



# Health and Social Care Board and Public Health Agency

## Annual Quality Report 2015/2016

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# Chief Executives' foreword

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

The HSCB and PHA are committed to ensuring safe, high quality services and putting patients, clients and their carers at the centre of everything we do. We continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves. We remain focused on modernising how our services are delivered, ensuring that they are responsive to the needs of a changing population.

This report highlights the broad range of work undertaken by both HSCB and PHA during 2015/16. While it is impossible to include information about every service the HSCB and PHA provide, nevertheless it is our hope that this report goes some way to reassure our patients, clients and the public of our commitment to ensuring safe, effective and high quality care. The report has been structured around the core Quality 2020 themes: **Transforming the culture, Strengthening the workforce, Measuring improvements, Raising the standards** and **Integrating the care.**

An important focus during the year has been the implementation of *Making Life Better* – the whole system strategic framework for public health. *Making Life Better* includes a range of strategic actions for government departments and other agencies and also sets the direction for a number of supporting areas for joint working at regional and local levels.

These are happening at a time of renewed focus on working together to achieve a world class health and social care system.

Finally, we recognise that our key asset is our staff; their dedication and commitment in ensuring safe, effective and patient client focused services is a source of great strength for the HSCB and PHA. We would like to thank all the staff for their continuing efforts over the past year, there will always be areas for improvement and we will continue to aim for the highest quality in the care we provide and put our patients at the heart of everything we do.

# Theme one:

## Transforming the culture

### How we measure and report on our work

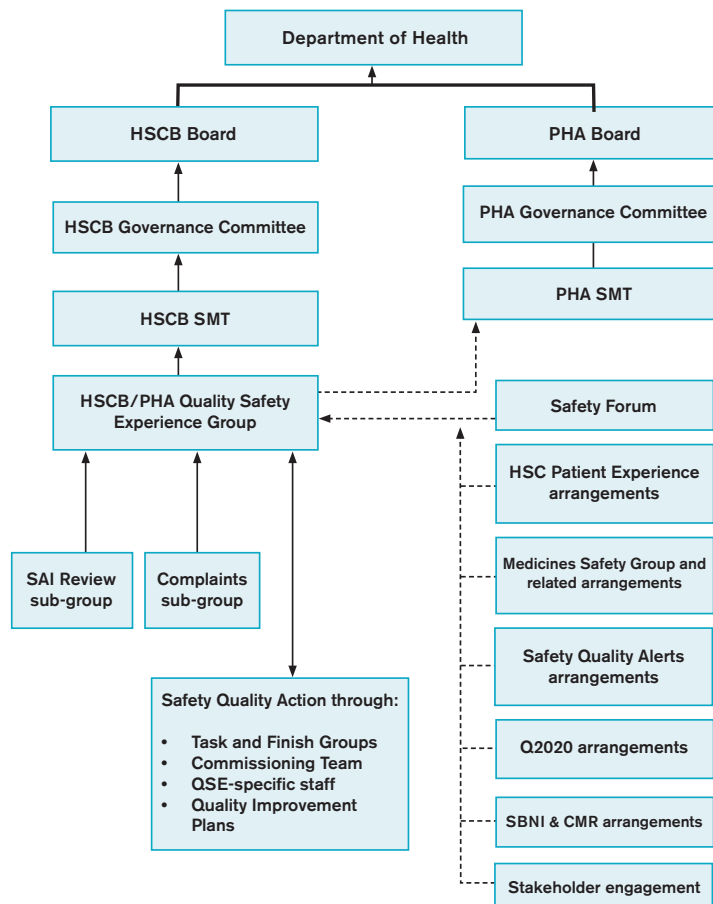
Within the HSCB and PHA, there is a comprehensive governance and assurance structure to support quality and safety. In particular there are two joint strategic groups which specifically review, monitor and report on safety, effectiveness and patient client focus: The **quality, safety and experience group (QSE)** and the **safety and quality alerts (SQA)** team.

These groups provide assurance to the PHA and HSCB boards' that matters of quality and safety are paramount and actions are taken to improve the quality and safety of services, and, ultimately, to improve the experiences of patients and clients.

### Quality, safety and experience group

The QSE group was established in November 2013 to oversee all issues relating to safety, effectiveness and patient client focus within the HSCB and PHA. This group is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals. It allows senior staff to share information, approve policy and identify areas of concern.

An overview of the QSE structures is outlined below:



### Regional serious adverse incident review sub-group

The regional serious adverse incident review sub-group (RSAIRSG) is chaired by the HSCB governance manager and the PHA senior manager for safety, quality and patient experience. Membership comprises professional representatives from the HSCB, the PHA and the Regulation & Quality Improvement Authority (RQIA). The RSAIRSG provides assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow up of serious adverse incidents (SAIs) arising during the course of the business of an HSC organisation or commissioned service.

The RSAIRSG also has responsibility (in conjunction with the QSE and SQA team) to ensure that trends, examples of best practice and learning are identified and disseminated in a timely manner. A number of professional groups from the RSAIRSG have been established to consider SAI review reports in order to close and/or identify learning issues.

#### 2015/16 professional groups

- Paediatrics and child health;
- Maternity;
- Mental health (including prison health);
- Acute.

These groups benefit from:

- multi-professional input and a wider circle of experience;
- group sign off, with decisions not made by one individual;
- more complete understanding of the range of SAI issues within these service areas, leading to the identification of regional trends.

### Regional complaints sub-group

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

Since the implementation of 'Complaints in HSC' in 2009, the number of complaints received by HSCTs and family practitioner service (FPS) each year has increased from just under 5,000 in 2009 to approximately 6,181 in 2015/16.

#### Top three categories of complaints

1. Attitude/communication;
2. Treatment/care;
3. Waiting lists/delays/ cancellations.

The RCSG reviews complaints information received from HSCTs and family practitioner services, as well as complaints received by the HSCB and PHA. Areas of concern, patterns, trends and information from complaints is shared with established professional groups. This ensures that issues of complaint inform key areas of work on the quality of patient experience and safety, including thematic reviews and strategy and policy development.

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

## Safety and quality alerts team

The SQA team was formed in April 2012 and provides a mechanism for gaining regional assurance that alerts and guidance have been implemented, or that there is an existing robust system in place to ensure implementation.

**Table 1: Category 1 alerts as of 31 March 2016**

Alert type	Total
DoH safety and quality alerts/circulars	<b>212</b>
Learning letters	<b>30</b>
Reminder letters	<b>19</b>
National patient safety alerting system alerts (NPSAs)	<b>28</b>
Safety or quality related letters	<b>17</b>
RQIA reports and independent inquiries	<b>71</b>
NCEPOD report and other confidential enquiries	<b>23</b>
GAIN reports	<b>7</b>
<b>Total</b>	<b>407</b>

Progress on all of the above are contained in a HSCB/PHA bi-annual safety and quality alerts report which is made available to HSC organisations and the Department of Health (DoH).

During 2015/16, the SQA team have issued a number of learning/reminder of best practice letters as a result of a SAI that has occurred within a HSC organisation/commissioned or FPS (see reminder of best practice table below).

The HSCB/PHA have worked with HSCTs to implement a number of key quality improvements, which include:

- ensuring protocols are in place for anaphylaxis in both hospital and community settings and that staff are provided with regular training in the management and treatment of anaphylaxis;
- development of an agreed list of pre-prepared products in relation to magnesium sulphate, through the regional medicines governance team;
- ensuring agreed referral pathways from emergency departments (EDs) to the maternity service are in place within each HSCT and that relevant staff are made aware of the pathway, including how to access the relevant contact telephone numbers;
- review of protocols for the management of major obstetric trauma by HSCT senior ED and obstetric clinicians;
- ensuring that staff follow best professional practice as recommended by ATLS/MOET training courses and manuals;
- ensuring that appropriately senior ED and obstetric staff are called to the ED as soon as it is known that a major obstetric trauma case is arriving;
- ensuring that relevant staff have appropriate skills update training, for example through in-house clinical scenario simulation drills;
- review of protocols for the ambulance transfer of pregnant women to confirm they are in line with the recommendations of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) report in relation to the prevention of hypotension from uterine pressure on the inferior vena cava;
- review of the additional training needs for ambulance staff in the techniques to prevent hypotension from uterine pressure on the inferior vena cava, and plans to address any such training needs;
- review and (as necessary) update HSCTs existing protocols or procedures in services looking after transplant patients to ensure that they reflect the requirements as detailed within the reminder of good practice letter;
- review and amend protocols for the perioperative preparation of patients to take account of the requirements as detailed within the reminder of good practice letter issued.;
- dissemination of a reminder of good practice letter to the HSC, which provides advice and highlights the requirements under current guidance on the management for patients/clients with swallow/dysphagia problems;
- review of HSCT protocols for the detection of pregnant/potentially pregnant women in ED to ensure that they reflect the content as set out in the 'Requirements under current guidance' section of the reminder of good practice letter issued as a result of an SAI;

In addition the HSCB and PHA jointly issue a bi-annual SAI learning report to the wider HSC. This learning report provides an overview of best practice reminders, learning letters, thematic reviews and other learning initiatives, undertaken or reported on during the period of reporting.

