HSC Public Health Agency

Transforming the Culture

Strengthening the Workforce

Measuring Improvement

Raising the Standards

Integrating the Care

QUALITY 2020

ANNUAL QUALITY REPORT 2022/23

CONTENTS

Welcome to the Tenth Annual Quality Report of the Public Health Agency (PHA)

As Chief Executive of the Public Health Agency I am delighted to share this report outlining how the PHA has continued to improve the quality of health and social care services in line with our commitments set out in the Q2020 Strategy. This report covers the period 1st April 2022 to 31st March 2023, the first year since the dissolution of the Health and Social Care Board and the creation of the Strategic Planning and Partnership Group (SPPG). Moving forward, the SPPG has continued to carry out the roles and responsibilities previously undertaken by the HSCB, working closely with PHA in all elements of Safety, Quality and Experience to improve outcomes for residents of Northern Ireland, but will no longer contribute to this Annual Quality Report.

We continue in this report to outline the impact of the COVID-19 pandemic. Previous reports demonstrated our commitment to learning from our pandemic response, and as such provided examples of how we changed our ways of working, remodelled our service delivery and developed innovative ways to implement change; all of which have contributed to the regional rebuild agenda. This year we implemented updated COVID-19 testing guidance to support clinical pathways issued by the Chief Medical Officer.

This report has afforded the Agency the opportunity to reflect on our successes over the past year and demonstrate not only how far we have come, but also our continued collective drive to improve outcomes for residents of Northern Ireland; against a backdrop of an aging population, increased demand for services and unprecedented challenges across the Health and Social Care sector. Looking to the future we are committed to delivering the highest standard of services, designed and implemented in partnership with service users, our teams and the wider community of stakeholders.

Finally, we would like to thank all our staff for their efforts over the past year, we are proud of what we have achieved together through these challenging times. We will continue to strive for the highest quality standards in the care and services we provide and put the residents of Northern Ireland at the heart of everything we do.

Thank you

Aidan Dawson

Transforming the Culture

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

INTRODUCTION

The PHA recognises that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, and transparent and, in particular, patient and client focused.

Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1. TRANSFORMING THE CULTURE: PROMOTING PERSONAL AND PUBLIC INVOLVEMENT (PPI)

Personal and Public involvement (PPI) is the active and effective involvement of Service Users/Carers and the public in health and social care services. People have a right to be involved in and consulted on decisions that affect their health and social care. Under the Health and Social Care (HSC) Reform Act (NI) 2009, involvement is a legislative requirement and this is underpinned by the Co-Production Guide of 2018.

The involvement of Service Users/Carers and other key stakeholders is critical in the effective planning, commissioning, delivery and evaluation of HSC services. involvement helps to ensure that voices are heard, views are listened to, experiences are shared and expertise is valued, respected and utilised to achieve the best outcomes for the person-centred HSC that we continually aim to achieve.

The Public Health Agency (PHA) was assigned primary responsibility for leading the implementation of PPI across the HSC system by the then DHSSPS in the 2012 PPI Policy Circular. The PHA is required to provide the Department of Health (DoH) with assurances that HSC bodies, and in particular Trusts, meet their PPI statutory and policy responsibilities.

A core function of the PHA PPI team is the provision of professional advice, support and guidance on involvement, on strategic, high profile, sensitive, cross organisational issues/projects. The support provided varies, but in the main entails:

- The provision of professional involvement advice and guidance, stakeholder analysis and development of involvement plans
- Practical support in helping the project promoter to identify, secure and facilitate Service Users/Carers participation
- Development of monitoring arrangements

Outcomes

Leadership, Advice and Guidance

The PHA PPI team has provided professional advice and guidance on involvement, on strategic, high profile, sensitive, cross organisational issues/projects. Advice, guidance and support has been provided to our PHA colleagues across several divisions including:

- Health Improvement
- Research and Development
- HSCQI
- Learning Disability
- Patient Client Experience
- AAA Screening

The PHA PPI team have been able to keep a focus on ensuring the voice of Service Users/Carers has been heard. We have worked with HSC colleagues to formally build involvement into the infrastructure and management arrangements for these initiatives.

In addition, the contribution made by Service Users/Carers across these fields has added insight, authenticity and ownership to key areas of work and has the potential to improve quality, efficiency and safety of services.

Training

The PHA commissions, designs, delivers and promotes involvement, Co-Production and Partnership Working training opportunities for HSC staff, Service Users/Carers and Community and Voluntary Sector colleagues.

We continue to build a cohort (critical mass) of people in the region with knowledge, expertise and experience in involvement, Co-Production and Partnership Working. We have seen a significant rise in the number of staff, Divisions and Directorates looking for bespoke training in involvement and Co-Production.

Monitoring

The PHA PPI Team has led on the development of a Co-Produced, standardised, involvement data collection template with key stakeholders from HSC, PHA, DoH and Service Users/Carers, to develop this agreed approach and methodology.

This approach to monitoring will further support the HSC to:

- Evidence compliance with the Statutory Duty to Involve
- Demonstrate how policy commitments to PPI & Co-Production are being met
- Identify areas which could benefit from improvement

Leadership, Advice and Guidance

It is important to note, that while the below graphic provides some indicative figures, the PHA PPI team are currently developing a more comprehensive and robust data collection system that will better reflect the advice/guidance provided to the HSC system and crucially what impact this has made towards supporting the Public Health agenda.

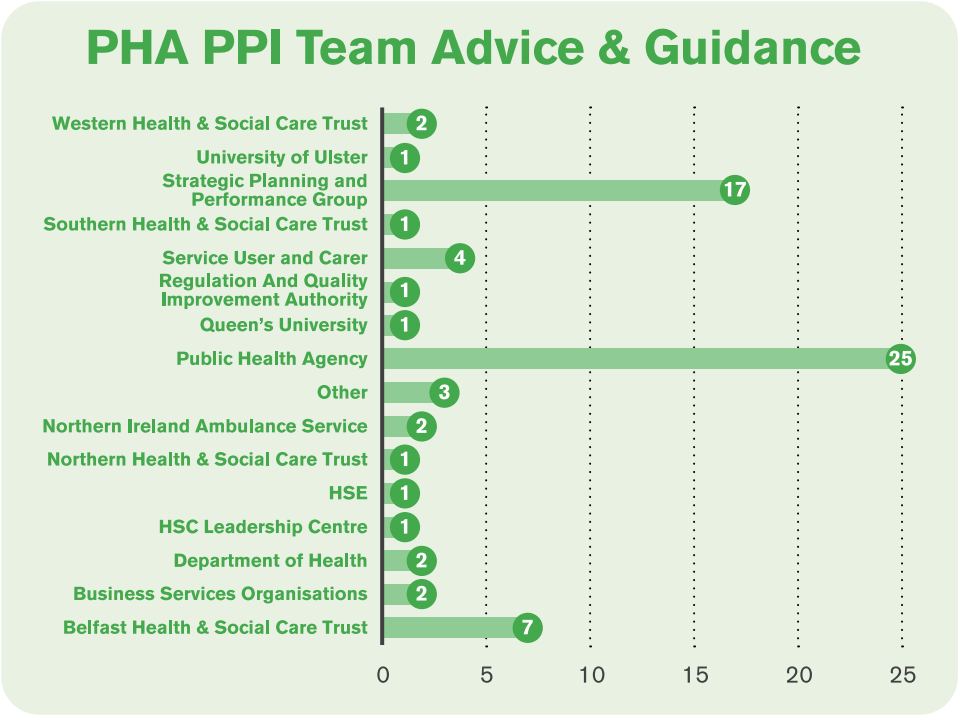


Figure 1: the above graphic shows some of the advice and guidance (71) the PHA PPI Team have provided to the HSC system from April 22 - June 2023.

With the information and evidence provided to the PHA PPI Team through our monitoring arrangements, the below graphics sets out the 6 HSC Trusts involvement high level achievements & deliverables.

Monitoring Involvement Activity:

Figure 2: How many Involvement activities have started and completed from January 2022 – March 2023

January 2022 - September 2022	October 2022 - March 2023	Total
115	**268**	**383**

Figure 2 demonstrates the total number of started and completed involvement activities have taken place from January 2022 to March 2023. From January 2022 to September 2022 there were 115 involvement activities reported and from October 2022 to March 2023 there were 268, giving a total of 383 involvement activities reported. It is recognised that the above number may not be a full reflection of all involvement activity taking place in the HCS Trusts, potentially due to under reporting in some services and the embedding of the new involvement Activity Data collection tool across the different Directorates and Divisions.

Figure 3: A breakdown in Service Users, Carers, Staff, Public and overall total participating in Involvement projects from January 2022 – March 2023

Number of public	Number of carers	Number of service user	Number of staffs	Total number of Involvement
494	8367	2034	1512	12407
211	275	728	332	1546
90	2	95	145	332
2524	1203	4736	448	8911
599	418	1571	291	2879
379	519	3360	1630	5888
4297	**10784**	**12524**	**4358**	**31963**

Figure 4: Overall Involvement Activity per Levels of Involvement January 2022 – March 2023

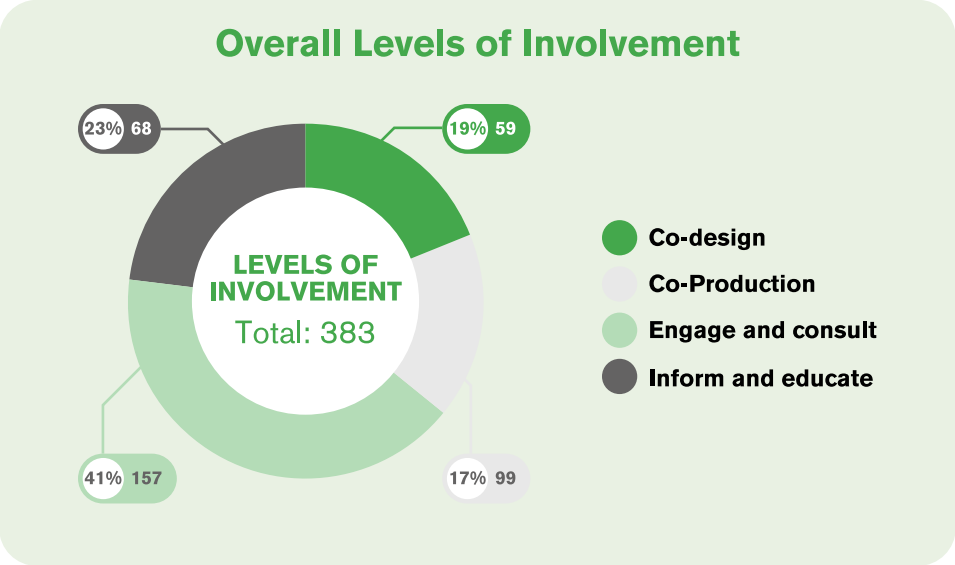


Figure 4, demonstrates the involvement activity per level of involvement across all HSC Trusts from January 2022 to March 2023. The majority of involvement activity fell into Engage and Consult, with a spread across the remaining levels of involvement.

