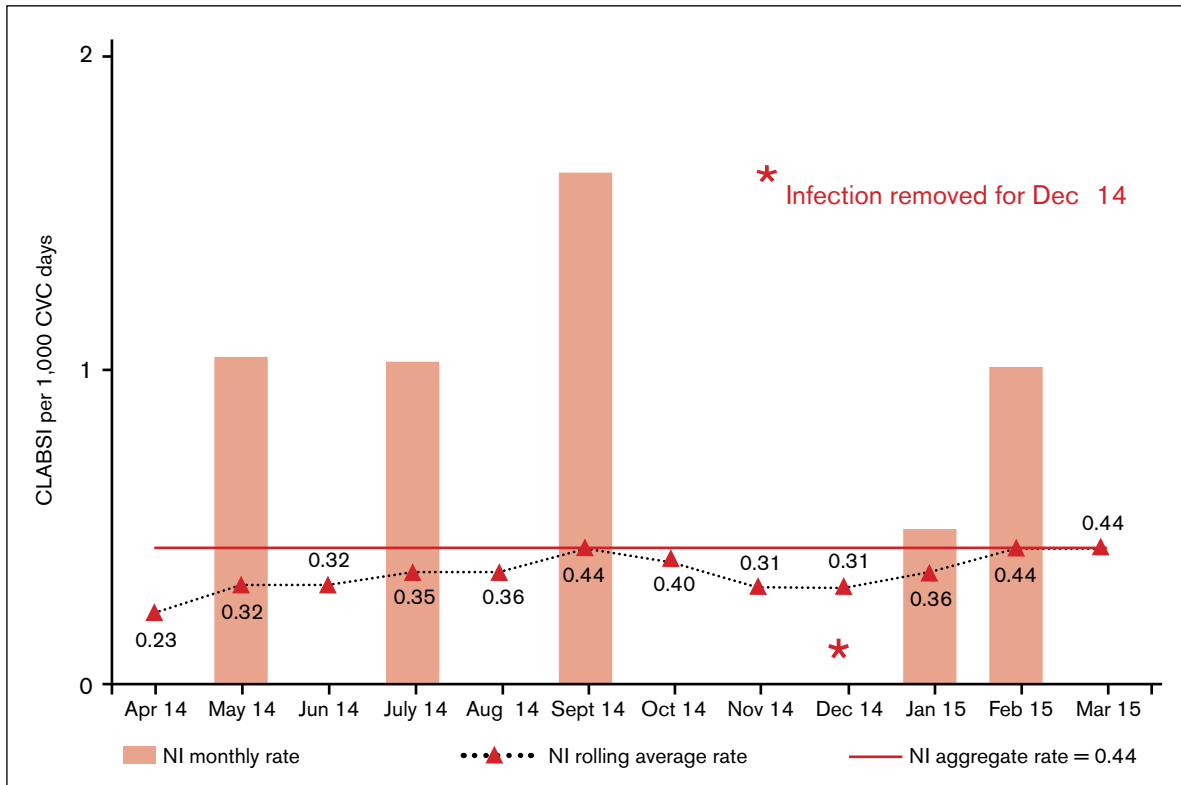


Central line associated infections (CLABSI)

The regional CLABSI rate for March 2015 was 0.44 per 1,000 central venous catheter days. This represents an increase in the regional 12-month rolling average CLABSI rate from 0.23 per 1,000 central venous catheter days in April 2014. During 2014 work commenced on a project to examine and validate CLABSI data reported from critical care units through our regional DAI surveillance programme. It is anticipated that findings of this validation project will be available in early 2016.

$$\text{CLABSI rate} = [\text{Number of CLABSI} / \text{Number of central venous catheter days}] \times 1,000$$

Figure 16: Regional CLABSI rate April 2014 to March 2015

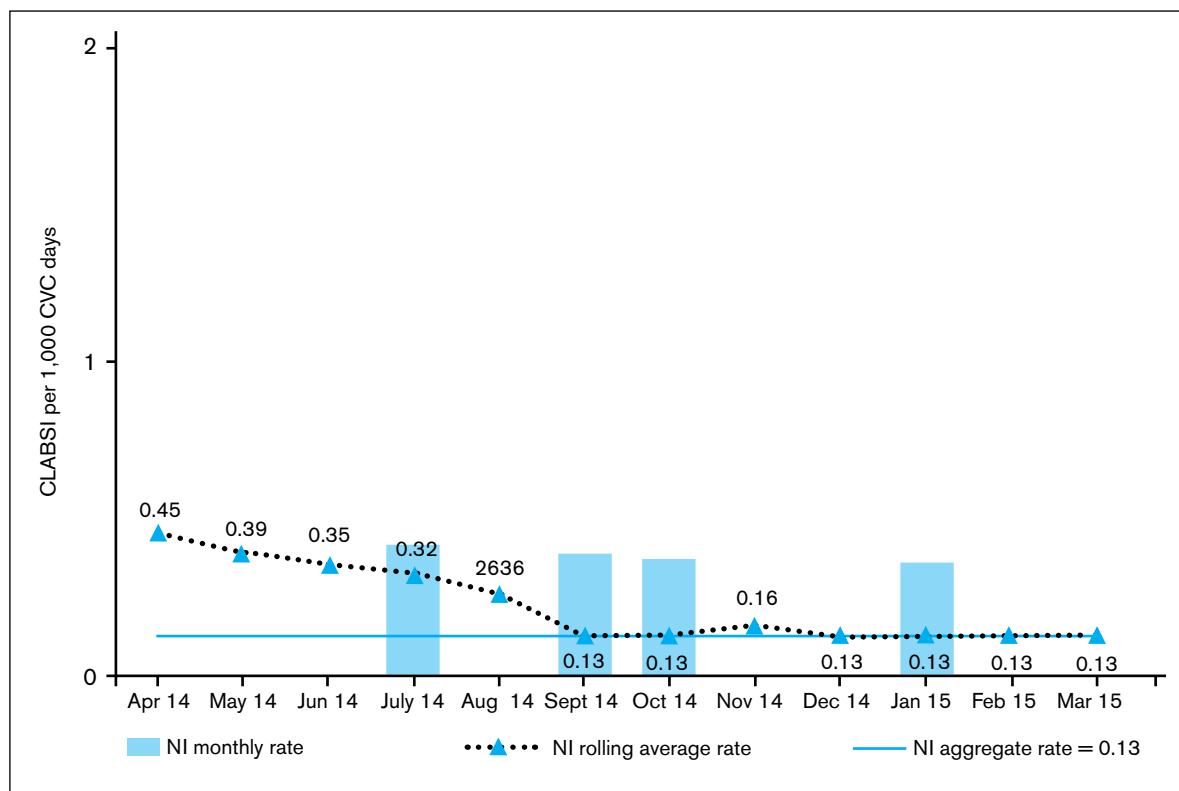


Catheter associated urinary tract infections (CAUTIs)

The regional CAUTI rate for March 2015 was 0.13 per 1,000 urinary catheter days. This represents an overall reduction and steadying of the regional 12-month rolling average CAUTI rate from 0.45 per 1,000 ventilator days in April 2014.

$$\text{CAUTI rate} = [\text{Number of CAUTI} / \text{Number of urinary catheter days}] \times 1,000$$

Figure 17: Regional CAUTI rate April 2012 to March 2013



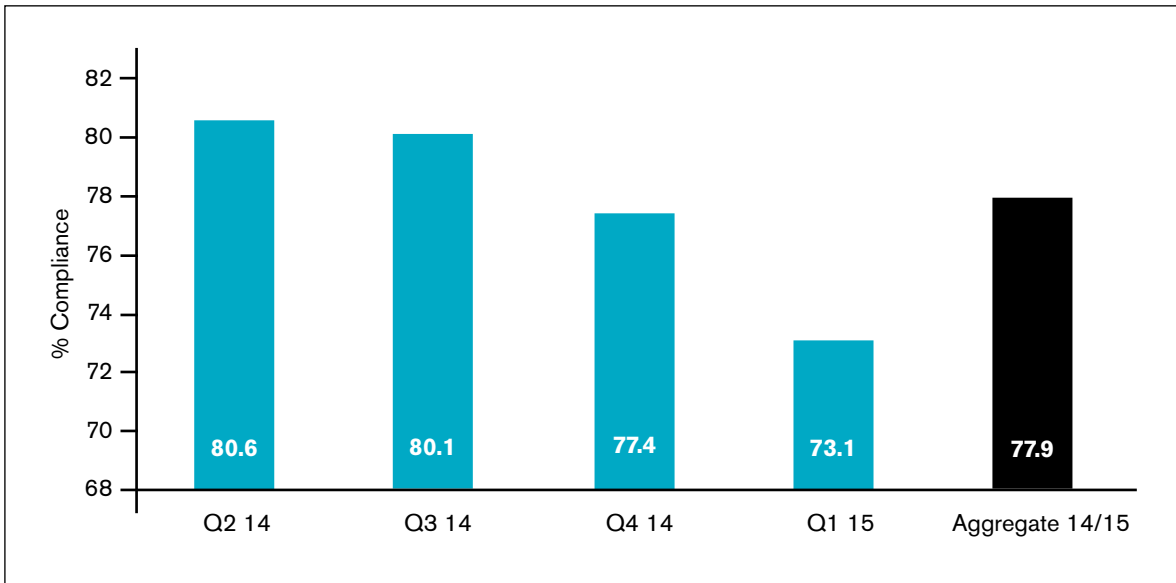
Part 2: Surveillance of surgical site infections

Surveillance of surgical site infections (SSI) following caesarean section

All HSCTs in Northern Ireland have established programmes for surveillance of post-operative surgical site infections (SSIs) occurring in women who have delivered by C-section. The health protection team in the PHA supports all HSCTs in operational delivery of this programme. The PHA team is responsible for delivering all regional aspects of this important surveillance programme.

