HSC Public Health Agency

HSC Health and Social Care Board

QUALITY 2020

ANNUAL QUALITY REPORT 2021/22

CONTENTS

CONTENTS

Raising the Standards 41 - 54

Integrating the care 55 - 65

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

As Chief Executive and Deputy Secretary we are pleased to share this report which outlines how we have 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 2021 to 31st March 2022, prior to the closure of the HSCB and the subsequent creation of SPPG. Moving forward, the SPPG will continue 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 citizens of Northern Ireland.

We continue in this report to show the impact the the COVID-19 pandemic has had on all staff, patients, service users and carers, this report, however, showcases our commitment to learning from our pandemic response, and as such provides examples of how we rapidly 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 report has allowed us 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 citizens of Northern Ireland; against a backdrop of an aging population, increased demands, and unprecedented challenges. Looking to the future we are committed to delivering the highest standard of services, designed and implemented in partnership with those who use and work in our services.

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

Thank you

Transforming the Culture

1.1 SAFETY & QUALITY GOVERNANCE

Up until closure of the HSCB on the 31st March 2022, both the HSCB and PHA were considered arm's length bodies within HSC. Both organisations had a number of Directorates covering a wide variety of specialities who consider Safety and Quality as integral to their everyday workings. Both organisations have continued to work collaboratively with focus over the last year on improving and streamlining safety and quality processes, systems and structures which is outlined within the two examples below.

Establishment of Safety & Quality Oversight Group

In January 2022, the Safety & Quality Oversight group was established in order to reduce silo working by using information and intelligence from across PHA/SPPG in order to facilitate the triangulation of learning and influence improvement of HSC commissioned services. Membership includes medical, nursing, AHP, social care, complaints, integrated care, PMSI, governance, NICE, commissioning, experience representatives.

Outcome

Since its establishment the group have commenced work relating to a number of areas including:

- Thematic analysis relating to stroke which will be formally issued to the HSC and shared with the Stroke Network.
- Triangulation of information relating to Safe Discharge to inform work of the Regional Discharge Group.
- Triangulation of information relating to Emergency Departments which will be shared with the Regional Unscheduled Care Group.
- Triangulation of information relating to Violence and Aggression which will be used to inform the work of phase 2 of the ECHO programme in October 2022.
- Review of Never Events SAIs reported and agree regional actions to take.
- Thematic review relating to Ophthalmology.

Implementation of Safety and Quality Improvement Plan

During 2021/22, the HSCB and PHA continued to review and streamline the quality and safety structures to improve the process for identifying and sharing learning and provide assurance to both organisations of all matters relating to safety and quality. This included:

- Continued distribution of a daily report on all serious adverse incident notifications monitored by the Assistant Director of Nursing, Safety Quality and Experience and sent to all Directors.
- Hosting a weekly multi professional incident review meeting to review all serious adverse incident notifications, coding of incidents and take any required action. This has been reviewed and refined over the last year taking account of feedback from leads to optimise learning and triangulation.
- Continuation of weekly safety brief which provides Director oversight of any safety & quality issues identified.
- Review the Terms of Reference for for SAI professional groups to provide support for staff involved in SAI reviews and optimise opportunities for early identification of learning.
- Engagement with clinical networks and forums to share learning and provide opportunities for thematic analysis of safety & quality issues.
- Facilitation on internal audit review of systems and structures in order to support areas of improvement.
- Establishment of Safety and Quality Oversight Group to facilitate the triangulation of information for learning from a range of areas including SAIs, complaints, experience, PMSI, NICE, and Social Care.
- Following a literature review of various different countries approach to Patient Safety, work to develop the core components of a regional Safety Framework has been underway. The Framework will ultimately provide clarity and direction to the HSC system and will support to support them to streamline and enhance their safety & quality processes and provide an overarching leadership and governance relating to Patient Safety.

Outcome

- Improved governance process for the management of serious adverse incidents and identification of learning which will continue to be further refined taking account of other areas such as NCE guidance, RQIA reviews and complaints.
- Improved leadership and oversight of safety & quality issues, through regular meetings and improved reporting mechanisms. Work will continue to further improve this over the next year.
- Increased use of organisational intelligence to optimise learning and triangulation of data.
- Improvement statistics relating to SAI KPIs:
  - A **72%** reduction in number of SAI reports awaiting action by HSCB/PHA.
  - A **63%** reduction in the number of learning letters awaiting development and issue.
  - 4 editions of Learning Matters newsletters were issued to service during the time period.

1.2 LEARNING FROM SERIOUS ADVERSE INCIDENTS (SAI)

The key aim of the SAI process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole. For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However as the HSCB/PHA has a role in reviewing all SAIs, they may also identify regional learning for dissemination across the wider HSC, through a number of mechanisms.

Identification and Dissemination of Regional Learning

The dissemination of learning following a SAI review is core to reducing the risk of re-occurrence and to ensure shared lessons are embedded in practice and maximise the safety and quality of care provided.

HSC organisations who have reported the SAI and who are responsible for conducting the review, will have in place mechanisms for cascading local learning from SAIs internally within their own organisations, in line with the Regional Procedure for the Management and Follow up of SAIs. The management of the identification and dissemination of regional learning is the responsibility of the HSCB and PHA.

The HSCB and PHA use a variety of mechanisms to fulfil this responsibility outlined within the following graphic.

Mechanisms used by HSCB/PHA to share learning

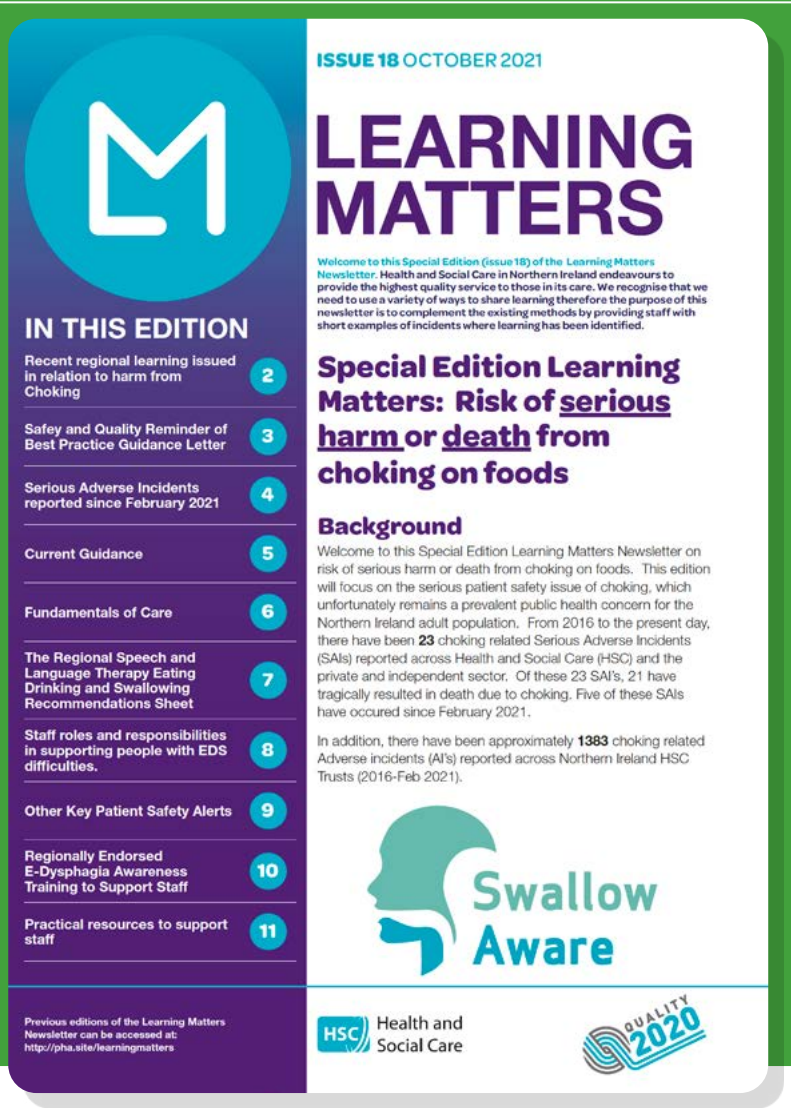
Outcome

During the reporting period 480 SAIs were closed by the HSCB/ PHA following review. The following methods of regional learning were approved to be taken forward in relation to the SAIs closed in 2021/22:

- 7 Reminders of Best Practice Guidance Letters
- 3 Professional Letters
- 3 Learning Letters
- 32 Newsletter Articles were identified
- 11 were referred to other specialist groups such as Radiology Network, regional Maternity Collaborative, etc.

Since 1st April 2021, 6 Learning Matters Newsletters have been issued to the HSC, these included two special editions relating to Choking (edn 18) and Maternity (edn 22).

In March 2022 a Project ECHO commenced which has been designed based on SAI learning themes relating to the deteriorating patient. A workplan for 2022 has been agreed with monthly sessions covering a variety of topics which relate to learning from the deteriorating patient such as NEWS, Human Factors, Psychological Safety and Communication with families. With over 250 HSC registered for the network, already there has been positive feedback relating to this method of learning.



ISSUE 18 OCTOBER 2021

LEARNING MATTERS

Welcome to this Special Edition (issue 18) of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

IN THIS EDITION

Previous editions of the Learning Matters Newsletter can be accessed at: http://pha.site/learningmatters

Special Edition Learning Matters: Risk of serious harm or death from choking on foods

Background

Welcome to this Special Edition Learning Matters Newsletter on risk of serious harm or death from choking on foods. This edition will focus on the serious patient safety issue of choking, which unfortunately remains a prevalent public health concern for the Northern Ireland adult population. From 2016 to the present day, there have been **23** choking related Serious Adverse Incidents (SAIs) reported across Health and Social Care (HSC) and the private and independent sector. Of these 23 SAI's, 21 have tragically resulted in death due to choking. Five of these SAIs have occured since February 2021.

In addition, there have been approximately **1383** choking related Adverse incidents (AI's) reported across Northern Ireland HSC Trusts (2016-Feb 2021).

Swallow Aware

HSC Health and Social Care

QUALITY 2020

1.3 LEARNING FROM COMPLAINTS

The HSCB and PHA review complaints received from HSCTs, family practitioners (FPS) and those received directly by the HSCB and PHA. For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some instances, the HSCB/PHA may also identify regional learning.

Regional Review of Complaints

The Regional Complaints Group ensures the effectiveness of the mechanisms in place to enable regional oversight of all HSC complaints. Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety including thematic reviews and strategy and policy development.

To set the context:

- The Trusts received **6,210** complaints
- HSCB received **150** complaints regarding Family Practitioner Services
- HSCB acted as honest broker in **80** complaints regarding Family Practitioner Services

The top three categories of complaints are:

1. **Treatment and care**
2. **Communication**
3. **Staff Attitude and Behaviour**

Over the last year, during their review of complaints, HSCB and PHA leads have noted a significant increase in the number of complaints regarding typical and less common symptoms of stroke. The HSCB and PHA produced a Learning from Stroke Newsletter which identified themes for the improvement of recognition of patients with stroke shared with Care Opinion.

The issue of COVID still influences complaints themes with HSCTs referencing the issue of elderly, vulnerable patients going through the HSC system, being unable to be accompanied by family members and this impacting on the history being given.

Other issues identified are complaints surrounding not being able to be with loved ones when they are dying due to COVID-19 restrictions in place, contact with wards and departments and delays in wards contacting families. In addition, visiting times having been reduced or removed completely during COVID.

Complaints regarding communication around vaccination; lack of communication about COVID status on discharge and delay in getting a COVID test are also emerging themes, along with impact of cancellations on patients referred for treatment and care.

Outcome

Following a review of complaints and the identification of themes and trends, a number of areas of improvement have been identified and shared. Examples include:

A family complained that an inappropriate sling was used to move their relative causing them to fall.

The Trust apologised for this incident following which the Ergonomics Team were contacted and confirmed that the appropriate equipment was used with the correct number of staff. The incident report had been checked and the information recorded was correct.

As part of the HSCB/PHA monitoring process, a redacted copy of the complaints correspondence was requested and reviewed by the relevant professional. A copy of the PHA/HSCB Safety and Quality Reminder of Best Practice Guidance Letter, issued on 20th Feb 2020, was shared with the Trust. (Risk Of Death Or Serious Harm By Falling From A Hoist - Attached).

Urgent assurances were also sought from the Trust that all employees within the facility are compliant with all elements of this letter and in particular the use of the 'recommended checklist before using a hoist' guidance.

The Trust responded providing assurances that all Trust facilities are compliant with the requirements and all elements of the letter and consistent across all of their services.

A family raised a complaint regarding the delay in their mother being diagnosed as having a stroke.

The Trust apologised for their experience and explained that the paramedic had used the regionally agreed FAST test which does not include vertigo as an indicator for Posterior Inferior Cerebellar Artery (PICA) stroke. The Trust advised that this is being examined by the National Ambulance Service Medical Director/Joint Royal Colleges Ambulance Liaison Committee at a national level to improve recognition of PICA stroke and are awaiting feedback from the Regional Stroke Network on how best to move this forward.

The Trust advised that, unfortunately, the patient fell outside the window for thrombolysis as there is only a 4.5 hour window to commence this therapy.

On review by HSCB/PHA professionals, this complaint was identified as being atypical presentation of stroke. This complaint informed the work on the identification of themes for the improvement of recognition of patients with stroke.

1.4 LEARNING FROM EXPERIENCE

The Patient Client Experience (PCE) programme seeks to provides robust analysis of the experiences of patients, clients, carers and relatives engaging with our Health and Social Care system through systems such as 10,000 More Voices and Care Opinion. It provides insight and learning to drive change and also enables services to further evaluate and understand the impact of changes made. Central to the analysis is to ensure the voice of the service user can make a difference at all levels – from service level to strategic planning and embed the principles of Coproduction into the actions taken.

Development of Care Opinion

One of the key initiatives which grew in 2021/22 is the online user feedback service (OUFS) built around the Care Opinion Platform, which launched in August 2020 (**Northern Ireland | Care Opinion**). This two-way feedback mechanism supports service users to share experience and for authors to engage with the story and respond in an open and transparent manner. This approach supports a shift in culture to enable a meaningful engagement and build relationships between the authors of stories and the services. In 2021/22, 4,035 stories were shared on the platform and read by the specific services or teams - 79% if the stories received a response within 7 days and demonstrated to the author that their experience was listened to and shared.

Outcome

Through Care Opinion services can record when they identify or have made a change as a consequence to the story shared. In 2021/22, there were **46** changes planned and **82** changes made in response to the stories (**Your stories | Care Opinion**).

The changes can be simple practical matters such as seating in the waiting to larger scale initiatives for a service or organisation -for example a new resident to a Care Home expressed nervousness when arriving at first and the responder has committed to reviewing how the Care Home can best support the admission process to reduce the anxiety (**Good chats | Care Opinion**).

The stories gathered through Care Opinion have also been analysed collectively to drive and influence change at a strategic level through briefing papers. For example:

- As part of the Quality and Performance Workstream within the Regional Review of General Surgery, over 280 stories were analysed to inform the current experience of attending surgery. To support evaluation of these services in 2022/23, there is a commitment to continue to engage with feedback shared in Care Opinion.
- In 2021/22, there has been exploration of how the stories can support and effect change at a strategic level with a valuable role in the triangulation of data through the Safety & Quality Oversight group; papers developed include the experience of discharge from hospital, experience of stroke and experience of Emergency Departments.