## Serious adverse incidents

### The management and follow up of serious adverse incidents

The HSCB and PHA have a responsibility to coordinate the management and follow up of SAIs. The aim of the SAI process is to:

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

#### Internal process for managing SAIs reported to the HSCB/PHA

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

During 2015/16, a number of issues were identified within the current SAI process that required immediate implementation and were therefore issued to all arm's-length bodies in June 2015. These were:

- a revised SAI service user/family/carer engagement checklist to enable easier data input and more meaningful information output, allowing for a systematic approach to monitor this information;
- minor revisions to both the Level 1 and Level 2/3 review templates and to also incorporate the above checklist.

In addition the HSCB and PHA issued guidance to all HSC organisations to assist both reporting organisations and HSCB/PHA staff when managing:

- SAIs that are also being reviewed as adult or children's safeguarding incidents;
- interface incidents that have been reported via the SAI process;
- early alerts that have reported in line with DoH process.

The HSCB procedure for the reporting and follow up of SAIs (October 2013) is currently under review and will take account of the recommendations made within the Donaldson Report, *The Right Time, The Right Place* and the RQIA/Guidelines and Audit Implementation Network (GAIN) SAI reviews outlined below.

### **SAI reviews**

During 2015/16 the DoH commissioned two regional projects from GAIN who are now aligned within RQIA. The two projects are:

- identifying learning from SAIs across Northern Ireland (including the death of a patient);
- examining learning arising from SAIs involving suicide, homicide and serious self-harm.

Both projects are being carried out in partnership with the HSCB, PHA and HSCTs. In taking the projects forward, a project board and project team has been established for each, with membership drawn from all relevant organisations.

### **Service user and family involvement in SAIs**

The HSCB procedure for the reporting and follow up of SAIs makes clear the need for appropriate communication and involvement of service users, relatives and carers. Following DoH communication and consultation across the HSC, the HSCB developed and issued guidance in February 2015 for HSC organisations when engaging with service users/families who have been involved in a SAI.

The purpose of the guidance is to ensure that communications with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner, thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. A leaflet has also developed to provide information for service users/families/carers on the process.

Given the unique position of FPS within the HSC, bespoke guidance based on the HSC SAI procedure has been developed in year specifically to assist FPS contractors and Directorate of Integrated Care (DoIC) staff who assist in the investigation and management of SAIs within primary care and in particular regarding the family/user/carer elements of the SAI process. A

leaflet also provides information for patients/families on the process. It is anticipated that these documents will be issued to practices very shortly following endorsement from their respective representative bodies. Feedback received to date has been positive.

## Learning from serious adverse incidents

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

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

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

### Learning letters/reminder of good practice letters

Last year the following learning letters and reminder letters of good practice were issued. Some of these have already been referred to above in relation to the improvements taken forward by SQA Team:

Reminder of best practice letters	Date published
Safe disposal of patients' drugs in the community	19 May 2015
Assessment of a potential undisclosed/unknown pregnancy – advice for ED staff	28 May 2015
Assessment of domestic violence	28 May 2015
Assessment and management of trauma in pregnancy – advice for ED and maternity staff	28 May 2015
Prescribing and dispensing high risk drugs eg immunosuppressants such as tacrolimus	30 June 2015
Services for infants/young children with suspected hearing impairment	30 June 2015
Supervision in accordance with individual care plans	14 July 2015



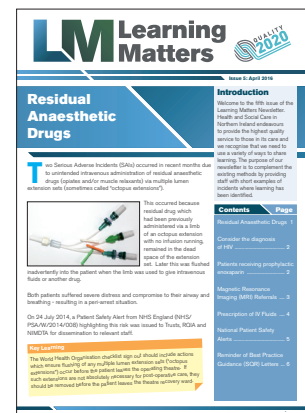
Preventing shoulder dystocia and brachial plexus injury	20 July 2015
Alcohol-based skin preparation solutions and the risk of fire in operating theatres	15 Sept 2015
Identifying an acutely unwell child on arrival at an ED	21 Sept 2015
Management and advice for patients/clients with swallow/dysphagia problems	1 October 2015
Management of patients who are on combined anticoagulant and/or antiplatelet therapy, pre and post a procedure/surgery	14 October 2015
Safe use of oral bowel-cleansing agents	8 January 2016
Reminder of risks associated with long term oral bisphosphonate therapy	12 January 2016
Residual anaesthetic drugs in cannulae and intravenous lines	19 January 2016

## Newsletters

The HSCB and PHA have developed a number of newsletters to share learning from complaints, SAls and adverse incidents (AIs) with the HSC.

Some of these include:

- Learning matters
- Optometric practice
- Medicines safety matters
- Prescribing matters
- General practice
- Medicines management



## Thematic reviews

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

The following thematic reviews have been completed and issued during 2015/16:

- thematic review of patients with a fall resulting in moderate to severe harm;
- thematic review of SAls relating to the misidentification of patients.

Other thematic reviews approved by QSE to be undertaken during 2015/16 are:

- thematic review of AIs relating to the prescribing, supply and administration of insulin;
- thematic review of SAls related to choking on food.

## **Collaborative working**

### **Improved care in mental health**

The mental health quality improvement collaborative was established by the HSC Safety Forum in 2014 in partnership with all HSCTs. The forum's first success was the redesign of processes and cultural change regarding the physical health needs of mental health patients. There were measurable improvements in areas such as reliable monitoring of blood pressure, body mass index and the use of health passports.

In 2015/16, the collaborative used the recommendations of a thematic review of suicides by the PHA to shape a programme designed to improve the culture of learning and reflective practice to support staff and improve the patient/client journey. The programme has:

- completed a safety climate survey across all HSCTs;
- is trialling tools to both guide and measure reflective practice in teams;
- is exploring the best way to use safety briefings and structured communication tools such as SBARD (Situation, Background, Assessment, Recommendation, Decision).

### **Improved care in nursing homes**

The work of the Northern Ireland nursing home quality improvement collaborative in 2015/16 was centred on palliative/end of life care (PEoLC). Using innovative Project ECHO methodology, the HSC Safety Forum worked in partnership with NI Hospice to deliver this programme to 26 nursing homes throughout Northern Ireland. Last year the ECHO project delivered 10 x 2 hour tele-mentoring sessions. Up to 70 staff participated in these tele-linked sessions on many aspects of PEoLC. The sessions included case presentations by nursing home staff to facilitate the sharing of learning and quality improvement training.

Feedback from 92 participants showed:

- 100% felt it helped translate knowledge into practice more than other teaching sessions they had been involved in;
- 100% felt it improved the care they provided for patients;
- 100% would recommend it to others;
- 100% would participate again.

## Managed clinical networks

### Paediatric networks in Northern Ireland

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

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

In line with this, a paediatric network manager, funded by the HSCB on the recommendation of the specialist services commissioning team and working within the Royal Belfast Hospital for Sick Children (RBHSC) has continued to lead on the following three main objectives:

#### (1) Formalise selected paediatric networks in Northern Ireland

The Northern Ireland paediatric gastroenterology network, the Northern Ireland paediatric epilepsy network and the Northern Ireland paediatric respiratory and allergy network have continued to build on excellent working and partnership arrangements to support clinicians and families throughout Northern Ireland. In 2015/16 the Northern Ireland paediatric endocrine and Northern Ireland paediatric neurodisability networks have commenced to deliver a programme of education and training for all interested clinicians at least four times annually.

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

In 2015/16 the BHSCT continued to formalise networks with UK providers to provide 'in-reach' services. These include very specialist clinicians coming to Northern Ireland to deliver clinics or operating theatre sessions that would otherwise be unavailable in Northern Ireland. Specialist in-reach clinics were delivered in 2015/16 including:

- urology;
- gastroenterology;
- metabolic bone;
- metabolic lysosomal storage disorders;
- endocrine;
- bone marrow transplant failure clinic;
- spasticity intervention assessment clinic;
- craniofacial assessment clinic.