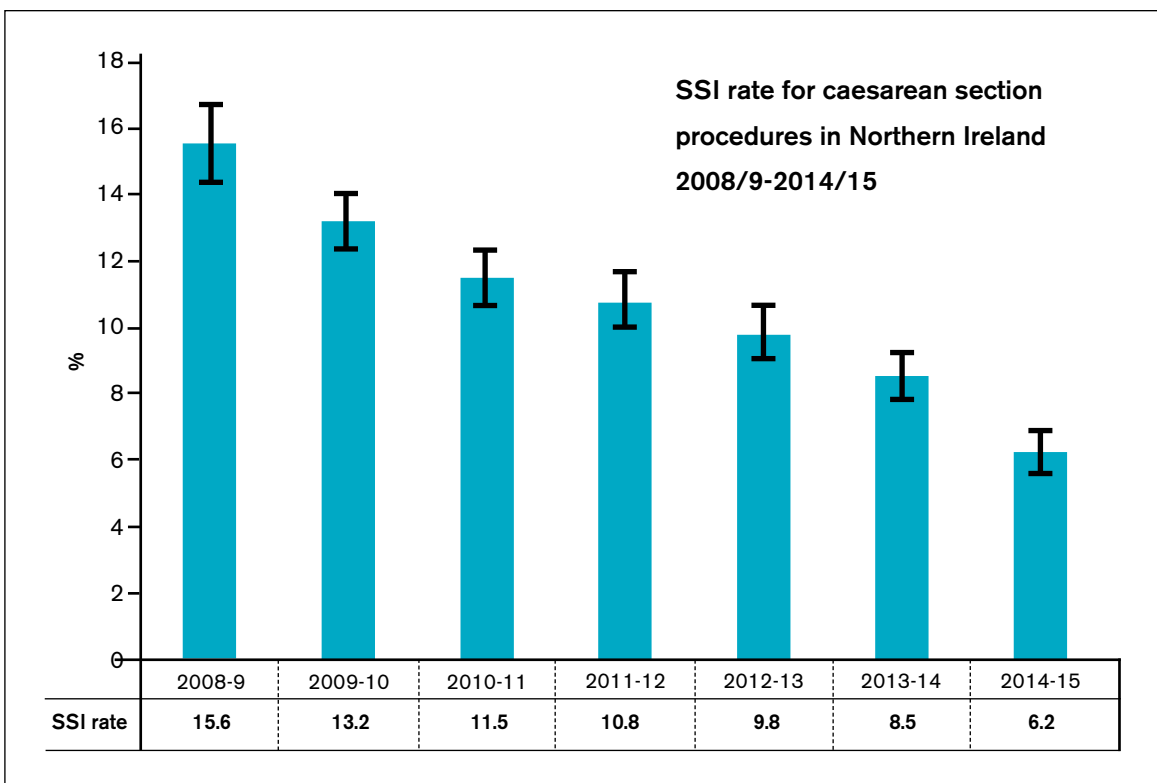
Compliance for C-section SSI surveillance is based on the number of C-section procedures for which data are reported to the PHA compared to the number of C-sections actually performed. Compliance in C-section SSI surveillance has increased from 44% in 2008/09 to 80% in 2013/14. For two of four quarters in 2014/15 compliance with C-section SSI surveillance was 80%. The overall compliance rate for 2014/15 across all HSCTs was 78%.

Figure 18: Compliance with C-section SSI surveillance 2014/15



During 2014/15 the regional SSI rate for C-sections was 6.2 per 100 C-section procedures. This represents a continuing reduction from an SSI rate of 8.5 per 100 C-section procedures in 2013/14 and an initial rate of 15.6 in 2008/09 when this regional surveillance programme was first introduced.

Figure 19: Regional Caesarean section SSI rate 2008/09 to 2014/15



Measuring improvements in social care

Improving information for CAMHS and Autism Services

The Health and Social Care Board have established CAMHS and Autism Minimum Data sets. These data sets have improved understanding of the needs of children and young people. Both data sets are being revised to include all elements of CAMHS provision and capture children and young people's experience and their outcomes. The data have been used to reshape and refine service delivery so that care is more attuned to the needs of children, young people and their families across all steps of care in the service model for CAMHS.

Service frameworks

Respiratory

The Regulation and Quality Improvement Authority (RQIA) completed an independent review of the implementation of the original (2009) framework and gave a positive report on progress achieved. In this review, the stakeholders considered that the implementation process has been a success that shaped the way services are being taken forward and that the framework contributed significantly to improvements in these services.

The original framework then underwent a formal revision process in 2014. The revision was conducted by the Regional Respiratory Forum, supported by the Long Term Conditions Service Team, and led by the PHA.

Subsequently, the draft revised *Service Framework for Respiratory Health and Wellbeing* went through public consultation process early this year. The consultation responses were broadly supportive of the service framework and relevant comments relating to the standards and KPIs in the framework document were considered by the Respiratory Forum Project Team (led by the PHA), and the framework has been updated as appropriate.

The final document includes stretching standards and KPIs, which are vital for improving the overall care of people with the respiratory diseases. Essentially, all standards reflect the patient care journey and are focused on addressing issues in relation to the quality and safety of the respiratory services across Northern Ireland.

The final document is with the DHSSPS for formal approval and launch.

Cancer

The *Service Framework for Cancer Prevention, Treatment and Care* (abbreviated to Cancer Service Framework) sets standards for cancer that specifically focus on prevention, diagnosis, treatment, care, rehabilitation and palliative care. The Cancer Service Framework (CSF) was published in 2011 and set out anticipated levels of performance against standards over a three year period.

The CSF comprises 52 standards, of which nine are generic, a further three refer to palliative care and the balance (40) are cancer specific standards. The cancer specific standards

include screening, awareness and early diagnosis, surgical management, chemotherapy and radiotherapy treatment and follow-up.

The CSF is currently under review – the following are some of the key achievements relating to the 2011 framework.

- HPV programme achieved target.
- Uptake of Bowel Cancer Screening Programme by both males and females continues to increase.
- Funding for commencement of roll-out of acute oncology services has been secured.
- Workforce plans for therapeutic radiography and medical physics associated with the expansion of radiotherapy services have been agreed by HSCB.
- NICaN Cancer Survivorship website has been developed and is live, allowing patients and families to identify statutory, voluntary and community services in their area. There has been a steady increase in traffic.

Cardiovascular

The Cardiovascular Service Framework sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of the individuals and communities who currently have or are at greater risk of developing cardiovascular disease. Given that several diseases can co-exist, share common factors and can adversely impact on prognosis, the framework includes consideration of coronary heart disease, cerebrovascular disease, peripheral vascular disease and renal disease.

The framework specified that the GAIN evidence-based consensus guidance on the prevention and management of acute kidney injury (AKI) should be implemented and that all FY2 doctors in Northern Ireland should have access to training on AKI recognition, which will improve patient outcomes. All FY2s receive the training through mandatory training sessions.

Atrial fibrillation (AF) is a cardiac arrhythmia occurring in 1-2% of the general population, with increased prevalence associated with increasing age. AF confers a five-fold risk of stroke. The framework specified that patients over the age of 65 years should have an opportunistic assessment of AF. In total, 98% of eligible patients over the age of 65 years have been assessed for AF in primary care.

Mental health

A new Mental Health and Wellbeing Service Framework for Northern Ireland is currently being drafted. The aim of the new framework is to evidence implementation of the regional mental health care pathway 'You in Mind', which was launched in October 2014. Key features of the

Framework will include a number of high level service standards along with key quality indicators and performance measures.

The draft Framework will be subject to a period of consultation, to be undertaken by DHSSPS, later in 2015/16. Thereafter, the aim is to implement the new Framework from 2016/17.

Learning disability

The aim of the Learning Disability Service Framework (LDSFW) 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 the quality of care.

2014 – 2015 (Year 1) has focused on establishing baseline information, to provide robust qualitative measures that can be monitored and reviewed to ensure standards improve over an agreed timescale delivered against key performance indicators.

Essentially many of the KPIs have not previously been measured and while some information systems were available, these were limited and provided only a fraction of the quantitative data required. There are relatively little data collected routinely within the HSC that reflect the largely qualitative data required by the Framework's standards.

The audit for the Learning Disability Service Framework is now complete, having used a range of audit tools such as Organisational Audit, Case Note Review and Online Survey, as well as available data sets. An Excel sheet has been populated outlining the baseline position as of 31 March 2015 for each of the five HSCTs, HSCB and PHA, identifying the data source and frequency of monitoring. The baselines will allow performance levels for 2015-2016 to be agreed with the HSCTs, HSCB and PHA. The audit has also identified areas where change in practice is required.

Older people

The older people service framework has benefitted from a range of initiatives in relation to person-centred care, safeguarding, carers, transitions of care and self-directed support. These have all lead to the provision of more person-centred, individualised support to older people and their carers.

A range of activities to seek older people's views on the effectiveness of improvements are in place, including short break development groups, short break evaluation and use of 10,000 Voices.



Children and young people

A draft service framework for children and young people has been developed 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 issued for public consultation which closed in January. The HSCB and PHA have reviewed and approved the consultation responses and are waiting for it to be launched by the Minister for Health. The framework will be implemented over three years.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE produce 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) and Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB have put in place processes to ensure that all Technology Appraisals, Clinical Guidelines and Public Health Guidance approved by NICE and endorsed by the DHSSPS are implemented within Northern Ireland. During 2014/15, the HSCB issued 24 Technology Appraisals to HSCTs and it continues to monitor the implementation of 100 CGs and 2 PHGs which have been issued to the service.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found at www.hscboard.hscni.net/NICE

Improving the care of multiple pregnancies

Multiple pregnancies (twins, triplets etc.) have a higher risk of complications, particularly if the babies share the same placenta which happens in around 20-25% of twin pregnancies. Multiple pregnancies have increased, mainly due to increased use of fertility treatments such as IVF. Nowadays around 1 in 60 pregnancies is a multiple pregnancy, compared to around 1 in 80 pregnancies 30 years ago.

NICE has published a clinical guideline on the management of multiple pregnancies which has been endorsed by the DHSSPS for implementation in Northern Ireland. This NICE guideline clarifies the expected national clinical standards for the care and management of women expecting multiple pregnancies, and is therefore the standard that women in Northern Ireland should expect to receive for themselves and for their babies.

Over the past 18 months the PHA and HSCB have worked with the HSCTs and with the voluntary organisation TAMBA (the Twins and Multiple Births Association) to facilitate the implementation of the NICE guideline. A regional care pathway has been developed and also a multiple pregnancy commissioner specification which sets out the expected standards of care. Funding has been provided for the development of specialist twin antenatal clinics at the five larger hospitals (the Royal, Ulster, Craigavon, Altnagelvin and Antrim Hospitals). These developments should help to ensure that women with multiple pregnancies receive the standard of care recommended by NICE.

Developing HSCT annual quality reports

Following the initial publication of the Annual Quality Reports by the five HSCTs in 2013/14, the reports were reviewed by the Task Group. This review examined how the reports could be standardised across the region. Recommendations were made by the Task Group through the further development of the core indicators for the reports. These core indicators act as a baseline to monitor quality improvement year on year. 2014/15 also saw the arm's length Bodies produce their Annual Quality Reports.

HSCTs have produced their Annual Quality Reports for 2013/14 and have included information on outcome measures and quality indicators with a distinct focus on safety, effectiveness and patient/client experience. The core indicators in the reports focus on five themes:

1. Effective Health and Social Care;
2. Delivering Best Practice in Safe Health and Social Care Settings;
3. Protecting People from Avoidable Harm (Putting Learning into Practice);
4. Ensuring People have Positive Experiences of Service;
5. Resilient Staff (Staff Health and Wellbeing).

The Annual Quality Reports were launched in November 2014 on World Quality Day. This will be the annual date that future Annual Quality Reports will be released on.

Theme four:

Raising the standards

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which are used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA recognise that the importance of the voice of the service user cannot be underestimated and their contribution to policy and procedures is essential to building a service user-based health and social care system. As a result, the HSCB and PHA have established dynamic partnerships between service users, commissioners and providers.

Setting the standards for personal and public involvement in care

Personal and Public Involvement (PPI) is a process that facilitates the active and meaningful involvement of service users, carers and the public, enabling them to inform and influence the commissioning, planning, delivery and evaluation of health and social care services. PPI is underpinned by a core set of values and principles, with a clear acknowledgement and recognition of the insights and expertise that services users and carers have. There is a clear and growing evidence base for the benefits of involvement, from the tailoring of services to need, thereby increasing efficiency, to improvements in quality and safety.



The PHA as part of its leadership role in this policy area, works closely with the Regional HSC PPI Forum take forward the concept and practice of involvement through a wide range of initiatives. One of the key developments undertaken in 2014/15 has been the co-production of a set of standards for engagement and involvement between HSC organisations and staff, on the one hand, and service users, carers and members of the public on the other.