3142
Stories received a response within 7 days

3349
Stories submitted via the Care Opinion Website

1081
Authors said "thank you" for the care they received

1695
Staff trained as responders to stories

2901
Stories reflected a postive experience of Health & Social Care

4035
Stories Shared

2732
Authors said that staff contributed to their positive experience

Strengthening the Workforce

2.1 SUPPORTING STAFF WITHIN THE HSCB AND PHA

The HSCB and PHA collectively employ over **1,000 staff**. They are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution, particularly during the COVID-19 pandemic. Below are two examples of work that has been undertaken to support staff within the HSCB and PHA over the last year.

Staff Health and Wellbeing

The Staff Health and Wellbeing Group was set up in March 2020 to provide leadership in the support of PHA/HSCB/BSO staff in relation to Health and Wellbeing during the COVID pandemic.

Over the last 12 months, the Staff health and wellbeing SharePoint site has been further developed, a resource staff which hosts a wide range of information and signposts staff to available help. It includes information on:

- Connecting with others
- Keeping active
- Supporting parents and carers
- Online learning
- Webinars
- Helplines
- Apps

Further information can be accessed on
Staff Health & Wellbeing - Home (hscni.net)

Outcome

- A designated staff member in BSO to support a consistent and co-ordinated approach to staff health and wellbeing across the 3 organisations.
- Staff champions have been identified in each locality to promote staff health and wellbeing issues through team meetings and informal discussion. Managers discuss health and wellbeing as part of the appraisal process and the new BSO manager guide was circulated to all staff.
- A Mental Health Advocates Forum has also been established; members of this forum have put themselves forward as mental health advocates across the 3 organisations and are trained appropriately to help empower staff to access the support they might need for recovery or successful management of symptoms. This may could include self-help books or websites, accessing Carecall, speaking with their GP, support groups, and more.
- A suite of workshops have been held on a range of topics including:
  - Stress management workshops
  - Menopause workshops
  - Men's health
  - Working from home
  - Ergonomics and work spaces
  - Top tips for relaxation
  - Screen fatigue
  - Financial wellbeing

AMBITION

Making a Difference... for you, your team, our population

Commitment to HSCB staff was demonstrated through the development and delivery of the new Ambition People Strategy to support staff in preparation for migration to the Department of Health 2021/2022. The three fundamental aspects of the strategy were:

- **Looking after our people** - HR colleagues supported HSCB staff with a range of workplace wellbeing resources, training and guidance on management practices and contributed to staff engagement and communication.
- **Growing and developing our people** - HSC Leadership Centre colleagues developed a comprehensive suite of development programmes specifically for HSCB staff which included virtual training sessions, self-guided development resources and access to eLearning programmes.
- **Our people as leaders** - staff were encouraged to avail of leadership and management development programmes and resources.

Outcome

- Directorates within HSCB were supported to ensure appropriately skilled staff were in place and engage.
- 100% Appraisal Compliance rate achieved.
- 416 overall attendances at leadership training programmes.
- Sickness absence accumulate rate 2.95%.
- Establishment of the 'People Development Toolkit' and 'Looking after Our People' portals.
- Monthly HR Workforce Information Report established.
- As a measurement of workforce engagement quarterly 'Pulse' staff surveys were issued. Demonstrating positive progressive trends against the following measurements;
  - staff feel valued, empowered and trusted and communicated with.
  - staff understand the organisation's direction and purpose.
- Over 70% of staff stated they would recommend HSCB as a positive place to work.
- All staff successfully migrated to the BSO as a host employer on 1st April 2022.

Organisational Workforce Development Group

During 2021/22 the Organisational Workforce Development (OWD) Group was re-established. The OWD, with representatives from across all Directorates and Trade Union identified some core areas to focus on. These included:

- Appraisal
- Induction
- Mandatory Training compliance.

Of particular note, the OWD group conducted a review and refresh of the appraisal system. The documentation was developed to ensure a focus on individual health and wellbeing of staff, understanding their contribution to the achievement of the organisation's strategic objectives and personal and professional development.

Outcome

- The revised paperwork was approved and then implemented across the organisations supported by training for line managers.
- Initial feedback from staff and managers has been extremely positive with those who have participated reporting they believed they had a meaningful appraisal.

2.2 TRAINING FOR HSC STAFF

The HSCB and PHA recognise that upskilling staff by providing training opportunities is a key component of delivering high quality health and social care. Through continuously investing in our workforce we will strengthen our ability to improve the safety quality and experience of those who use our services. Below are two examples of Training which has been commissioned by HSCB and PHA for HSC staff.

Involvement Leadership - Bespoke Webinar Series

The PHA successfully ran a series of bespoke Webinars which were designed to support Involvement leadership across the HSC. The Co-Production and Consultation - "Tuesday Topics" were developed as part of the PHA's ongoing schedule of training for best practice in partnership working. The series was designed to support HSC staff continue to meet their statutory obligations to Involve and Consult as they navigate Involvement, Co-Production and Consultation, as part of HSC Rebuild and resumption of business. Service Users and Carers as well as our statutory and community and voluntary partners were also invited to attend each of the sessions.

The Webinar series looked at some of the fundamental Involvement and Co-Production issues facing HSC staff, including:

- Understanding Involvement, Co-Production and Consultation
- Advanced stakeholder mapping
- Choosing dialogue methods
- Risk assessment of Involvement and Consultation
- Hard to Reach/Seldom Online
- Embedding PPI within HSC - measuring outcomes, developing and maintaining partnerships, building community capacity
- What have we learned from COVID?
- How can the HSC contribute to the climate emergency response?

PHA PPI team in partnership with The Consultation Institute would like to run a further webinar series that would cover topics highlighted by previous participants and focus on the rebuild of HSC following COVID and maintain the focus of Involvement, Coproduction and Partnership Working as we emerge from this pandemic.

Outcome

- Increased number of staff who have access to involvement training.
- Increased knowledge and understanding of Personal and Public Involvement (PPI), Coproduction and Partnership Working for staff and service users and carers as a statutory obligation by building a critical mass of staff equipped with the requisite skills, knowledge, expertise and experience in Involvement, Co-Production and Partnership Working to support the HSC to meet its obligation in this regard.
- Ensure HSC statutory duty to Involve & Consult service users and carers and local communities in health and social services remains at the forefront of planning, development, implementation and evaluation of services.
- Highlights the need for the HSC to deliver on PPI policy and the Co-Production agenda.

Adverse Incidents – Building Competency training

The HSCB and PHA commissioned the delivery of a training programme for HSC staff who are involved in the investigation of adverse incidents and serious adverse incidents (SAI). The aim of the programme was to build the competency of staff, focusing initially on those who complete level 1 SAI reviews. This included developing knowledge and skills in relation to:

- **Preparing incident review team:** this included the confirmation of regional & local requirements in relation to team composition and sharing best practice approaches. How to identify team membership and an overview of roles and responsibilities of review chairs and facilitators.
- **Discovery of key incident information:** this included sharing tools and techniques on analysis / fact-finding and developing an incident chronology to support review. Approaches on how to evaluate information sources and how to undertake a structured approach to information gathering were also explored.
- **Engagement with patients, service users, families and carers:** this included developing an understanding of the regional requirements for patient and family engagement. Sharing best practices for engagement and developing knowledge of a 'Just Culture' concept. In addition, participants also explored practical approaches to staff engagement and support.
- **Analysis theory:** this included developing an understanding of best practices in relation to the identification and application of casual factors statements and contributory factors of an incident.
- **Developing recommendations, action planning and lessons learned:** this included improving knowledge and skills in relation to development of preventative actions, exploring participant ability to critically evaluate the development and effectiveness of recommendations and developing an understanding of best practice-based action planning and lessons learned.

Outcome

- 107 HSC staff attended the programme in Feb 2021
- A five point rating scale was used to assess participants levels of confidence regarding each of the programme elements for both pre and post course evaluations.
- All aspects of the course were positively evaluated by all participants.
- Analysis of the feedback highlighted a noticeable increase in competency relating to all 5 course components following participation in the programme.
- Plans are underway to commission further opportunities for HSC participation in the programme.

> ***Very relevant to my current post.***

> ***Explained concepts that I was unsure about. Distilled the information well in a short time. Used real cases.***

> ***Excellent presentation and structured approach. Availability of many helpful resources.***

> ***The logical approach to incident investigation and report writing.***

2.3 EDUCATION & VIRTUAL LEARNING FOR HSC STAFF

Providing opportunities for education and continuous learning for staff within the HSC provides a strong platform in the delivery of high-quality health and social are.

Project ECHO

Project ECHO® NI (Extension of Community Health Outcomes) provides an evidence based model for education, training, sharing best practice, co-creating new service delivery models and supporting more integrated working for people within HSC and beyond. The ECHO methodology models the behaviours and practices which promote effective virtual learning and its effectiveness across the world is supported by 250+ peer reviewed journal articles. Across the world more than 1.3 million health care workers are engaged in ECHO networks across 45+ countries.

Each Project ECHO® network brings a community of practice together online, from across different parts of the system, organised around a jointly agreed education programme and using case based discussions to consolidate the theory and work through the challenges on the ground. Sessions are facilitated to create a safe learning environment where everyone is respected and has an equal voice. These networks are breaking down barriers that currently exist in the system enabling better integration.

Some examples of ECHO Networks:

- Heart Failure - Primary Care (SHSCT initially) referring patients to a HF ECHO Network to get advice from Secondary Care and share learning across the region.
- Lisburn Health Inequalities - Significant learning emerging which could be central to informing how the locality and community levels of the ICS might operate.
- HSCQI - Regional Network providing the system with a platform and an approach to share their experience and learning while sharing their use of QI approaches.
- Serious Adverse Incidents - Sharing learning in a safe environment and reduce SAIs.

Outcome

Recent evaluation of Project ECHO Networks highlighted:

- Improved knowledge, self-efficacy and confidence.
- Easier access to education and training.
- Increased capacity - force multiplier effect of telementoring.
- Benefits of being part of a community of practice including reduced isolation and peer-support.
- Increased access to services.
- Support for new ways of working – enabling environment to underwrite the trust, governance, and learning required to shift models of care.
- Access to key coal face information from participants to help inform planners and commissioners.
- Helping meet strategic objectives regarding service transformation, integration of care, and reducing strain on secondary care.

Further information is available at – **Evaluation-2018-2020-Report-FINAL.pdf**

Dysphagia NI - Capacity & Capability

Dysphagia is the medical term for eating, drinking and swallowing difficulties (EDS), and the PHA-led Dysphagia NI Partnership was established to ensure a whole-system approach to better understanding and addressing the public health challenges associated with eating, drinking and swallowing difficulties. In 2021, following a review of serious adverse incidents and adverse incidents, the updated 'Choking Improvement Plan' included as one of its key actions the need to develop awareness and build capacity amongst staff throughout HSC. To support this action, an Eating, Drinking and Swallowing ECHO Network was established. This would be a regional network for staff involved in this clinical area in all settings and at all levels, for sharing knowledge, learning, and best practice and exchanging ideas with the ultimate aim of building capacity and supporting better outcomes for adults with dysphagia, thus reducing the risk of choking.

In partnership with the Regional Project ECHO® NI team and the Trust Dysphagia Support Teams, the Eating, Drinking and Swallowing ECHO network was set-up, with the programme of sessions agreed by members of the network itself for nine sessions to run from March 2022 - January 2023. This ensured that the topics covered were relevant, priority areas for frontline staff who are working with people diagnosed with or at high risk of dysphagia. Sessions include education presentations from expert speakers, case presentations providing learning from the experiences of colleagues, breakout room discussions and interactive feedback.

Outcome

- Almost 800 participants have now registered as members of the network.
- Attendance at sessions has also increased steadily, with an average of c. 100+ people attending each session to date.
- Network members represent a wide range of clinical backgrounds and roles.
- The virtual platform used by Project ECHO® NI enables large numbers to attend from across Northern Ireland from their own workplaces, thus facilitating the sharing and amplifying of knowledge and best practice throughout the system.
- The combination of using breakout rooms for smaller group discussion and interactive feedback platforms has enabled all participants to become involved in and contribute to discussions.
- Feedback gathered anonymously via the interactive platforms has also been collated and shared on to the Dysphagia NI Partnership to further disseminate the knowledge and learning.
- Project ECHO has therefore facilitated the development and consolidation of a 'community of practice' for dysphagia across the HSC system, and contributed to the Dysphagia NI Partnership's objective of developing awareness and building capacity for this key patient safety issue.

2.4 STRATEGIC PLANNING TO SUPPORT THE WORKFORCE

Regional strategic planning for investment and guidance is core when delivering a high quality health and social care system; as this reduces silo working by providing a regional solutions which improve outcomes for patient, clients and families by strengthening the capacity and capability of the workforce.

Improving the health of our people

Supporting and empowering staff

Improving the quality and experience of care

Ensuring sustainability of our services

Delivering Care Investment

The Nursing and Midwifery Task Group was established to maximise the contribution of Nursing and Midwifery to deliver safe and effective person and family centred practice. The Delivering Care Framework is a key component of this work which will provide direction on future investments.

The Minister for Health committed to £60m over 5 years (commenced 20/21). To date this has:

- Strengthened the nursing and midwifery workforce by investing £25m Delivering Care allocation via an agreed Strategic Investment Plan.
- Provided a robust Governance structure to include a performance management and monitoring arrangements so we can provide assurance that objectives are being realised.
- Strengthened the regional workforce within PHA with a number of clinical lead roles to support the implementation of allocations and support the role out of the Nursing and Midwifery Task Group Action Plan.
- Enhanced the Delivering Care Papers with the addition of System Dynamic Modelling.

Outcome

Delivering Care Investment provided funding for **362 WTE** new roles across the nursing and midwifery arena.

- Improved and clearer reporting structure in place.
- Increased regional supporting roles for implementation of NMTG.
- System Dynamic Modelling provided the evidence to allow to consider how a future service should look over the next 10 -15 years and plan the workforce accordingly.
- Learnt a few lessons:
  - The need for early planning
  - Preparation of staff for interview
  - Need for standardised job descriptions

Development of an Adult Acute Mental Health Inpatient Bed Dashboard

In December 2021 work commenced, led by SPPG and PHA, and supported by HSC Trusts, and Mental Health Service User Consultants, to develop an Adult Acute Mental Health Inpatient Bed Dashboard. The aim of the Dashboard was to monitor daily bed pressures and provide a regional platform to manage capacity and demand, and acuity on the mental health service.