Figure 5: Overall Involvement Activity per Programme of Care from January 2022 – March 2023

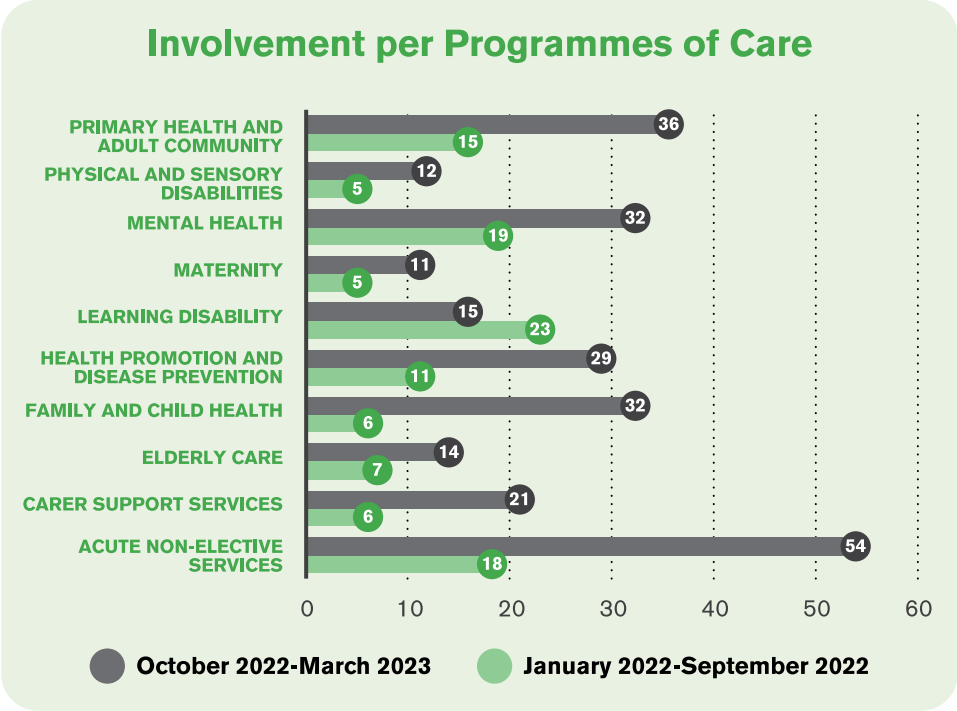


Figure 5, demonstrates the over-all number of involvement activities per Programme of Care across the different HSC Trusts. There is a spread of involvement across the different Programmes of Care, with Acute Non-Elective Services and Primary Health & Adult community showing the majority of involvement.

Figure 7: Overall Involvement Measurement Methods January 2022 – March 2023

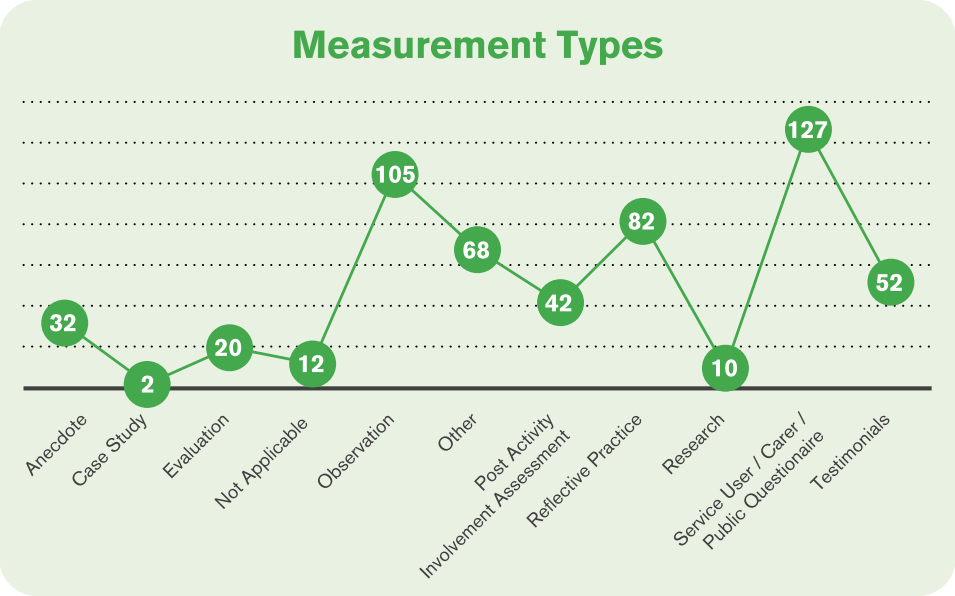


Figure 7, demonstrates the wide range of methods the HSC Trusts have utilised to help determine and measure the impact and outcomes for involvement from January 2022 – March 2023.

Figure 8: Overall Involvement Outcomes from HSC Trusts January 2022 – March 2023

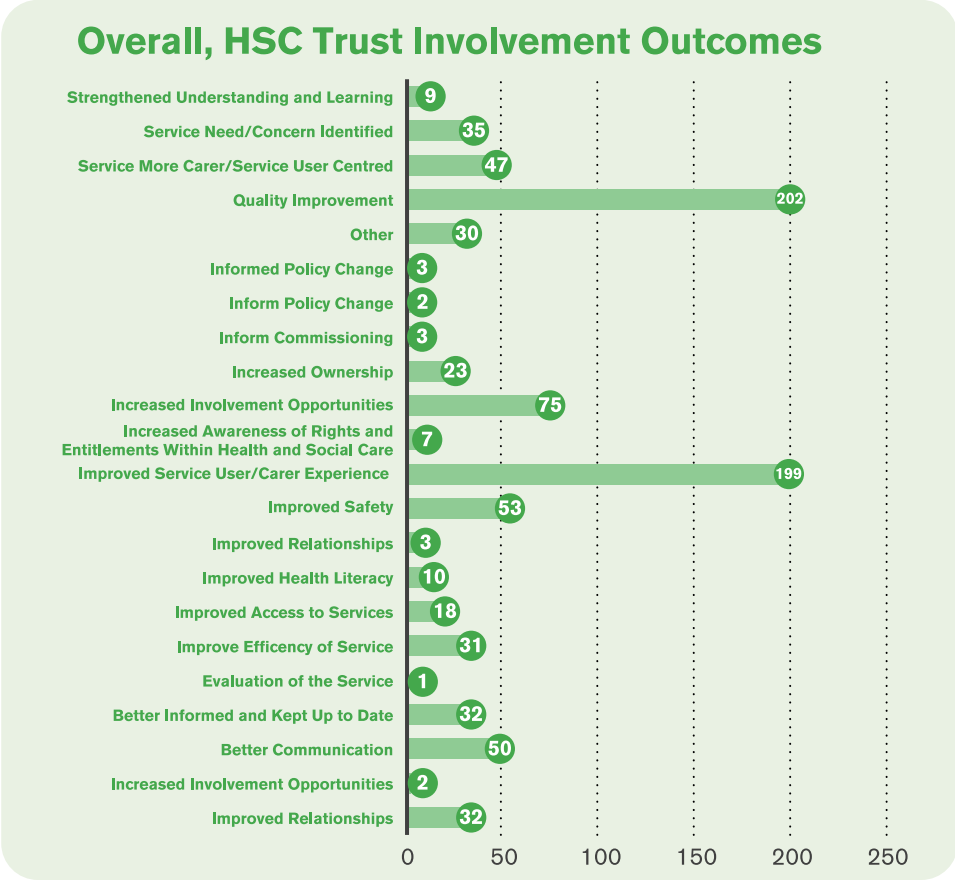


Figure 8, demonstrates the wide range of involvement outcomes and impacts that the 383 involvement activities have made across the HSC Trusts from January 2022 to March 2023.

Involvement Training:

The PHA commissions, designs, delivers and promotes involvement, Co-Production and Partnership Working training opportunities for HSC staff, Service Users/Carers and Community and Voluntary Sector colleagues.

A variety of training programmes have been delivered including:

- An 8th cohort of Leading in Partnership
- A 5th series of bespoke webinar broadcasts

involvement and Co-Production training delivered to:

- Health Improvement
- Commissioning leads
- Pharmacy undergraduates
- Senior Social Work Staff
- Procurement
- HSCQ

13 Service Users and Carers involved in PHA PPI training

72 Undergraduate/Post graduate students attended PPI training

65 HSC staff attended PPI training

49 Applicants for 8th cohort of Leaders in Partnership Programme

25 Participants begin 8th Cohort of Leadership in Partnership Programme

3 webinars commissioned for a 5th series of Tuesday Topics

2. TRANSFORMING THE CULTURE: SHARING LEARNING FROM HOSPITAL INPATIENT FALLS

HSC Trusts are no longer required to report inpatient falls that have resulted in moderate, major or catastrophic harm as a Serious Adverse Incident (SAI), unless serious care or service delivery issues are identified from the initial post fall review; instead inpatient falls are classed as **Adverse Incidents** and a timely Post Fall Review is completed internally. The aim of this is to allow for local learning resulting in a change in practice, to reduce the incidence of future falls.

A **Shared Learning Form** (SLF) following a Post Fall Review is then submitted to the PHA Falls Inbox falls.learning@hscni.net. This allows for a regional analysis of incidents where falls have occurred and for the sharing of this regional overview. The Safety Quality and Innovation Team between July and September 2022, carried out a detailed analysis of all the forms submitted to the PHA Falls Inbox in the period April 2021 to March 2022.

In addition, all Serious Adverse Incidents where analysed and patients' stories where included from Care Opinion.

A newsletter was created to share this information with HSC colleagues with the intention of improving future practice.

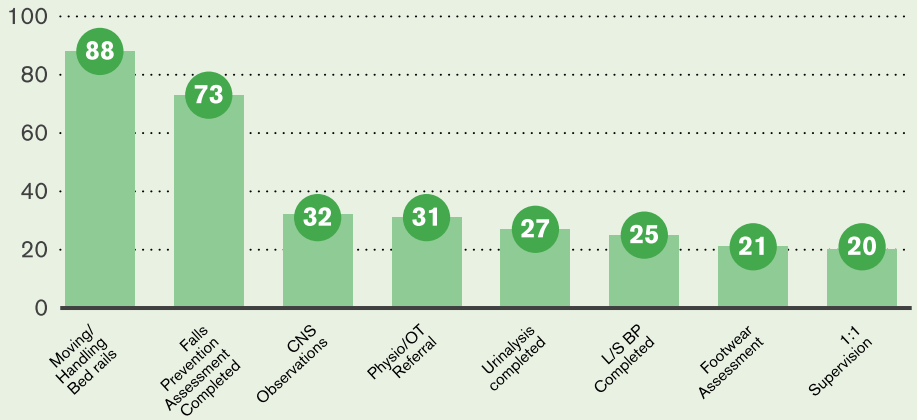
Outcomes

- A thematic analysis of 123 shared learning forms from incidents of inpatient falls resulting in moderate/major/catastrophic harm was completed. Four thematic headings were used, 'what happened to the patient', 'what went well', 'what we could improve' and 'what we learned'.
- 3 SAIs had been submitted in the period and these were reviewed individually with learning identified and shared from each SAI.
- 4 stories outlining patient experience were submitted from Care Opinion.
- A newsletter was produced and shared with HSC colleagues during Falls Week, in September 2022.