The five PPI Standards support the key principle of people being involved and consulted on decisions which affect their health and social care. The five standards are:

- 1. Leadership** – HSC organisations will have in place clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.
- 2. Governance** – HSC organisations will have in place clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.
- 3. Opportunities and support for involvement** – HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.
- 4. Knowledge and skills** – HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver their statutory PPI obligations.
- 5. Measuring outcomes** – HSC organisations will measure the impact and evaluate outcomes of PPI activity.

The PPI Standards will help to embed involvement into HSC culture and practice and clearly set out what is expected of HSC organisations and staff. The Standards are now being disseminated across the HSC system and these will help to standardise practice and support the drive towards a truly person-centred system.



Members of the Regional HSC PPI Forum at the launch of the PPI Standards, March 2015

PPI training

The need for staff to be aware of how to engage well and enhance their PPI skills is recognised. The Personal and Public Involvement and Leadership training programme which was developed in 2009 continued to be commissioned and funded by HSCB during 2014/15. The 'Involving People' Programme is open to staff in all HSC Trusts, other agencies, and the community and voluntary sectors. It is anticipated that by the end of 2015/16, 100 candidates will have obtained a Level 5 award in Leadership. In addition the HSCB during 2014/15 commissioned a Level 3 accredited training programme aimed at service users and carers. "Finding Your Voice" is due to commence in September 2015.

Annual HSCB recognition event

The second HSCB Annual Service User Recognition Event was held in December 2014. Building on the success of the previous year's event, the importance and value of engaging with service users was acknowledged by the Chairman and Chief Executive, who also thanked and recognised the contribution of those who work with the Board. The event was not only an opportunity for networking amongst service users and carers, but enabled service users to contribute directly to the development of the Health and Social Care Board's new Personal and Public Involvement Strategy and to engage with Directors of the Health and Social Care Board.



Improving patient and client experience

Within Northern Ireland we want to ensure that throughout the entire patient/client journey in healthcare, people are treated with compassion, dignity and respect. In April 2009, the DHSSPS published the “Improving the Patient and Client Experience Standards”.

This highlighted five core standards:

- Respect
- Attitude
- Communication
- Behaviour
- Privacy and Dignity

The PHA is responsible for monitoring the implementation of these Standards. Since the implementation of the Patient and Client Experience Standards, the PHA and HSCB worked collaboratively with the HSCTs to develop an annual comprehensive Patient and Client Experience work programme which uses a range of methodologies to gain the ‘patient’ experience of health and social care and drive quality improvements to enhance the patient and client experience. A triangulated methodology is used which includes patient stories, patient satisfaction surveys and observations of practice. The most appropriate methodology is used depending on the individual settings.

10,000 Voices initiative

The PHA and HSCB commissioned ‘10,000 Voices’ to provide a vehicle which listens to patient, client and staff experience using story methodology to affect, inform and influence rapid changes in the way services are commissioned and delivered. The 10,000 Voices initiative has focused on a range of areas throughout 2014/15, which include the following:

- Care received in unscheduled care services including ED, GP OOH, MIU
- Care received by patients / clients in their own home
- Nursing and midwifery care
- Care delivered by Northern Ireland Ambulance Service



The 10,000 Voices initiative offers patients and clients the opportunity to provide real time feedback on the services they have received. The stories are read on a weekly basis by senior staff within the PHA and HSCTs. Immediate action is taken when appropriate. It facilitates 'real time' improvements, demonstrating a learning culture and engaged organisations. Stories are fed back to wards and departments on a weekly basis which provides a real-time response for staff, enabling them to implement 'quick fixes' and change practice appropriately. The information is then analysed for themes and trends which are then shared with relevant staff and action plans are developed for more longer-term improvement.

Impact

To date 6,741 patient, client and staff stories have been received. The findings from the information received provides a rich source of evidence from which local and quality improvements can be identified and implemented as outlined below:

Unscheduled care areas

Based on the information received from the first period of story collection (September 2013 – June 2014) and through the monitoring of the Patient and Client Experience Standards, a number quality improvements have been implemented, including:

- Improved information for patients
- Improvement in patient comfort while waiting
- Review of cleaning schedules
- Refurbishment of waiting areas
- Review of pain management in EDs

Story collection from patients in unscheduled care was recommenced in January 2015 and alongside this the collection of staff stories in unscheduled care areas was commenced. Early analysis of the information shows that the majority of patients are satisfied with the level of care they have received. Patient experience is being further integrated within the HSCTs with the inclusion of patient stories at daily safety briefs.

Experience of nursing and midwifery care

Analysis of the information received through 10,000 Voices and monitoring of the patient and client experience standards indicates a high level of satisfaction with the standard of nursing and midwifery care throughout Northern Ireland. However there is also some areas for learning and development. The following improvements have been progressed:

- Experience of women/partners who have been cared for in midwifery led units (MLUs) have been used to inform the development of regional guidelines for MLUs

- Teaching session for student nurses and midwives
- Learning events across HSCTs to provide feedback and allow reflection on patient stories
- Programme developed for Band 2/3 staff
- Integration of patient experience information into induction programmes
- Production of patient experience DVD for staff training

Care in your own home

A high proportion of stories indicate that people who receive care in their own home in all Trusts are very satisfied with the care they receive. This is demonstrated in many of the stories which describe the compassionate care, help and support which carers deliver. Patients and clients are very grateful for the opportunity to remain in their own home and to have their independence maintained. For residents in supported living accommodation, they are very appreciative of the security and company that this type of housing offers.

Regional and HSCT findings have been collated and the key messages from people who receive care in their own home include the following:

- staff do not always have enough time to spend with the person;
- the timing of calls at home do not always meet with individual requirements;
- people who receive care at home report that they have feelings of isolation and loneliness;
- staff do not always have the appropriate skills to care for patients with dementia.

These findings are currently being shared with the appropriate staff who will identify any actions which can be progressed.

Care delivered by the Northern Ireland Ambulance Service

The collection of stories in relation to care delivered by the Northern Ireland Ambulance Service is ongoing, with the majority of patients reporting positive experience with this service.

Cancer patient experience survey

During 2014-15 the PHA and Macmillan funded the first National Cancer Patient Experience Survey (CPES) undertaken in Northern Ireland. It has been based on the CPES surveys used in England, Wales, the Isle of Man and Australia, with the first survey being undertaken in England in 2010. The survey has been designed to monitor progress on cancer care, to provide information that can be used to drive local quality improvements, to assist Multi-Disciplinary Teams, Commissioners and HSCTs in improving services for patients, and to inform the work of the charities supporting cancer patients.

The survey covered all adult patients in active treatment for cancer in Northern Ireland during the period December 2013 - May 2014. The number of respondents was 3,217 from all five HSCTs in Northern Ireland, from an initial sample of 5,388 (62% response rate).

Cancer patients tend to give positive responses about their treatment and care, and also give higher scores than hospital inpatients in the UK context. Scores of 80% and over have been achieved in Northern Ireland on questions such as: information on tests; being told sensitively they had cancer; verbal information on operations; privacy when being examined, treated and when discussing their condition; confidence and trust in doctors; pain control; being treated with respect and dignity; controlling the side effects of chemotherapy and radiotherapy; and the GP being given the right amount of information in order to care for the patient. These high scores on these types of questions are congruent with the results of the CPES in England and in Wales and in some cases are even more positive.

92% of respondents in Northern Ireland (89% England in 2014) said that their overall care was excellent or very good.

Improving dementia services in Northern Ireland

The 2011 regional dementia strategy focused largely on improving the quality of life, care and treatment for people living with dementia, their carers and staff working in the field of dementia.

In September 2014 an investment was made through the 'Delivering Social Change Project' which will contribute significantly to the implementation of recommendations across three broad thematic areas of the strategy i.e. (i) awareness raising, information and support, (ii) training including delirium and (iii) short breaks, respite and support for carers. This programme will aim to transform the commissioning, design and delivery of dementia services in order to improve the quality of care and support for people living with dementia, promote better awareness, reduce stigma attached to the condition and improve the skills and competency of those working in dementia care services.

Review of releasing time to care (RTTC)

On 3 September 2009 the regional launch of the Productive Mental Health Ward programme 'Releasing Time to Care' took place in Northern Ireland. The programme set out structured methods designed to improve ward environment, systems and processes. The ethos was that the time released by making processes more efficient could then be used for patient care, with a subsequent improvement in the safety, quality and reliability of both patient care and the patient experience. Eleven modules were rolled out as follows:

It was introduced across all acute mental health inpatient admission wards and has been operational for the last six years. A Joint HSCB/PHA Review was commissioned to evaluate the current benefit and impact in relation to Releasing Time to Care through provision of evidence of improvement/quality in the areas of safety, effectiveness and efficiency of care, and service user experience.

The Review found evidence which demonstrated that the principles of Releasing Time to Care were embedded in practice across the majority of the region, underlining the success of the programme in Northern Ireland. The model was instrumental in fostering empowerment, creativity and leadership and each HSCCT demonstrated safety, effectiveness and patient experience through a plethora of initiatives which emerged. It was also evident, however, that the ability to sustain the momentum needed to continue Releasing Time to Care requires protected time for reflective practice and time to repeat the modules on an ongoing basis.

A number of recommendations have been identified in the Review and reflect the key priorities set out in Quality 2020 in relation to transforming culture, strengthening workforce, measuring improvement, raising standards and integrating care across the health and social care system in Northern Ireland.

Raising the standards with Transforming Your Care

TYC-led work with the Consultation Institute

As part of the HSCB led regional Statutory Residential homes for older people project the TYC Directorate engaged the services of the Consultation Institute - a UK-based, not-for-profit organisation who promote the highest standards of public, stakeholder and employee consultation by initiating research, publications and specialist events in order to disseminate best practice and improve subsequent decision-making. During 2014/15 the Institute undertook a retrospective review of the pre-consultation engagement processes which the Statutory Homes Project team undertook. As well as endorsing the pre-consultation approach adopted, the Institute also provided advice to the project team in respect of the next stages of the project – formal consultation and post-consultation analysis and reporting. Engagement of the Institute ensured that lessons learned from other public sector consultation exercises and best practice in respect of stakeholder engagement were deployed to the project.

Partnership working with Age NI

As part of the HSCB led regional Statutory Residential homes for older people project the TYC Directorate engaged the services of Age NI to provide peer facilitators to engage directly with residents of statutory residential homes. The HSCB and Age NI facilitated a joint training programme for the peer facilitators, prior to facilitators visiting each of the residential homes affected by proposed changes to engage directly with residents and seek their views on the criteria proposed to help assess the future role and function of each home. The use of peer facilitators was complementary to a range of other consultation processes deployed during the project to engage with residents of homes, their families and carers, and was acknowledged by the Consultation Institute as innovative practice to secure the views of key group of stakeholders.

A human rights-based approach

The HSCB and PHA are committed to fulfilling their obligations with regards to equality and human rights, as well as integrating an equality and human rights-based approach into the design of services. This commitment and close cooperation with human rights organisations was strongly endorsed in the Vision to Action Consultation.

For example, during 2014/15 the HSCB commissioned expertise in the area of human rights in respect of the statutory residential homes project. The Northern Ireland Human Rights Commission was able to develop a human rights-based approach to the project. This involved mapping potential human rights issues against proposed mitigation actions in the management of the project. This allowed the HSCB to ensure that any proposals for change to statutory residential home provision and the undertakings associated with same comply with human rights law.