To ensure regional consistency and standardisation of reporting, work is being finalised on a regional Definitions Protocol for the Dashboard. The information provided in the Dashboard is inputted twice daily by HSC Trust Mental Health Bed Capacity Co-ordinators and provides a regional overview of areas such as:

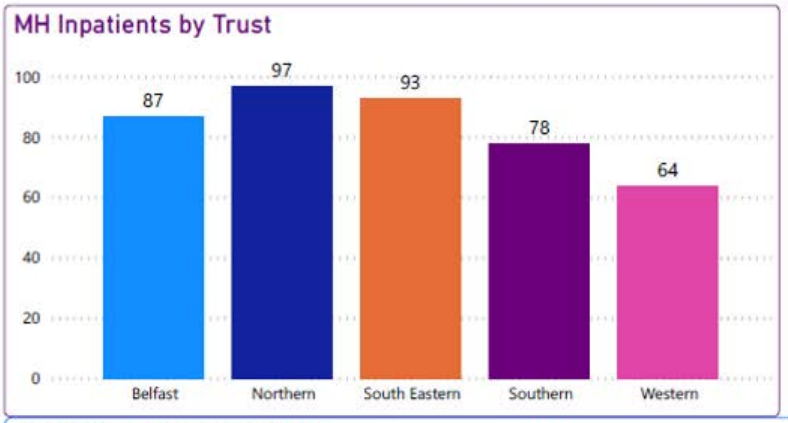
- Vacant beds
- Admission and discharge trends
- Detained patients
- Delayed discharges
- Continuous Observations
- Contingency beds
- Out of Trust beds
- Mental health acuity.

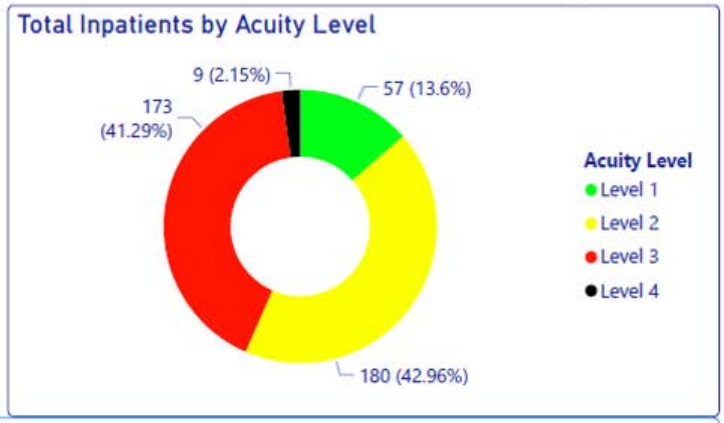
The Dashboard is used to inform discussion at Daily Huddle meetings with multi-disciplinary teams and is used as a platform to ensure effective regional and consistent management and utilisation of mental health beds across the Trusts.

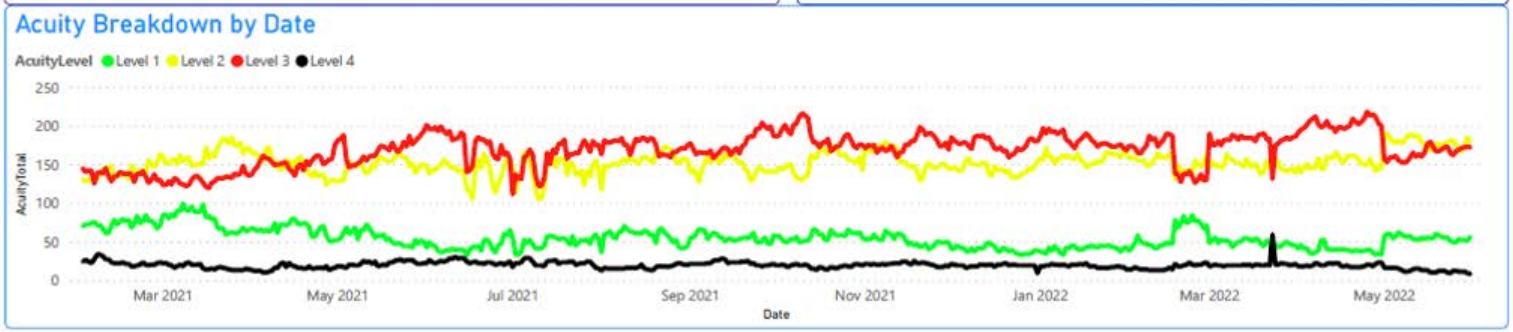
Outcome

- The Adult Acute Mental Health Inpatient Bed Dashboard is now live and is updated twice daily by HSC Trusts.
- Improved safety & quality of services through timely and accessible capacity and demand data associated with adult acute mental health services.
- Timely, accurate information is available on a regional basis displaying a variety of metrics associated with Mental Health Services.
- The Dashboard enables timely decision making and service delivery responses from mental health teams across the region.
- Regional and local teams can monitor capacity and demand on service and make timely decisions to improve patient flow.
- Supports regional decision making though the daily updates
- Highlights areas of good practice.
- Enables trend analysis at a glance.
- Supports planning and areas highlighted for further investment.

Mental Health Acuity Reporting - Updated to end May 2022







REGIONAL PAGE

Select Date 20/7/22

AMH Commissioned Beds	PICU Commissioned Beds	Total Commissioned Beds	Occupied Beds	% Occupancy excluding Contingency	% Occupancy including Contingency	Delayed Discharges 8-27 Days	Delayed Discharges Over 28 Days	Total Delayed Discharges	Patients on Continuous Obs	Total Admissions	Total Discharges	Unavailable Unoccupied Beds
360	36	396	410	103.5%	98.1%	6	29	35	54	11	15	14

Vacant Admission Beds	Vacant PICU Beds	Available Leave Beds	Leave Beds Used	Total Contingency Spaces	Contingency Spaces Used	Pts in Add'l Contingency Spaces	Detained Patients	Percentage Detained	Patients Aged Under 18	Total LD Patients	Pts in Other Trusts/Areas	Pts from Other Trusts/Areas	Pts Awaiting Admission
0	0	0	25	22	19	8	211	51%	0	8	4	9	8

Infection Prevention & Control

The Regional IPC Cell was established to oversee the co-ordination of infection prevention and control across the HSC systems. The IPC Cell continues to be an important forum for ensuring regional consistency of IPC practices across NI and also for providing advice and guidance for organisations such as the Department of Education and Care Home providers.

Over the last year the Regional IPC Cell has had significant input to the development of a wide range of guidance documents and policies including the development of the Services Remobilising Pathway for Adult Social Care Services, the development of the interim Regional Fit Testing SOP and the development of the Supporting Care Homes SOP for the management of outbreaks. The IPC Cell has also worked closely with the Children's Team to strengthen guidance for children's homes and IPC guidance for schools.

The COVID-19 pandemic has highlighted the importance of IPC and therefore the PHA in conjunction with members of the IPC Cell is developing a Regional IPC Framework and a Managed Care Network. This Framework will be an excellent opportunity to shape IPC practice across HSCNI, improve standardisation and build capacity of IPC Teams. The Managed Care Network will be multidisciplinary and will replace the current Regional IPC Cell.

The IPC Product Review Group continues to meet to ensure that, prior to introduction, all new PPE products are tested and deemed fit for purpose for use in HSCNI.

Outcome

- Improved standardisation across the region through the development of HSCNI guidance and standard operating procedures.
- Assisting the reopening of services through providing local guidance, advice and support.
- Improved practices, monitoring and auditing for fit testing services through the implementation of the regional standardised SOP.
- Highlighted importance of the role of IPC in all services and this will be reflected in the Regional IPC Framework.
- Ensuring all new PPE items are fit for purpose before they are implemented across HSCNI services.

Measuring Improvement

3.1 QUALITY IMPROVEMENT PLANS

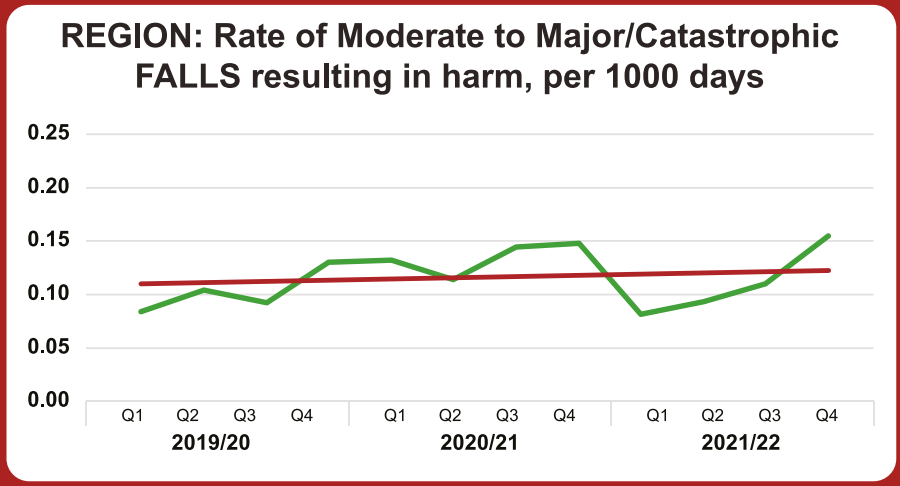
The Quality Improvement Plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support HSCTs on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout NI. Two key priority areas include inpatient falls prevention and pressure ulcer prevention.

Regional Falls Prevention

During 2021/22 the PHA and HSCB, through the Regional Inpatient Falls Prevention Group, have supported HSCTs to monitor the number of incidents of inpatient falls and support the spread the Royal College of Physicians 'Fallsafe' bundle, an evidence-based collection of interventions proven to reduce falls in inpatient settings. The Regional Falls Prevention Group provides advice, support and shares regional learning across NI and focuses on strategies for falls prevention and management across the HSCTs.

Outcome

Whilst there is regional oversight of a variety of key performance indicators related to falls prevention, the focus during 2021/22 was on reduction of the number and rates of falls incidents classified as causing moderate to major or catastrophic harm. The following graph shows the total regional **rates** of falls resulting in major or catastrophic harm from April 2015 - March 2022.

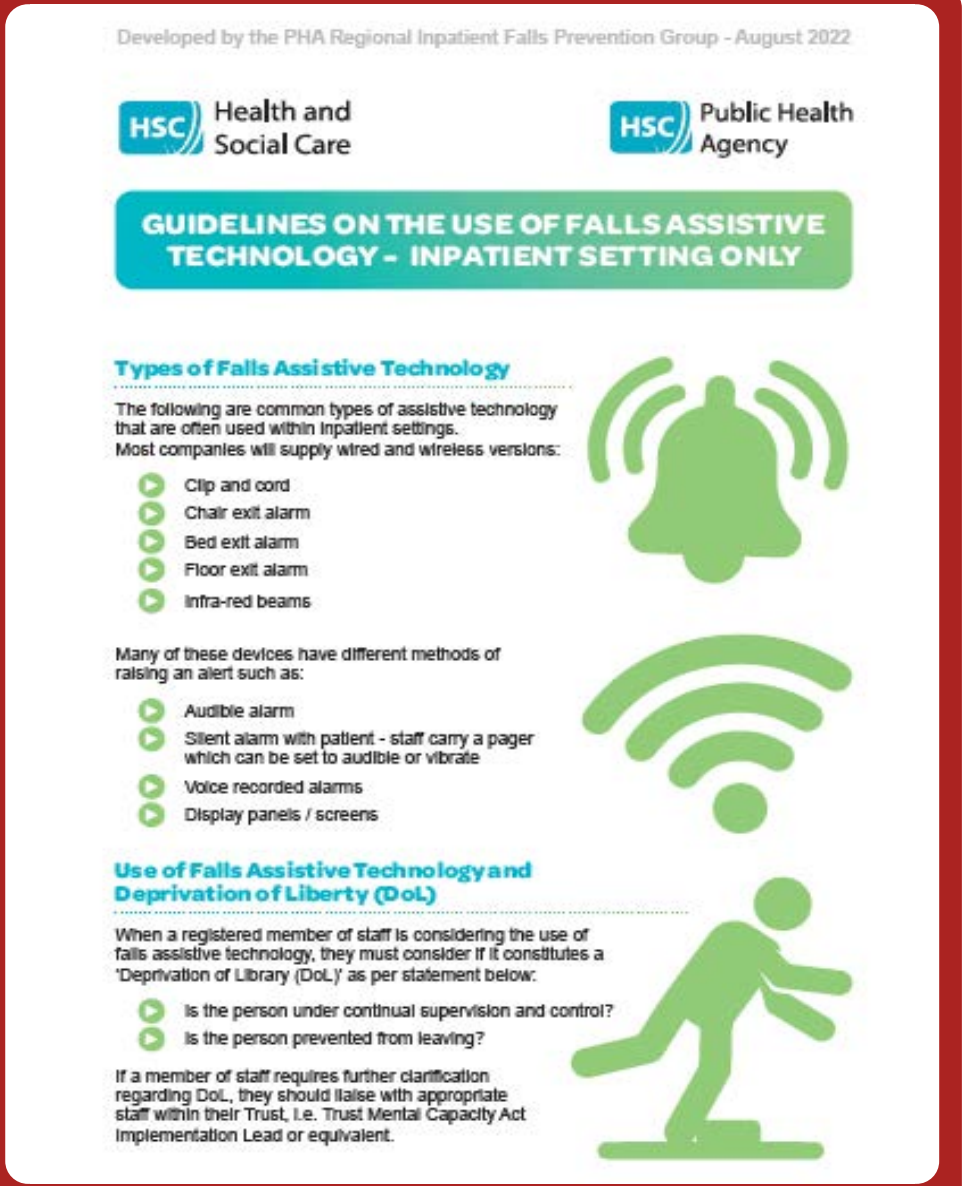


The graph indicates that the regional rates of falls resulting in moderate/major or catastrophic harm across Trusts remain stable with no trends notable. This is due to the commitment, dedication and improvements made across HSC Trusts to embedding falls prevention strategies and embracing new technologies in tackling the incidents of inpatient falls.

This ultimately correlates to providing a safer healthcare system and reduction in mortality and morbidity associated with falls. All Trusts continue to monitor closely the numbers and rates of falls and implement quality improvement initiatives as required.

The Regional Inpatient Falls Prevention Group have recently produced a new Regional Guideline on the Use of Falls Assistive Technology which has been distributed widely across HSC Trusts and discussed at team meetings/safety briefs. 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.

Additionally, the Regional Inpatient Falls Prevention Group have been working in collaboration with colleagues in the HSC Clinical Education Centre in supporting the development of a new Regional Fall Awareness eLearning programme. Although delayed due to the pandemic Module 1 of the programme which is a generic module, aimed at all staff working in health care across the HSC and the residential and care home sector is due to be launched in September 2022. A further 3 modules are currently in development which go into more detail relevant to specific areas of work (community, inpatient and residential and care homes).



Developed by the PHA Regional Inpatient Falls Prevention Group - August 2022

HSC Health and Social Care

HSC Public Health Agency

GUIDELINES ON THE USE OF FALLS ASSISTIVE TECHNOLOGY - INPATIENT SETTING ONLY

Types of Falls Assistive Technology

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

Many of these devices have different methods of raising an alert such as:

- Audible alarm
- Silent alarm with patient - staff carry a pager which can be set to audible or vibrate
- Voice recorded alarms
- Display panels / screens

Use of Falls Assistive Technology and Deprivation of Liberty (DoL)

When a registered member of staff is considering the use of falls assistive technology, they must consider if it constitutes a 'Deprivation of Library (DoL)' as per statement below:

- Is the person under continual supervision and control?
- Is the person prevented from leaving?

If a member of staff requires further clarification regarding DoL, they should liaise with appropriate staff within their Trust, i.e. Trust Mental Capacity Act Implementation Lead or equivalent.