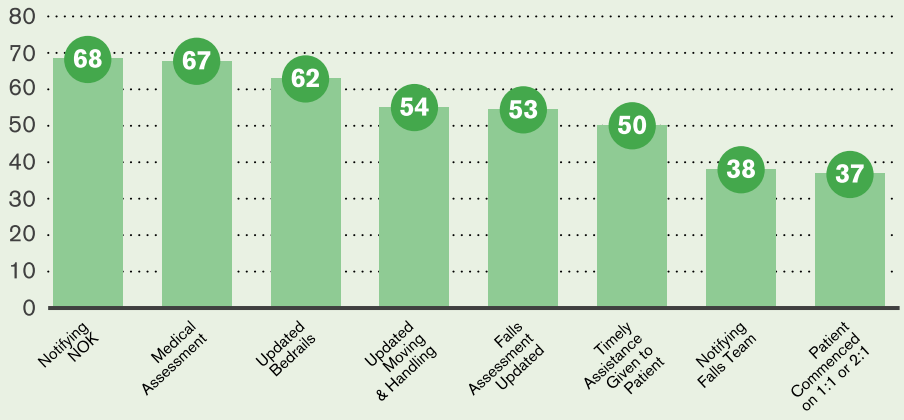
Table 1: Number of Shared Learning Forms (templates) Submitted per Trust April 2021 - March 2022

NHSCT	32
BHSCT	38
WHSCT	15
SHSCT	8
SEHSCT	30
Total	123

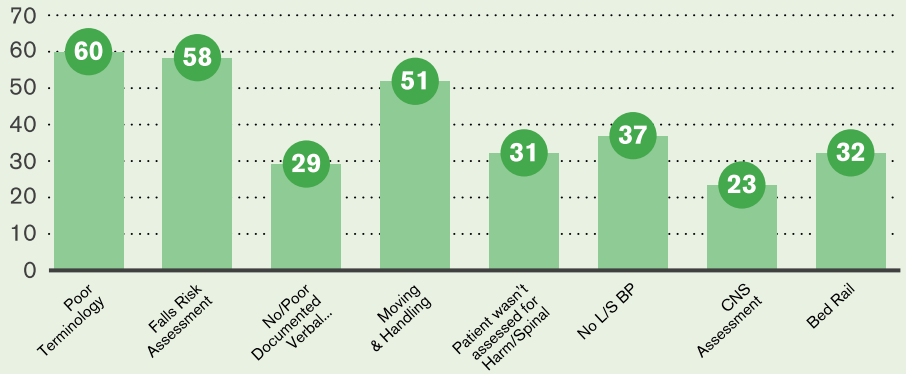
What went well? (Before fall) April 2021-March 2022



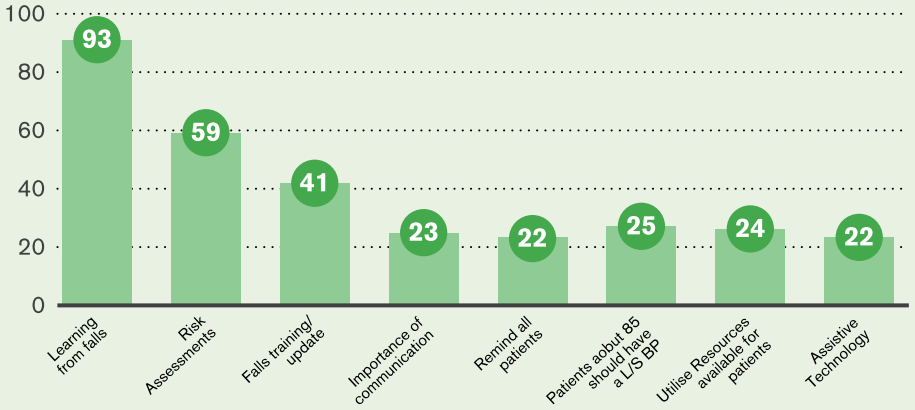
What went well? (After fall) April 2021-March 2022



What could we improve? April 2021-March 2022



What have we learnt? April 2021-March 2022



3. TRANSFORMING THE CULTURE: MEALTIMES MATTER – REGIONAL RESOURCES

The Regional Mealtimes Matter Group aims to maximise patient safety and ensure a high-quality patient experience **always** occurs at every meal, drink and snack time. Based on the feedback received from monitoring the patient and client experience, the area of meal and snack times was identified as a key area for improvement.

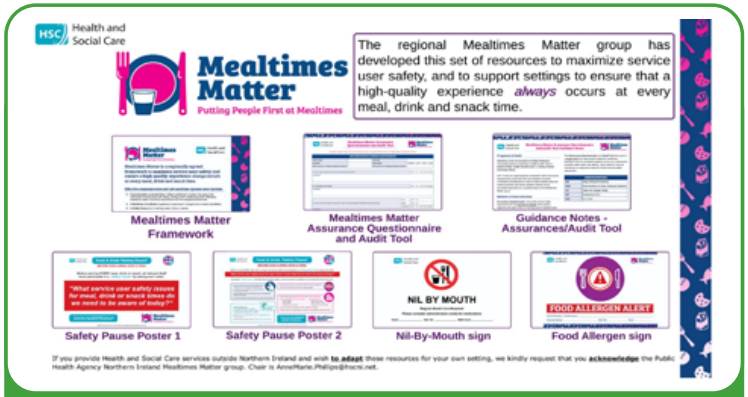
With choking related harm being a significant patient safety issue in Northern Ireland and a Safety and Quality Reminder (SQR) of Best Practice letter issued on in February 2021, the Mealtimes Matter Group chaired by the Public Health Agency co-produced and implemented a number of resources such as;

- **Regional Mealtimes Matter Framework**
- **Regional Mealtimes Matter Assurance Questionnaire and Audit Tool**
- **Guidance Notes on the Assurance and Audit Tool**
- **2 x Food and Drink Safety Pause Posters**
- **Regional Nil By Mouth Sign**
- **Regional Food Allergen Sign**
- **Regional 'Mealtimes Co-Ordinator' Badge**

We are still in the early stages of analysing impact of reduction of patient safety incidents but anecdotally it has supported prevention of incidents as per feedback from staff focus groups.

Outcomes

- Regionally agreed standardised resources embedded across all hospital and community settings in Northern Ireland.
- Audit data is in early stages but shows promise in delivering demonstrable and positive outcomes for patient safety both in hospital and community settings.
- Hugely positive feedback from patients/families, healthcare staff including support staff i.e. catering.
- Provides assurance to the NI Chief Medical Officer.
- Finalist for an HSJ Patient Safety Award 2023 – Category Early-Stage Patient Safety Innovation of The Year.



Mealtimes Matter Resources - 1

HSJ PATIENT SAFETY AWARDS 2023

WE ARE PROUD TO BE A FINALIST

EARLY-STAGE PATIENT SAFETY INNOVATION OF THE YEAR

Mealtimes Matter

Putting People First at Mealtimes

Our work in action

Mealtimes Matter

Mealtimes Coordinator

Mealtimes Matter

Strengthening the Workforce

Objective 3: We will provide the right education, training and support to deliver high quality service.

Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

INTRODUCTION

The PHA is determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution.

Health and Wellbeing 2026: Delivering Together asks HSC organisations to become exemplars of good practice in supporting staff health and wellbeing. The HSC Workforce Strategy 2026: delivering for our people also sets out ambitious goals for a workforce that will match the requirements of a transformed health and social care system.

The World Health Organisation (WHO) defines what is meant by workplace health:

"A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace..."

The PHA is committed to supporting staff health and wellbeing particularly over the last few years during the COVID-19 pandemic, and currently during the Reshape and Refresh programme of work. The PHA has introduced a number of initiatives to listen to and engage with staff and promote best practice through investing in training and education, and ensuring that the perspectives from all staff are heard and incorporated into the future of the Agency.

1. STRENGTHENING THE WORKFORCE: PROJECT ECHO: LEARNING FROM SERIOUS ADVERSE INCIDENTS RELATED TO THE DETERIORATING PATIENT

In March 2022, the Safety, Quality and Innovation Nursing Team in the PHA, led on the development of a new Project ECHO. Project ECHO (Extension of Community Healthcare Outcomes) is a worldwide movement providing an online learning and support methodology. It supports knowledge sharing between professionals from across health and social care, and facilitates the exchange of specialist knowledge and best practice. The theme of the ECHO was learning from Serious Adverse Incidents related to the Deteriorating Patient and the common patterns and trends that arose in various cases. The format of the ECHO was a short 30 minute teaching session followed by a short case study where participants were then placed into various breakout rooms to discuss key questions. Each session lasted 2 hours. The areas covered included:

- Recognition and Response to the Deteriorating Patient.
- Human Factors to include non-technical skills.
- Safety Culture: The Importance of Psychological Safety and Embedding a Just and Learning Culture.
- The Importance of Communication & Listening to Families in Relation to Patient Deterioration.
- Learning: How we Apply and Disseminate the Key Learning from SAIs – are we succeeding?
- Medication Safety and Systems Thinking.
- Learning relating to the newly adopted Patient Safety Incident Response Framework (PSIRF) within NHS England.
- Northern Ireland Ambulance Service – 'Thinking as a system to reduce harm from Ambulance delays'.

Outcomes

- From May 2022 to April 2023 there were six sessions of ECHO.
- The infographic below provides an overview of the End of Year Survey results.
- The ECHO was rated 'very high quality' by the majority of participants.
- It achieved a sense of community for all participants.
- Over 90% of participants, participating in ECHO Sessions increased their confidence in treating patients.
- 92% of participants reported the topics covered in the ECHO sessions were relevant to their role.
- 100% of participants reported that case-based learning as the focus for discussion is a highly impactful way of learning.
- 96% would recommend Project ECHO as a useful learning tool to others.
- Over 75% reported they have applied knowledge gained through the ECHO to their practice.

"I've thoroughly enjoyed all the different presenters as well as the opportunity to participate in break out rooms!"

"The importance of good communication between patients, relatives and staff and by taking the time to listen to concerns and think objectively can prevent SAIs."

Project ECHO® Northern Ireland

"It's a good systematic way of looking at things when they have gone wrong and getting the learning out."

"Some of the case studies shared have changed how I approach families."

"has allowed me to network with others and look at how we can implement learning and change."

"psychological safety was provided within the sessions."

Serious Adverse Incidents
Deteriorating Patient
ECHO Network
End of Year Survey

Objective & Summary

A key theme emerging from SAIs in recent years is 'responding to the deteriorating patient'. Collectively between HSC Trusts, the HSCB and PHA we recognise that there is a lot of learning arising from recent SAIs on this broad area which could be shared with a focused audience.
We believe the ECHO model will provide the appropriate platform and technology in order to collectively discuss the themes, trends, causative factors around the deteriorating patient, share learning from both individual / team experiences, share best practice from experts in particular topic areas.