Monitoring and reducing healthcare associated infections

Healthcare associated infections (HCAs) are an important and preventable cause of mortality (death) and morbidity (illness). Older patients and patients with co-existing illness are at increased risk of developing infections either as part of, or as a result of, their healthcare.

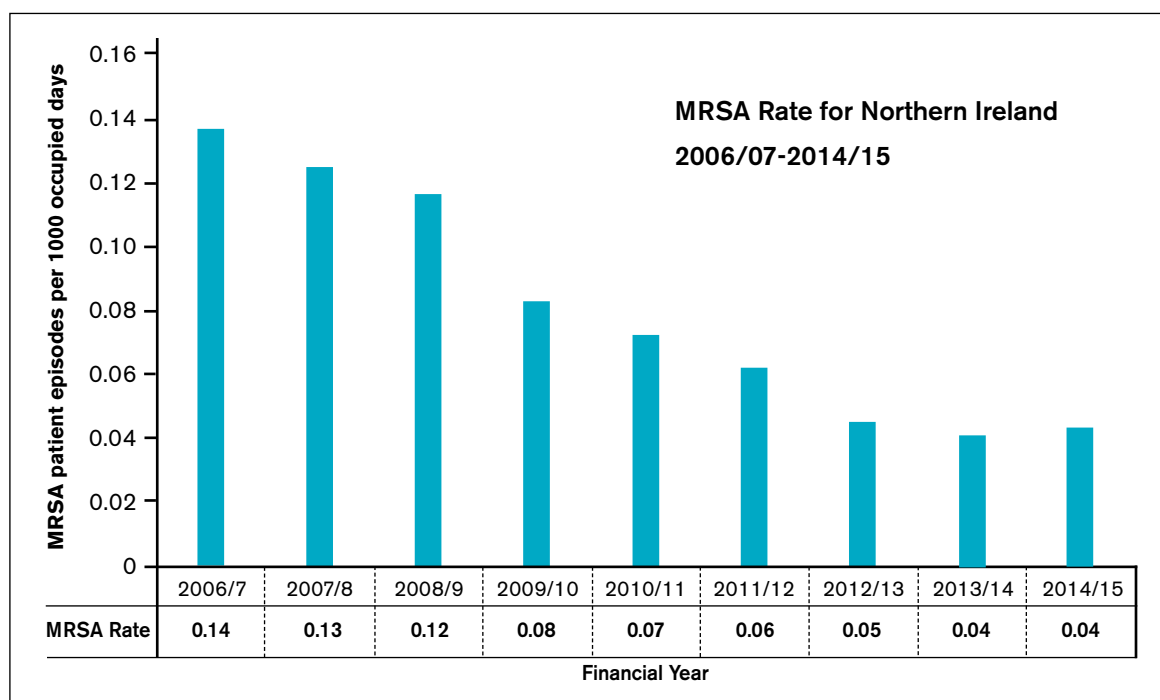
The PHA oversees and delivers a number of regional HCAI surveillance programmes. Partners across health and social care (Trust, primary and community services) use the information reported through our regional surveillance programmes to monitor the impact of infection prevention and control programmes and service improvements.

Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections

The regional rate for MRSA bacteraemia has decreased considerably from 2006/07. In 2014/15 the regional MRSA rate was 0.04 per 1,000 occupied bed days, remaining unchanged from the rate reported for the previous year and representing one quarter of the regional MRSA rate reported in 2006/07.

Five more MRSA bacteraemias were reported by HSCTs during 2014/15 than in the previous year. The regional ministerial target of 50 MRSA bacteraemias was exceeded by 17 infections, with two HSCTs meeting their individual MRSA reduction targets.

Figure 20: Regional MRSA bacteraemia rate per 1,000 occupied bed days 2006/07 to 2014/15



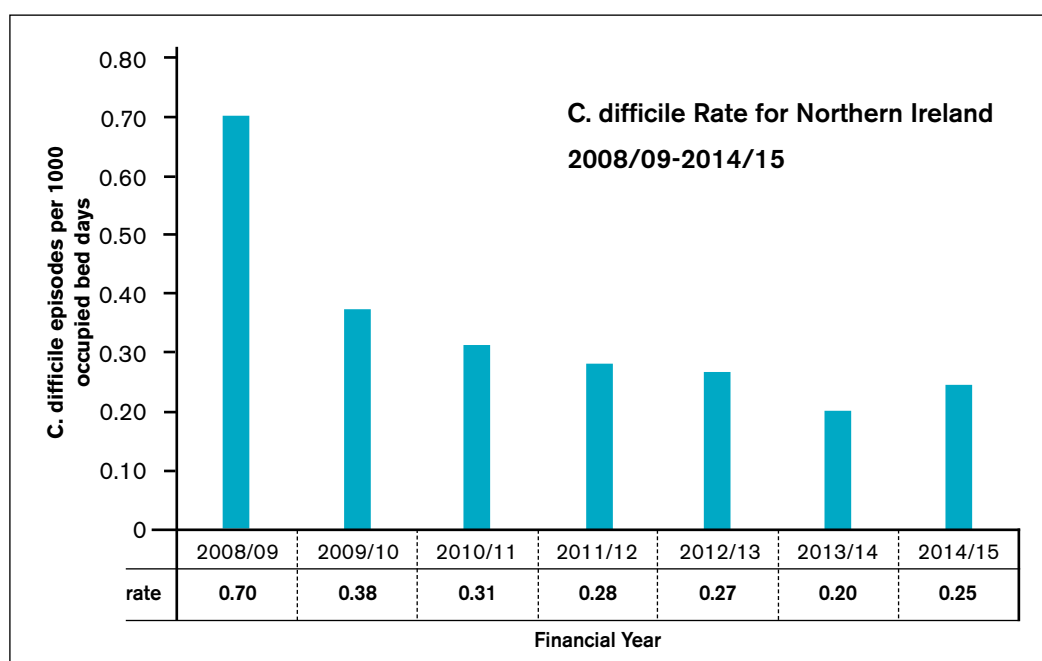
Clostridium difficile infections (CDI)

The regional rate for CDI among hospital in-patients aged two years and over has decreased considerably from 2007/08 onwards. In 2014/15 the regional CDI rate was 0.25 per 1,000 occupied bed days, representing approximately one third of the regional CDI rate reported in 2008/09.

The CDI rate for 2014/15 has increased slightly from the rate reported for the previous year (0.20 per 1,000 occupied bed days). This is the first occasion that an increase has been reported for CDI rates among this group of hospitalised patients.

Sixty nine more CDI cases were reported by HSCTs during 2014/15 than in the previous year. The regional ministerial target of 288 cases among patients in acute hospitals was exceeded.

Figure 21: Regional CDI rate per 1,000 occupied bed days, in-patients aged 2 years and over, 2008/09 to 2014/15



Peer review of cancer multidisciplinary teams

During 2014-15 the HSCB's Cancer Network coordinated the peer review of Breast, Colorectal, Gynae and Lung Multidisciplinary Team Meetings (MDTs) by the NHS National Peer Review Team. This enabled MDTs from the 5 HSCTs to be assessed against the Manual of Cancer Service Standards for benchmarking purposes both within Northern Ireland and across England and Wales. Lay reviewers were recruited from the Cancer Network Patient and Public Involvement Forum for all Northern Ireland visits. These lay reviewers were trained by the National Peer Review Team alongside the Clinical Reviewers on the process – in addition a separate lay reviewer development programme was developed to include active listening, report writing, critical questioning and confidence building.

Many examples of good practice were identified by the clinical and lay reviewers and action plans have been agreed for areas where the reviews indicated improvements were required.

Five further disease areas are to be peer reviewed in 2015-16, namely Head and Neck, Urology,

Skin, HPB, and Brain and CNS. Preparatory work was undertaken during to standardise the management of patients treated for these five disease areas.

Regional information system for oncology and haematology (RISOH)

Work via the Regional Information System for Oncology and Haematology Programme (RISOH) has resulted in development of standardised clinical management guidelines and associated systemic therapies protocols for all oncology regimens. Work is ongoing to agree clinical management guidelines and to rationalise haematology regimens. The system will during 2015 enable electronic prescribing of oncology and haematology regimens in line with National Chemotherapy Advisory Group (NCAG) safety guidelines.

Raising the standards in primary care

GP practices have a contract to provide core services to patients registered with their practice who are unwell. To build on this core work the Health and Social Care Board also offer additional payments to practices providing additional services such as vaccinations and structured reviews and care plans for groups of patients.

Enhanced services

Enhanced services are elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services which are designed around the needs of the local population. Enhanced services provide the HSCB with opportunities to develop more local and integrated services across primary and secondary care.

Provision of enhanced services is optional and those GP practices who agree to provide each enhanced service have a contract individually with HSCB.

Below are three examples of enhanced services that have been well received by patients, their carers and GPs in 2014-15. All services offer a holistic approach to improving patient care and involve patients, families, carers and healthcare staff in decisions about future care.

(1) Healthcare for adults with a learning disability

Following the Northern Ireland Review of Mental Health and Learning Disability (Bamford), it was clear that people with a learning disability have higher mortality rates and live with greater levels of ill health than the general population. They are more likely to have general health problems, sensory impairments, mental health problems, epilepsy, cerebral palsy and other physical disabilities. Specifically:

- Uptake of breast and cervical screening by women with a learning disability is poor.
- People with a learning disability tend to access primary care much less than they need to.

- Many people with a learning disability have undetected conditions that cause unnecessary suffering or reduce the quality or length of their lives. HSCB ophthalmic services have worked with medical services staff to highlight how visual impairments may be flagged up and detected in persons with a learning disability.
- Often not easily identified on patient lists as having a learning disability.

In an effort to improve the health and wellbeing of people with a learning disability the Directorate has put in place an enhanced service for HealthCare for Adults (aged 18 years +) with a learning disability.

One of the keys to success is joint working between local HSCTs, primary care, voluntary bodies, users and carers. This service is intended to assist local partnerships to use enhanced services to deliver better healthcare to patients with a learning disability. As a result it is aiming to enhance the life and independence of those patients and is achieved by:

- Partnership working between GP practices and the local HSCTs.
- Providing a detailed patient health assessment and liaising with other organisations to provide further care and appropriate screening - for example community and learning disability health professionals, social services and educational support services in order to provide seamless care for patients and their carers.
- Providing a patient / carer health action plan that is reviewed on an annual basis with the outcomes updated. The health check is then integrated into the patient's personal health record.
- Promotion of a team-based approach to care, with improved liaison with carers and health care professionals.

Table 13: Learning disabled 2014/15

LCG Area	Total number of Practices	Contracting Practices	Percentage signup	Nos of Health Checks carried out
Belfast	85	76	89%	845
South Eastern	54	53	98%	1047
Northern	78	77	99%	1400
Southern	76	67	88%	1309
Western	57	54	95%	1169
Regional Total	350	327	93%	5770

(2) Multiple sclerosis/Parkinson's Disease local enhanced services (LES)

This local enhanced service was developed in 2014-15 by Directorate staff and has 329 of Northern Ireland's 350 (94%) GP practices contracting to provide this new service.

It has been reported as a useful and helpful service by GPs, their patients and carers as the service enables the proactive management of patients with multiple sclerosis/Parkinson's Disease through a detailed annual review.