Regional Pressure Ulcer Prevention

The PHA along with the HSCB supports HSCTs through the Regional Pressure Ulcer Prevention Group, to provide advice, support and share learning across the HSC in Northern Ireland. There is also regional oversight of ongoing pressure ulcer prevention work. This includes monitoring the incidents of pressure ulcers across Trusts and measuring the implementation of SSKIN (an evidenced based collection of interventions proven to prevent pressure ulcers) in all hospitals in Northern Ireland.

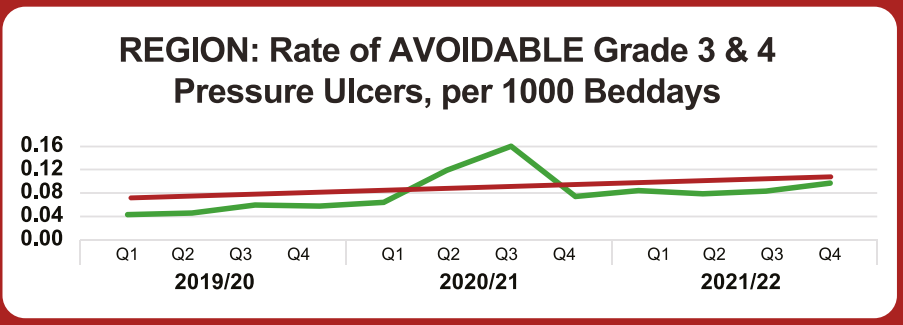
HSC Trusts are committed to ensuring pressure ulcer prevention is a priority as part of their own local Quality Improvement Plan. Trusts routinely monitor incidents and have internal governance processes to provide assurance.

In response to the HSC Commissioning Directive, HSC Trusts are expected to:

- Monitor the number of incidents of “avoidable” hospital-acquired grade 3 and 4 pressure ulcers that occur in adult inpatient wards.
- Monitor and provide reports on SSKIN bundle compliance and the rate of pressure ulcers per 1,000 bed days.
- Submit data to HSCB and PHA on a quarterly basis through sharepoint.

Outcome

Whilst there is regional oversight of a variety of key performance indicators related to pressure ulcer prevention, the improvement focus continues to be on reduction of avoidable grade 3 and 4 pressure ulcers; as these create deeper cavity wounds which can result in more pain and suffering to patients. The following graph shows the total regional **rates** of pressure ulcers grade 3 and 4 from April 2015 - March 2022.



The graph does indicate an upward trend line in relation to the rate of avoidable grade 3 and 4 pressure ulcers, per 1000 beddays since the baseline in 2015. In 2021/22, there has been a significant reduction across the region in avoidable pressure ulcers in comparison to the previous year. Analysis and understanding of this data require several factors to be taken into consideration. The awareness and reporting of pressure ulcer incidents have greatly improved through education on prevention.

There are other factors that need consideration:

- Tissue Viability Nurse (TVN) teams within all Trusts however composition varies.
- Each Trust provides monthly/quarterly updates to senior groups within. Organisations, i.e. safety governance committees/ boards.
- Data quality/reporting culture has changed substantially since 2015.
- COVID-19 pandemic has affected pressure ulcer prevention work:
  - **Capacity due to TVN team reduction (redeployment/ shielding/reduced face to face support to wards)**
  - **Challenges maintaining safe nursing workforce resources & higher use bank and agency**
  - **COVID is linked to increase risk of pressure ulcers***
  - **Overall increase in hospital demand**
  - **Increase in ICU patients and thus device/treatment related acquired pressure ulcers**

*** REFERENCE** Black, J., Cuddigan, J. & the members of the National Pressure Injury Advisory Panel Board of Directors. (2020). Skin manifestations with COVID-19: The purple skin and toes that you are seeing may not be deep tissue pressure injury. An NPIAP White Paper. https://npiap.com/*

In one Trust in NI the impact of the Covid-19 pandemic is described:

- As an increased level of acuity within acute hospitals which correlated with a rise in incidence in facility acquired pressure damage.
- 22% of pressure ulcers reported in 2020/21 were medical device related: patients within ICU being proned as part of their treatment plan.

Each Trust is continually striving to improve the rate of avoidable pressure ulcers and the Regional Pressure Ulcer Prevention Group have supported Trusts in 21/22 in relation to the challenges the pandemic has provided in relation to preventing skin damage. The Group produced new support tools for frontline staff, to aid the management of pressure ulcer prevention during 21/22 such as the:

Apples - getting to the heart of pressure ulcer staging guide - available in A4 poster format or pocket guide.

Repositioning Techniques Poster - Pressure Ulcers

Keep Calm and Protect your Skin Poster

3.2 INTRODUCING COVID VACCINATION TO NORTHERN IRELAND

The Northern Ireland COVID Vaccine Programme officially commenced on 8th December 2020 led by DOH with input from PHA and HSCB. The main objective of the programme was to protect against serious illness and death, by getting those most vulnerable vaccinated as quickly as possible.

Implementation of NI COVID Vaccination Programme

Guided by the advice from the Joint Committee on Vaccination and Immunisation the following were among the first to be vaccinated as part of the NI COVID vaccination programme.

- Care Home Residents
- Frontline Health and Social Care Staff
- Individuals aged over 80 years old
- Immunosuppressed individuals

Huge logistical challenges had to be resolved from the outset. Vaccination Centres where established across the Region and involved co-ordinated efforts across a range of stakeholders including Trusts, General Practice, Community Pharmacies, Councils and Voluntary Groups. Workforce was recruited to help deliver this programme, which saw the return of many retired Practitioners offering their skills, as professional bodies opened temporary COVID-19 registers.

Other challenges addressed included the storage, distribution and maintenance of these fragile vaccines.

Outcome

The vaccination programme has been a huge success and has allowed us to come out of lock down and return to more normal ways of living. PHA has taken over the Management of this programme from March 2022.

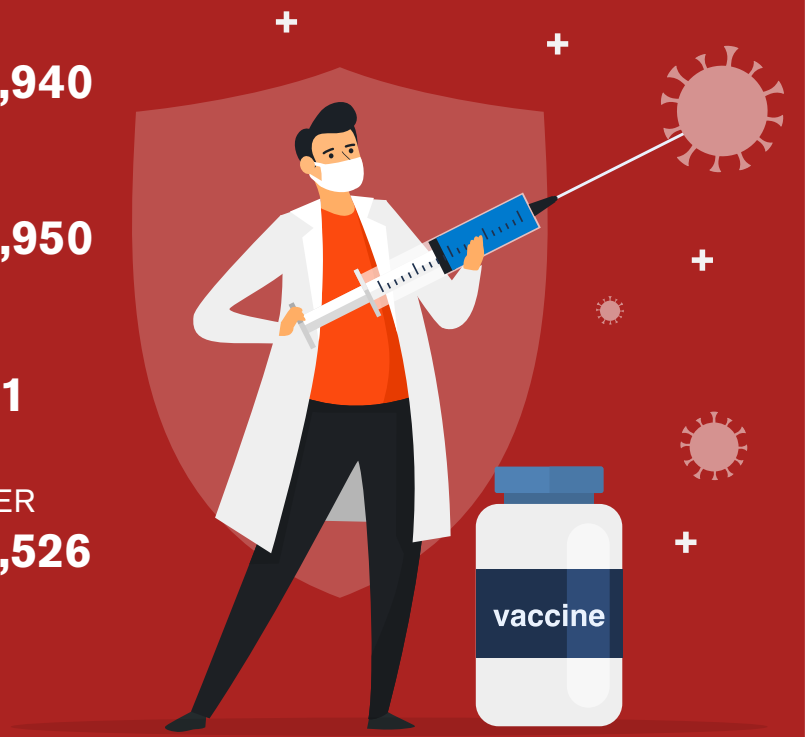
Vaccines administered up to this date:

DOSE 1
1,428,940

DOSE 2
1,354,950

DOSE 3
23,481

BOOSTER
1,153,526



Vaccine Management Solution

The Vaccine Management system (VMS) comprising of an end to end solution enabling the scheduling, clinical recording and analysis of COVID vaccination in Northern Ireland has been highly successful in the roll out and analysis of the NI COVID vaccine programme.

Pre-pandemic, the approach to vaccination management/information recording for vaccines administered outside primary care with the exception of childhood immunisations in NI was largely paper based and admin-resource intensive. This manual approach did not support efficient, safe, or secure data recording or sharing within an urgent, pandemic-based, mass vaccination programme.

It did not support the ability to report on efficiently, accurately or analyse vaccination uptake - a key facet of effective vaccine management. Nor did it adequately support uptake at a local or regional level.

The VMS started development in early December 2020 and is now used in all vaccination settings where a vaccination is delivered, i.e. GP practice, clinic, care or residential home, patient's home (housebound), ward (long stay patients) and community pharmacy.

VMS is Northern Ireland's first region wide Health and Care citizen facing appointment capability. It enables citizens to view and manage their vaccination bookings. The platform also has the capability of handling an enormous amount of traffic.

Outcome

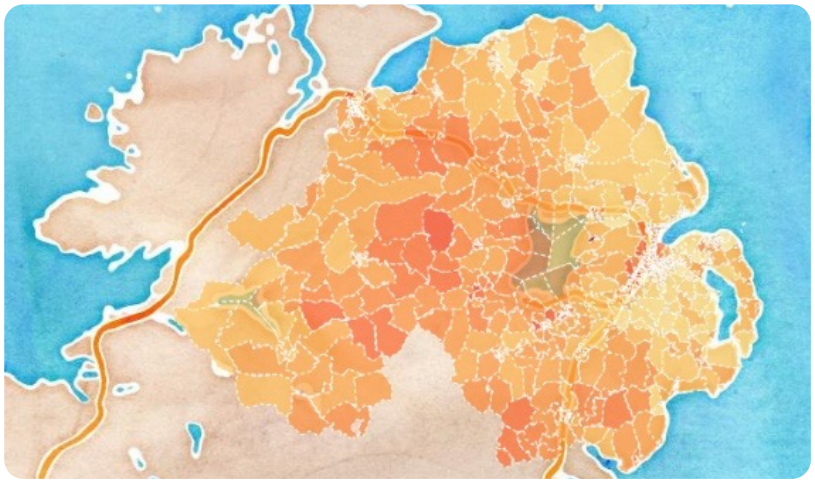
- The VMS has enabled near-real-time recording of over 4.5 million vaccinations.
- The VMS has enabled over 1.7 million self-booked citizen appointments.
- The VMS has, alongside other COVID projects, enabled citizens to interact directly in a digital way, with NI's healthcare providers.
- The VMS has enabled near-real-time reporting on vaccinations, for example enabling identification of low-uptake areas which have required additional attention.
- The VMS enables writeback to GP systems where possible.
- The VMS has enabled the COVID certification project to flourish.
- The VMS products have been continuous, agile and adaptive to rapidly changing requirements from DoH, PHA and JCVI - the pace of change has continued throughout the programme rollout - adding new cohorts of eligible groups, new child vaccines and parental booking on behalf of a child, as well as the ability to book more than one appointment for families.
- The design and build of the product suite using Microsoft applications ensures that future use case requirements, response to emergent clinical and public health need could be met using the existing underlying technology.

Improving COVID Vaccine Uptake in Lower Uptake Communities

A review of the NI Vaccine uptake data in March 2021 identified a number of geographic areas and ethnic background groups where vaccine uptake levels were lower than the general population. In April 2021 the PHA set up a Covid-19 Vaccine Low Uptake Working Group to support a number of key population groups identified as having lower uptake of the COVID-19 Vaccines. These groups included;

- People living in deprived areas
- Ethnic Minority & Migrant (EM & M) Communities (estimated 90,000 population)
- Travellers
- Homeless people
- Asylum Seekers

COVID-19 Vaccine Uptake by Super Output Area'



Outcome

1. Workplace interventions to target Ethnic Minority & Migrant communities

- In May & June 2021, vaccination clinics were established in 3 workplaces in Ballymena, Dungannon & Craigavon due to concerns with the low uptake levels amongst Migrant Workers, and the high-risk working environment with high numbers of staff working in close proximity.
- From July to September 2021 PHA worked with the NI Meat Exporters Association (NIMEA) and their 11 members across NI to deliver a range of vaccination options to the Meat Factory staff. This included onsite clinics with Trusts or local pharmacies, arranging community transport to local large vaccination centres, signposting to local Trust pop-up clinics & providing translated materials & videos to dispel anti-vaccine mis-information and encourage uptake.
- As a result, 1st dose vaccine uptake increased by 20% across all food processing companies between June 2021 and September 2021.

2. Community Based Interventions

- These interventions targeted areas of high deprivation, areas with higher ethnic minority & migrant population, vulnerable groups including the homeless community, asylum seekers and fishermen from outside NI.
- Interventions included the provision of “Pop-up” vaccine clinics by the SHSCT in ‘the Junction’ in Dungannon - a community-led facility established by South Tyrone Empowerment Programme (STEP), an organisation who work with ethnic minority, migrant and traveller communities in the Mid-Ulster area.
- As a result, three clinics were delivered at ‘the Junction’ in July/August 2021 with 400 - 600 people attending, over 70% of which, were from ethnic minority & migrant communities.

3. Low Vaccine Uptake Toolkit

- A vaccine online toolkit was developed by PHA Health Protection, Communications and Health Improvement teams in early 2022 to provide a single source of materials and resources for individuals and organisations seeking to promote COVID-19 vaccination uptake within their local communities. It was designed for use by HSC Trusts, Communities Pharmacy and Local Councils and the Community and Voluntary Sector.
- It contained resources targeted at the general population, as well as materials specifically designed for specific groups - to support the design and implementation of interventions to improve COVID-19 vaccine uptake.
- The toolkit also contains ‘good practice’ examples of interventions to improve COVID-19 vaccine uptake already been implemented across NI and other regions in the UK.

3.3 ELECTIVE CARE WAITING LIST MANAGEMENT

The COVID-19 pandemic has had a severe impact on NI HSC waiting lists. Many of the actions taken during the pandemic have shown that there is a better way to work. We have learned a great deal about the weaknesses in our system and the obstacles to a better, more efficient way of working. A new approach on how elective care is planned and delivered in NI has been developed.

Elective Care Framework

The Elective Care Framework (June 2021) which sets out the key actions required to improve elective waiting times in NI included an action for the HSCB to establish a Waiting List Management Unit (WLMU) to manage elective waiting lists. The WLMU was established on 1 August 2021.

The WLMU provides a regional role in the oversight and delivery of elective care. This includes:

- Managing elective waiting lists on a regional basis to minimise the risk of a postcode lottery and ensure available capacity (both in-house and in the independent sector) is maximised.
- Driving improved performance through the provision of high-quality data across a range of key performance indicators, e.g. chronological management, cancellations, DNAs, etc. to hold Trusts to account.
- Reviewing key productivity information, including theatre management data, to drive improved productivity and efficiency.
- The Unit has developed a range of monitoring tools and dashboards which has informed discussions with Trusts to identify data quality issues and to monitor adherence to policies and procedures, such as the Integrated Elective Access Protocol (IEAP).
- The Unit has established regional forums to create partnership working between primary and secondary care in managing and delivering improved waiting times.

Outcome

- The WLMU has been working with Trusts to agree a regional approach to waiting list validation, ensuring that Trusts have mechanisms in place to undertake this validation and communicate the outcomes of the validation to patients' GPs. PAS Technical Guidance has now been developed which will ensure that Trusts can record the outcome of the validation for each patient providing an audit trail across the process.