Networks Objectives - Particpants review of Objectives being met:

- **92%** To use an all teach/all learn method to improve safety across the region
- **83%** To collaborate across areas, professions and organisations to share learning and good practice
- **79%** To better understand and inform the SAI process
- **71%** To provide an opportunity for front line staff to input to SAI discussions
- **88%** To create a safe learning environment

Benefits

79% agreed that participating in ECHO sessions had '**increased their confidence in treating patients**' ranging from a 'moderate amount' to a "great deal'.

92% of participants surveyed would like to continue for another year.

92%

Outcomes

100% of participants surveyed agreed that a sense of community was achieved ranging from ' a moderate amount' to a 'great deal'.

100%

Attendance

42% of participants have attended 5+ ECHO sessions.

Quality

100% of participants surveyed rated the quality of the ECHO Sessions from **High to Very High Quality**

100%

Applied Learning

75% of participants learned something through ECHO that has been **applied to their practice.**

2. STRENGTHENING THE WORKFORCE: ADVANCED NURSING PRACTICE EDUCATION PROGRAMME

In Northern Ireland the first ANP education programme was commissioned from Ulster University in 2017. The programme initially offered three pathways: Children's, Emergency Care and Primary Care, and since its inception Mental Health and Adult Medicine & Older people have been added. The development of this programme is aligned with the Department of Health's strategic policy direction, Health and Wellbeing 2026 Delivering Together (DoH, 2016) and the Advanced Nursing Practice Framework (DHSSPS, 2016). The Nursing and Midwifery Task Group (NMTG) report and recommendations (NMTG 2020), provides a roadmap with direction towards achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. This is set within the context of a population/public health approach and aims to maximise the contribution of nursing and midwifery to improve health and social care outcomes. However, while there is significant evaluation evidence of the clinical and care effectiveness of these roles with generally positive feedback from patients, these roles have not been evaluated within an integrated care system and have had limited evaluation within primary care. PHA nursing directorate assisted with data collection in the recent evaluation- led by Professor Alison Leary to understand the impact of the introduction of ANPs into the Northern Ireland health system.

Outcomes

- The introduction of ANPs into Northern Ireland has increased flexibility and service capacity, particularly in primary care.
- In common with other studies, ANPs in Northern Ireland have the characteristics of an agile, accessible workforce which can see and treat "whoever comes in the door".
- There was a distinct nursing contribution.
- Stakeholders (patients, colleagues, managers) valued the role and found it beneficial.
- Value drivers and enablers such as expert care, leadership, improved access, variety of service and access, enabling self-care and self-management and the development of specialist areas of practice all emerged from these data indicating that patterns of work compare well to other well evaluated/productive ANP workforces globally.
- There are some common challenges to practice, comparable to ANPs in other countries.

3. STRENGTHENING THE WORKFORCE: DEVELOPING AN ALLIED HEALTH PROFESSION POPULATION HEALTH STRATEGY FOR NORTHERN IRELAND

The 4 nations Allied Health Profession's Public Health Forum was established in 2019, to agree a 5-year UK population health strategic plan for AHPs. Subsequent to this, each jurisdiction developed and led on a localised framework aligned to UK goals that:

1. **Developed the workforce**
2. **Demonstrated impact**
3. **Increased profile**
4. **Developed strategic connections**
5. **Considered the health and wellbeing of the workforce**

In November 2022, AHP Consultants in the PHA and the Chief Allied Health Professions Officer agreed a Northern Ireland Population Health Strategy aligned to the UK plan and to meet requirements of a new Health and Care Professions Council standard being introduced in September 2023.

Outcomes

Northern Ireland's strategic framework developed in November 2022 has achieved the following outcomes:

- PHA developed and delivered online population health training for 200 of Northern Ireland AHPs. Outcome results indicated over 90% of staff rated their understanding or population health and the wider determinants of health as good/very good post training. An improvement of over 70%.
- PHA hosted a whole systems workshop in conjunction with NICON for AHP Leaders during which participants prioritised actions to develop the framework. Action teams are now rolling out agreed priorities across Northern Ireland.
- PHA supported AHPs from Northern Ireland to publish 5 case studies showcasing good practice on Royal Society for Public Health website.
- PHA develop and distribute AHP Population Health Newsletters online to share good practice and increase population health awareness across the region.
- PHA works closely with UK AHP partners and has developed strategic links internationally with USA and New Zealand to share learning on maximising the potential of AHPs in reducing health inequalities at a population level.

4. STRENGTHENING THE WORKFORCE - PHA IN-HOUSE OUTCOMES BASED ACCOUNTABILITY (OBA) AWARENESS TRAINING 22-23

Outcomes Based Accountability (OBA) methodology is an approach that is being actively promoted across Government Departments and Arm's-Length Bodies. It is a system for organising our efforts and resources towards achieving desirable end results or outcomes, and measuring how well we're doing. It is also known as Results Based Accountability (RBA). It focuses on:

- **Population outcomes** i.e. conditions of wellbeing for whole populations (such as those included in the draft Programme for Government and the Making Life Better strategy), and
- **Performance measurement** of our efforts and actions/what we do to achieve or contribute towards achieving those population outcomes (such as by delivering patient & service level outcomes).

From November 2022-January 2023, staff from the Planning and Business Services Team within Operations, delivered 7 x two-hour, interactive, online sessions, to 150 participants, with the aims of building OBA capacity and embedding OBA across the organisation.

The programme provided an introduction/refresher to OBA–what it is, where it came from and why we need to know about it, as well as what we need to do with it, when and how, and who can help. It provided staff with the opportunity to work through practical examples relevant to the organisation.

The desired outcome from the training was to increase participants' knowledge of OBA and their confidence in applying it in their work.

Outcomes

- **Usefulness of the session:** 85% of respondents rated the sessions as Extremely or Very Useful.
- **OBA Knowledge before and after the training:** The average level of OBA knowledge reported before the session was 'a little' (2.4 stars out of 5) and increased afterwards to 'a lot' (3.7 stars)
  - **Before** the OBA Sessions only a tenth (10%) of respondents rated their knowledge of OBA as a 4 or 5 out of 5 – i.e. felt they had a lot or a great deal of knowledge. Nearly half (47%) gave a rating of 1 or 2 out of 5 – i.e. only a little or very little.
  - **After** the sessions almost two thirds (64%) rated their knowledge as 4 or 5 out of 5, with another third (33%) rating it as 3 out of 5 (moderate).

- **Confidence in applying OBA before and after the training**: The average level of confidence reported before the session was 'slightly confident' (2.2 stars out of 5) and increased afterwards to 'moderately confident' (3.2 stars).
  - Before the OBA Sessions NO respondents rated their confidence in applying OBA as 5 out of 5 (extremely confident). Only 3% rated their confidence as 4 out of 5. A third (33%) rated moderate (3 out of 5). Just under half (49%) were slightly confident and 15% were not at all confident.
  - Afterwards 4% felt extremely confident (5 out of 5) and a quarter (25%) felt very confident (4 out of 5). A large proportion (62%) gave a 3 out of 5 rating – moderately confident – and only 9% felt slightly confident. NO respondents said they were not at all confident.
- **Likelihood of using OBA in work:** On average, respondents indicated they would be 'very likely' to apply OBA after attending the session.

"Thank you both for a really insightful session and clear training."

"I was told by my manager last week it was one of the most useful PHA training sessions she has attended."

"I attended the OBA workshop on 24th November and found it very useful for my role."

"That was a wonderful session, I thought I knew OBA but realise I still need to continue developing my knowledge."

Average Levels of OBA Knowledge

Before Training	After Training
★★☆☆☆	★★★★☆
(2.4 stars - a little)	(3.7 stars - a lot)

Average Levels of Confidence in applying OBA

Before Training	After Training
★★☆☆☆	★★★☆☆
(2.2 stars - slightly confident)	(3.2 stars - moderately confident)

5. STRENGTHENING THE WORKFORCE- PRIMARY CARE MULTI-DISCIPLINARY DIABETES EDUCATION PROGRAMME

Nationally and globally the incidence of diabetes diagnosis and prevalence continues to increase, posing challenges for all healthcare professionals involved in the management of diabetes. In Northern Ireland there were almost 112,000 GP patients aged 17+ recorded on the Diabetes Mellitus register at 31st March 2023. There have also been changes in the management of Type 2 diabetes as well as advances in diabetes treatment and technology. The majority of people living with Type 2 diabetes are managed mainly in primary care. General Practitioners (GPs), General Practice Nurses and Practice Based Pharmacists play a key role and it is essential that they have the required competencies.

It is recognised that a multi-disciplinary primary care team approach is needed to respond effectively to the health needs of people with diabetes. Formerly, primary care diabetes education programmes were commissioned from outside Northern Ireland but due to the increasing demand a local programme was deemed necessary.

In collaboration with representatives from the Public Health Agency, NI Diabetes Network, Ulster University, General Practitioners and GP Federation Clinical Pharmacists a bespoke course was developed. The focus of this blended learning education programme on diabetes management in primary care was to promote a consistent standard of care, develop supportive relationships and promote an environment that encourages shared learning.

Outcomes

- The PHA, in collaboration with key stakeholders, led the development of a Multi-Disciplinary Primary Care Diabetes education programme, which was approved in 2022.
- The first cohort of students commenced the programme in January 2023 (there were 23 students in total, 1 GP, 13 General Practice Nurses and 9 Practice Based Pharmacists).
- The post module review showed positive results with 95% of participants reporting an increase in knowledge and confidence.
- The blended learning approach included virtual sessions which reduced travel time for participants.
- Following the success of the first programme and wide interest from General Practice the DoH Education Commissioning Group has commissioned a second cohort to commence in January 2024.

Measuring Improvement

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Introduction

The PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. The PHA promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

1. MEASURING IMPROVEMENT: COVID-19 TESTING - IMPLEMENTATION OF LATERAL FLOW DEVICE TESTING FOR HOSPITAL INPATIENTS IN NORTHERN IRELAND

- In May 2022, updated COVID-19 testing guidance to support clinical pathways was issued by the Chief Medical Officer, in the CMO letter HSS(MD) 22/2022 (1). This included a change in policy regarding testing in hospital inpatients, with a move to the use of lateral flow device (LFD) testing for many clinical pathways.
- A regional group was established to support the implementation of lateral flow testing in inpatient groups, as outlined in the CMO letter. Members included representatives from the PHA, the Department of Health, the Pathology Network Point of Care Testing Specialty Forum, HSC Trusts, BSO PaLS and digital health colleagues. The purpose was to implement the roll out of LFD testing to support clinical pathways for inpatients and to identify implementation issues, challenges and solutions.
- A number of issues and challenges were identified by the group and work was undertaken to resolve these.

(1) Addressee (health-ni.gov.uk)

Outcomes

Training

- The regional group agreed that the method of testing should be fully administered LFD tests, administered by trained and competent health care workers in accordance with Trusts' point of care testing (POCT) policy.
- A regional e-learning training package was developed, hosted by the Health and Social Care (NI) Learning Centre (hsclearning.com). Following discussions at the regional group, it was agreed that Trusts would be given flexibility in either availing of their own internal training methods (as agreed with their POCT team) or alternatively, utilising the specific inpatient e-learning training.