Multiple sclerosis and Parkinson's Disease are common neurological conditions affecting patients. The prevalence of multiple sclerosis in Northern Ireland is around 170 per 100,000. For Parkinson's Disease, prevalence is estimated between 100 -180 per 100,000. Incidence increases with age. Although hospital doctors will treat these diseases, GPs have a role in the identification and management of both new and unmet healthcare needs of their patients.

Due to the chronic, progressive nature of both these neurological conditions, this service includes the early identification of palliative care (end of life) needs and planning ahead may be required in the advanced stages of both diseases.

Patients receiving care under this service can now expect their practices to:

- Develop a register of patients with multiple sclerosis
- Develop a register of patients with Parkinson's Disease
- Proactively manage their healthcare needs through annual review. This is a holistic review which should identify any new or unmet needs and is recorded in their medical notes and includes for example:
 - A review of daily living, social support and carer involvement activities
 - Health promotion including review of uptake of health checks in practice (eg blood pressure monitoring, cholesterol checks), vaccination programmes and national screening programmes (eg cervical/breast/bowel screening)
 - Review of any co-morbidities
 - Review of current specialist support including any planned hospital reviews and any recent hospital attendances
 - Review of all current medication, including side effects (eg use of steroids, analgesia, anti-depressants) and recording of Red List Drugs
 - Symptoms review

Common symptoms of chronic multiple sclerosis include: fatigue, pain, spasticity, bladder / bowel dysfunction, visual problems, mood disorders, cognitive problems, sexual dysfunction, speech and swallowing problem.

Common symptoms of Parkinson's Disease include: mental health problems, cognitive changes, sleep disturbance, falls, constipation, bladder dysfunction, orthostatic hypotension, swallowing problems, sweating, sexual dysfunction, excessive saliva.

- Referral to other health professionals depends on the outcome of review

Table 14: Multiple Sclerosis and Parkinson's Disease 2014/15 as of March 2015

LCG Area	Total Number of Practices	Contracting Practices	Percentage sign up	Multiple Sclerosis No of Annual Reviews of Patients to date	Parkinsons No No of Annual Reviews of Patients to date
Belfast	85	79	95%	459	436
South Eastern	54	50	93%	478	344
Northern	78	78	100%	763	592
Southern	76	66	87%	550	435
Western	57	56	98%	404	451
Regional Total	350	329	94%	2654	2258

(3) Optometry local enhanced service (glaucoma service)

In late 2013 the HSCB introduced the first optometry local enhanced service in response to the implementation of NICE Clinical Guideline 85 (CG85). This guideline required patients with eye pressures over a certain limit to be referred to the hospital eye service for assessment for ocular hypertension (OHT) and glaucoma. Eye pressures can fluctuate for many reasons and as a result many patients were being referred to the eye clinic unnecessarily, causing worry and concern when the eye pressure reading was recorded as being over the limit advised in CG85.

HSCB worked to redesign the glaucoma pathway, funding a new first class glaucoma service in the Shankill Wellbeing and Treatment Centre and also introducing a new service for primary care optometrists. Over 350 optometrists across Northern Ireland underwent additional training and assessment to provide an enhanced service. This service allows patients whose eye pressures were above the stated limit at first measurement to return to their optometrist for an additional test which would help determine if referral to the eye clinic was necessary.

Since the introduction of the service in December 2013 over 2,000 patients have accessed it and 65% of them have not required referral. This means that now there is less pressure on the glaucoma clinic and also that patients are not subject to undue worry because of an unnecessary referral. Quality and patient experience are therefore improved, and demand better managed.

When referral from the optometrist is indicated, investment in the new glaucoma service at the Shankill Wellbeing and Treatment Centre means that patients attend a one-stop clinic where all the necessary tests are conducted and the patient is seen by a doctor or optometrist about their eye problem and any other advice they may need in regard to their eye condition and support services.

The optometrist who referred the patient will also receive feedback on the patient and hence the patient's eye care is integrated. The HSCB monitors the activity and quality of the local enhanced service and is engaged with the hospital eye service to ensure audit and evaluation of quality and safety.

In 2015/16 the HSCB will progress plans to further develop the enhanced service available in community optometry practices.

Developments in oral medicine referral criteria/oral cancer

Oral medicine is the specialty of dentistry which is concerned with the oral healthcare of patients with chronic, recurrent and medically-related disorders of the mouth and with their diagnosis and non-surgical management.

General dental and medical practitioners refer patients to specialist services at the various HSCTs.

Referral criteria and guidelines were issued in 2013 to all dentists and doctors. The referring practitioner is required to indicate the urgency of the referral using the three recognised categories: Red Flag (suspected cancer), Urgent or Routine. They are also required to provide a provisional diagnosis and sufficient information to allow the referral to be appropriately triaged by the receiving consultant.

The HSCB has also worked with the HSCTs to develop guidelines for other dental specialist services including restorative dentistry, orthodontics and oral surgery. These guidelines can be downloaded at: www.hscbusiness.hscni.net/services/2470.htm

The need for referral criteria and guidelines was a key finding of the Dental Inquiry Report and action from the Dental Inquiry Action Plan (July 2013). The implementation of these guidelines will ensure the best use of hospital-based specialist dental services, improve clinical outcomes for patients and reduce waiting times for these services.

In November 2014, the HSCB, PHA and Cancer Focus Northern Ireland (CFNI) joined forces to develop a new patient information leaflet and posters to raise awareness of mouth cancer, stress the importance of early detection and add emphasis on prevention. Smoking, regular alcohol intake, the human papilloma virus (HPV) and over exposure to sunshine or sunbeds are the main risk factors for developing mouth cancer. It is more common in men than women and is rare in people under the age of 40. These resources can be downloaded at www.hscbusiness.hscni.net/services/2626.htm

HSCB practice inspections of wholly health service practices

The HSCB, in conjunction with the Regulation Quality and Improvement Authority (RQIA) inspected seven practices in 2014/15 that declared themselves to be wholly NHS practices and would have otherwise fallen outside the remit of RQIA. RQIA is responsible for the monitoring and inspection of private dentistry.

These inspections were based on the RQIA forms and protocols for 2014/15 to ensure parity between private and NHS facilities. The inspection process has been set up to mirror RQIA's system as closely as possible. The report is written by RQIA, with a copy of the report along with a Quality Improvement Plan (QIP) forwarded to the practice. A completed QIP is also returned to HSCB.

As a result of the inspections, issues related to decontamination and radiography were identified in three of the practices. A Board dental adviser worked with the practices, RQIA and the Health and Safety Executive to successfully implement the recommendations contained in these practices' QIPs. This meant that all wholly Health Service dental practices met the required dental standards in 2014/15.

Domiciliary eye care

In 2014 the HSCB Optometry team undertook a regional audit of the Guidelines and Audit Implementation Network (GAIN) Best Practice Guidance for Domiciliary Eye Care Provision. In 2013/14 there were over 14,000 domiciliary eye examinations provided to people in care homes and to people who could not leave their own home to access eye care from the community optometrist. The audit provided information on many aspects of how eye care is provided. This will help HSCB to further raise the standard and quality of domiciliary eye care to ensure that it is of the highest standard and gives the best outcomes for patients at all times. The HSCB is currently engaging with care home providers, optometrists and to implement the recommendations of the audit.

HSCB electronic prescribing eligibility system (EPES) prescribing safety indicators project of five safety searches

The EPES was established in March 2013 to explore the possibility of using data already contained within the 2D barcode of scanned prescriptions in order to identify prescribing of medicines with potential safety issues or prescribing that is not in line with current recommendations.

The aim was that the indicators would assist GPs in identifying patients who are at risk (before they have come to harm) due to potentially unsafe prescribing. Five indicators were developed and the information fed back to GP practices are listed below:

1. Patients taking both verapamil plus a beta blocker.
2. Patients taking warfarin who have had two or more issues of an NSAIS over the three month period (as a marker of long-term NSAID use).
3. Aspirin (300mg or more) prescribed to a child under 16 years of age.
4. Pregabalin prescribed (or taken) at a higher than maximum dose.
5. Protopic® ointment (tacrolimus)
 - a. In children under the age of two years (either strength, ie 0.03% or 0.1%)
 - b. 0.1% strength in children aged between 2 and 16 years.

Source of indicators

Indicators 1, 2 and 3 are validated prescribing safety indicators taken from the King's Fund Research Paper on The Quality of GP Prescribing. The King's Fund prescribing indicators were devised by a panel of 12 GPs for use in assessing the safety of GP prescribing for the purposes of revalidation.

Indicator 4 was developed following local incidents where patients have taken high doses of pregabalin resulting in hospital admissions.

Indicator 5 was developed following MHRA advice on new age restrictions due to the risk of malignancies.

Method

Patients were identified from prescriptions issued by GP practices during March - May 2013. GP practices were provided with the Health and Care numbers of their patients who were identified in the searches.

GPs were given information on the evidence/guidance to support the rationale for the indicators along with advice on review of patients.

The searches were repeated for October - December 2013, to estimate percentage uptake of advice (calculated as % patients in baseline search not appearing in follow-up search).

Table 15: Potential benefits of identifying patients within each indicator

Indicator	Potential Risk to Patients	Advice to GPs	Estimated Uptake of Advice (% of patients identified in baseline search but not in follow up search)
Verapamil plus beta blocker combination	<p>Additive negative inotropic effects on the heart. Risk of marked bradycardia & asystole, severe hypotension or heart failure.</p> <p>Increase risk of Torsades de Pointes if another drug that prolongs the QT interval added at a later date – e.g. erythromycin, citalopram</p>	<p>Review affected patients</p> <p>For uncomplicated hypertension or angina it may be appropriate for GP to change from verapamil to e.g. amlodipine</p> <p>If started by a cardiologist, ensure they are reviewed and monitored by a cardiologist – e.g. once a year</p>	47%
Warfarin plus NSAID (2 or more issues of NSAID in the 3 month period as an indicator of long term use)	Increased risk of life threatening upper GI bleeding	<p>Review affected patients</p> <p>Review need for NSAID, signs of bleeding, consider PPI etc</p>	82%
Aspirin 300mg t a child less than 16 years of age	Risk of Reye's Syndrome	Review patients & prescribe a safer analgesic if required – e.g. paracetamol or ibuprofen	100%
Higher than maximum dose of pregabalin. Max licensed dose is 600mg daily. Search has identified those on an average dose of 800mg or more daily	<p>Patients have been admitted to hospital with pregabalin overdoses (drowsiness, confusion, agitation, restlessness). See Medicines Safety Alert for more details</p>	Review patients for appropriate dose & review prescribing systems if patients are overusing by ordering early	89%
Protopic® Ointment < 2 years	<p>Risk of malignancies.</p> <p>MHRA recommend to no longer give any strength of Protopic ointment to children <2 & only the lower strength (0.03%) to 2-16 year olds</p>	<p>Review patients</p> <p>Consult with dermatology</p>	100%
Protopic® Ointment 2-16 years			92%

There is no direct evidence that correcting the patterns of prescribing leads to a reduction in harm; however, the potential risks associated with each pattern of prescribing are well documented and subsequent correlation of this is likely to improve patient safety.

The potential risks for patients are documented in Table 15, along with the rationale for the indicator and a summary of the advice given to GP practices where patients have been identified. For example, the combination of warfarin and oral NSAID increases the risk of upper GI bleeding. Acute upper GI bleeding is a potentially life threatening condition and accounts for an estimated 50,000-70,000 hospital admissions per year in the UK.