From September 2021 to June 2022, validations has resulted in more than **26,770 patients being removed from assessment (23,527) and treatment (3,243) waiting lists.**

- The WLMU has developed several outpatient waiting list dashboards and are currently working with Trusts focusing on Red Flag, Urgent and Routine outliers and breachers. This is ensuring waiting lists are accurate and up to date and has facilitated discussions with Trusts in the equalisation of waiting times across the region.
- In an analysis of Out Patient Waiting Lists the Unit has identified over 13,000 patients who are on duplicate waiting lists. The Unit is working with the Trusts to implement a validation process.
- The WLMU has established a Regional Operational Working Group which includes Trust representatives who will primarily discuss all patient access related issues.
- The Unit has further developed dashboards to facilitate discussions with Trusts in relation to chronological management, equalisation of waits, hospital/patient cancellations and DNAs.

Primary Care Elective Services

The establishment of primary care elective services in 2018 aimed to develop an innovative comprehensive approach to improve access to services for patients and to place elective care on a sustainable footing. This service provides five key pathways (Dermatology, Gynaecology, Vasectomy, Minor surgery and Musculoskeletal) to enable patients to be managed appropriately and efficiently in primary care, avoiding the need for onward referral to secondary care services. These pathways support improved demand management through the provision of education, training and peer support to ensure the enhancement and utilisation of the skill set across GP Federations.

Outcome

- 66 Host Practices providing care for the management of routine conditions across 5 pathways (Dermatology, Gynae, Vasectomy, Primary Care Surgery and MSK) thus removing reliance and demand on secondary care routine services.
- Enabling patients with routine conditions to be assessed and treated in an appropriate setting closer to home in line with Delivering Together 2026.
- Over 37,000 patient referred to the services with 28,000 of those managed by primary care avoiding attendance at a hospital setting since 2018.
- Delivery of 17,837 face to face and remote consultations in Primary Care across the five specialty pathways in 2021/22.
- Delivery of clinical leadership, education, peer review and peer support to GP with Enhanced Skills across the 17 Federation areas.
- Delivery of accredited training programme across the five speciality pathways via online Webinars hosted by the GPES Programme Team.
- Provision of the only vasectomy service in NI when secondary care intervention is not available given the continued pressures on the service.

Regional Expansion of the Dermatology Photo Triage eReferral Pathway

Last year work commenced on the regional expansion of the pathway to 319 Practices and five Trusts across NI in December 2021.The pathway provides the solution to capture dermatology images in primary care with specialised devices. Images captured are to the standard specified by the British Association of Dermatologists (BAD, 2020) and are attached to the CCG referral initiated by the GP. This enables both the images and clinical information to be reviewed by the Consultant Dermatologist at point of Triage and enables the improved management of patients with a suspected skin cancer diagnosis.

Outcome

- Regional expansion of the Dermatology Photo Triage e-Referral Pathway fully implemented as of July 2022.
- 96% uptake to the Local Enhanced Service by Primary Care (307/319 practices).
- Regional letter templates implemented across all 5 Trusts for the outcomes of the eTriage pathway which are sent to both GP and patient.
- Minimum dataset and dashboard developed to enable the monitoring of referrals and outcomes for the photo triage pathway.
- Further development of the SmartDerm App to enable offline image capture sessions and further expansion to urgent and routine dermatology referrals
- Shortlisted for NIHSC Award for Innovation.
- Further work ongoing in collaboration with PHA to raise awareness of skin cancer and the photo triage pathway.

3.4 PILOTING NEW WAYS OF WORKING

The HSCB and PHA recognise that piloting a service, gathering information and examining the results is an important first step prior to the implementation of new ways of working. Below is an example of two effective pilots which have been tested and evaluated in the past year.

Orthodontic Cases Requiring Oral Surgery

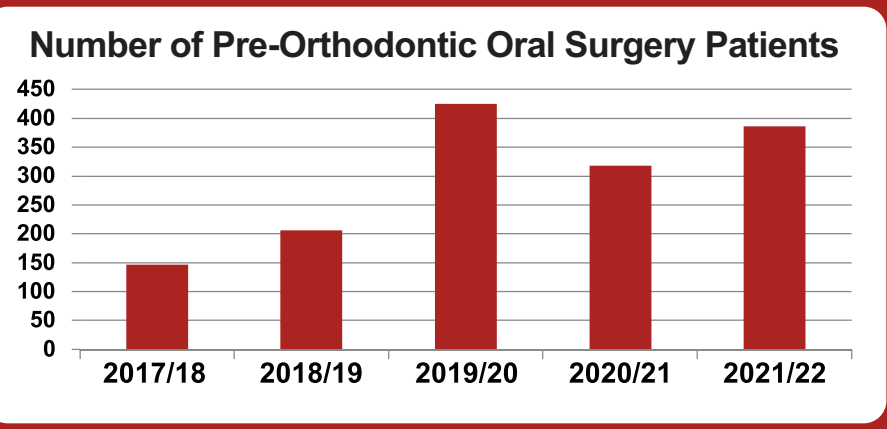
A small proportion of children aged 11-13 years have teeth which are submerged so deeply in the jaws that they cannot come through the gum into the mouth. Not only are these teeth then effectively missing but they can also permanently damage the roots of adjacent teeth leading those teeth to loosen and fall out. For children of this age, the physical, psychological and social impacts of losing permanent teeth at the front of the mouth are lifelong. Orthodontic braces can be used to pull the tooth into place but before the orthodontic treatment can begin the child will need to undergo oral surgery.

This type of oral surgery is generally undertaken in the secondary care setting, however, it can also be done by specialists based in primary care. There are six specialist oral surgery practices in NI but from 2014 onwards they were gradually providing less Health Service care and more private care. Combined with the long waiting list for Trust-provided oral surgery, this meant that children with submerged teeth were waiting too long for their pre-orthodontic surgical treatment.

In October 2017, the then HSCB implemented the Oral Surgery Personal Dental Services (PDS) pilot and in November 2018 the pre-orthodontic surgical treatment was added to the range of services provided. Discretionary fees for pre-orthodontic cases were replaced by enhanced set fees meaning the oral surgeon would know in advance how much they would earn from these often difficult and time-consuming treatments.

Outcome

- Oral Surgery PDS Pilot practices increased the number of pre-orthodontic treatments they provided to HS patients.
- Children with orthodontic need, irrespective of means, received improved access to pre-orthodontic and therefore also orthodontic care.
- Overall Orthodontic treatment times were reduced, due to a reduction in delay of surgery.
- Fewer children, usually only the most complex cases requiring general anaesthetic were referred to secondary care.
- Fewer children were placed on long hospital waiting lists where they were at risk of deteriorating oral health including resorption.
- Treatment in Primary rather than Secondary Care achieved financial efficiencies and better use of secondary Care resources.
- At the individual patient level, the quality of life benefits of this care were very significant.

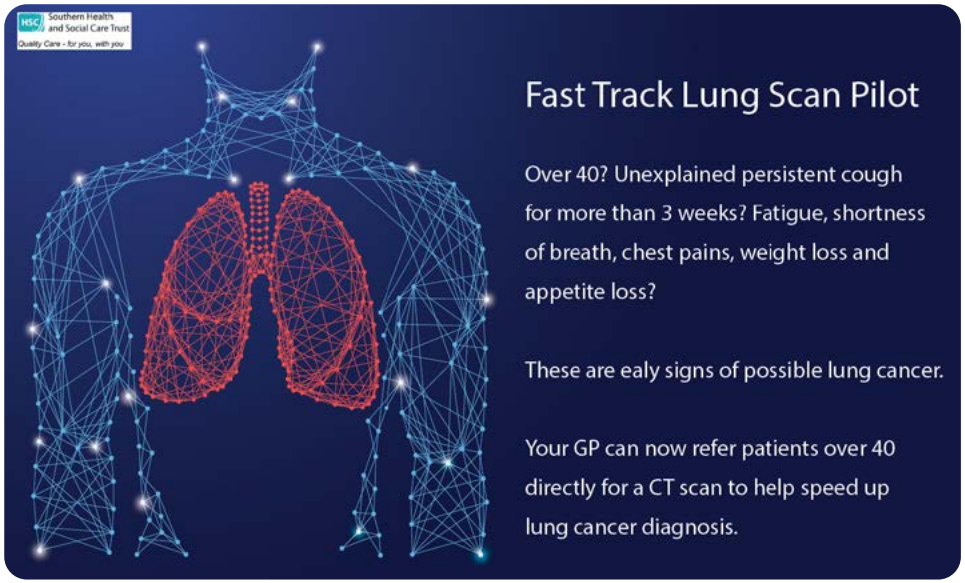


GP Direct Access to Low Dose CT Pilot

Partners across the Integrated Care Partnership (ICP) and the Southern LCG (SLCG) worked collectively to introduce an innovative pilot programme through the development of agreed pathways; allowing GPs direct access to Low Dose Computerised Tomography (LDCT) scans for patients with a suspected lung cancer diagnosis in line with the agreed criteria.

Outcome

- Over the period of October 2020 to June 2021 the length of time from diagnosis to first Outpatient appointment has **reduced** compared to a nine-month period in the previous year from **61 days to 21 days.**
- Chest x-rays reduced by **2,074.**
- CT chest +/- contrast reduced by **310.**
- There were **426** Low Dose CT scans completed & reported during the first 12 months of the project.
- **85%** of scans requested by primary care were approved by the radiologists and the scans completed & reported within the project timelines.



Enhanced Care Response Team (ECRT) Pilots in East Antrim (EA) and Mid-Ulster Care Homes

A responsive service delivery model was devised in partnership with the NHSCT Responsive Education and Collaborative Health Team (REACH), ICP GP Lead East Antrim, East Antrim GP Federation Chair and the NI Hospice. Using Quality Improvement methodology, the ECRT pilot was established to reduce avoidable ED attendances by 10% from three care homes over a six-month period from the same period in the previous year through delivery of an MDT enhanced care response and evaluate experiences for residents, staff and team members.

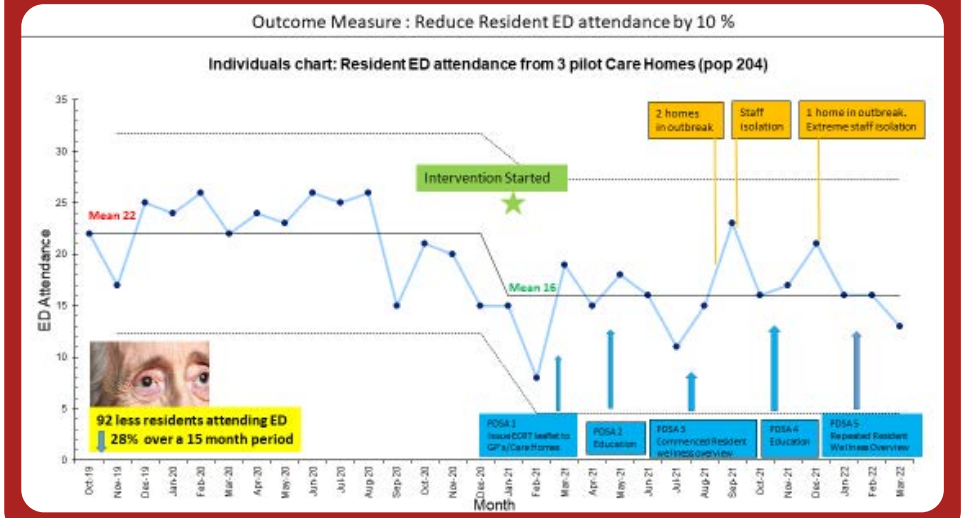
A key objective for the ECRT service is to reduce an avoidable resident emergency department or hospital attendance. Previous findings have demonstrated this outcome has been achieved.

The use of the Residents Wellness Overview Screening Tool by Nursing and AHP staff in collaboration with care home staff prompting the early detection of care home residents with frailty or entering a period of clinical decline was seen as an essential component to continued success of the pilot.

The ECRT team delivered multiple training sessions to staff across all care homes participating in the 2 pilots, adopting a “whole care home staffing” approach including registered staff, care staff and ancillary staff. Programme content was determined as an outcome of specific training needs identified with the care home staff in a comprehensive training needs analysis process

Outcome

- Reduced ED attendances by more than 10% demonstrated in all pilot homes
- Evidence of reduced hospital admissions from the pilot homes, noted that this may be for a variety of reasons.
- Positive impact of holistic, multi-professional integrated approach to resident’s care.
- Timely referrals for AHP input for residents compared to lengthy core waiting times.
- High visibility within care home resulting in enhanced relationship between trust and care home staff.
- Care home staff report feeling listened to, reassured and valued.
- Importance of a comprehensive delivery of educational programmes based on care home priorities and adopting a whole home approach were appropriate.



Raising the Standards

4.1 MANAGED CLINICAL NETWORKS

A managed clinical network is a linked group of health professionals and organisations across different sections of the health service (including community, hospital and specialist care) working together in partnership with social services, voluntary organisations and, most importantly, patients and carers. Below are some examples of where clinical networks have improved quality and raised the standards through standardisation and implementation of best practice

Frailty Network

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)). Indeed many residents find themselves in a care home following a fall.

Led by the Frailty Network, and using quality improvement methodology a multi-disciplinary team engaged extensively with stakeholders including residents and families, to co-produce, test and implement a regional pathway that will reduce falls and harm from falls with the ultimate aim of improving resident experience and safety.

18 Partner Care homes across NI were involved in this project including Nursing & residential homes including homes for people with learning Disability and Dementia. Thus the need for a pathway that would meet all needs of our residents was a key priority.

Outcome

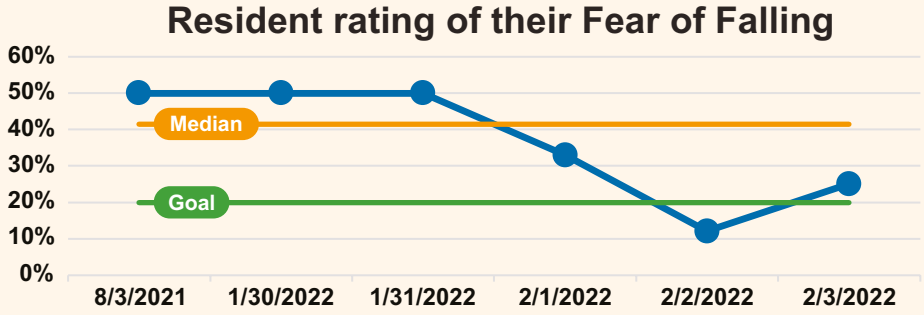
The project produced 2 Regional documents including a risk assessment and post falls protocol which are being tested.