In 2015/16 the BHSCT maintained formal arrangements with Great Ormond Street Hospital for delivery of a 24/7 specialist telephone clinical advice service for Northern Ireland paediatricians treating paediatric patients with suspected or confirmed endocrine and metabolic conditions when the consultant team based in the RBHSC is unavailable. Northern Ireland has also strengthened formal links with the Northern Children's Epilepsy Surgery Service (NorCESS), which is a joint service between Alder Hey

Children's Hospital NHS Foundation Trust and Royal Manchester Children's Hospital NHS Foundation Trust, to deliver an epilepsy surgery and rehabilitation service. This is one of only four designated units in the UK. BHSCT and NorCESS colleagues have visited each other's units and agreed a specific patient pathway for families in Northern Ireland.

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

In 2015/16 the BHSCT have continued to deliver:

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

### **Critical Care Network Northern Ireland**

The Critical Care Network Northern Ireland (CCaNNI) work with all HSCTs and with commissioners to monitor and review issues relating to critical care staffing.

During the past year, CCaNNI have facilitated the submission of workforce data to the National CC3N Critical Care Non-Medical Workforce Survey.

The CCaNNI senior nurses committee have worked with colleagues from throughout the United Kingdom in the development of 'Step 3 Competencies' for both nursing staff new to critical care (Step 1) and for those staff completing post registration courses in critical care (Step 2 & 3).

In addition, CCaNNI have undertaken an audit of patient handover practices when a patient is transferred from the critical care setting to the ward. The audit reflects generally good practice and has helped units identify individual aspects of patient handover which can be further enhanced.

CCaNNI continue to have a key role in collecting, monitoring and reporting incidents of influenza within critical care, which form the basis of a local and national report.

Quarterly regional patient flow exercises in adult, cardiac surgical intensive care and PICU (fortnightly) are carried out and units/HSCTs are supplied with individual reports.

Eleven standardised critical care transfer trolleys with attached monitoring and ventilation equipment have been embedded in hospital sites across the region, improving the safety of transfer for critically ill adults and children. To further support this work, multi-disciplinary critical care transfer training days have been held in collaboration with colleagues from the Northern Ireland Ambulance Service with attendance from across the region.

## Neonatal Network Northern Ireland

Neonatal Network Northern Ireland's (NNNI) collaborative way of working aims to achieve regional consistency in care and drive quality improvement within the network and beyond with a family centred approach. It is delivering this through a number of network led multi-disciplinary and interdependent service area working groups producing regional guidance, protocols and tools. This is further supported by the networks hosting of quarterly CPD quality improvement events focusing on key network priorities. These use a PDSA cycle approach to service improvement via engagement with the wider network and its interfacing service areas to raise standards and outcomes for patients and families. This bottom-up top-down approach supports engagement, innovation and problem solving. A cohesive network culture continues to effectively manage network cot capacity at a time of significant challenge through the facilitation of weekly regional network teleconferences. This reduces the risk of out-of-region in- and ex- utero transfers to support families. Throughout 2015/16 network led work has strived to attain agreement and consistency in care resulting in:

- the development and regional implementation of an NNNI policy for testing and isolation to prevent infection (TIPI) in neonatal units provides guidance to staff and parents to reduce risk and improve consistency in approach supporting capacity management;
- the development of regional antimicrobial guidance for neonates;
- across the perinatal spectrum the development of guideline and parental leaflet for the counselling of women at risk of delivering an extremely preterm baby.

Furthermore the NNNI's parental engagement group (co-chaired by the service user organisation Tiny Life) is a key influencer of the neonatal work plan and parental products.



The ongoing neonatal service review has assessed national evidence supporting multi-disciplinary team working to secure positive outcomes for staff and families. It has also clarified the current neonatal workforce baseline across the network, identifying requirements to strengthen the neonatal workforce in specific areas/professions/grades. Within 2015/16 it has secured:

- investment in allied health professional (AHP) services to support the multi-disciplinary neonatal team in managing complex children's needs within the neonatal setting;
- medical and nursing investment to augment the regional centre to neonatal unit to reduce risk of out of region transfers and support staffing ratios towards BAPM standards;
- investment in neonatal transport services to provide 24/7 service provision;
- support for the regional normative nursing model to be applied to neonatal nursing;
- investment in HSCT neonatal breastfeeding roles to support the regional breastfeeding strategy;

The network provides peer and professional support through continuous engagement and collaborative working to the wider network, its quarterly service improvement events and through inclusion in its projects. 2015/16 regional quality improvement projects include:

- supporting breastfeeding within neonatal units;
- thermoregulation of neonatal babies.

The ongoing analysis of the NNNI regional discharge questionnaire from parents across Northern Ireland provides a measurement improvement tool for units and on regional service provision. In 2015/16 the questionnaire themes were revised to support areas of interest. The outcomes were presented at the Neonatal Nurse Association Conference.

Standards continue to be raised by focusing on priorities, utilising time specific task and finish groups to develop tools, guidance and documents to improve consistency across the region in service delivery.

The NNNI operates most effectively by engaging staff from related interfacing areas with parental representation through its series of task and finish groups. By taking a complete care pathway approach the network's work plan seeks to raise the quality of care linking with other networks and service areas as necessary to drive up quality for families and utilise opportunities for investment and support. In 2015/16 the network hosted a regional perinatal event to support a work area. This will now become an annual event.

## **Northern Ireland Pathology Network**

The Northern Ireland Pathology Network enables HSC pathology services to plan and implement regional standardisation and quality improvement initiatives in partnership with stakeholders including commissioners, policy makers, universities, professional bodies and patient representatives through a regional network board and seven clinical specialty forums covering the main pathology disciplines.

In 2015/16 key achievements included:

- developed proposals for HSC pathology service modernisation in line with policy and best practice, including extensive consultation with stakeholders;
- developed a business case for, and coordinated the establishment of the Northern Ireland Genomic Medicine Centre, which will enable HSC patients to take part in the UK 100,000 Genomes initiative;
- secured support for the establishment of a project to modernise HSC pathology information systems, including a project for regional primary care electronic test ordering;
- completed a partnership project engaging primary and secondary care and secured funds to establish a regional H Pylori testing service in line with NICE guidance. Commencing in autumn 2016 the service will enable GPs to test patients in primary care to see if H Pylori is the cause of their dyspepsia, and to test that treatment to eradicate H Pylori has worked;
- secured agreement for HSC Laboratories to participate in a new, enhanced national benchmarking scheme that will provide information that can be used to standardise practice and further improve quality and safety;
- formed close links with the national Digital Diagnostic Data Board to begin a process to ensure HSC pathology data will be of standard quality to other UK pathology data;
- coordinated regional initiatives to improve quality and safety including: a regional pathway and patient information for handling the transfer of specific samples for regional testing; developed regional guidance and protocols including guidance on placental histology and swabbing; and testing to manage acute kidney injury;
- supported Cancer Research UK national audit into capacity and demand for pathology services in the UK;
- facilitated the development of regional inter-HSCT pathology business management tools, including for example the development of a regional service level agreement, initiated a new regionally standardised approach to management of block funding, developed regional laboratory service contingency plan in case of disaster;
- continued programme of ongoing standardisation of practice in all HSC Laboratories to improve efficiency and ensure that clinical service users and patient receive a high quality standard service from all laboratories.

## **Regional Stroke Network**

In November 2014 a network co-ordinator was appointed to establish a Regional Stroke Network. The network brings together stakeholders from patient groups, the voluntary sector, HSCTs, PHA, primary care and HSCB. Already a number of benefits have been achieved that will result in improved patient experience and recovery following stroke.

### Stroke information system

- All five HSCTs in Northern Ireland participate in the Stroke National Audit which has facilitated local service improvement activities. The network has developed and implemented the stroke information system in a number of HSCTs to support this. This allows detailed analysis of performance against NICE quality standards and DoH targets.

### Thrombectomy

- Northern Ireland is one of a limited number of UK regions with access to a new clot retrieval intervention called 'mechanical thrombectomy' for suitable stroke patients. It is provided by the Royal Victoria Hospital on weekdays on a 9 to 5 basis. Fifty three patients benefitted from thrombectomy in 2015. The stroke network is working in partnership with the BHSCT to identify options for phased expansion of this service.
- The stroke network has brought together clinicians to streamline processes to ensure the maximum number of stroke patients are identified who would benefit from the current thrombectomy service. This has involved clinician training, review of imaging pathways, agreement on patient selection processes and the development of inter-HSCT referral, transfer and repatriation procedures.

### Stroke modernisation

The network has developed a comprehensive draft consultation document on the modernisation of all aspects of the stroke pathway in Northern Ireland. The HSCB plans to consult on this in 2016. This will inform the development of a new model for stroke services to deliver hyperacute stroke unit care for every stroke patient, access to mechanical thrombectomy service hours to 24/7, improved speed of access to clot busting treatments, seven day access to transient ischaemic attack (TIA) services on a walk in basis, appropriately resourced community services and continued support for stroke survivors.