Results and conclusions:

- GPs and community pharmacists are in an ideal position to work together to identify unsafe prescribing.
- Uptake of advice was high (>82%) for all indicators, except for the verapamil/beta-blocker indicator (47%), which may have reflected patients being continued on this combination under the supervision of secondary care.

The initial email was only sent to practices who had patients appearing in the baseline searches. Since there were new patients and new practices appearing in every indicator at the second time period, it was decided to share advice around each indicator with all practices and community pharmacies via the Medicines Safety Matters newsletter for prescribers and community pharmacists.

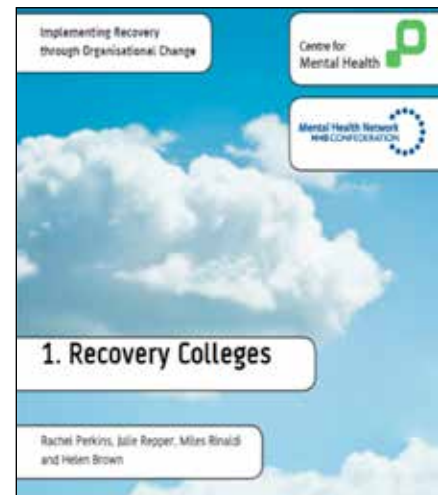
Raising the standards with social care

Improving the involvement of experts by experience in mental health care

The Implementing Recovery through Organisational Change (IMROC) programme offers a way of working that draws on the experiences and skills of people who have used mental health services and the staff who work in them. 'Recovery' in the mental health context means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition. The outworking of IMROC has two key benefits. Firstly it assists individuals in their personal and collective journeys of recovery by promoting hope that it is possible to pursue personal goals and ambitions, maintain a sense of control over one's life and have the opportunity to build a life 'beyond illness'. Secondly, they assist services to become more recovery-focused through true partnership working. The programme has resulted in:

- Improved co-working between people with lived experience and professionals delivering care.
- Establishment of recovery colleges in every HSCT area with over 100 co-produced education and training programmes and a transformed workforce.
- 18 peer support workers across all the HSCTs in Northern Ireland.

In recognition that psychological recovery also requires social and occupational recovery the Health and Social Care Board alongside the PHA is establishing recovery colleges in each HSCT. Recovery Colleges offer a fresh way of working that draws on the experiences and skills of people who have mental health needs. The power of Recovery Colleges is two-fold. Firstly, they assist the individuals whom they serve in their personal and collective journeys of recovery. Secondly, they will assist Health and Social Care services to become more recovery-focused. The colleges will create opportunities for people with mental health problems during and post-treatment to discover personal talents and develop new skills for life and can help people enter the labour market, engage in volunteering or enter formal education. Deciding to use education as the model for approaching recovery, rather than a more traditional model, has been based on the body of knowledge that reinforcing and developing people's strengths rather focusing on what is wrong with them enables recovery. The Recovery Colleges follow an adult education model, offering focused workshops and courses designed to re-skill and assist students to grow in the way they want.



Through this initiative the Health and Social Care system is now proactively seeking to create supported employment opportunities. **Over the last year, 18 peer support worker posts have been created for people with mental health needs. These posts represent an investment of £360,000 annually.** This work is creating real employment opportunities and the Health and Social Care Board will be working with its partner organisation to expand these initiatives with a view to creating additional employment opportunities for people with mental health needs.

Older people

The Northern Ireland Single Assessment Tool (NISAT) is a person-centred, holistic assessment tool designed for multi-disciplinary use. The NISAT delivers a better experience for the service user and assessor, and decisions based on the service user's perspective, professional opinion and the views of others (eg carer). It also reduces duplication, multiple assessments and inappropriate referrals. Following the Review of Community Care in 2002 and its recommendations including the development of a single assessment tool for Northern Ireland, the NISAT was commissioned by the DHSSPS and endorsed by the Health Minister in 2005. Following academic research, tool design and validation, a paper version of NISAT was rolled out regionally in 2011. It was recognised that to deliver the benefits both in terms of service user experience as well as addressing issues around duplication and multiple assessments, an electronic version (eNISAT) was required. The eNISAT implementation project commenced in April 2013. As at the 31 March 2015, 84% of integrated care teams in the community sector have eNISAT and by 31 May 2015 all teams will have eNISAT. There are currently 28,000 service users on eNISAT with over 47,000 assessments. Information is being shared both locally and regionally where appropriate. eNISAT has also been piloted in an acute admissions setting.

Learning disability resettlement

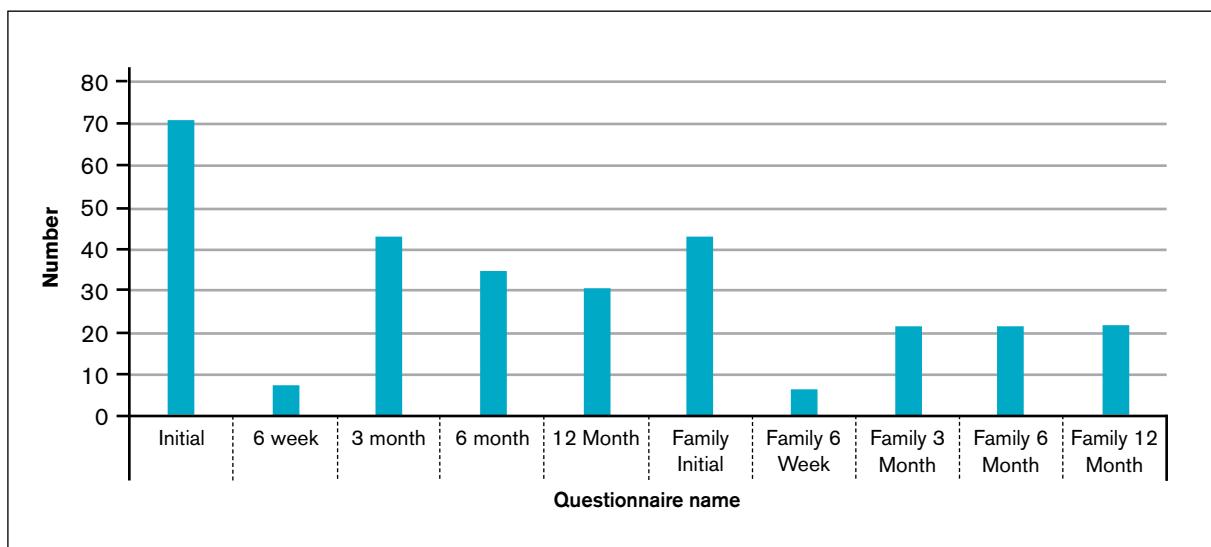
Quality of life measurement pre- and post-resettlement by independent advocates was commissioned by the HSCB during 2014/15.

This overview report will provide the initial findings from the quality of life questionnaires completed to date by residents of Muckamore Abbey Hospital who have been resettled into the community.

A Quality of Life Assessment is an overall assessment of a person's wellbeing, which may include physical, emotional and social dimensions, and which goes on to measure the degree of satisfaction an individual has regarding a particular style of life. The purpose of these questionnaires is to see if betterment (an improvement in their life) has been met during the process of moving from long stay hospital to their own home.

So far the HSCB has received quality of life information on 84 individuals. Of these, 60 were from Bryson Advocacy Service and 24 from Mencap. Below is a breakdown of how many of the questionnaires had been completed, starting from the initial questionnaire which was completed before the residents had been resettled up until 12 months after their resettlement and the same for Family and Carer questionnaires.

Figure 22: Number of questionnaires returned



There are various reasons for the discrepancy in numbers. Some reasons given on the questionnaires were that Quality of Life Assessment was started after the individual had been resettled so in some cases there are no initial questionnaires completed, although in several instances a note has been included that initial questionnaires will be sought. There are also a very small number of completed six week assessments which seems to be because only a small number of individuals received these. It was always thought that the settling-in period would go beyond this first six week period. The low number of family questionnaires compared with individuals is mostly due to the individual not having any family, having no family contact or the family requesting not to be contacted. Questionnaires are still being received so these gaps in numbers may get smaller as more questionnaires come in.

Main points and themes

At a glance, the overall opinion is an extremely positive one. In almost all assessments a major theme has been the feeling from individuals and their families that betterment has been met through the move to the community. It should be noted that in the initial questionnaires almost all families and carers were very pessimistic and negative about moving their family member out of the hospital setting where they felt they were well cared for and safe, and there were worries that medical care would not be as good outside the hospital setting. These feelings change dramatically in the follow-up questionnaires where family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff. This view was mirrored by the individuals and the multi-disciplinary teams. A very small number of residents found it hard to settle in and get used to their surroundings but within six months this issue seems to resolve itself. One issue that families and multi-disciplinary teams have found is that essential equipment such as power packs for wheelchairs took a long time to be fitted and delivered. Another positive trend that has come out of these questionnaires is that individuals have a lot more choice in the community than they did in the hospital with regards to the food they want to eat, clothes they want to wear and things they like to do. The individuals have also indicated that they have much more opportunity to get out and socialise with others in the community and pursue interests and activities which has improved their overall quality of life.

The next stage will involve an evaluation of the responses to each of the questions on the questionnaires to ascertain individual's attitudes to the resettlement process through key views and themes. The initial questionnaires will be analysed first and then compared with the 12 month review after resettlement has taken place.

Quality 2020 task 3 review the policy framework for safety and quality

This task group has collated a catalogue of standards across Northern Ireland and has completed their work. The catalogue is available on the Quality 2020 page on the DHSSPS website - www.dhsspsni.gov.uk/quality_strategy_2020

Theme five:

Integrating the care

In order to provide the best possible service, the HSCB and PHA have developed integrated pathways of care for individuals, making better use of multidisciplinary team working and shared opportunities for learning and development within the HSC and external providers.

HSC Safety Forum

Early warning score systems - maternity

The early detection of severe illness in pregnant women remains a challenge for all clinicians involved in their care. The relative rarity of such events, combined with the normal changes in physiology associated with pregnancy and childbirth, compounds the problem. The Northern Ireland Regional Obstetric Early Warning Score chart and escalation protocol was developed by the Health and Social Care Safety Forum in collaboration with frontline staff for use antenatally, post-natally and in early pregnancy in maternity and gynaecology wards. This regionally agreed single integrated early warning score system for all maternity units in Northern Ireland has standardised the approach of clinicians to patient deterioration, reduced the variation of care and eased the movement of patients, staff and students through all of our units.

Early warning score systems - paediatrics

Paediatric early warning score systems have been established for use in acutely unwell children in order to identify the physiological and behavioural signs of deterioration prior to collapse. In Northern Ireland four out of the five HSCTs were using a range of early warning score charts for children in the acute care setting. It was agreed that as part of the HSC Safety Forum Paediatric Collaborative, a subgroup would develop and agree a single chart(s) for use in all units to standardise the process and to facilitate the movement of both patients and staff between HSCTs. It was agreed that four standardised age bracketed charts would be required: under 1 year, 1 – 5 years, 6 – 12 years and 13 – 16 years. In addition a regional escalation protocol was also agreed, supported by the use of the SBAR structured communication tool.