Recording of results and reporting

- It was agreed that Trusts should ensure that regional POCT guidance was followed with respect to the minimum data requirements for recording results. Various methods of recording results were discussed within the regional implementation group and, following discussions, Trusts were given flexibility in how this was taken forward for their organisation.

Procurement

- The method for ordering LFD tests was agreed between Trusts and the PaLS team.
- A management information template was developed for Trusts to utilise for their own internal stock management in relation to ordering and distribution of tests.

Standard operating procedure

A standard operating procedure document was developed to outline the procedures associated with the LFD testing. This was approved by the Northern Ireland Pathology Network's Point of Care Testing Specialty Forum.

2. MEASURING IMPROVEMENT: IMPROVING QUALITY FOR CHILDREN AND YOUNG PEOPLE WITH EATING, DRINKING AND SWALLOWING DIFFICULTIES (EDS) IN EDUCATION SETTINGS IN NORTHERN IRELAND

Eating, drinking and swallowing difficulties (dysphagia) affects 8.1%-11.15% of individuals with learning disabilities (Robertson,2017) and can cause aspiration, choking or death. There has been an 25% increase in demand for special school places over the past 5-years and increased level of complexity of presentation. This innovative partnership approach between PHA, HSC Trusts, Department of Education and Education Authority aimed to reduce risks and improve quality for children and young people in education settings by ensuring best use of resources and upskilling of education staff ensuring resources can be redirected for more specialist levels of support.

This project utilised knowledge and expertise from a range of AHPs including SLTs, OTs, Dietitians and Orthoptists to develop a comprehensive training programme whilst maximising digital solutions.

This multifaceted project has 3 strands:

1. **Training**
2. **Clear roles and responsibilities**
3. **Regional resources**

Regional eLearning awareness training developed by PHA in partnership with Trusts replaced ad-hoc training. The Education Authority has stipulated that training is mandatory for all staff working with and preparing food for children in education settings. This has had a subsequent impact on reducing risk and ensuring high quality care, feedback included “I didn’t know about the signs of difficulty but now I do”.

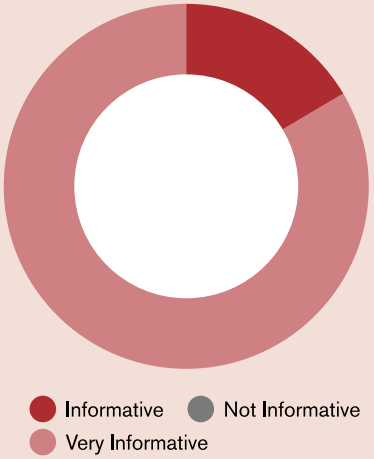
Roles and responsibilities were defined to ensure robust processes to support children effectively, ensure timely referrals to SLT and ensure care-plans were comprehensive, accessible and food/drinks were prepared correctly.

A regional safety alert poster was developed to summarise signs of Eating, Drinking and Swallowing Difficulties to reinforce the content of the eLearning.

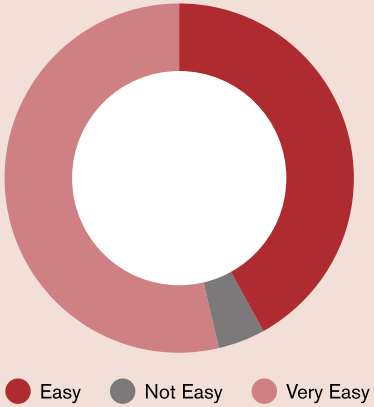
Outcomes

- Since going live in August 2022 1984 staff have completed the 90-minute awareness training, a 200% increase on numbers who had completed local training in the previous year.
- Feedback was very positive, 96% reported training was easy or very easy to access, 100% reported training was informative and 99% reported training met their needs.
- Training improved knowledge, skills and confidence so reducing risk and enhancing quality of care including timely referrals and understanding the risks and needs of children with eating, drinking and swallowing difficulties.
- Training was rolled out to all education settings at no additional cost and resources are available on Department of Education website for easy access. The training allows participants to review content anytime. The eLearning is always accessible addressing staff turnover issues.
- This work was a finalist in Advancing Healthcare Awards Northern Ireland in the category of Working in Public Health.

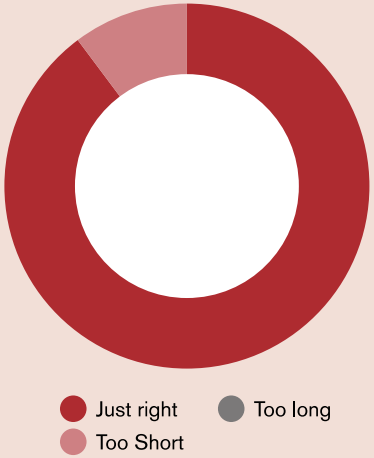
How informative was this awareness training?



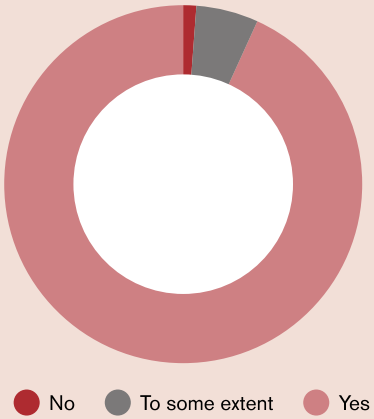
How easy was the training to access?



What did you think about the length of the training?



Did this training meet your needs?




AHA
2022 NORTHERN IRELAND
Allied health professionals
HSC Public Health Agency
Advancing Healthcare Awards
Northern Ireland 2022
AWARD FOR PARTNERSHIP WORKING IN PUBLIC HEALTH
FINALIST
Reducing Risk ... improving quality for children and young people with eating, drinking and swallowing difficulties in education settings in Northern Ireland
Alison Ferris,
AHP Consultant
Public Health Agency


HSC Public Health Agency
CHILD SAFETY ALERT
Signs of Eating and Drinking Difficulties
Swallow Aware
During or after eating and drinking watch me closely for the following:
COUGHING / CHOKING
Changes to my COLOUR E.g. if my skin turns red or blue
Wet or "gurgly" VOICE
EYE-TEARING
Changes to my BREATHING E.g. If I become "wheezy" or gasp for air; my breathing rate gets faster or slower
WEIGHT LOSS / DIFFICULTY PUTTING ON WEIGHT
Repeated or recurrent CHEST INFECTIONS: Especially if I have no other symptoms of a cold!
If you have any concerns about my eating, drinking or swallowing Please contact the Speech and Language Therapy Team
This work originated from the Speech and Language Therapy Team in South Eastern Trust

3. MEASURING IMPROVEMENT: DEVELOPING A CO DESIGNED, REGIONALISED APPROACH TO FALLS IN CARE HOMES IN NORTHERN IRELAND THROUGH SAFER MOBILITY, IMMEDIATE MANAGEMENT AND FOLLOW UP OF FALLS.

Why we did it:

NICE guidelines suggest that 30% of adults aged 65 years and older and 50% of adults aged over 80 years fall at least once per year (NICE, 2013). Globally, fall related death rates are the highest among adults aged over 60 years (World Health Organisation (WHO). Many residents find themselves admitted to a care home following a fall. Falls are one of the biggest problems reported within Care Homes in NI for their residents as they can have a major impact on residents quality of life, physically and mentally and can be catastrophic.

This Project was mandated by the Minister for Health through the Enhancing Clinical Care Framework.

What:

Using Quality Improvement methodology this MDT team (which includes care home staff, service users and relatives) engaged extensively with all key stakeholders (identified using Stakeholder Analysis) to co-produce, test and implement a regional falls pathway in care homes in NI that will reduce falls and harm from falls with the ultimate aim of improving resident experience and safety.

Co-production and engagement with residents and families was key- Resident interviews (PCE PHA) and Regional workshops via PCC.

We had 18 Partner Care homes across NI involved in this project, all Trusts were represented with equal numbers of Nursing Homes and Residential Homes. Also included were homes for people with Learning Disability and Dementia. Trust and Independent homes were included. The need for a pathway that would meet all needs of residents is a key priority so that equity and accessibility would be beneficial for all.

Project produced Regional documents for testing - Risk assessment and review document, Falls Calendar, long lives poster, Oral intake guidance and Post Falls Guideline (infographic below)

Collaborated with MOOP regarding medicine optimisation

Provided equipment for falls

Phase 1 testing - Dec-Feb 22

Phase 2 testing - May-July 22

Phase 3 Scale and Spread, meaningful activity, accessible communication. 23/24

Outcomes

How:

Outcome measures and process measures were used to demonstrate results across the quintuple aim (see diagram below). Whole system working resulted in whole system results.

Aim:

Resident wellbeing

Fear of falling was at **50%** pre-testing of new pathway, it is now **25%,** further testing and change ideas are needed.

Falls rate

Within 8 partner homes a reduction of falls was found by **33%**

Process Measures

Staff confidence - **82%** of staff felt confident in promoting safer mobility, and managing falls

NIAS call outs **reduced by 37%** This demonstrates savings and efficiencies across the system with less pressure also on Emergency Departments.

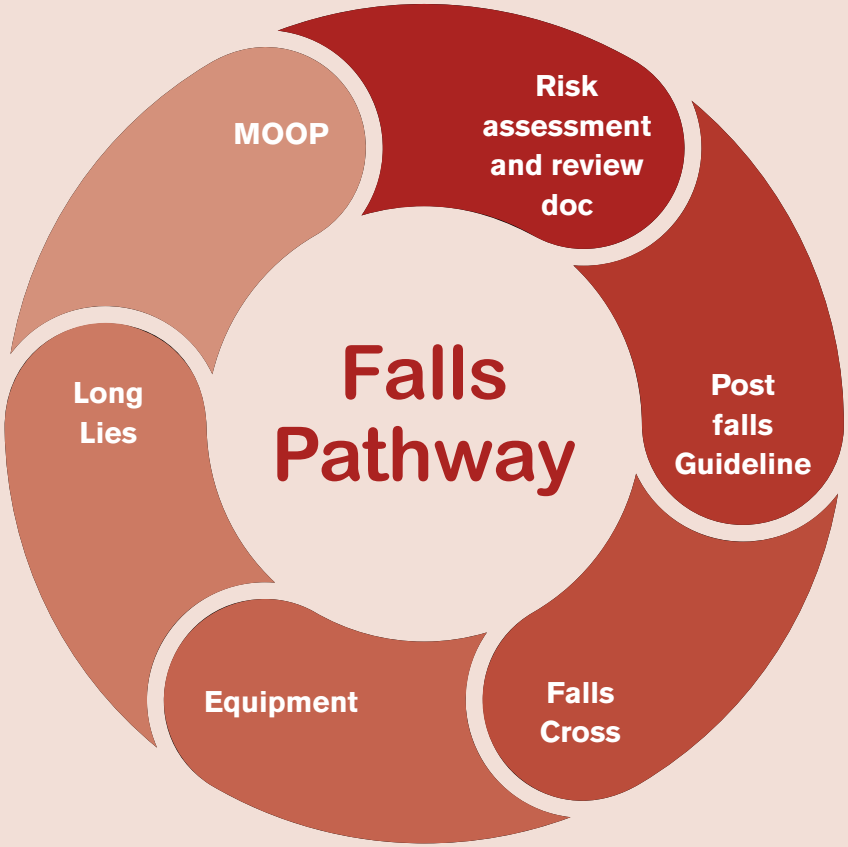
Other outcomes have been evident:

- Culture of falls-It's everyone's business-all staff involved.
- Home building on the pathway and creating their own innovative changes.
- Residents, from being involved in the surveys are becoming proactive about what keeps them safer from falls.
- Winner of the HSCQI Awards for Care Homes 2022.