### Transient ischaemic attack

- The network developed an electronic TIA referral form that is now being used for all TIA referrals from primary care.
- The stroke network completed an audit of 128 TIA patients and has identified several areas for service improvement.
- The stroke network collaborated with the local commissioning groups (LCG) and ICPS to implement early supported discharge services, over seven days in the SEHSCT and BHSCT.



## MAGIC project

- Northern Ireland through the Stroke Network is a partner in a three million Euro, Horizon 2020 EU procurement project. This project, through collaboration with service providers, will develop new and innovative technologies to enhance patient empowerment and rehabilitation after stroke. Over 150 stakeholders from Northern Ireland have been involved in shaping this project so far and new technology solutions will be tested in Northern Ireland stroke services in 2017/2018.

## Governance in primary care

The HSCB Directorate of Integrated Care (DoIC) manages contracts across four contractor service areas: **medical, dental, ophthalmic and community pharmacy**, who provide primary care services to patients in Northern Ireland. All contractors are independent organisations or providers and operate within the framework of their own regulatory and professional codes of conduct. This report will provide some key highlights in the directorate's continuing drive to improve quality, safety and service delivery for patients in 2015/16 within each contractor service.

### General medical services (GMS)

There were 349 GP practices in Northern Ireland in 2015/16

GPs play a key role in ensuring that health service provision in Northern Ireland is effective and efficient. GPs provide:

- the main point of entry to the health care system;
- person-centred, ongoing care covering whole episodes of ill health;
- delivery of the majority of care for all but the most uncommon conditions;
- coordination of care provided by others

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

Each visit covers the following key contractual areas:

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

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

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

## **General dental services (GDS)**

As of April 2015 in Northern Ireland, there were 1216 dentists working across 384 dental surgeries providing general dental care and treatment. A small number deliver specialist dental care and treatment eg orthodontics and oral surgery.

### **Quality assurance**

Quality of care provided by dental practitioners is monitored by the HSCB Referral Dental Service (RDS) through post-treatment examinations. In addition under GDS Terms of Service, all dentists in each practice are required to work under a Quality Assurance Scheme and each practice must make an annual return to the HSCB through the local offices.

In 2015/16 the Quality Assurance return was revised and updated eg clarification that a Standard Operating Procedure is required for Buccal Midazolam/ Emergency Drugs irrespective of whether or not IV sedation is provided.

Also in 2015/16 a monthly news sheet has been issued through the BSO website, to communicate non-urgent alerts, news items and notices to dentists.

## **General ophthalmic services (GOS)**

In 2015/16 there were 267 optometry practices in Northern Ireland with approximately 500 optometrists providing or assisting in the provision of General Ophthalmic Services (GOS). The health service ophthalmic services provided in these practices are eye examinations, spectacle and contact lens fitting and local enhanced eye services. The latter services relate to additional or 'enhanced' care, outside general ophthalmic services, for certain patients who present with an ophthalmic problem which require additional investigation. 'Developing Eyecare Partnerships' (DEP) is the strategy to improve eyecare provision and promote eye health. Through the DEP the HSCB is actively working with service users and other organisations to develop better patient centred eyecare services. The HSCB optometry team monitors the activity and quality of eyecare services on an ongoing basis and undertakes checks which seek feedback from patients on the quality of eyecare services. Optometry practices are requested to provide annual quality assurance information in relation to complaints, adverse incidents and ophthalmic guidance which has been issued from HSCB.

## **Community pharmacy**

## Community pharmacy

The most common primary care medical service is the prescribing of medication. Community pharmacies are responsible for dispensing and advising on these medicines and providing advice on a range of wider health issues. Currently there are 533 community pharmacies across Northern Ireland.

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

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

## Transforming the culture within social care

### Introducing Rapid Access Interface and Discharge (RAID) Model to Northern Ireland

The Raid Model aims to improve access to mental health care for citizens who present to Hospital Emergency Departments and reduce waits for mental health assessments with in the Acute General Hospital System.

RAID project objectives	Measurable targets
1. Reduce the length of time that people who present with a mental health problem wait in emergency department for mental health	90% of patients referred for mental health assessment will have an assessment commenced within two hours in the ED.
2. Ensure the appropriate management of patients who present to the emergency department with: <ul style="list-style-type: none"> <li>i. Self-harm</li> <li>ii. Harmful hazardous use of alcohol and drugs</li> <li>iii. Mental health difficulties associated with old age</li> </ul>	<p>A demonstrated increase in the percentage of assessments carried out for patients in the ED within the specified categories with a month on month increase from the commencement of the service.</p> <p>A decrease in the percentage of patients leaving the ED without having a specialist mental health assessment with a month on month decrease from commencement of the service.</p> <p>Reduction in the percentage of patients with deliberate self-harm or suicidal ideation who re-present to the ED within 30 days of original assessment.</p>
3. Reducing the overall cost of care, by reducing time spent in general hospital beds, optimising medical investigation and the use of medical and surgical facilities. This is achieved by the reduction of potentially avoidable admissions to medical or surgical wards and reduced length of stay in medical hospital beds through early intervention and detection of delirium, depression and dementia.	<p>Percentage month on month increase in the number of assessments offered and completed for patients over 65 years in the ED.</p> <p>5% reduction in the number of emergency hospital readmission with 30 days of discharge</p>
4. Provide a seven day integrated substance misuse liaison presence across the HSCT and also provide to groups currently excluded (CAMHs and learning disability).	An increase in the percentage month on month of interventions provided for those presenting with harmful hazardous use of alcohol and substance misuse in Antrim Area and Causeway Hospital.

The RAID model has been prototyped in NHSC and has resulted in 5% reduction in the number of emergency hospital stays, over 17% reduction in bed days and over 90% of patients referred for mental health assessment had their assessment commenced within two hours in the Emergency department. Plans are underway to roll out the RAID Model across all HSC Trusts.

## **Separated/unaccompanied children**

Separated/unaccompanied children arriving in Northern Ireland is a relatively new and developing phenomenon for Northern Ireland. Given the adversity faced by such children and their associated circumstances of arrival in Northern Ireland it is increasingly evident that this is a highly complex and specialist area within family and childcare and interfaces with serious risks of trafficking and child exploitation. These children and young people are vulnerable to potential traffickers and the risk of such children going missing and remaining missing is significantly high. Although the number of such children entering Northern Ireland year on year is relatively small there have been incidents of these children disappearing, usually within days/weeks of entry into Northern Ireland. A major challenge faced was the availability of a suitable, safe and protective environment in which to place such children which would afford them immediate care, support and reassurance. A dedicated residential facility for separated/trafficked young people aged 13 to 18 years with capacity for eight young people was established in 2014/15. The facility provides a culturally sensitive reception and assessment residential unit aimed at protecting and safeguarding separated young people thereby reducing, if not eliminating, the risk of their disappearance. It also provides an initial stable living environment to orientate young people and to undertake immediate information gathering and assessment, embed coordinated working with key statutory and voluntary agencies and ensure safe and holistic care planning for each young person.

During its full year of operation (2015/16):

- All separated children aged 13+ presenting in Northern Ireland have been safely placed in this facility;
- Assessment, safety planning and care planning arrangements have been fully attended to;
- The risk of young people going missing has significantly reduced with no reports of any young person going missing and remaining missing from the facility to date; and
- An independent evaluation of the facility reported positively on the experiences of the young people placed in the facility in terms of their care, feeling safe and being supported

Social work staff within the facility report increased knowledge, skill and competence in working with separated children which is a welcome and much needed source of expertise for Northern Ireland to ensure the provision of high quality care and support to this particular group of children and young people.

## Adults with learning disability

The Regional Health Care Facilitator Forum (sub regional group of the Learning Disability & Healthcare & Improvement Steering Group) has been working on a range of initiatives to develop quality systems and improve governance with Adults with learning disability as follows:

- **Standardised annual health check assessment form for adults with learning disability**

The GPs and Health Care Facilitators carry out annual health checks for adults with learning disability through a Directed Enhanced Service (DES) using a health check form (based on the Cardiff annual health check). A range of different templates were being used across the Region. This forum agreed to develop a standardised form for implementation across the region and ensure that all of the new screening programmes such as AAA, Bowel cancer screening etc. had been included as well as adding some additional questions around detecting early signs of dementia. The revised form has been approved by the Regional Directed Enhanced Service Group and can be accessed on the Integrated Care website by the GP practices.

The standardised health check form has also been converted to allow electronic entry and completion of the form which will reduce administration of the service and ensure more quality time is spent with the patient and the health outcomes to be addressed following the Health check.