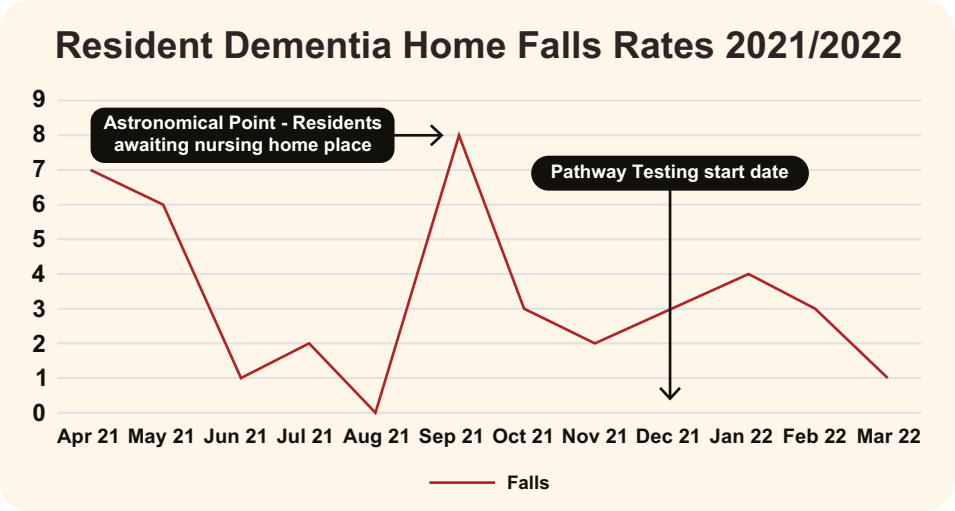
Initial results from one partner home include:

- Fear of falling was at **50%** pre-testing of new pathway, it's now **below 30%.**
- **Falls rate** reduced from 4 falls a month to 1 fall a month during testing period.
- Frequent fallers reduced number of falls. **38%** falls **rate** in Jan-March 2022 compared to **62%** September to December 2021.
- **100%** of staff felt confident in promoting safer mobility, managing and learning from a fall.
- 100**% of staff** felt the pathway was useful.
- NIAS call outs **reduced by 40%** in Quarter one of this year compared to Quarter one of last year. This demonstrates savings and efficiencies across the system with less pressure also on our Emergency Departments.
- Culture surrounding falls prevention has improved, by involving all staff and promoting that it's everyone's business, e.g. Thursday falls focus day.
- Through involvement in the surveys, residents are becoming proactive about what keeps them safer from falls.

"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





Diabetes Network - Regional Pump Service

The NI Diabetes Network has been driving the development of a Regional Pumps Service in partnership with health care professionals, clinicians, people living with diabetes (PLWD) and Diabetes UK. In January 2022, to mark the 100th anniversary of the use of insulin to treat diabetes, NI Diabetes Network launched the new regional pump service to improve the lives of people living with the condition.

In 2020, having secured a £1.6m annual budget, a Regional Pumps Task and Finish Group was set up to support the establishment of a regional service model to administer a regional pumps approach. With representatives from all HSCTs across health care professionals and clinicians, PLWD alongside Diabetes Network, Pump Clinical Lead and Diabetes UK, this group have reviewed current systems and practice, identified key service pillars and a regional service ethos to enable appropriate oversight of a new regional pathway for NI.

The service specification outlines a regional clinical model to provide equity, reduce variability and enhance patient outcomes with a regional pathway to create efficiencies in process and time, better patient experience and clinical care, improved quality of care and outcomes.

Service implementation, led by BHSCT on behalf of NI Diabetes Network, and the Regional Task and Finish Group continue to meet regularly to support set-up through to service delivery.

The Regional Service key pillars are:

1. Evidence Based Practice – NICE / Association of British Clinical Diabetologists/Quality of Life as a key indicator
2. Regional/Local Alignment
3. Psychological provision across the pathway

Outcome

- Following an expression of interest process, BHSCT was commissioned to deliver this regional service in partnership with all HSCTs, on behalf of NI Diabetes Network.
- A Clinical Project Manager has recently been appointed to take this important work forward in partnership with key stakeholders.
- The operational systems and processes, protocols and procedures to support the administration of the regional service are being developed.
- The recruitment of a regional multi-disciplinary team (including Diabetes Specialist Nurse, Diabetes Specialist Dietitian and Psychologist) will deliver the service for the region through the pumps pathway for PLWD across all HSCTs.
- Equitable access to insulin pumps and pump support for PLW1D will be available, regardless of postcode.
- Provision of adequate healthcare professional support to optimise pump outcomes and a clear training framework for healthcare staff will develop and maintain skills in pump care.
- Standardisation of pump service delivery with regional documentation and protocols alongside regular communication between pump centres will take place through regional Multi-Disciplinary Team meetings.
- Efficient use of staff time, with the ordering of pumps and consumables taking place centrally and at scale.
- The regional service will facilitate smooth transition from paediatric to adult service.
- The regional service will be responsive to user and provider feedback.

The NI Diabetes Network can be contacted via email at:
Diabetes.Network@hscni.net

4.2 RAISING THE STANDARDS THROUGH NEW MODELS OF SERVICE DELIVERY

Identifying new methods of service delivery is key to continuously raising the standards of care and the quality of services delivered for the HSC; providing opportunities for reshaping services and innovative design and delivery.

No More Silos

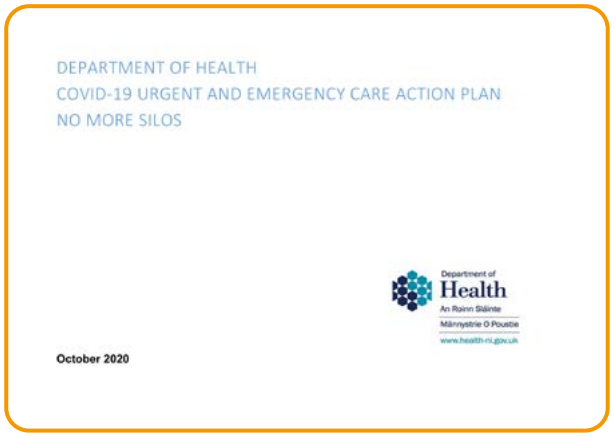
The No More Silos Network was established to ensure that urgent & emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and for staff. This work is supported by HSCB and PHA through a combination of regional planning supported by 5 Local Implementation Groups (LIGs).

No more silos 10 Key Actions

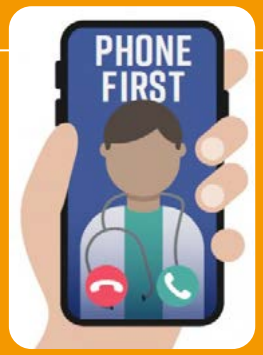
1. Introduce Urgent Care Centres
2. Keep Emergency Departments for Emergencies
3. Rapid Access Assessment and Treatment Services
4. 24/7 Telephone Clinical Assessment Service – 'Phone First'
5. Scheduling Unscheduled Care
6. Regional Anticipatory Care Model
8. Acute Care at Home
8. Ambulance Arrival and Handover Zones
9. Enhanced Framework for Clinical and Medical Input to Care Homes
10. Timely Discharge from Hospital

The ongoing development of Phone First, Urgent Care Centres and Rapid Access Ambulatory Pathways has created a multi-disciplinary family of urgent care services that safely manage non-emergency demand, promoting the scheduling of unscheduled care, and retaining Emergency Departments for emergencies only.

In addition, No More Silos has supported Hospital at Home Services, Enhanced Care Support into Care Homes, and a range of Community Discharge and Social Work services to reduce unnecessary ED attendances and unscheduled admissions, and facilitate timely discharge from Hospital.



Outcome



- Phone First is now operational in 4 of the 5 Trust areas, with Urgent Care Centre services in place in the BHSCT, and to a lesser extent, the SEHSCT and SHSCT. Up to 30th June 2022, almost 266,000 patients have utilised the Phone First and Urgent Care Centre services across Northern Ireland. Of these patients:
  - 23% were discharged with advice or referred back to their GP
  - 54% were scheduled for an appointment at an Emergency Department, Minor Injuries Unit, Urgent Care Centre or alternative pathway
  - 23% were referred directly to an Emergency Department
- In terms of impact on the system, this translates into a reduction in ED demand, particularly among lower acuity patients. Compared with baseline year 2019/20 (pre-covid), 2021/22 saw a reduction of almost 62,000 ED attendances (equivalent to an 8% reduction) across all Trusts.
- Ambulatory Hubs funded in SEHSCT, SHSCT, and WHSCT have allowed primary care and hospital clinicians to access Rapid Access Assessment and Treatment Services across a range of clinical areas as an alternative to ED attendance or Hospital Admission. Up until 30th June 2022, NMS-funded hubs delivered over 24,000 patient appointments, and there continues to be good evidence of impact on ED attendances, admissions and early discharges.
- A multi-disciplinary Enhanced Community Response Team Service pilot in Northern Trust received 802 referrals from the 13 participating care homes, and delivered 1300 initial professional assessments.
- No More Silo funded Hospital at Home services:
  - In BHSCT received 1,370 patient referrals, which resulted in an estimated saving of 7,780 hospital bed days
  - In WHSCT, accepted 227 patient referrals, saving an estimated 1,816 acute hospital bed days
- The funding of independent sector Community Beds in BHSCT supported the discharge of 85 patients delayed in hospital awaiting domiciliary care.
- Funding of Red Cross Assisted Discharge Service in SEHSCT and SHSCT areas providing transport, medication and equipment delivery to support timely discharge of 1913 patients.

New Models of Prescribing Programme

The New Models of Prescribing (NMOP) programme is a transformation project to enable prescribers working at the interface to issue prescriptions (HS21s) directly to patients rather than asking GPs to implement their recommendations. Four pilot projects were established to test process, governance, and policy frameworks required for prescriptions to be issued across the interface between Trusts and GP practices. These areas included:

1. Physiotherapist prescribers - 20 physiotherapist prescribers are now writing HS21 prescriptions for patients to assist with management of lymphoedema, pain, musculoskeletal conditions, respiratory illnesses, neurological complaints and women's health issues across the SEHSCT and SHSCT.
2. Nurse prescribers - Heart failure nurses in WHSCT and NHSCT are issuing prescriptions to support the optimal management of heart failure patients; providing greater opportunity to access the right medicines, at the right time, by the right person. This maximises professional skills at the point of care, which in turn reduces the amount of unnecessary health care appointments.
3. Dietitians - Dietitians across three Trusts have been assessing nutritional needs for patients in a small number of care homes, and ordering oral nutritional supplements (ONS) for patients using a stock order form.
4. Home Treatment Team - BHSCT Home Treatment Team medical prescribers have been issuing HS21s when there is an urgent need to prescribe or amend medication to prevent a mental health emergency.

Outcome

- The NMOP programme delivered an innovative and flexible approach to ensure that the patient remained at the centre of the healthcare professionals' interventions.
- The multidisciplinary approach enabled the programme to be tailored to individual patient requirements and delivered integrated care.
- As a result of this work an Integrated Prescribing programme has secured permanent funding to enable roll-out of key successes and wider commissioning of NMOP.

Community Pharmacy Emergency Supply Service

The Community Pharmacy Emergency Supply Service was introduced at the start of the Covid-19 pandemic in April 2020 to ensure that, at that time of unprecedented demand, patients could access an emergency supply of their regular prescription medicines where they were unable to obtain a prescription. As the challenges of Covid-19 remained the service was continued throughout the 2021/22 year. The service was provided by all 526 community pharmacies during 2021-2022 and ensured equity of access to medicines irrespective of the patient's ability to pay.

Following receipt of a request for an emergency supply to be made, the community pharmacist would firstly establish the need for the medicine to be supplied. Then, the pharmacist would seek to establish that the patient had been previously prescribed the medicine, either by checking their pharmacy records or by other means such as checking medication packaging or other documentation the patient may have such as a prescription reorder form.

Where the community pharmacist deemed it appropriate to make a supply, up to 30 days' treatment could be provided although some Controlled Drugs, were excluded.

Details of the medicines supplied via the service were also shared with the patient's GP practice.

Outcome

- Almost **120,000** prescription items were supplied to patients via the service.
- A survey was undertaken over the course of one week at the beginning of March 2022. Of the 219 pharmacies that responded:
  - **1,560** patients requested an emergency supply
  - A total of **2,308** items were requested
  - Of these, the pharmacist was able to make an emergency supply for **1461** patients
  - In less than **7%** of cases (106) the patient had to be referred to their GP practice or Out-of-Hours service to obtain a prescription

4.3 NATIONAL STUDY PARTICIPATION

The participation in National health studies is vital to raising the Standards of the health and social care we deliver through discovering new treatments for diseases, as well as new ways to detect, diagnose, and reduce the chance of developing the disease. Below is an example of NI participation in a National Study programme.

SARS-CoV-2 Immunity & REinfection EvaluatioN (SIREN) in NI

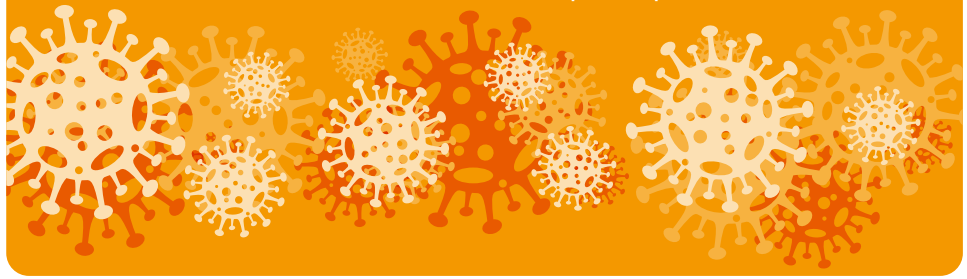
In June 2020 the DoH tasked the PHA, Trusts and the Northern Ireland Clinical Research Network (NICRN) to implement the NI arm of a UK-wide prospective cohort study SIREN in response to the COVID-19 pandemic. SIREN's primary aim was to examine whether healthcare workers, with evidence of previous COVID-19 infection, are protected from future infection compared to those without.

Subsequently, SIREN has been crucial in analysing vaccine effectiveness, and in monitoring immune response to vaccine over time. Participants have regular blood antibody tests and PCR swabs, and complete online surveys providing information on symptoms, demographic characteristics and vaccination status.

A study implementation group, with representatives from Trusts, PHA, BSO and NICRN, was established to collaborate, communicate and develop tailored processes for management of laboratory samples; complex data linkages; robust information governance; and funding. It was originally intended to run for twelve months but was extended for another year, with all NI Trusts opting in to this extension.

Outcome

- Thanks to the enthusiasm and commitment of research teams, Northern Ireland recruited 1247 participants to SIREN (2.9% of UK total) with high retention rates. The proportion of Northern Ireland participants in the extension is higher still, around 5%.
- A regional multidisciplinary network was established including healthcare Trusts, BSO, NICRN and PHA to collaborate in implementing a research study of national and international importance.
- SIREN continues to inform government policy by helping to answer questions concerning vaccination, new variants and reinfection rates.
- New systems and processes were developed for management of laboratory samples; complex data linkages; robust information governance; and funding.
- Multiple SIREN publications in leading peer-reviewed scientific journals include an analysis published in the prestigious New England Journal of Medicine in February 2022, the first to include data from Northern Ireland participants.



SIREN: Overview

Study

A national multi-centre prospective cohort study

Participants

Healthcare workers, support staff and administrative staff working at hospital sites participating in SIREN

Primary Objective

- To determine whether the presence of antibody to SARS-CoV-2 is associated with a reduction in the subsequent risk of re-infection over the next year

Secondary

- Prevalence: of SARS-CoV-2 infection in healthcare workers by region
- Incidence (cumulative and density): of symptomatic and asymptomatic SARS-CoV-2 infection
- Relationship of prevalence and incidence by participant, region and trust.
- Culture viable virus: from cases of reinfection diagnosed by RT-PCR
- Genomics: experiencing persistent infection or reinfection, phylogenetic relatedness
- Serology: changes over time, relationship between commercial and non-commercial assays, clinical or demographic factors

Since December 2020

- To monitor effectiveness of a vaccine/vaccines against an infection and symptomatic disease
- To monitor immune response to vaccination over time

Source: UK Health Security Agency. Used with permission.