Regional NEWS

Led by the HSC Safety Forum, the National Early Warning Score is now fully implemented across all HSCTs (since November 2013). This tool helps professional staff identify early deterioration in a patient's condition. NEWS utilisation audits were performed by all HSCTs during March 2014 and 2015 and the information was used to improve practice. The HSC Safety Forum will be facilitating further work to develop a regional approach to difficulties in the scoring of patients with long-term conditions.

Nursing homes – transfer form

In order to improve communication and flow when residents are transferred to hospital from a care home setting, the Nursing Home Collaborative developed and tested a Transfer Form “Information for Transfer to Hospital/Other Facilities for Residents of Care Homes”. This will be disseminated to all Care Homes and is contained in the recently launched Revised Minimum Care Standards for Nursing Homes.

Version 7 April 2015

HSC Health and Social Care in Northern Ireland

INFORMATION FOR TRANSFER TO HOSPITAL/OTHER FACILITIES FOR RESIDENTS OF CARE HOMES
(to accompany resident through hospital journey and copy to file)

Name of resident: _____ HCA Number: _____
 Name resident known by: _____
 Date and Time: _____
 GP Name and Address: _____
 Accompanied by: _____
 Is English the 1st language: Yes No If No, what is first language: _____

Name/Address of Home: _____ Allergies: Yes No
 Home Contact Tel No: _____ Please List: _____
 Residential Care Manager: _____
 Nursing _____
 Date of Birth: _____ Religion: _____
 Next of Kin / main carer name and contact telephone / mobile: _____
 Notified: Y N

Reason for Transfer:
 Situation _____
 Background _____
 Assessment _____
 Recommendation(s) _____

Past Medical History
 Learning Disability Y N
 History of Dementia/ Confusion: Y N

Activities of daily living (prior to illness):	Independent (please indicate)	Needs Help / Aids (please indicate)	Level of assistance (please indicate)
Communication: e.g. aphasia, hearing / vision loss, Orientated?		Hearing Aid: <input type="checkbox"/> Glasses: <input type="checkbox"/> Other: _____	
Personal hygiene / dressing, Dentures		Dentures: Yes <input type="checkbox"/> No <input type="checkbox"/> In situ: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Continence management			
Nutritional Needs: (Specialist Diet, Enteral nutrition, Dysphagia difficulties?)			
MUST SCORE (last)		DATE:	
Mobility / Transfers			

Tissue Viability - current wound management, risk assessment
 Pressure-relieving equipment in use: Yes No
 History of Falls: Yes No
 Date of last fall: _____
 Weight (current) & Date recorded: _____

Last medication given (specify) Date and time: _____ Last meal/Drink Taken (date and time): _____

ATTACHMENTS:
 Record of Clinical Observations: Yes No Current Medications: Yes No
 Body Map: Yes No DNACPR: Yes No (firm)
 Infection Control Form: Yes No Other - please specify: _____

If any further information is required, please contact the Nurse in charge

Signature: _____ Print Name: _____
 Designation: _____ Contact Tel No: _____

The Northern Ireland Electronic Care Record (NIECR)

The Northern Ireland Electronic Care Record (NIECR) continues to go from strength to strength and in 2014/15, won two prestigious national awards - the EHI award for 'Best use of IT to support integrated healthcare services' and the HSJ award for 'Enhancing Care by Sharing Data and Information'. The Health Service Journal Awards judges said: “Judges were impressed by this pragmatic initiative and with the way clinicians from all areas can access a whole range of information about patient care.”

In June 2015 over 11,500 unique, active users accessed NIECR which, in 2 years, already exceeds business case targets of having 10,000 users within 7 years.

The NIECR has been used by Health and Social Care professionals for better access to more than 670,000 service user records (~40% of total Northern Ireland population).

The NIECR project team has continued to enrich the system through integration of more health and social care systems with the following key systems added in 2014/15:

- Cardiology investigation reports
- Diamond diabetes letters
- GP referrals
- RVH, MIH, RBHSC ED systems
- LCID community system in NHSCT and SEHSCT
- SosCare social care in NHSCT
- OOH GP letters
- Sectra liteview (allows viewing of radiology images)

In September 2014 NIECR was integrated into the OOH systems in all HSC locations and has already been used to access over 65,000 patient records.

Over 100 GP practices can access NIECR at the click of a button which will launch NIECR in the context of the patient being viewed in the GP system.

In collaboration with the NHSCT the NIECR team have developed and implemented an eReferrals Triage Management tool. After a pilot in General Surgery in Causeway Hospital it will be rolled out to all specialities in the NHSCT by October 2015. BCH nephrology and Altnagelvin endocrinology and respiratory will be using this functionality in BHSCT and WHSCT respectively in the near future. This solution removes paper from the GP and the hospital referral process and, using a function developed by BSO ITS integration team, registers the referral directly onto PAS. Since going live on 16 December 2014, evaluation has found that 30% of GP electronic referrals are added to PAS waiting list or appointed on the same day.

A Diabetes Care Pathway has been developed within NIECR with input from health and social care professionals across the spectrum of those providing diabetes care. The aim of the pathway is to develop a first step towards a truly integrated shared care pathway for those patients with long-term conditions. The pathway is complemented by the clinically rich NIECR patient record. This will allow an integrated, multi-disciplinary approach where health and social care professionals can update the patient record in relation to their diabetes treatment and make this information immediately available via NIECR to all health and social care professionals who have an interest in the patient's care.

Finally, in collaboration with Cardiology/Cardiac surgery the NIECR team implemented a MDM module which has, according to the regional cardiology group, "been working unbelievably well and has integrated seamlessly into clinical practice".

Marie Curie out-of-hours rapid response nursing service

As part of USC reform, the HSCB and PHA have worked with Marie Curie to appoint new nursing staff to pilot an out-of-hour's Rapid Response palliative care nursing service. These skilled nurses work with GPs to help provide support and comfort, particularly to those identified as being in the last year of life. The emphasis is on supporting patients to stay in their home, through the provision of expert advice and care in areas such as pain management or relief of symptoms such as nausea.

The initiative also involves NIAS by providing a protocol enabling direct referrals from NIAS to Marie Curie, therefore avoiding unnecessary attendances at emergency departments. The pilot is being expanded in the Northern and Southern HSCTs and implemented in areas within the Western HSCT.

It complements services already available in the other HSCTs. The service has been running since 1 January with positive feedback from staff and service users.

Since its introduction on 1 January, there have been approximately 650 out-of-hours activities recorded. These have been a combination of telephone advice calls and house visits, which have included symptom management, catheter care and patient and family support.

Integrated care partnerships (ICPs) in primary care

A key area for driving quality improvement within Primary Care in 2014/15 has been work undertaken by the newly established ICPs

Seventeen ICPs have been established as collaborative provider networks and facilitate:

- Front line staff to address system-wide issues
- Delivery of integration of care
- Focus on quality improvement, local decision making and problem solving/ innovation

A range of development support has been delivered to facilitate multidisciplinary and collaborative working:

- A clinical leadership programme
- Organisational development sessions
- Service user and carer development support
- A regional workshop
- Regional sharing events for clinical condition areas
- Quarterly meetings for ICP Chairpersons

As a result an effective mechanism was established to allow collaboration and local service change to deliver integration:

- Clinical leaders were put in position and supported to understand the wider context in which they are working so that they can be effective change agents
- Pathways of care reviewed, discussed and improved based on local on the ground knowledge and based around the patient experience
- Service change initiatives developed and resourced for local implementation with measures in place to allow impact to be evaluated

Some comments from ICP Members at the ICP Regional Workshop held on 4 June 2014:

'ICPs are important because they allow improved communication and understanding of all the players so that you can see the bigger picture outside your own part'

'The leadership and partnership development support provided has been vital to me in my role and to the committee overall, has helped us to work together and be persistent when things got tough'

Joining up health and social care provision across organisations though ICPs

The two Integrated Care Partnerships in the West established a multi-disciplinary group to review services and care pathways for frail elderly people. An integrated falls prevention and management pathway was identified by the group as a priority to improve outcomes for older people in the locality.

Research has shown that one third of people aged over 65 will have one fall each year rising to a prevalence of 50% among the over 80s population. Up to 60% of all falls result in physical injury of some degree, ranging from minor cuts, bruising and fractures to major head trauma and hip fractures. In addition, about one third of elderly people who have previously fallen will suffer emotional distress and develop a fear of further falling. Those with a fear of falling have been shown to have an increased risk of falling again, reduced activities of daily living, social



isolation, depression and increased admission to institutional care. The elderly population in institutional care, and who have previously fallen, are at the highest risk category of falling again, with up to 70% having a fall every year.

The community sector representative on the group highlighted the 'Stepping On Programme' as a key part of the pathway for frail older people. It was recognised that there was an opportunity to improve access and outcomes by better integrating this service within the pathway of care.

The 'Stepping On Programme' offers older people a way of reducing falls and at the same time increasing self confidence in situations where they are at risk of falling.

This evidence based programme was commissioned by the PHA and is delivered across the Western area by the five Healthy Living Centres.

The 10 week programme is as follows:

Week 1	<p>Pre-assessment - Physiotherapist</p> <p>Pharmacist medication review</p> <p>WHEAP – Home safety visit, information and packs</p> <p>BMI Check (BP and Pulse postural drop)</p>
Weeks 2 - 8	<p>Otago - 17 different exercises</p> <ul style="list-style-type: none"> - Leg strengthening exercises - Balance retraining exercises <p>Walking programme</p> <p>Moderate intensity</p> <p>Exercises are progressed, 4 levels- resistance increased, support given reduced, etc.</p> <p>Assessments and Information talk provided by ophthalmology – Looking after your eyes</p> <p>Podiatry – Looking after your feet</p> <p>Information talk</p> <p>O.T. – Preventing a fall</p> <p>Health improvement – Fall messages</p> <p>Dietitian - Nutrition information related to falls</p>
Week 9	<p>Post assessment physiotherapist</p> <p>Pharmacist Medication Review</p> <p>WHEAP – Home safety visit, Information and packs</p> <p>BMI Check (BP and pulse postural drop)</p>
Week 10	Health fair

Through the ICP, awareness of this programme was raised among GPs across the locality. Using the quality and productivity aspect of the GP Contract, agreement was reached to refer as appropriate to the scheme.

In the three months since 1 January 2015, 83 older people who have had a fall were referred to this programme to support them in their recovery, to rebuild their confidence and to prevent further falls.

Co-production with service users and carers through the Southern ICPs in development of an integrated diabetes care pathway

In delivering on the commissioning specification for paediatric diabetes, the Southern ICPs established a multidisciplinary working group including patients with diabetes and the parents of children with diabetes.

This group worked together to review the current diabetes services in the locality and to co-design how a more integrated and community based service could be delivered.

One of the key proposals from the service user and carers involved was the need for 24/7 access to diabetic specialist nursing as referenced in the quote below from the parent of a child with diabetes.

‘Without the help and support of her Diabetic Specialist Nurse (DSN) my daughter would have endured countless visits to either her GP or Emergency Department and admissions. If it had not been for the support of my DSN not only in hours when she was paid, but when she gave me her personal telephone number for contact in the Out-of-hours (OOH) period.

While reluctantly I often called my daughters DSN in the OOH period, her help, support, advice, and on occasion, home visit prevented a number of admissions for my daughter.’

It has long been recognised that direct access to specialist nursing services for parents of children with diabetes reduces the rate of calls to GPs, emergency department and admissions.