> **"We can see by improving learning for staff and residents via the Safer Mobility learning materials, checklist, paper work and surveys, this has resulted in increased staff motivation, staff doing their own audits, assessments which is ideal as it is the Carers who are giving the care."**
>
> QUOTE FROM CARE HOME MANAGER

> **"Families came up with collaborative solutions. Reinforcing learning from falls with their loved one."**
>
> QUOTE FROM CARE HOME MANAGER

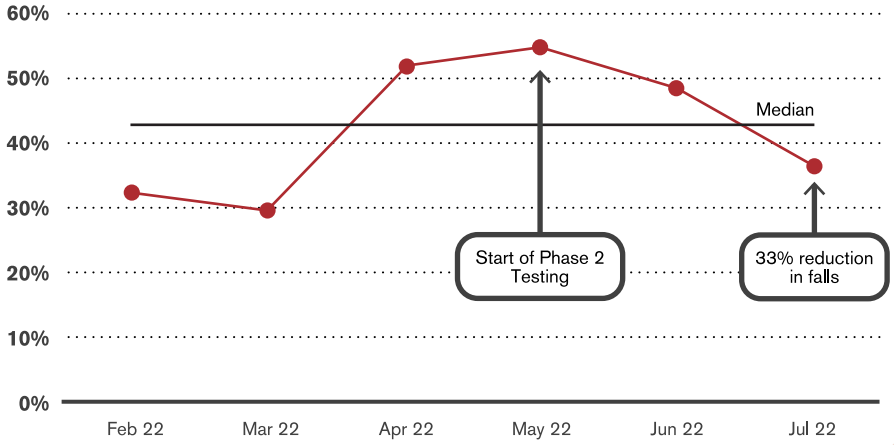
> **"...Residents got involved and started to self-manage their own safer mobility better."**
>
> QUOTE FROM CARE HOME



Falls rate run charts

33% reduction in falls in 8 Partner Homes

Aim Achieved

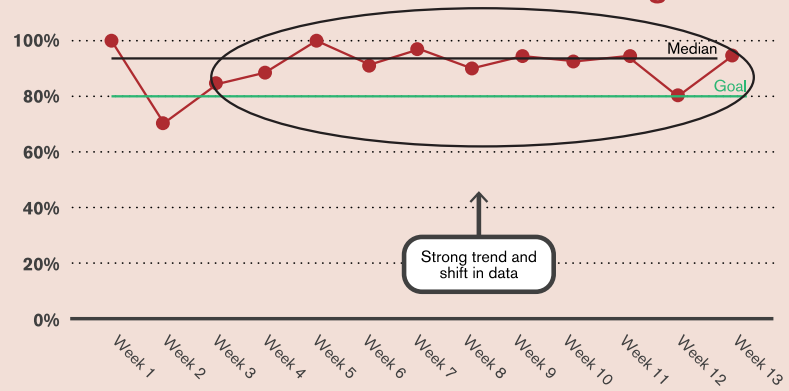


Resident Outcomes

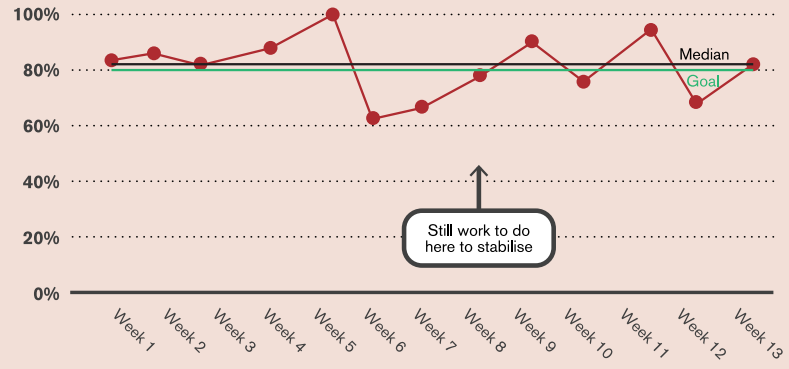
Aim:

- To improve resident experience and quality of life to 80%.
- Reduction in falls - decreases risk of long lies, better health and wellbeing.

Resident less fearful about falling



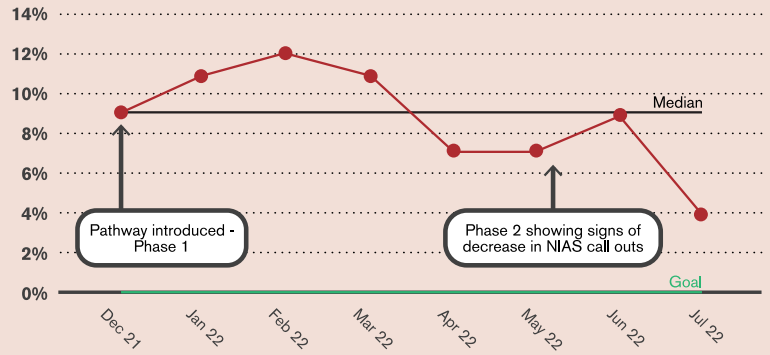
Resident feels safe and confident moving



NIAS Results

- **37%** reduction in NIAS Call Outs across the Partner Homes from Phase 1 to Phase 2 of project.

NIAS Falls Call Outs across the partner Care Homes



Evaluation of the Falls in Care Homes Project using the components of the quintuple aim

Improved resident experience of care

- **75%** of residents who report less fear of falling
- **82%** of residents who report they know how to move safely
- **82%** of residents who report they feel safe and confident moving around the home
- **93%** of residents who report they had equipment required to help them move safely
- **91%** of residents who report feeling less worry about tripping and falling

Falls in Care Homes Project

Better value for money

- **37%** reduction in NIAS call outs
- **33%** reduction in falls rates within partner care homes

Better staff engagement/exprience

- **82%** of staff reporting improved confidence promoting safer mobility in residents
- **82%** of staff reporting improved confidence in managing a resident fall

Better quity

- **100%** of Partner Care Homes using Regional Falls Pathway

Improved safety/health outcomes

- **131** changes made following medicines optimisation review
- **84%** increase in pharmacist knowledge

4. MEASURING IMPROVEMENT: FALLS: GAME CHANGING INNOVATION PROJECT

A consortium including Age NI, the Public Health Agency (PHA), the Southern Health and Social Care Trust, a UK-based technology firm and Taking Care, part of AXA Health, won a highly competitive UK innovation award aimed at delivering "game-changing innovations" to help people as they age, allowing them to remain active, independent and socially connected for as long as possible.

The funded project, *Move More Live More*, is aimed at tackling falls affecting the health and wellbeing of the older population. It uses wearable digital technology, combined with a unique data monitoring platform, which can predict an increased chance of a fall up to 32 days before a fall would occur. Through monitoring and early detection, the wearer can then be prompted with movement, actions and interventions aimed at preventing them from falling.

"The key message of the project is that falls are *not* always an inevitable part of growing older and there are actions and lifestyle changes which can help us all to stay stronger for longer."

Who's it for?

Move More Live More will deliver three tiers of support to people aged over 65 ranging from anyone interested in learning how to stay strong to prevent falls, to those who have experienced a fall and may be seeking health and wellbeing guidance to get more out of life, through to individuals experiencing slowing down and deemed as being at a higher risk of falling, who will trial innovative new remote monitoring technology.

Age NI deliver a new tailor-made six-week online course of expert sessions aimed at educating older people in health, wellbeing and movement to build all-important strength and balance to stay stronger for longer, all under the close guidance of physiotherapists.

The consortium's lead partner, **Taking Care**, part of AXA Health, is one of the UK's largest providers of personal alarms and monitoring services.

Working closely with the project's technology partner, **Technicare,** Taking Care will provide support and information to those users designated at higher risk of a fall.

How the technology works:

Technicare's ground-breaking remote monitoring platform captures data collected from wearable devices, including activity levels, sleep, heart rate and SpO2. The unique monitoring platform uses predictive analytics (computer learning) to detect changes which can indicate an increased risk of falling. Earlier research on the platform's predictive analytics indicates it can detect an increased risk of a fall up to 32 days before a fall occurs.

If a risk is flagged on any wearer's data, Taking Care's highly trained Prevention Team assess the individual and provide health and lifestyle information or intervention measures to avoid a fall. This can include guidance on exercise and movement, or may include prompts to self-refer for healthcare support (e.g. GP, pharmacist, falls clinic).

If risks are elevated and sustained, the wearer and their nominated advocate (family member or friend) will be alerted.

Age NI Chief Executive Linda Robinson said,

> **"It is brilliant to see an application of digital technology which is aimed specifically at supporting the older generation in such an impactful way. Move More Live More has the potential to alter the shape of later life for so many people, so it's really interesting and exciting."**

Also link to BBC Newsline article below:

New technology aims to prevent falls for elderly - BBC News

Raising the Standards

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Introduction

The PHA has established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The PHA is continuously striving for excellence and raising the standards of care and the quality of services delivered.

1. RAISING THE STANDARDS: NEW MODELS OF PRESCRIBING

New Models of Prescribing (NMOP) aims to make it easier for patients to get their urgent medicines without delay and from the most appropriate healthcare professional. Some prescribers working in Trusts can now write prescriptions for patients that can then be dispensed by community pharmacists rather than waiting for a GP to write the prescription following an outpatient appointment.

Prior to the NMOP project, Northern Ireland did not have a mechanism to allow prescribers working at interfaces between HSC Trusts and General Practice to prescribe a medication directly to the patient which can then be dispensed in the community. This means that there is often duplication of work, as the prescriber relies on the patient's GP to implement their recommendations and ensure that the required medicines are obtained.

In 2020/21, a number of small pilot projects were initiated to test what was needed to allow direct prescribing to the patient by a number of professionals. These included:

Outpatient and community physiotherapists writing prescriptions for respiratory symptoms, musculoskeletal problems and lymphoedema (long-term condition that causes swelling in the body's tissues) among other conditions.

Heart failure nurses prescribing at outpatient appointments to manage symptoms quickly.

Medical prescribers working in Belfast Trust's Home Treatment Team prescribing urgent medicines to prevent rapid deterioration of a patient's mental health.