4.4 WORKING TOGETHER TO RAISE STANDARDS

Recognising the importance of working together to understand what matters to people is crucial to delivering quality health and social care. The HSCB/PHA are committed to creating opportunities through engagement for people to influence the decisions and shape the direction of health and social care. Some examples are highlighted below.

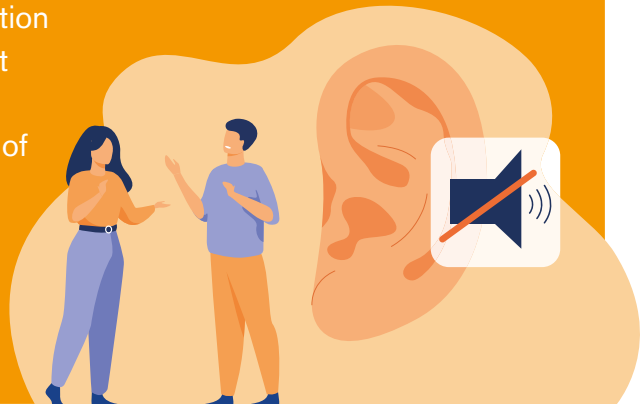
Regional Communication Support Service for Deaf

In April 2020, the HSCB established a temporary remote interpreting service for British Sign Language (BSL) and Irish Sign Language (ISL) users. This service was introduced as an urgent measure to improve access for the Deaf community to HSC services during the COVID-19 pandemic. The service has two key elements:

1. A Video Relay Service (VRS): This enables Deaf people to telephone a HSC service provider via a remote BSL or ISL interpreter.
2. Video Remote Interpreting (VRI): This enables Deaf people to communicate with a HSC practitioner in person, via an online BSL or ISL video interpreter.

Outcome

- The Remote Service was an important learning opportunity as it was a unique project that helped us to understand the extent to which remote sign language interpreting works for Deaf people and improve their access to health and social care.
- The service was independently evaluated by the Patient Client Council who concluded that, overall, remote sign language interpreting has a positive impact on the accessibility to health and social care services for the Deaf community and would be continued to be required.
- Ongoing engagement with the Deaf community and stakeholders determined that this service is now an indispensable access requirement for Deaf service users.
- Further opportunities have been identified to develop the current service models to include a new holistic communication support service that maximises all Deaf, deafblind and hard of hearing peoples' access to HSC services.



Co-production Voice for Young People

The Children and Young Peoples (CYP) Participation Network was formed in 2021 to strengthen the voice of the child in the Children's Services planning process through meaningful co-production activity to improve the quality of early intervention services. Last year, the CYP participation network was instrumental in a number of significant pieces of co-production work. These include the development of

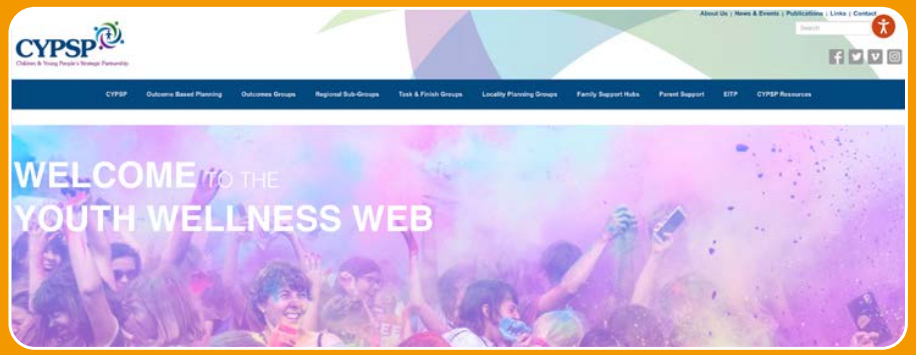
1. **Youth Wellness Web** - Following engagement with HSCTs, locality planning groups, schools, direct engagement with children & young people and community planning, CYPSP identified a need in relation to children and young people accessing relevant and appropriate mental health information and resources in a user friendly format.

2. **Guidance on Right to Complain for Young People** - following a recommendation in the NICCY Still Waiting report, work was undertaken to design and produce a child friendly complaints guidance for the Child and Adolescent Mental Health Services (CAMHS) across Trusts.

3. **Attitudes Survey relating to vaccine uptake** - The CYPSP team enabled the CYP Participation network to assist the PHA with a survey and collation of information from 65 young people from across NI about vaccine uptake for Covid19 and how the programme could be improved.

Outcome

Youth Wellness Web - A central unique page was developed by young people for young people, to provide simple and easily navigated access to emotional mental health and wellbeing information, signposting to services and support, all co-produced and designed with young people for young people.



Guidance on Right to Complain for Young People - Guidance was completed and launched in March 2022.

Attitudes Survey relating to vaccine uptake - Learning from Young People on their anxieties and concerns about COVID vaccine has assisted with future service improvement.

Review of NI Family Support Hubs

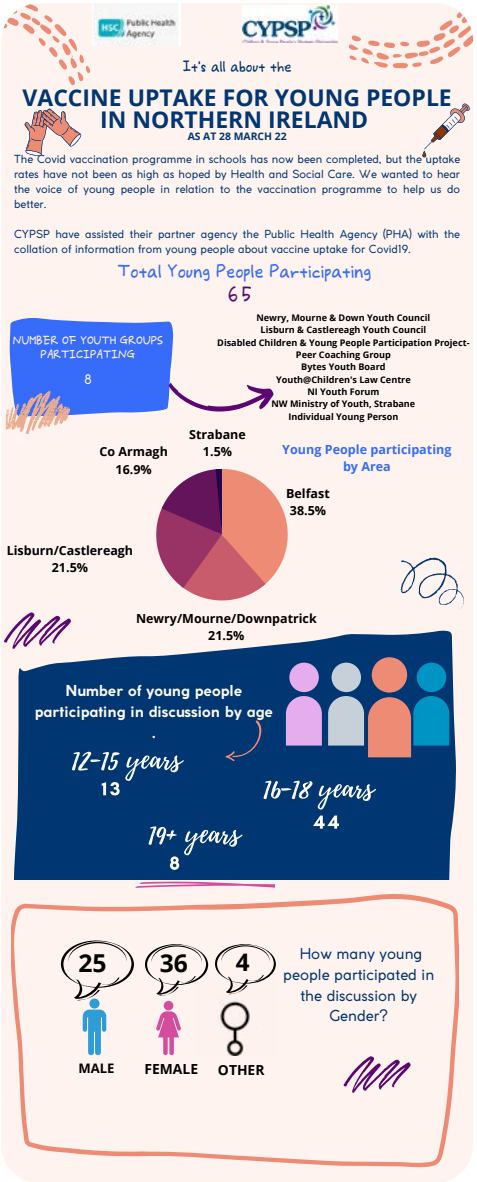
The 2021 a review of Family Support Hubs focused on key aspects of the Hub Model including:

- The impacts of the Hubs on families and local services
- The interaction between the Hubs, community services, and statutory services
- The access of families with children with disabilities to local services

The methodology included a workshop with Hub Coordinators, semi structured interviews with Hub members, stakeholders and families and also included an analysis of the monitoring data.

Key benefits of the hub were noted:

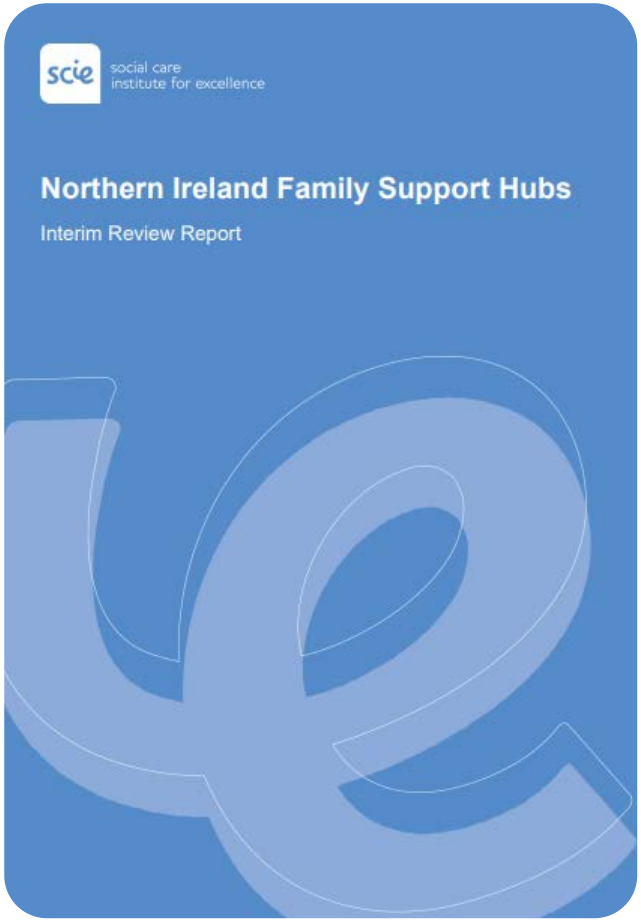
> ***"Families highlighted that the hubs offer accessible and timely support that are community-based, trauma-responsive and non-stigmatizing. For hub members, the key benefits included having access to accurate and up to date information about the community and local services, better integration between services, and having the access to families who are reluctant to engage with support facilitated. On the strategic level, participants highlighted that hubs are key in providing information and influencing strategic developments at the local level and across Northern Ireland."***



A number of recommendations to further improve and develop the Hubs were highlighted which were in line with work already being progressed such as improving reach towards Ethnic Minority Migrant (EMM) families as a result of increased referral activity, and the development of a Hub collective as a quality improvement measure.

Outcome

- Monitoring forms completed monthly and quarterly have been amended to better capture areas that have consistently been reported as unmet need. The amendments will ensure we have real time and quality information to evidence the specific areas of unmet need.
- Changes are particularly focused on referrals for families and children with, or waiting for a diagnosis of Autism/ADHD/ ADD as this remains one of the greatest areas of unmet need identified. This revision to the data will enable evidenced based discussions in respect of the future provision of early Intervention services via the Family Support Hub Network.
- Improved access to interpreting services and translated materials for Ethnic Minority families and the rollout of specific training for Family Support Hub members.



Integrating the Care

5.1 RE-SHAPING SERVICES TO IMPROVE OUTCOMES

Continually reviewing and re-shaping how we deliver health and social care services within NI is key to supporting an integrated system; and in doing so we are improving the quality of care for people and improving their outcomes.

Continuity of Midwifery Care

Continuity of Midwifery Carer (CoMC) has been proven to deliver safer maternity care by reducing interventions, improving clinical outcomes and saving babies lives. The model facilitates effective personalised care, trust and empowerment and improves women's experience and perceptions of quality of care whilst supporting greater professional satisfaction and autonomy for midwives.

The term CoMC describes a model of care that provides a woman with care from the same midwife or team of midwives during her pregnancy, birth and the early parenting period with specialist obstetric care provided as needed.

The ambition is to implement and embed a consistent CoMC model across NI, available to all pregnant women and this will require significant reform and transformation of HSC Trust maternity service delivery.

A CoMC Midwife Consultant was appointed within the PHA to lead the regional programme implementation and direct the work of five CoMC Lead Midwives, one appointed in each of the HSC Trusts.

A CoMC programme plan was developed which outlines a phased approach with a robust outcomes-based accountability framework for implementing the new regional CoMC service delivery model across NI.

Outcomes

- CoMC Programme Structure has been established which includes a Regional Steering Group, Regional Working Group, five HSC Trust Local Implementation Groups and five regional workstreams which include:
  - Communication and Engagement
  - Education
  - Infrastructure and Enabling Resources
  - Monitoring and Measuring Outcomes
  - Workforce
- Following extensive stakeholder engagement, a CoMC Model for NI has been agreed.
- A CoMC communication and engagement strategy has been developed and activities include extensive communication and engagement events and the development of a regional 'Frequently asked Questions' sheet to 'myth bust'.
- Promotional and marketing activities have been underway including the development of a logo and a webpage and promotional materials such as leaflets, posters, pop up stands have been produced.

Primary Care Multi-Disciplinary Teams

Health and Wellbeing 2026: Delivering Together sets out a vision for an enhanced primary care service, including the development of Multidisciplinary Teams (MDTs) within the primary care setting. MDTs involve the inclusion of practice-based Physiotherapists, Mental Health Practitioners and Social Workers in GP practices; these professionals work alongside GPs and practice staff with the aim of better meeting the needs of the local population. Investment in additional nursing specialist roles such as Health Visiting and District Nursing has been made as part of the MDT model.

Significant progress has been made in the implementation and expansion of the MDT model in NI led jointly by the HSCB and Department of Health (DoH). This process began on 2018 and at present, the model is fully or partially realised in 7 Federation areas with ambitious plans to see the model fully rolled out in all 17 Federation areas. An MDT roadmap paper agreeing the sequence and timeline for the remaining 10 Federation area's has been approved in principal by the Minister for Health subject to funding.

To further support MDT a regional professional leads forum has been established for the three core professions to ensure regional standards for Clinical Governance. Seed Funding has been allocated to each Federation to further develop and support community-based initiatives in partnership with local Community and Voluntary Organisations. Additional funding to support staff training has been used across a wide variety of professional and thematic areas to ensure upskilling of workforce and service sustainability.

Outcome

Staff in Post

- MDT staff in post in 7 of the 17 Federation areas:
- 651,729 patients have access to an element of the MDT model across 101 GP Practices
- 98.48 WTE Social Work staff across 67 Practices (40% complete)
- 56.67 WTE Physiotherapy staff across 84 Practices (64% complete)
- 62.90 WTE Mental Health Staff across 90 Practices (72% complete)
- 53.47 WTE Health Visitors in Post across 7 Federation areas
- 64.84 WTE District Nurses in Post across 7 Federation areas

Dashboard development

- Review of templates used by MDT to record patient interactions to further improve data quality including regionally agreed codes and definitions.
- An interactive dashboard has been developed which pulls coded data from clinical systems and enables the merging of data from the different systems. This is the first of its kind for primary care in NI and has the potential to assist in determining population health and local need going forward.
- The dashboard can evidence the following outcomes to date:
- 107,505 unique patients have accessed an MDT service resulting in:
  - 84,985 Mental Health consultations
  - 85,088 Social Work consultations
  - 119,304 Physiotherapy consultations
  - 73.6% of MDT patients are managed by MDT staff without onward referral

5.2 INNOVATION & DIGITAL HEALTH

Digitally enabling the pandemic response

To support and enable the PHA's work to deliver against the Department of Health's COVID-19 pandemic policy, we established and led the Digital Test, Trace and Protect (DTTP) that delivered:

1. A central repository for all COVID-19 tests
2. A system to enable the provision of Contact Tracing services
3. A citizen-facing service to enable people testing positive to directly notify known contacts
4. The StopCovid NI proximity app
5. A dedicated Covid Care app and website
6. An analytics platform capable of linking, analysing and visualising complex data multiple from multiple sources
7. The means to identify people from within the community who may be eligible to receive COVID-19 therapeutic interventions (monoclonal antibodies – mAbs)

These digital products combined with the intelligent use of data were a fundamental part of the PHA response and management of the pandemic. They supported the citizen facing messaging process from test result to messaging of close contact starting.