## Promoting Good Nutrition strategy

The overall vision of the Promoting Good Nutrition (PGN) strategy is to improve the quality of nutritional care of adults in Northern Ireland in health and social care, whether delivered or commissioned, through the prevention, identification, and management of malnutrition in all health and social care settings, including people's own homes.

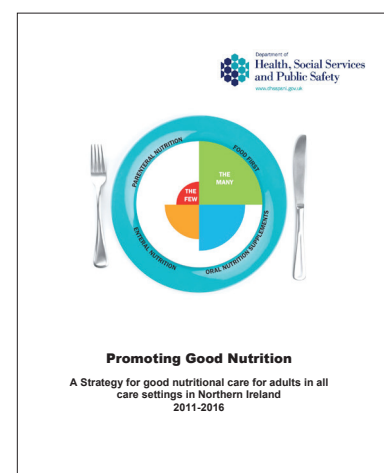
The implementation of this strategy was overseen by the PGN steering group chaired by the Director of Nursing, BHSC on behalf of the PHA with representation from HSCB/PHA, all HSC HSCTs and other relevant HSC organisations.

The actions within the PGN strategy have been set out into the following themes:

1. training (and MUST);
2. assessment and assistance with feeding;
3. food service provision;
4. patient client experience;
5. governance and structures.

Ten key characteristics have been adopted which form the basis of good nutritional care in health and social care settings.

There has been a significant amount of work progressed across sectors to improve good nutrition, good hydration and enhance the



patient/client experience of mealtime during 2015/16. Following the evaluation it was noted that progress has been made in acute hospital settings on implementing and improving the key characteristics. It has been agreed that the focus will now be on full roll out of the PGN strategy in the community and developing and adopting an outcome based approach.

## **Improvements in unscheduled care**

The Improving Patient Flow in HSC Services report, prepared at the request of the Chief Medical Officer and the Chief Nursing Officer, recommended a number of actions that HSCTs could take to improve patient flow. A number of these of these priorities were developed and implemented across the five larger acute hospitals within EDs and the wider hospital setting:

### **Emergency department professional staff**

Over the past year the regional unscheduled care team, LCGs and HSCTs have been working collaboratively to put this in place, meaning a multidisciplinary assessment at the front door of the larger five hospitals to identify the most appropriate patient pathway across seven days. This has led to a consistency across Northern Ireland in terms of seven day service in ED, meaning patients have access to the same assessment, intervention and discharge planning regardless of their day of admission. This will also contribute to a move towards discharge across seven days from current discharge patterns.

### **Minor injury streams in emergency departments**

Minor injury streams within EDs have the ability to see and treat patients who present with a wide range of conditions. Extending their hours of operation facilitates a higher volume of patients who can be directed to this stream and ease potential congestion within the ED.

Across the five larger sites in 2015/16 additional emergency nurse practitioners (ENPs) and nursing staff were funded to allow the minor streams to operate 12 hours a day, seven days a week, and further work taken forward to standardise the role of ENPs to maximise their potential to see patients, order investigations and provide treatments. Physiotherapists have been able to complement consultant and ENP roles, to maximise the opportunity for see, treat and discharge from learning of similar models across the UK. This right person, right place, right time approach can impact on waiting times and patient experience.

### **Same day/next day access to radiology services**

Patients attending EDs often need investigations to confirm a diagnosis, to determine a diagnosis and treatment plan, and for those patients admitted to hospital; access to diagnostic services is important to prevent delays in their in-patient journey. Additional investment for CT, MRI and Ultrasound scans with same day/next day investigation and report production across seven days a week was made to assist improving patient flow.

### **Twice daily senior decision making for in-patients**

Additional medical staffing was provided in 2015/16 to support HSCTs to: facilitate more frequent reviews of patients admitted to hospital; maintain timely assessment of patients; ensure treatment plans are on course; prevent delays in the patients' journey.

## Theme two:

# Strengthening the workforce

## Strengthening the workforce

The HSCB and PHA employ over 900 staff (582 in HSCB and 319 in PHA as of March 2016) who work in a range of areas including nursing, medicine, social care, allied health professions, finance, informatics, family practitioner services, commissioning and corporate services. The HSCB and PHA are determined to invest in the development of our staff and the creation of a working environment that enables everyone to make their best contribution.

Sickness absences have an impact on quality and productivity, affect service delivery and are therefore an important factor when measuring an organisation's culture of quality. The cumulative percentage absence in respect of staff sickness for 2015/16 was 3.92% for the HSCB and 4.35% for the PHA. The BSO human resources department are continuing to work with managers within the HSCB and PHA with a view to reducing the levels of absenteeism.

## Supporting staff

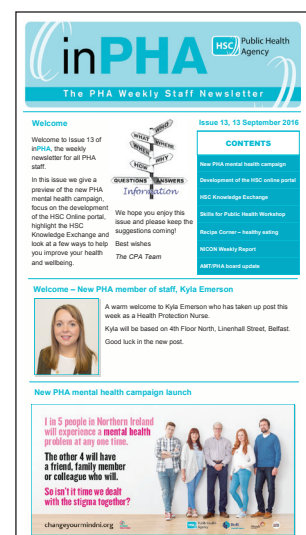
### Staff health fairs

In June 2015 the HSCB and PHA staff in each of the four main offices were provided with the opportunity to participate in the annual health fairs which were organised by the occupational health department and human resources, BSO. Staff were able to avail of a range of advice sessions such as occupational health physio, an introduction to mindfulness, mental health awareness and stress relief, blood pressure and cholesterol checks. The fair also included a range of exhibitors including alcohol and nutrition advice, Staff Services, Cycle to Work, Carecall, Cancer Focus and Addictions NI.

### Information sessions

The HSCB and PHA is committed to supporting staff in their roles and keeping staff informed on developments across the HSC system. Following the then Health Minister Simon Hamilton's announcement regarding the future of the HSCB and PHA on 4 November 2015, communications arrangements to support staff through this change management process were put in place.

For the HSCB, this has involved both the Chief Executive and Chairman leading on regular engagement sessions with staff both via video conferencing and visits across all local offices. A human resources representative was in attendance at meetings to address concerns and issues.





For the PHA this has included an offsite workshop for all PHA members of staff on 16 November 2015 and regular communications from the Chief Executive by email, intranet 'Connect' featured news items and via a new internal staff newsletter 'in PHA'.

The sessions provide an opportunity to provide information and update staff on progress in taking forward this agenda as well as an opportunity for staff to ask questions directly and discuss developments.

The sessions are also supported with regular Chief Executive emails and directorate team meetings which are aimed at ensuring staff are kept informed and involved in a timely manner.

### **Online information resource**

A dedicated information section has been created on the HSCB and PHA staff intranet. This provides a valuable information resource, including latest published information, updated frequently asked questions and answers as well as an online facility for staff to ask questions directly to the Chief Executive.

### **Organisational workforce development group**

The HSCB and PHA has established an organisational workforce development group which is aimed at providing support to staff during this period of change. Proposals for staff development and training are currently being developed.

### **PHA internal communication**

Effective internal communication is essential to the efficient running of the organisation, particularly since the PHA is located over several regional offices.

To ensure this, the PHA continued to work to develop and progress an internal communications strategy and action plan which will ensure PHA business is supported by efficient and effective internal communication systems. Work to take forward the development of PHA's intranet site, Connect, was led by the internal communications working group which is made up of staff from all locations and across different bands.

Connect continues to be one of the primary internal communications channels with regular updates and organisational information provided to staff as well as carrying daily features on staff-related activities and achievements.

Important changes were also made during the year to internal emails which has assisted with the streamlining of internal communications, allowing staff to better manage and prioritise internal email.

### **HSC programme board – communications working group**

The HSC programme board has set up a regional communications working group to ensure that staff employed across the HSC are kept informed and up to date on its work in taking forward the HSC Restructuring Programme. The HSCB is represented on this Group.

## **Moving forward programme**

During the year the PHA promoted the moving forward programme which offers a suite of short course programmes through the HSC Leadership Centre that are tailored for middle and senior managers within HSC regional organisations.

## **Staff policies applied**

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to promoting equality of opportunity and good relations for all groupings Under Section 75 of the *Northern Ireland Act 1998*.

The PHA has a range of policies in place that serve to advance this aim including an equality of opportunity policy.

Where an employee has become disabled during the course of their employment with the PHA, the organisation works closely with human resources who are guided by advice from occupational health.

Subsequently, reasonable adjustments can be made to accommodate the employee, including possible redeployment, in line with relevant disability legislation. This legislation is incorporated into selection and recruitment training and induction training and is highlighted in relevant policies where necessary.