To this end, the multidisciplinary working group supported the need to formalise the establishment of an out-of-hours DSN On-Call Service - Monday to Friday 5pm – 9am and for 24 hours on Saturday and Sunday.

The ICP put together a business case for a pilot service which was approved by the Local Commissioning Group.

This service is now in place and enables 24 hour telephone access for specialist diabetes advice to patients, GPs and professionals seeking advice.

In the first six months:

- **79 calls** were made to the service by parents of children with diabetes seeking advice and support in managing their child’s condition.
- **5 of the 79 patients** required admission and this was subsequently managed by the DSN directly in discussion with the paediatric ward thus reducing adverse reactions and need for subsequent lengthy admissions.

The partnership with patients with diabetes and the parents of children with diabetes provided a valuable insight into the experience of those affected by diabetes and highlighted that often parents feel vulnerable and afraid of adverse outcomes, particularly soon after diagnosis.

The support of the service in helping children and parents in managing insulin pumps, the insulin regimen, carbohydrate counting and high and low blood sugar readings has been valuable.

The pilot services continues to operate and will formally report its overall findings in August 2015, including patient experience reports, which will help inform its sustainability and support commissioning decisions in relation to a regional approach to 24/7 diabetes services.

Transforming your palliative and end of life care

The Transforming your palliative and end of life care programme supports the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care.

The programme is being delivered by the Health and Social Care Board and PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

The programme is based on the Delivering Choice Programme approach developed by Marie Curie which has been used in 19 sites across the UK where it has contributed to improved experiences for people with palliative and end of life care needs and their families.

Transforming your palliative and end of life care is supporting the implementation of some of the recommendations in the *Living Matters: Dying Matters - A Palliative and End of Life Care Strategy for Adults in Northern Ireland* (2010).

Eight initiatives are being taken forward under the programme with the support of a design group for each initiative. The initiatives have been developed following on from a significant engagement exercise in spring 2014 including seven workshops held across the region and involving many people with an interest in palliative care, including patients and carers. Engagement with carers and service users is continuing throughout the programme.

Mental health: putting evidence and people's experience at the heart and design of mental health care systems

The GAIN Sense Maker Report - *Your Story Can Change Lives: a Regional audit of the experience of users and carers within mental health services* published in 2013 highlight the need to improve peoples' experience of care and to ensure regional consistency of approach across all HSCTs. In addition NICE CG 136 *Improving the experience of people using adult mental health service* required the embedding of user led quality standards in new and emerging care pathways.

The Regional **"You in Mind"** Mental Health Care Pathway was co-produced with experts and carers with experience and sets out the key standards and service model for the delivery of mental health care across Northern Ireland. The pathway has been developed using the best available evidence and marks a new phase in the delivery models for mental health care and in changing the narrative associated with mental health care practice. The Regional Mental Health Care Pathway will be the foundation on which all other mental health care pathways will be developed. The care pathway was launched by the minister in October 2014 and 376 staff have been trained. In addition the pathway is supporting the redesign of mental health service documentation and has been used as the foundation for the development of the new DHSSPS mental health service framework due to be launched later this year.





Promoting mental and emotional wellbeing

It is estimated that mental health problems in Northern Ireland are 20–25% higher than in the rest of the UK. Therefore one in four adults (about 25%) will experience a diagnosable mental health problem at any given time. This makes mental ill health the largest cause of disability in Northern Ireland. Currently over 40% of people claiming Employment and Support Allowance, Incapacity and Severe Incapacity Benefit have identified mental health problems as their primary condition. In addition Northern

Ireland has the highest prescribing rates of anti-depressants in the UK and currently we spend £16 million on such drugs.

In addressing this the evidence clearly shows that organising mental health care around primary care is not only more effective, but is also more efficient. Addressing common mental health problems in primary care also creates the opportunity for secondary mental health care resources to be directed towards those most likely to benefit from more intensive care. Whilst mental health services have traditionally focused on responding to the needs of people as they develop, one of the key objectives of the stepped care model is the development of services which enables earlier and more effective intervention for people with common mental health care needs. In delivering this objective,



The HSCB has established Primary Care Talking Therapy Hubs across each HSCT area. These hubs will focus on providing a range of psychological therapies such as counselling, cognitive behavioural therapy, psychotherapy and lifestyle support

for those people who are experiencing common mental health problems. The hubs provide low intensity talking therapies and lifestyle mentoring for people with common mental health problems in line with NICE CG 123. They have been developed around general practice and when fully implemented will improve access to earlier support, and in time, reduce the numbers of people with common mental health needs being referred to secondary care mental health services.

The hubs not only create a single gateway for psychological and wellbeing services but also offer a real alternative to drug therapies, and help improve governance across all sectors. These innovative hubs bring together GPs, community, voluntary and statutory services into a wellbeing consortium. The HSCB has invested £1.8 million in establishing these hubs and, early indications show that not only are the hubs improving partnership working but are improving access to early intervention with the average waiting time of only four weeks. In addition the hubs are also reducing referrals into secondary mental health services. The HSCB plans to further strengthen the range and scope of service provision within these hubs. Indeed it is our intention to strengthen the links between these developing primary care talking therapy hubs and our family support hubs creating real opportunities to strengthen both a family and community based approach to good mental health and wellbeing.



Regional care pathway for personality disorder (PD)

The regional care pathway for personality disorders was issued in October 2014. It ensures consistency and equity of access to specialist PD services in line with best practice (NICE Guideline). The care pathway provides a framework for reviewing and prioritising the functions of specialist PD services, and a platform for addressing the stigma and exclusion that people with PD have historically experienced when trying to access services.

An audit of compliance with specialist team functions described in NICE (2009) has been completed and improvement planning within current resources commenced. The awareness and training strategy aimed at reducing stigma and exclusion is currently being reviewed and refreshed.

Assessment of patients with mental health problems in emergency departments and the 'Card before you leave' scheme

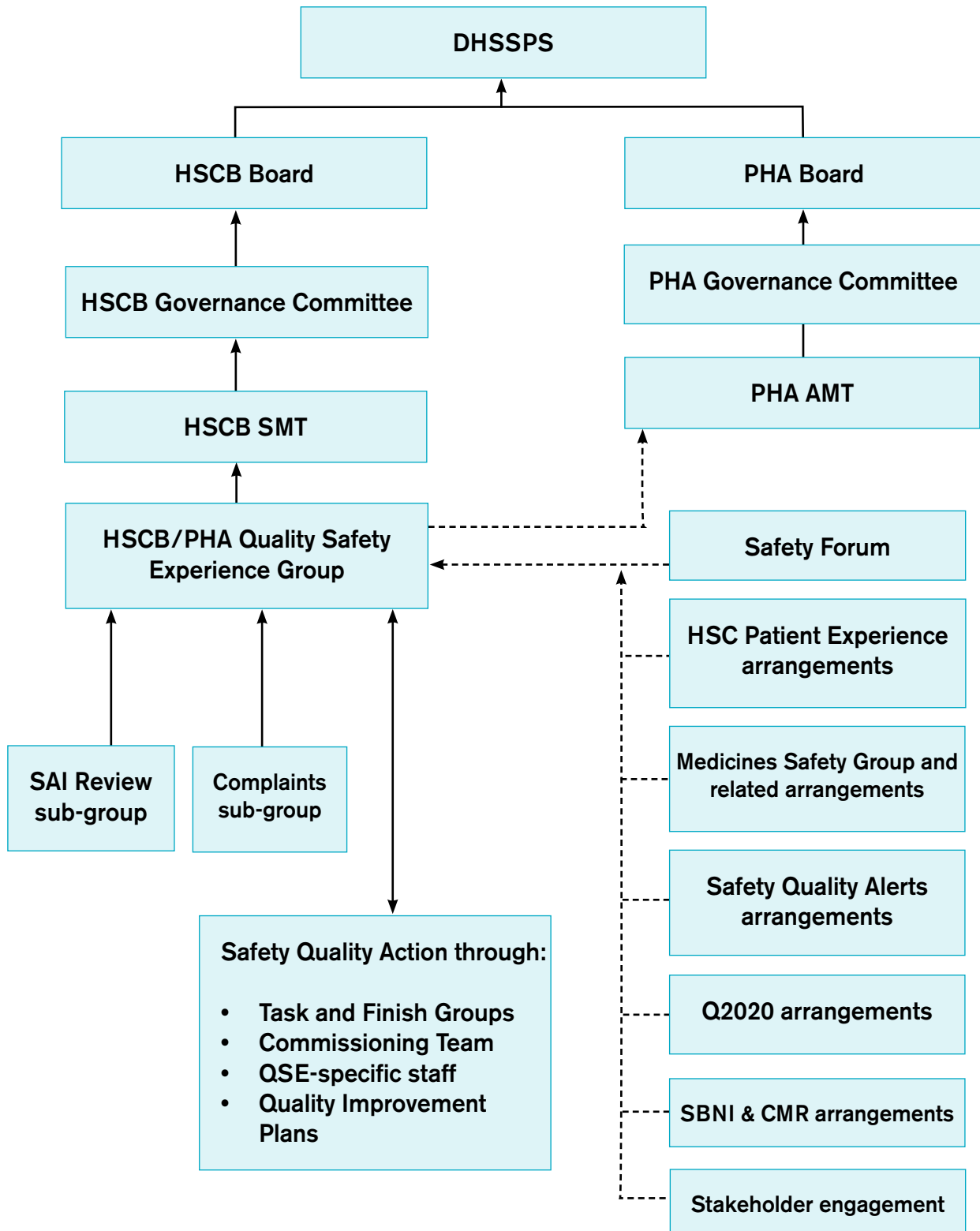
Due to the continued efforts of HSCT staff and recent investment the majority of patients who attend hospital with self-harm or thoughts of suicide are now seen by a specialist mental health practitioner before they leave hospital. A smaller group of patients are not seen prior to discharge and this varies across the HSCTs. In 2010 the 'Card before you leave' (CBYL) scheme was introduced to ensure that such patients who are not seen at the time of attendance have the opportunity to have an assessment by a specialist mental health practitioner the following day. The CBYL scheme is specifically aimed at patients where it has been assessed that the patient poses no immediate risk to themselves or others. While this service works well for people who engage there have been concerns from the outset about the numbers of people who do not attend the next day appointments.

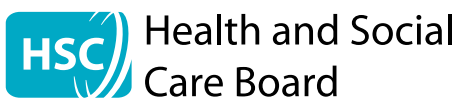
Quality improvement work has been ongoing through the regional self-harm steering group to facilitate improvements in how these patients are managed. This has included improvements to consistency and also work to facilitate timely assessment of patients with mental health issues in the ED. There was investment, by the HSCB during 2013-14, in extra mental health staff to provide mental health liaison services into EDs and the need for further investment is being examined pending resources. A training programme for ED staff has been developed by the Clinical Education Centre and PHA. Trainers were trained in each of the HSCT areas during 2014-15 and they will roll out the programme within each of the EDs during 2015-16. A range of literature was also produced for self harm patients attending the ED and this is available in each HSCT.

The Northern HSCT has secured funds to carry out a pilot which will commence in autumn 2015. A mental health team will be on site 24/7 at the ED, to provide a rapid response. This will further reduce the need for a next day appointment (CBYL) to be issued. The learning from this pilot will help shape future service provision for this group of patients across the region.

Appendix

Overview of HSCB and PHA quality safety experience internal coordination arrangements





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