A wide range of colleagues from across the health and care system were brought together to work with commercial vendors to make the programme hugely successful – all colleagues truly "put their shoulders to the wheel".

Looking at contact tracing as an example, a prototype system to support the initial June '19 pilot of contact tracing was developed (in conjunction with system users) from a standing start in 8 days. Adopting an 'Agile' methodology, this prototype was continually evolved in response to feedback from system users and emerging policy. As part of this evolution we developed a citizen-facing self-service product (Digital Self Trace or 'DST') which was deployed to significant effect during the pandemic Autumn 2020 surge.

Outcome

During a single month - October 2020

- Central Test Registry received 250,488 covid results of those 28,374 were positive
- 15,588 SMS messages were sent to positive cases inviting them to use DST.
- 3,543 (23%) of cases completed digital self-trace.
- 35,000 SMS messages were generated to contacts identified by positive cases (either verbally or via DST).
- The contact tracing system had 720 assigned users

5.3 POPULATION HEALTH AND WELLBEING

Population Health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. Below is a number of examples where a population health approach has been taken to improve health outcomes and quality of care.

Living Well - Community Pharmacy

Under the Living Well Service provided by community pharmacy, four public health campaigns were promoted to help the public make positive changes to their health and lifestyle, through raising awareness and behavioural interventions. These campaigns include:

1. Know Your Units
2. Be Cancer Aware
3. Boost Your Immunity
4. Making Healthier Choices

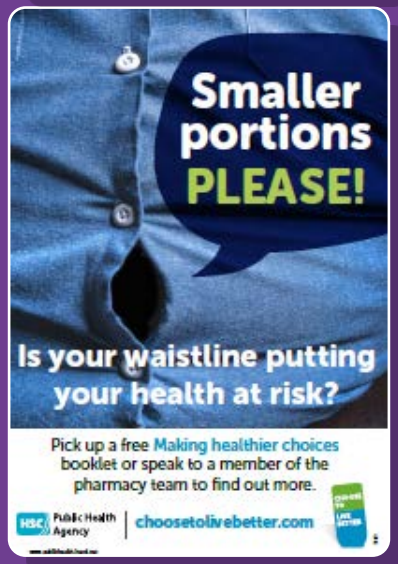
Below is an example of the work relating to the “Be Cancer Aware” campaign, a NI campaign aimed at helping the public to recognise the signs and symptoms of cancer and aid them in making lifestyle changes to reduce their risk of cancer.

Community pharmacies engaged with the public using various methods, including creating visual instore displays, disseminating information via delivery drivers and/or disseminating information to other healthcare professionals, schools, retail shops, churches or community groups. They also displayed and provided leaflets alongside prescriptions and used social media or their websites to promote the key messages. A campaign briefing document was also developed to provide training for the pharmacy team. This provided campaign activity suggestions such as engaging patients on staying safe in the sun, stop smoking services, promoting physical activity, encouraging screening and raising awareness of alcohol units. Social media assets and schedules were also available. From direct patent engagement and consultations, pharmacy staff were able to make appropriate referrals when necessary and provide support and advice to patients at a time when other healthcare professionals/ services were hard to access.

Outcome

- It is estimated that over 47,175 patients were engaged in the “Be Cancer Aware” campaign topic.
- Queries were addressed by pharmacy that spanned the whole cancer journey, from symptom awareness and reducing risk to cancer treatments, end of life care and bereavement support.
- **36** pharmacies reported patients being diagnosed with cancer, precancerous cells, emergency consultant care or surgery as a result of their engagement.
- **73** pharmacies reported patients signed up to their ‘Stop Smoking’ service as a result of the campaign.
- **68** pharmacies reported making GP referrals for suspected skin cancer.
- **16** pharmacies reported addressing specific queries on breast screening programme during pandemic.
- **22** pharmacies reported addressing specific queries on suspected bowel cancer.
- **198** pharmacies referred patients to another pharmacy service.
- **218** pharmacies referred patients to another healthcare professional.
- **27** pharmacies referred patients to a community or voluntary service.
- **5** pharmacies referred patients to a social prescribing project.

In total for 2021/22, it is estimated that during the four Living Well campaigns, community pharmacy reached over 231,510 patients.
** this is an estimation of patients engaged directly in pharmacy but pharmacy also engage via other mechanisms, such as gyms, schools, sports clubs, scouts, men’s sheds, etc. In light of this, we are unable to fully quantify the exact outreach of each campaign.



An Inequalities Informed Approach to Health and Wellbeing in Lisburn

Lisburn Integrated Care Partnership has been working in collaboration with a wide range of partners to understand the **role they can collectively play in better understanding and addressing the impact of health inequalities** for the people of Lisburn.

Informed by the experience of COVID-19, Lisburn ICP saw a strong need to maintain the collaborative, person centred responses necessary during the COVID community response. Lisburn ICP with support from Community Development and Health Network (CDHN) sought to ensure systems and actions were focused on identifying and addressing the level of inequalities being experienced across the City.

A concept paper was developed to create a call to action across agencies, services and people living and working in Lisburn. Two online workshops were held in Autumn 2020 and this process helped to co-create a way forward to further develop an inequalities informed approach for Lisburn.

Through collaboration, we have been able to:

- Define what is meant by inequalities
- Define the geography (5 District Electoral Areas (DEA)
- Understand the level of inequalities in our City – what data is being held by whom and what does the data tell us? What does inequalities feel like to people living and working in the City?
- And develop a community of practice to share learning, better understand how inequalities are being experienced across a wide range of topics and services which we progressed using Project Echo methodology.

Outcome

- This process has been collaborative in nature and therefore a wide range of organisations and individuals across all sectors encompassing the social determinants of health have participated in the different work streams.
- This process has helped to improve our collective understanding of health inequalities and how this is experienced by people living and working in Lisburn.
- Gathering data across sectors and services has helped to profile health inequalities providing a width and depth of understanding previously not provided at DEA level.
- In addition, the lived experience workshops have helped to identify recurrent themes and challenges that need to be addressed in order to be more inequalities informed in how we plan, deliver and receive services across the City.
- This has been an organic, inclusive, learning process and therefore the next steps will be to take our learning back out to the wider community in Lisburn to check how the information gathered to date align with what is experienced by individuals, families and organisations in Lisburn. Reaching a shared understanding is significant to this work.

Diabetes in Adults - A Population Approach

The Integrated Care Partnership in South Belfast have been working with the BHSCT, Community & Voluntary sector, GPs, Pharmacists, service users & carers as part of a multi-disciplinary group to design a Diabetes service which will test a New Model of Care for patients living with diabetes.

The new model of care which has been developed aims to:

- Provide equitable access to the services they need in an appropriate setting including vulnerable and hard to reach groups, e.g. homeless, nursing home residents.
- Identification, management and support of people 'at risk' of developing T2 Diabetes or those living with diabetes.
- Effective use of appropriate information technology in primary care to risk stratify patients and enable effective multi-disciplinary discussion on the care management of those at risk of developing or living with type 2 Diabetes.
- Enhancement of GP knowledge and involvement to manage the demand and to ensuring more of these are managed in primary care including a shift from most patients having care in specialist settings.
- Rapid access to assessment and treatment to address emergency and urgent issues in a timely way (avoiding attendance and/or long waiting times in EDs).

Outcome

This model of care has been endorsed by the Diabetes Network with the intention of rolling it out across the region when funding has been identified.

ICP Proposal	Expected impact
Use of GPIP for Practice-level screening for patients at high risk of developing T2 diabetes	Programmed interventions for patients at high risk
Protected GP time for biannual practice reviews	Enhanced practice-based knowledge and skills to manage diabetes; reducing need for specialist care; increased support for vulnerable groups; targeting inequalities; reducing risk of serious complications
Specialist in-reach support to practices and protected GP time	
Expansion of Community MDT service	Meet demand for timely specialist assessment; education for practice teams through ECHO
Fast Track Assessment and Treatment Service	Hotline for urgent assessment to avoid unnecessary admissions
Integrated discharge model	Reduce risk of readmission
Psychological support	Up skilling all professionals in managing patients with complex needs and the disengaged to support self-care

Multi-morbidities: Providing Integrated Care in a Rural Area

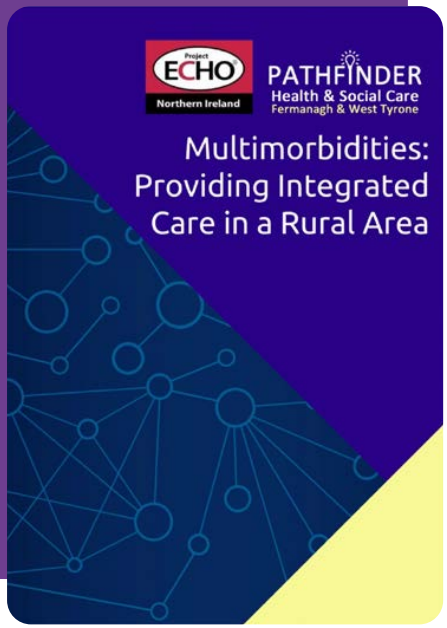
Fermanagh and West Tyrone Pathfinder was launched in 2018/19, It aims to use participative, place-based approaches to identifying need and shaping services in a locality served by the WHSCT.

In 2021/22 Pathfinder, working with Western Integrated Care Partnerships utilised Project Echo to:

- Bring together those who experience and those who deliver services, to create connections and build relationships in Fermanagh and West Tyrone.
- Build on the formal population needs assessment undertaken by the PHA
- Provide a comprehensive “ground up” insight to garner intelligence
- Co-produce the priorities for action with local people and partner organisation

Outcome

- Six ECHO sessions were held, with an average of 26 attendees from a range of different backgrounds including Western Trust staff, community and voluntary organisations, GPs, NIAS, primary care, service users and carers.
- The sessions refined priorities, and aided in the development of action and implementation plans on the future planning and delivery of services in the area.
- The outcomes are central to an SEUPB application to PEACE Plus Integrated Care Working Group and seeks cross border funding to deliver a cross border approach to Integrated Care.
- The overriding need identified by the ECHO network was for a **single point of access**. This is now in development with WHSCT, Fermanagh and Omagh District Council and PHA to create an integrated approach to supporting residents in Omagh and Erne East, by facilitating access to Primary and Secondary care, Council services and wider community and voluntary care.



5.4 CROSS-SECTORAL WORKING

Cross-sectoral working is key to providing quality integrated care in health and social care. Given that individuals will regularly interlink with a range of sectors throughout their lives, such as education, healthcare, housing, environment, etc. it is crucial that a multi-faceted approach to designing and delivering health and social care is undertaken. Below are two examples of cross-sectoral working with Department of Justice to improve health outcomes.

Healthcare and Criminal Justice: improving the Provision of Prison Eyecare

Prior to March 2021 primary eyecare services in prisons had been historically-procured and not always fully aligned with robust governance, accountability, or quality and experience measures. Emerging policy across Healthcare and Criminal Justice systems presented an opportunity to review service provision and outcomes, and to work on a new planning and commissioning framework for prison eyecare.

The objectives of the service transformation, as agreed by the Improving Health within Criminal Justice Planning and Commissioning Team are laid out below:

1. To provide an accessible, equitable, quality and safe Optometry service within NIP Population, with particular focus on those most in need.
2. To implement appropriate governance and assurance processes for the Optometry service within NIP sites.
3. To ensure an integrated approach in respect of the Optometry Service within the overall health care service provision within the NIP sites to deliver an integrated service where all providers work together as a team to deliver patient-centred care and promote and nurture quality improvement in the service.

Following successful tendering and procurement, new service providers were appointed by March 2021, with the newly commissioned service commencing early 2021/22.

Outcome

A review of the new Healthcare in Prison Optometry Service was undertaken for 2021/22. In addition to improved governance and accountability measures, patient experience and outcome measures demonstrate service improvements and enhanced quality in care provision for this vulnerable group.

Care has been further integrated within the wider Healthcare in Prisons holistic approach with the establishment of electronic referral (eReferral) via the Clinical Communications Gateway (CCG) for use by the optometry service was a practical piece of work to integrate eyecare services provided in the prison setting into the wider HSC system, enabling efficient referral of patients to appropriate care pathways - right patient, right pathway.

Increasing Testing for HIV, Hepatitis B and C in Prisons

HIV, Hepatitis B and C are important causes of illness and death, but if detected can be treated successfully. Prisons are a key setting for finding people living with undiagnosed blood borne viruses.

The aim of the improvement project was to increase blood borne virus testing in prison in order to identify people living with undiagnosed HIV, Hepatitis B and C, so they can then be offered life-saving treatment and avoid infection of others. Enhanced case finding is necessary for elimination of these viruses.

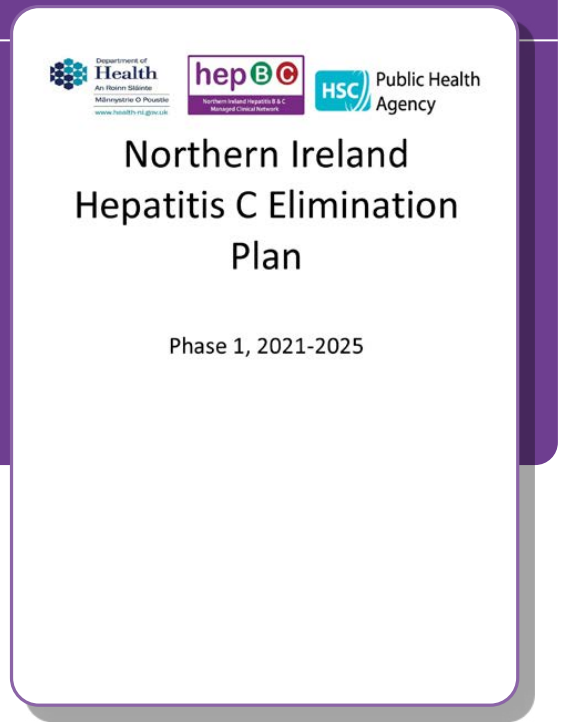
Prior to the improvement project, uptake of testing was 13%. To understand the low uptake, PHA conducted three focus groups with people in prison, observed the committal process, and interviewed key staff. Following wider stakeholder engagement and learning about best practice through literature reviews and professional networks, two key improvement ideas were implemented: (1) Opt-out testing in the new Comprehensive Health Assessment for all committals, and (2) Rapid point of care testing. In addition to this, education and training on blood borne viruses was provided to healthcare in prison and NI Prison Service staff.

Training was delivered on how to offer testing, with the suggested wording used of:

'We test everyone for HIV, Hep B and Hep C. Hep C can be cured, and HIV and Hep B treated. Is that ok with you?'

Outcome

During the pilot stage, uptake of testing increased threefold. This approach has now been rolled out across all three prison sites, and the improvement in testing has been sustained



5.5 HEALTH AND SOCIAL CARE QUALITY IMPROVEMENT (HSCQI)

Health and Social Care Quality Improvement (HSCQI) is a Network of Quality Improvement experts and enthusiasts. HSCQI 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 2021 entitled Programmes, Partners, People spans the five themes of this Quality report which are aligned to the Q2020 Strategy.

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HSC Health and Social Care Board

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