The pilot projects have enabled longer-term funding to be secured under the Integrated Prescribing Programme. This will mean that we can build on the success of NMOP to benefit more patients across Northern Ireland and to consider other patient journeys that may need to access to prescriptions.

Outcomes

- NMOP reduces delays in accessing medication that should be started quickly, allowing the patient to access the right medicines, at the right time, from the right person.
- NMOP supports a reduction in unnecessary appointments and promotes a faster recovery, and a self-care approach to health needs.
- NMOP enhances the delivery of tailored interventions to patients, and maximises the use of the professionals' skills at the point of care.
- NMOP increases care that can be delivered by non-medical prescribers e.g. nurses, physiotherapists.
- NMOP reduces pressure on GPs.

2. RAISING THE STANDARDS: IMPLEMENTATION OF PURPOSE-T (PRESSURE ULCER RISK PRIMARY OR SECONDARY EVALUATION TOOL)

Purpose T is an evidence-based pressure ulcer risk assessment instrument that was developed using robust research methods.

The PHA, Safety, Quality and Innovation Team led a multidisciplinary and multiagency team, on the introduction of Purpose T, which was implemented to replace the previous Braden Scale, as PURPOSE T identifies more patients at risk of pressure ulcers.

In September 2022 the Public Health Agency Regional Pressure Ulcer Prevention Group members requested that CNO Business Meeting Attendees consider approving the safe implementation of PURPOSE T across all hospital and community care settings in N. Ireland.

In October 2022 a Task and Finish Group led by the PHA was formed.

Outcomes

Meeting of PHA and Clinical Education Centre (CEC): Senior Education Manager briefed on requirements for education sessions on Purpose T.

Meeting with Chief Nursing/Midwifery Information Officers (CNMIO) from 5 HSC Trusts and agreement to replace Braden with Purpose T within Person Centred Assessment Care documentation.

The e-learning programme amendments made by Leadership Centre.

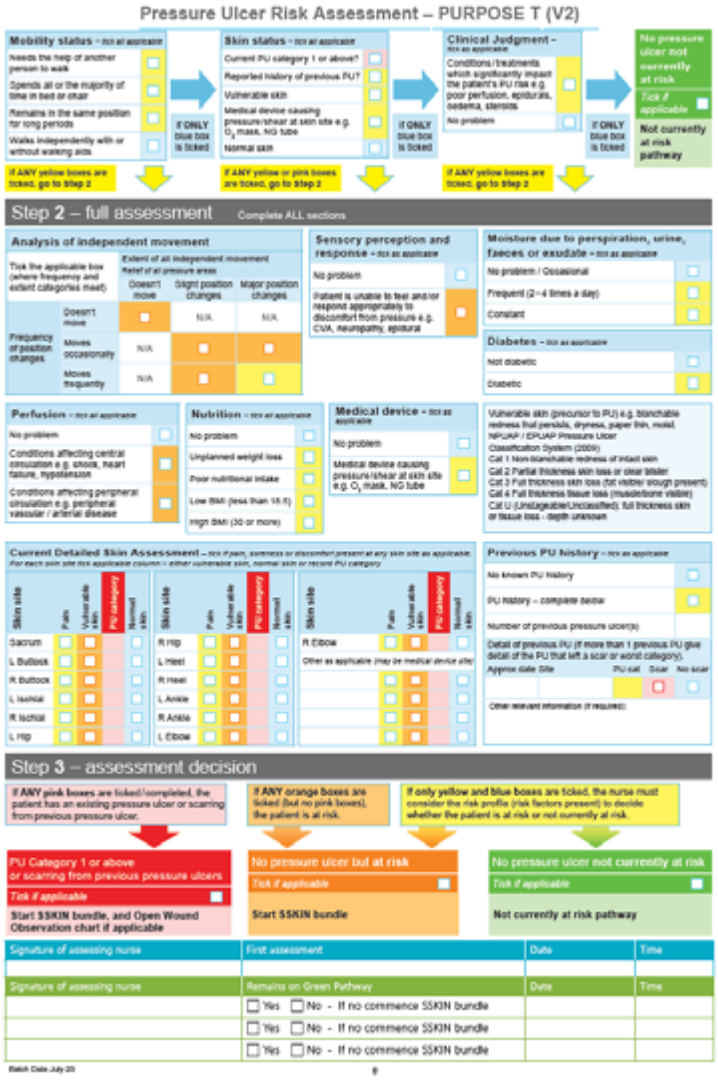
Agreed regional training date for Purpose T.

January 2023, a masterclass was provided to train the trainers, and a agree plan to ensure cascade of learning to all stakeholders.

February 2023 Person-Centred Assessment Care documentation testing completed and new documentation finalised for regional procurement. Regional Procurement of Person-Centred Assessment Care documentation commenced.

March 2023, ensured the project was in line for full roll out by June 2023.

Purpose T: Person Centred Assessment Care documentation



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Mobility status – tick all applicable

- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If ONLY blue box is ticked

Skin status – tick all applicable

- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – tick as applicable

- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If ONLY blue box is ticked

- No pressure ulcer not currently at risk — Tick if applicable
- Not currently at risk pathway

If ANY yellow boxes are ticked, go to step 2

If ANY yellow or pink boxes are ticked, go to step 2

If ANY yellow boxes are ticked, go to step 2

Step 2 – full assessment Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement / Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – tick as applicable

- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – tick as applicable

- No problem / Occasional
- Frequent (2 – 4 times a day)
- Constant

Diabetes – tick as applicable

- Not diabetic
- Diabetic

Perfusion – tick all applicable

- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – tick all applicable

- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – tick as applicable

- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1: Non-blanchable redness of intact skin
Cat 2: Partial thickness skin loss or clear blister
Cat 3: Full thickness skin loss (fat visible/ slough present)
Cat 4: Full thickness tissue loss (muscle/bone visible)
Cat U: (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment – tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum				
L Buttock				
R Buttock				
L Ischial				
R Ischial				
L Hip				
R Hip				
L Heel				
R Heel				
L Ankle				
R Ankle				
L Elbow				
R Elbow				

Other as applicable (may be medical device site)

Previous PU history – tick as applicable

- No known PU history
- PU history – complete below
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
		☐		

Other relevant information (if required):

Step 3 – assessment decision

If ANY pink boxes are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

- PU Category 1 or above or scarring from previous pressure ulcers
- Tick if applicable ☐
- Start SSKIN bundle, and Open Wound Observation chart if applicable

If ANY orange boxes are ticked (but no pink boxes), the patient is at risk.

- No pressure ulcer but at risk
- Tick if applicable ☐
- Start SSKIN bundle

If only yellow and blue boxes are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

- No pressure ulcer not currently at risk
- Tick if applicable ☐
- Not currently at risk pathway

Signature of assessing nurse	First assessment	Date	Time
Signature of assessing nurse	**Remains on Green Pathway**	**Date**	**Time**
	☐ Yes ☐ No - If no commence SSKIN bundle		
	☐ Yes ☐ No - If no commence SSKIN bundle		
	☐ Yes ☐ No - If no commence SSKIN bundle		

Batch Date July 20

9

3. RAISING THE STANDARDS: UPDATED GUIDELINES ON THE USE OF INPATIENT FALLS ASSISTIVE TECHNOLOGY

Assistive technology has a role in enabling, maintaining and supporting the lifestyle of individuals. Advances in assistive technology have continued to develop within hospitals, given the pressures on inpatient services.

Assistive technology used correctly complements health provision, with the need for the health and social care professionals to select and justify the right kind of intervention to support the individual, while fully considering the needs, wishes, capacity and circumstances of the individual.

The role of Falls Assistive Technology in reducing falls on wards is growing. The following are common types of assistive technology that are often used within inpatient settings. Most companies will supply wired and wireless versions:

- Clip and cord
- Chair exit alarm
- Bed exit alarm
- Floor exit alarm
- Infra-red beams

To assist with the correct use of assistive technology, regional guidelines where developed. The guidelines on the use of Inpatient Falls Assistive Technology required amendment as a result of learning identified from a Serious Adverse Incident. The Regional Inpatient Falls Group, which incorporates multidisciplinary staff from all Trusts and is chaired by the PHA, Safety, Quality and Innovation Team, updated the guidance highlighting the importance of daily monitoring of any assistive technology that is in use.

Outcome

As part of their programme of work, the Group have developed an amended version of the **Falls Assistive Technologies** guideline for inpatient settings, that was issued on the 19th August 2022.

The purpose of this document is to provide key information on Falls Assistive Technologies, which will support staff in ensuring safe and effective use of falls prevention equipment, which may be available in the inpatient setting.

A print ready copy and a PDF copy of the guidelines were shared with all Directors of Nursing to be disseminated to all relevant staff discussion at team meetings/ safety briefings. The document can be found at:

Guidelines on the Use of Falls Assistive Technology - Inpatient Setting Only

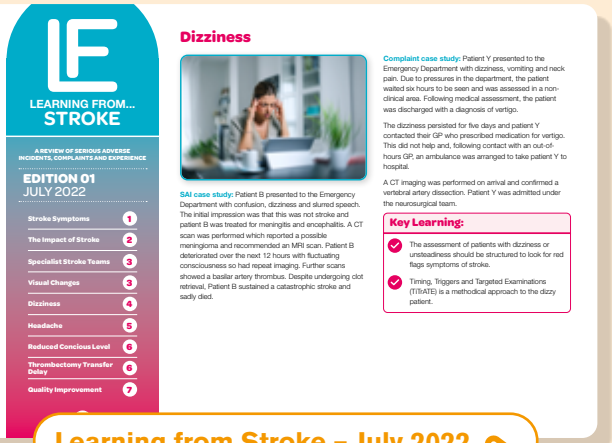
4. RAISING THE STANDARDS: REGIONAL LEARNING NEWSLETTERS

The Safety, Quality and Innovation Nursing Team in the PHA led on the development and design of several Regional 'Learning Matters'/'Learning From' Newsletters, which were issued to a wide range of key stakeholders, including all staff across the 5 Health and Social Care Trusts, Education providers for Healthcare and the private and independent health care sector. The various editions were distributed electronically and for the period of 22/23 **six editions** were issued:

- Learning from Falls – Sept 22 (launched on National Falls Awareness Week)
- Learning Matters Special Edition Sept 22 – Medication
- Learning from Stroke – July 2022
- Learning Matters Special Edition June 22 – Maternity
- Learning Matters Edition 21 June 22
- Learning Matters Edition 20 April 22

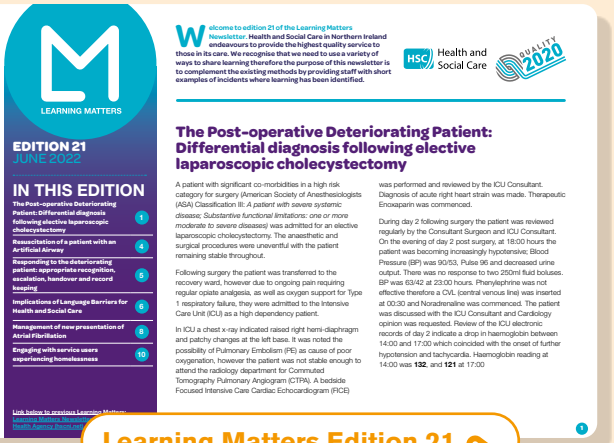
All editions are available on the public facing PHA website.