The PHA is fully committed to the ongoing training and development of all members of staff and through the performance appraisal system all staff are given this opportunity irrespective of ability/disability as well as having the same opportunities to progress through the organisation.

More information on the PHA's work regarding equality is available in this report under the section entitled 'Equality' as well as on the PHA's website [www.publichealth.hscni.net](http://www.publichealth.hscni.net)

## **Staff health and wellbeing working group**

The purpose of the staff health and wellbeing working group (SHWWG) is to act as a focus for the promotion of the health and wellbeing of all staff in the PHA. The work of the group reinforces the PHA's commitment to this goal. The process of working together across all divisions has been important in building understanding and sharing perspectives. The group developed an action plan entitled 'Promoting Health and Wellbeing in the PHA as a Workplace: An Action Plan for the PHA' which recognises the importance of the workplace as a setting to promote health and wellbeing. The action plan remains a live document in order to reflect on feedback from staff and adapt to changing needs.

A regular newsletter is produced to update staff on the progress of initiatives and future developments, and the minutes of each meeting are published on the staff intranet site, Connect. During 2015/16, the group continued to lead on the implementation of a number of initiatives/programmes to assist in promoting health and wellbeing for staff.

## **Lesbian, gay, bisexual and/or transgender (LGB&T) forum**

During 2015/16, the LGB&T HSC staff forum continued to meet quarterly, in order to ensure the provision of a safe, welcoming and open space for LGB&T staff to discuss a range of issues and to promote visibility and inclusivity in the organisation as a whole. Membership of the forum continues to grow and is supported by a confidential mailing list which is managed by PHA.

Meetings of the forum are regularly advertised via internal communication networks and are sent to all staff via email. Posters to advertise forum meetings are placed in staff areas. Connect also contains a link to the LGB&T website (<http://www.lgbtstaff.hscni.net/>) and a link to a dedicated LGB&T e-learning tool 'Creating Inclusive Workplaces' (<http://lgbtelearning.hscni.net/>). The tool aims to give participants a better understanding of LGB&T issues in the workplace.

The PHA was present at Pride festivals throughout Northern Ireland in 2015. To coincide with Pride, information stalls were organised in hospital stalls throughout the region. All staff were also invited to take part in the Pride parade, to show support for LGB&T colleagues and service users.

The PHA has been working with the Rainbow Project during 2015/16 to become the first HSC organisation to be recognised as a 'Diversity Champion'.

The Diversity Champion Northern Ireland Programme enables organisations to be recognised as having effective equality and diversity policies and practices on LGB&T issues.

This initiative is one of a number of developments over recent years to help improve the health and social wellbeing and reduce the health inequalities experienced by LGB&T individuals and their families across Northern Ireland.

PHA has been working closely with human resources to review policies and benchmark these against best practice. Training has been delivered to key personnel within the PHA and BSO and others from across wider health and social care, and feedback has been most positive.

The next stage in the process is to carry out a staff survey and a series of engagement opportunities with staff from across all divisions within the PHA.

Feedback from the survey will be invaluable and will be used to inform future developments relating to the Diversity Champion Programme.

By becoming a Diversity Champion the PHA will build upon existing good practice in helping to promote inclusive work environments where all staff feel valued and respected regardless of their sexual orientation and/or gender identity. In addition, it is hoped that by participating in the programme, the PHA will demonstrate leadership to other HSC organisations and the public sector as a whole which will encourage others to take part in the programme.

## Weight loss programme

The '£ for 1lb' weight loss challenge continues to be offered in partnership with Business in the Community with the aim of supporting staff who wish to lose weight over a 12 week period, with the support of a designated 'champion' and expertise from community dietitians.



## My Mood Matters/Living Life to the Full

Mental and emotional health and wellbeing in the workplace is recognised as an important issue by the PHA, both as an employer and for all employees. A range of mental and emotional wellbeing courses have been made available to staff during 2015-16, such as 'My Mood Matters' and 'Living Life to the Full: Life Skills'; both of which have evaluated very positively. The courses have been offered to each locality and have been well attended in each area.

## Physical activity

SHWWG recognises the importance of regular physical activity and seeks new and innovative ways to encourage staff to incorporate movement into their daily routine. In support of the work of SHWWG, a 'Take the Stairs' (TTS) proposal has been developed.

A baseline study was conducted to ascertain the current level of stair use and to seek ways of encouraging stair use. Best practice and evidence in other public health settings were taken into account to aid SHWWG in the developing a number of posters (or 'point of decision prompts') to encourage behaviour change among staff.

It is anticipated that by changing sedentary behaviour, employees will increase their daily physical activity, reduce stress, improve muscle tone and maintain a healthy weight. This work also builds on the momentum of Active Belfast and the 'Leading the Way' initiative which seeks to use the power of the public sector in order to help shift the norm of physical activity more generally. It is hoped that a pilot will be conducted during summer/autumn 2016 to determine the impact of the initiative.

The group has also made improvements to the working environment during 2015/16 by informing the food choices in site premises to ensure healthy options are made available. Plans have also been made, and funding secured, to replenish gym equipment in the PHA headquarters. The possibility of 'female only' gym slots is also being considered.

SHWWG also continues to work with human resources to establish men's and women's health forums, negotiate concessionary rates for staff who wish to join gyms and provide information to staff on how to access other support services such as occupational health and Carecall.

A 'Wellness Day' is planned to take place in Autumn 2016. This will include sharing information on topical cancers, how to check yourself, nutrition and exercise and mental health. A physiotherapist will also be invited to offer advice on back health.

## Domestic violence policy

SHWWG worked with human resources to develop a domestic violence policy. The aim of the policy is to ensure that PHA contributes to the health and wellbeing of all staff by, as far as

possible, creating a workplace which is safe and supportive for staff who are experiencing domestic violence. The policy outlines potential sources of support for individuals experiencing domestic violence and provides guidance for line managers.

### **Smoke-free**

From Wednesday 9 March 2016 all health and social sites across Northern Ireland adopted smoke-free status. The move coincided with No Smoking Day, and means that smoking is not permitted by staff, patients, contractors or visitors on any HSC premises. This major step by the health and social care system is leading the way in helping to change the culture and highlight where smoking is unacceptable.



Support for smoking cessation, including Nicotine Replacement Therapy, was offered to all staff. A number of workshops were organised early March 2016 in different localities. A smoke-free policy has been developed with input from the equality unit. The policy seeks to guarantee staff and those who access their facilities and services, the right to air free of tobacco smoke, which contains a class "A" carcinogen, in order to improve health and wellbeing.

### **Active travel**

During 2015/16, 'Leading the way with active travel' continued to grow. This initiative encourages employees to get more active through the way they travel, for example by foot, bicycle, or taking public transport.

PHA commissioned Sustrans to run the programme to encourage more staff in Belfast to walk or cycle to work, and it is being delivered in PHA, Belfast City Council, BHSCT, HSCB and BSO.

The programme is important in helping shift the norm and encourage greater physical activity. Accredited cycle training was offered to all staff (and the general population) to help increase confidence and safety on the road.

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

### **Training for HSCB, PHA and HSC staff**

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

## **SAI related training**

During 2015/16 a number of training events were held:

### **Regional root cause analysis (RCA) training**

RCA training provides the tools to support staff when conducting or reviewing an SAI investigation. Training was held on 19 May 2015.

### **SAI learning events**

The HSC Safety Forum hosted two regional SAI learning workshops during 2015/16. The first was held in April 2015 and the second in March 2016. The events provided an opportunity to share learning from SAIs regionally. HSCTs and integrated care presented a number of case studies for discussion. A relative of a patient involved in a SAI and a senior clinician both shared their experience of the process and the impact it had on them individually and their wider family. Feedback on both events has been very positive and a third event is scheduled for April/May 2017.

### **Designated review officer (DRO) workshops**

Workshops for DROs were carried out during September and October 2015, across each of the four locations. The rationale for holding the workshops provided DROs with a clear outline of the key stages of the:

- SAI process taking account of any recent/imminent;
- service user/family engagement process;
- learning process;
- early alert process;
- provided an overview of key documentation involved in the process.

### **Thematic review training**

A half day training session on how to complete a thematic review was held in January 2016.

### **Working with HSCT SAI groups**

#### **BHSCT RCA forum for Chairs**

Following the success of DROs attending the first BHSCT RCA Forum for Chairs in November 2014, DROs across a number of programmes of care were invited to attend the third forum in October 2015.

This provided HSCT RCA Chairs with a perspective on the role of a DRO within the SAI process. The meeting also provided an opportunity for DROs to share anonymised examples of well written review reports.

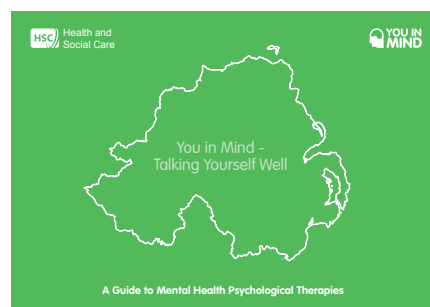
## NHSCT SAI review group

The NHSCT SAI review group invited DROs across a number of programmes of care, to meet with this group of their lead directors to do a question and answer session in July 2015. The HSCT welcomed this opportunity and the session was positively evaluated by all members present.

## Training in mental health

### You in Mind Mental Health Psychological Therapies Guide - providing leadership in evidenced base practice and introduce of new ways of working

Delivering evidence-based psychological therapies are a critical component of mental health recovery. With the publication of many NICE Mental Health guidelines recommended talking therapies there was a need to produce a consolidated guideline which enables mental health professionals to provide personalised citizen focused psychological therapies. The guide was developed in partnership with people with lived experience and professionals involved in delivering psychological therapies services. The guide was launched on World Mental Health Day on 10 October 2015 and is now being used by all Health and Social Care Trusts to modernise mental health care. It enables HSCTs to tailor their staff continuous professional development needs in line with NICE guidelines. The new guide complements the Regional Learning Together and Working Together Mental Health Continuing Professional Development Framework. Over the last year a further 46 Mental Health staff have been trained in a range of psychological therapies.



## Regional reablement service

The reablement service provides a person-centred approach to promote and maximise service users independence to allow people to remain in their own home for as long as possible. Implementation of a regional reablement dataset for performance monitoring includes key performance indicators in relation to service users starting reablement, length of stay and outcome following discharge.

A longitudinal audit was undertaken in 2015 to measure the length of benefit of reablement this demonstrated that it significantly contributes to long-term care cost avoidance and demand management. Further work has been undertaken with service users and carers to co-design a regional reablement leaflet, FAQs, and DVD. The provision of training to 30 Reablement Occupational Therapists on FIM/FAM as a regional outcome measure tool has also been undertaken.

## Adult safeguarding demand and capacity modelling

Adult Safeguarding is recognised as a complex and critical area of work within HSCTs. The DHSSPS and Department of Justice (DOJ) introduced a new adult safeguarding policy; Prevention and Protection in Partnership in 2015 identifying the need for safer communities and safer organisations across all sectors and set out clear and proportionate safeguarding expectations across the full range of relevant organisations. Within the HSCTs it was recognised that demand in terms of adult safeguarding referrals was increasing year on year. In addition

staff working in this area had concerns that the complexity of adult safeguarding referrals was increasing with new types of safeguarding concerns arising such as human trafficking and disability hate crime. Set against this was a fairly constant workforce capacity that spanned a very large proportion of the adult services workforce within the HSCTs.

Review of the operating service models in the HSCTs revealed that a variety of operating models existed with the majority of the work being completed by non-specialists who had received safeguarding training. The very limited specialist safeguarding resource had adopted a largely advisory function in addition to co-working some of the most complex investigations. The modelling exercise considered both the preventative and protective elements of work. An improvement science methodology was applied to measure both the demand and the capacity elements.

The outcomes from the modelling exercise were:

- An informed demand analysis that reflected the time requirements and intensity levels of investigations
- An informed capacity analysis that reflected the volume and competencies of the adult safeguarding workforce and the degree of gap between demand needs and capacity availability
- A proposed standardised regional adult safeguarding operating model which sees safeguarding as a continuum of activity with responses becoming increasingly more targeted and specialist as the risk of harm increases. The operating model reflects the aspirations within the new Northern Ireland regional adult safeguarding policy as well as best evidence in terms of an emphasis on a prevention approach and only proceeding to a protection approach when serious harm has occurred or is likely to occur. Non-specialist staff would focus on early intervention approaches for adults at risk of harm through HSCT risk assessment processes and targeted services proportionate to need. Specialist safeguarding staff would be best placed to respond when a protection approach is required.
- Through the stepped care approach within the proposed standardised regional operating mode, adults at risk of neglect, abuse and exploitation would experience a more proportionate and effective response and HSCT resources would be more appropriately targeted.

## **Learning disability training**

### **Excel training to support the implementation of data collection following annual health checks for adults with learning disability**

Following on from the development of a revised data collection system to support the work of the HCFs and the annual health check, regional excel training to support the implementation of the system was identified. A half day training session has been planned for September for the HCFs, administration and Heads of Service within learning disability. The training will be delivered by the Leadership Centre. It is hoped at the end of the session participants will be able to extract the significance from a large, detailed data set, produce pivot tables to provide analysis, information tables, graphs etc. from the range of data that has been gathered. It is anticipated the excel sheet will provide key information to support future commissioning of services for adults with learning disability.



## **Guiding principles for personal relationships and sexual health training (for adults with learning disability, parents, carers and staff working with adults with learning disability).**

Regional guidelines on personal relationships and sexual health for adults with a learning disability have been developed by the HSCB in partnership with the PHA, Family Planning Association (FPA) Belfast and the HSCTs. A regional operational protocol has also been developed by the HSCTs. The aim of the operational protocol is to ensure that services for adults with a learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities (standard 15 of The Service Framework for Learning Disability).

HSCB are keen to ensure a regional approach of training for staff to support them with the implementation of the personal relationships and sexual health operational protocol. Funding is currently being explored with the PHA to facilitate the delivery of appropriate training regionally this year.

To support this, guiding principles for personal relationships and sexual health training (for adults with learning disability, parents, carers and staff working with adults with learning disability) have been developed by the HSCB. The guiding principles define values that underpin relationship and sexuality education, to ensure best practice training is being developed and delivered. Quality improvement is a common goal and is central to the development of health and social care services. Guiding principles provide an essential level of quality to ensure safe and effective practice against which performance can be measured.

## **Training in social work**

### **Post qualifying in social work**

In September 2015 saw the start of the post qualifying module 'Evidence informed practitioner and organisation' between HSC organisations in conjunction with Ulster University. The objective of this module is to build the capacity of social workers in understanding and using research to inform professional practice and organisation development in social work. This module has been developed to address the need of professional social work practitioners, managers, trainers, policy-makers, regulators, reviewers and beginning researchers to:

- develop the knowledge and skills in shaping answerable practice and policy questions;
- identify and retrieve relevant research, service evaluations and professional audits;
- appraise the quality of this research and related materials;
- combine findings into a coherent message;
- disseminate conclusions and recommendations effectively in their organisation.



The module is designed to contribute to improving our social work service to service users and carers by improving professional knowledge and skills, service quality and the effectiveness of organisations delivering social care services. Services users and carers have been involved in the academic assessment of the current cohort of participants this is intended to contribute to accessibility of reviews of evidence

### **Launch of the social work research and continuous improvement strategy**

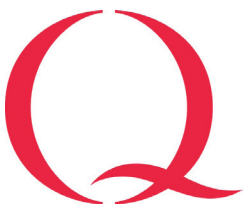
The social work research and continuous improvement strategy was launched in November 2015. A strong evidence base underpinning services is an important hallmark of any profession to build credibility and enhance service user and carer outcomes. To build an organisational culture that recognises the value and contribution of research and evidence and integration at all levels of policy development and practice and will benefit over 5,700 social work staff. The target is all social workers in Northern Ireland. Engagement and involvement of the profession and service users through- out the development of the strategy commenced the building of the necessary cultural shift. A range of outcomes, indicators and associated evidence have been developed to measure what difference we are making across the seven priority areas in the strategy.