- Successful publication of 6 editions of a regional Learning Newsletter by the PHA Safety, Quality and Innovation Nursing Team, to share learning from the triangulation of data such as SAIs, Patient Experience and Complaints.
- Highly positive verbal and written feedback received from a selection of HSC staff.
- Raising the profile of the Learning Matters Newsletter which has meant additional engagement from frontline HSC staff who have asked for our Team to use Learning Matters to raise profile of certain patient safety issues i.e. ingestion of Caustic Soda in children.
- All editions cover a wide range of topics where key learning is identified and with each article the latest evidence-based practice is referenced.
- The Safety, Quality and Innovation Nursing Team co-produced various editions with frontline health and social care staff.
- In the coming year the Team plan to undertake a robust evaluation of Learning Matters to drive improvements in engagement and make any other suggested amendments to the format, which makes it easier for Health and Social Care staff to be aware of learning from incidents.



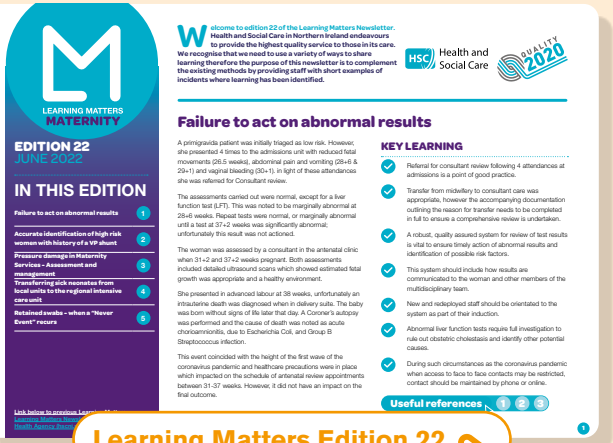
Learning from Stroke – July 2022

Learning Matters Edition 20

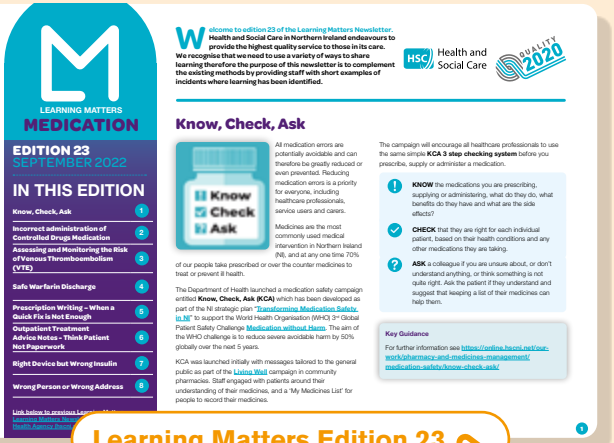


Learning Matters Edition 21

Learning from Falls – Sept 22



Learning Matters Edition 22



Learning Matters Edition 23

5. RAISING THE STANDARDS: DISTRICT NURSING CONFERENCE - SEPTEMBER 2022

The District Nursing Conference which took place in Belfast between 5th-7th Sept 2022 was successful in that it enabled the NI District Nursing family to come together face to face again after two years and review progress in a number of areas, re-energise and action plan regionally.

It was a chance to welcome all the DN teams regionally, thank them for their exceptionally hard work and versatility during Covid-19.

It was an opportunity to update the group on some of the policies and direction of travel including the implementation of the Nursing and Midwifery Task Group (2020) and the District Nursing Career Pathway (2022) whilst raising issues concerning the limited use of technology in District Nursing.

In addition, it provided an opportunity for district nurses, managers and neighbourhood district nursing coaches to collectively reflect on the challenges and opportunities for the further implementation of the Neighbourhood District Nursing model.

There were many presenters and workshops at this event and it was an effective mix of information sharing and staff having their own voices heard and documented. All of this work was themed and later informed the three new NMTG DN groups.

Furthermore, a conference scribe was commissioned to capture key points from this conference and this image below demonstrates the transformative journey that District Nursing continues to be on regionally.

Outcome

Integrating the Care

Objective 9: We will develop integrated pathways of care for individuals.

Objective 10: We will make better use of multidisciplinary team working and shared opportunities for learning and development in the HSC and with external partners.

Introduction

The PHA is committed to supporting an integrated HSC system in Northern Ireland, which will enable the seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the PHA last year which contributed to raising the quality of care and outcomes experienced by patients, clients and their families.

1. INTEGRATING THE CARE: COLLABORATING ACROSS ALL SECTORS TO OPTIMISE SAFE PRACTICE WITHIN PALLIATIVE CARE

The syringe pump is used extensively within palliative care to help manage symptoms. It can deliver a combination of drugs. Often a patient may have 2, and sometimes 3 syringe pumps at one time.

In May 2022 we brought together 37 stakeholders from across care settings, sectors, and professions including Nursing, Pharmacy, GPs and Clinical Engineers. The purpose of the focus group was to identify issues regarding the safe prescribing and management of syringe pumps and to share learning and insight.

Issues explored were

- The Syringe Pump Ability to Safely and Continuously Administer Medication
- One Syringe Pump for NI Position
- Scale of Need for additional devises and servicing
- Learning from SAIs
- Prescription and Administration Documentation for Syringe Pump
- Authorisation to Administer and Access to Medicines
- Training

Issues were addressed in order of urgency and priority. Assurance of devise safety and functionality was of priority as this was hindering investment by some HSC Trusts who were finding that they needed to urgently replenish their stock to meet the demand, but were faced with concerns raised by the clinical engineers.

A paper setting out the regulatory process and the salient points associated with the reported incidents, highlighting roles and responsibilities when escalating concerns regarding the performance of a device was developed. It included key points of learning established during meetings between Northern Ireland Adverse Incidents Centre (NIAIC), Trust clinical engineers, Trust managers and users of the device, the Becton Dickinson (BD) Manufacturers of the device and Rockford Healthcare (Medical Supplier).

Whilst the decision on the need to purchase a medical device is the sole responsibility of the individual organisations the process and learning undertaken during the meetings enabled individuals to make a more informed decisions about their future procurement.

Outcomes

HSCNI Trusts who were reluctant to purchase the new edition of the devise have now progressed procurement. This will ensure that people with complex symptoms, who are unable to take or absorb their oral medication can have their symptoms such as pain, nausea and vomiting well managed.

Resulting points of learning addressed practice and training and was shared across all sectors.

- Staff operators should attend syringe pump training in accordance with the Trust/Organisation policy.
- Training should highlight that, in accordance with manufacturer DFU
  - infusion should not be started if volume in syringe does not match volume on display, it should be removed from clinical use. Training will advise the user to check that the volume to be infused correlates with the volume in the syringe, the duration of the infusion is correct and that the rate is correct.
  - if a System Error occurs a pump should be removed from clinical use.
  - pumps removed from clinical use should be returned to the clinical engineers detailing error noted and requesting service check.
- To reduce the low risk of pre-load interruption due to the device being cold, the user should avoid leaving the syringe pump in an environment which is outside the temperature parameters recommended. This should be detailed in the Trust/Organisation policy.
- A regional Learning From communication has reviewed a number of SAIs relating to prescribing and will be published soon.
- Work is now being taken forward to develop a regional syringe pump guidance to standardise safe practice and inform training. A review of all prescribing and administration documentation is also being progressed.

2. INTEGRATING THE CARE: HEALTH & CRIMINAL JUSTICE

A major focus of SPPG/PHA Improving Health Within Criminal Justice Planning & Commissioning Team over the past year has been responding to the RQIA report 'Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons'. Six task and finish groups were established to take forward the recommendations from the RQIA review including:

- Benchmark prison health services with rest of the UK.
- Review the capacity & capability of prison addiction services.
- Develop an algorithm to assess the suitability of individuals placed in prison Care & Supervision Units.
- Review capacity & capability of prison psychology services and consider introduction of specialist psychology services for trauma and personality disorder.
- Align mental health appointments with the Quality Network for Prison Mental Health Standards including a reviewing the capacity and capability of mental health service.
- Plan, commission and implement a therapeutic approach to personality disorder.
- Identify options for expediting the transfer of acutely mentally unwell who require hospital admission.
- Identify a single point of entry to access PICU and acute mental health beds.
- Develop a regional service specification.
- Develop metrics to inform ongoing assessment of need including data collection for specific vulnerabilities and develop traffic light dashboard.

In the challenging financial context, the Planning & Commissioning team are endeavouring to identify potential funding sources to support investment in health care in prison.

Improving the health outcomes for those involved in the criminal justice system has a wider impact than just the men and women themselves, and affects their families and the wider society.

Outcomes

- Benchmarking identified lower resourcing in Northern Ireland compared with North East and South West regions of England. Subject to caveats as different commissioning arrangements and like for like comparison not possible.
- Investment in Administrative Support for the Transition pathway for Healthcare in Prison Addiction services, to free up clinical time from administration.
- In year funding for clinical addiction team to include nursing, medical and pharmacy.
- Recovery model for alcohol dependence being developed.
- Papers developed to improve prison psychological services including development of a personality disorder service and the development of an Enabling Environment approach across three prison sites.
- Improved collaborative working between SEHSCT, Northern Ireland Prison Service and Probation Services psychological service teams.
- Care and Supervision Algorithm is operational.
- Transfer Direction Order (TDO) process final stage of drafting, pending consultation.
- Care Plans in place for people with mental health concerns which do not meet the threshold for acute in-patient care.
- Telephone self-referral trial for people in the care of prison service experiencing mental health concerns initiated.
- Single point of access for mental health inpatient admission confirmed as Shannon Clinic.
- Revised interface with Regional Bed Management Protocol for acute Psychiatric Beds.
- Improvements to internal prison healthcare transition to community processes established between key stakeholders.
- Key metrics and KPIs developed but subject to further work by information specialists to ensure new regional patient information system (Encompass Epic) will be able to capture.
- Prison Health Needs Assessment at final draft.

3. HSC QUALITY IMPROVEMENT

Health and Social Care Quality Improvement (HSCQI)

Health and Social Care Quality Improvement (HSCQI) is a Network of Quality Improvement experts and enthusiasts which was established by the Department of Health in 2019 in order to support transformation of the Northern Ireland Health and Social Care system.

This HSCQI Annual Report 2022/23 highlights the range of work undertaken by the HSCQI Network during 2022/23. It is divided into four main sections, each section being aligned to one of the four key drivers stated within the HSCQI Strategy "Moving Forward, Shaping the Journey 2022 – 2024". The four sections are: Developing Leadership for Improvement; Building a Learning System; Quality Improvement Methodologies and Building QI Capability; and, Partnership and Co-Production.

The link to the HSCQI Annual Report 2022/23 is
https://hscqi.hscni.net/about-hscqi/annual-report/