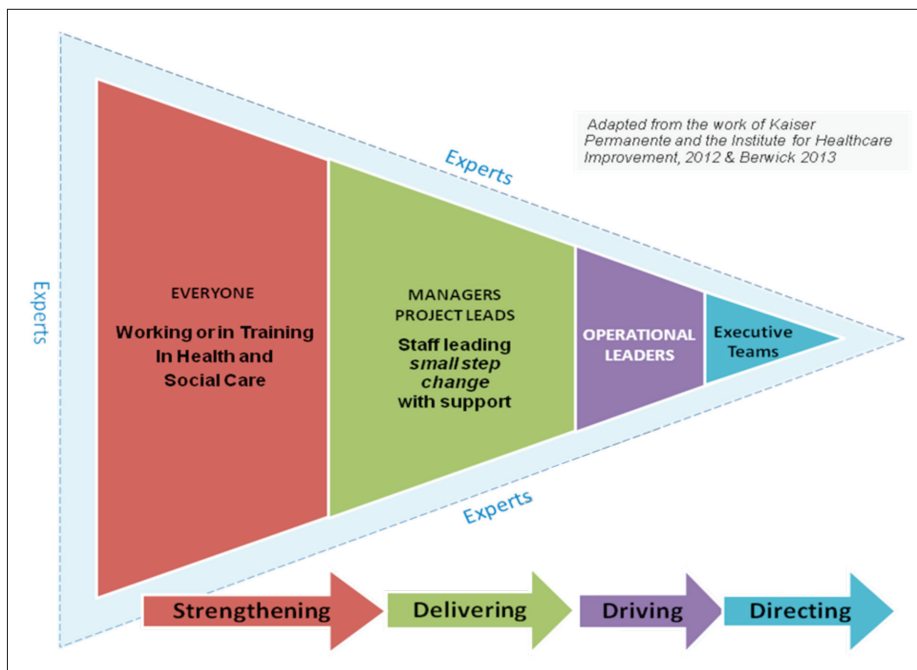
### **HSC quality improvement training**

In 2015/16, The HSC Safety Forum helped to progress several initiatives which support the strategic aims of Quality 2020. This was achieved in partnership with many organisations including DoH, NIPEC, HSCTs, the HSC Leadership centre and the Health Foundation. The initiatives are:

- the Quality 2020 attributes framework; supporting leadership in quality improvement and safety;
- the Improvement Network Northern Ireland;
- the Q initiative.

The attributes framework is now a key driver for quality improvement training of HSC staff across the system. The online training module for level 1 of the attributes framework is now available to all HSC staff.





Locally, the Safety Forum has been building a network of quality improvement enthusiasts in the Improvement Network Northern Ireland (INNI). The network exists to build a community of practice and a shared purpose which will improve care and improve the way we work. Our strengths lie in the size of the region, our shared policies and strategic plans and our ability to influence future strategic direction. INNI recognises that local identity, ownership and belonging is important to people. Every organisation is working to align its improvement resource to serve its purpose and the network is mindful to enable and not distract from this work. The intention is to build on the emerging hubs in each member organisation and to have a network that is the link between and across hubs.

In 2015/16 INNI hosted the inaugural Northern Ireland HSC Safety Forum Awards. Q, an initiative led by the Health Foundation, links people with commitment, experience and understanding of health and social care improvement in the UK in a community. It is anticipated that this community will expand, complimented by local networks in all four nations. In Northern Ireland, the developing local network is INNI. The Health Foundation partnered with the HSC Safety Forum as the regional recruiting body for the HSC. The founding design cohort for Q (2015) had 11 representatives from Northern Ireland, drawn from professions across health and social care.

Q will help accelerate the improvement system within the UK as well as supporting the improvement work of individual members. Q members will be well placed to be local connectors and supporters for other improvers within their locality. Q will also provide opportunities for innovation and the sharing of ideas across professions and perceived boundaries.

## Training for pharmacists

### Health+Pharmacy

Over 120,000 people visit a community pharmacy each day making this the most accessible healthcare venue. It has been recognised that through use of the tremendous interface that pharmacy has with the general public, there is a huge opportunity for engagement around health improvement strategies. We already see this through the large contribution that pharmacies make to smoking cessation. Building on this, HSCB and PHA have been working collaboratively with stakeholders to develop the Health+Pharmacy accreditation process. Health+Pharmacy was formally launched in February 2016 by Minister. Over 200 pharmacies are now going through the process of training and ultimately accreditation which will recognise the commitment of their pharmacies and staff to delivering health improvement activities.



### Practice-based pharmacists

One of the most common interventions in health care is the prescription of a medicine. In Northern Ireland over 39 million prescription items were issued in 2015/16 with a cost of over £400m. HSCB works on an ongoing basis with primary care practitioners to review their prescribing practice, provide advice to support medicines optimisation and provide training in specific therapeutic areas. Each year, HSCB supports the delivery of thirty advanced clinical practice workshops for primary care professionals, focussing in on various disease areas. These are co-facilitated by HSCB pharmacists and secondary care consultants.

For a number of years, HSCB has also commissioned sessional pharmacy support into GP practice. Building on the experience of this sessional pharmacy support, a business case was developed in 15/16 to take forward the development of Practice Based Pharmacists over the next five years. Minister formally launched this initiative in December 2015 and work is underway to recruit the first wave of pharmacists. Their role will be to support the management of prescribing within General Practice to include repeat prescribing, medicines reconciliation, medication review and prescribing within the multidisciplinary team. It is anticipated that there will be improved outcomes for patients through improvements in the quality of prescribing as well as improved resilience within the General Practice team given the pressures there are on the GP workforce currently.

## Personal & Public Involvement (PPI)

### Engage and Involve

As the organisation with lead responsibility for PPI in the HSC, the PHA, working through the Regional HSC PPI Forum, identified the need for



awareness raising and training to help staff to understand and embrace PPI, embedding it into their culture and practice. A PPI programme entitled "Engage and Involve" has now been co-designed with service users and carers.

Engage and Involve is an accessible and practical learning and development programme, aimed at HSC staff. The programme aims to increase awareness and understanding of PPI, stimulate thinking and encourage staff to recognise the value and benefits of engaging with service users and carers, whether that is in commissioning, service development or delivery. The programme has been developed to bring consistency of understanding and approach to PPI in the HSC locally. The Engage and Involve PPI programme consists of:

**PPI e-learning** - An online, self-taught introduction to PPI. Participants are recommended to undertake this training prior to delivering or attending any of the Engage and Involve modules.

**Modular based taught programme** - To facilitate learning based on identified needs. The modules are stand alone and can be chosen according to need. It covers areas such as practical involvement and consultation, facilitation, communication and measuring impact.

## Training and workforce planning for nursing and midwifery

### Delivering care framework

Workforce planning across nursing and midwifery presents many challenges as the largest professional workforce in the NHS responsible for the continuous care provision 24/7 365 days of the year.

*Delivering Care* sets out a framework for commissioners and providers of HSC services for planning, discussing and reviewing the apportionment of planned resources to maximise the potential for the implementation of safer nursing staffing levels in Northern Ireland. The framework currently focuses on a phased approach of implementation within the following areas:

1. General and specialist medical and surgical care hospital settings
2. Emergency departments
3. District nursing
4. Health visiting

The **Phase 1** model has been completed with an agreed staffing ratio/range agreed across Northern Ireland. The implementation has secured recurrent resources to enable HSCTs to meet the required and agreed nurse to bed ratios across medical and surgical wards. Additional senior posts have been secured including the agreement to have ward sisters and charge nurses in a 100% supervisory capacity. The PHA and the HSCB continue to monitor the target with HSCTs and report on progress to the DoH.

In relation to **Phase 2**, Northern Ireland has currently nine EDs across the five HSCTs. The staffing model for core ED has been agreed for phase 2. This reflects the activity, the attendances, the range of presenting need, the influencing factors as they apply to ED, the senior nurse experience and appropriate skill mix. This work has been progressed with completion of a sense check and benchmarking exercise by the HSCB/PHA. The implementation of phase 2 will continue throughout 2016.

**Phase 3** is progressing with consideration being given to the workforce metrics that will be utilised across the region following testing of methodologies. The model for the district nursing workforce will be based a range of data intelligence which will include population requirements, interventions and activity, the development of a 24 hour community nursing model and GP aligned staff. It will incorporate the district nursing team leaders role and the implementation of allocated time to deliver on the key worker role for end of life care.

The proposed model for **Phase 4** health visiting workforce has been progressed taking into consideration the delivering care principles and assumptions as well as the factors impacting on the delivery of the health visiting service for Northern Ireland. The model sets out the key roles of the required workforce in health visiting teams including skill mix, a process for caseload scoring and reflects the delivery of the child health programme for pre-school children, responding to the needs of children with identified needs, safeguarding roles and responsibilities and participation in public health initiatives.

## **General practice nursing framework for Northern Ireland**

### **“Now and into the future”**

The Health Minister, in October 2015, announced the establishment of a DoH led working group to review the issues facing GP-led primary care services and to bring forward recommendations to help address demand for these services. The review of GP-led services highlighted specific challenges, a changing workforce profile and the need for a greater skill mix including nurses in GP practices.

Following discussions with a range of stakeholders it was agreed that a regional commissioning framework for primary care nursing in Northern Ireland was needed, in order to address increasing demands and challenges. The objectives of the framework were as follows:

1. Review the current provision of nursing services, including workforce profile.
2. Consider international evidence and best practice in nursing in primary care.
3. Make recommendations on future model for nursing in primary care to include:
  - a. the range and type of nursing services required to meet current and future anticipated needs;
  - b. educational requirements, skill mix and support to deliver services;
  - c. structures and processes to support revalidation;
  - d. strengthening closer integrated working with nursing colleagues in HSCTs;
  - e. potential impact/opportunities afforded through collaborative initiatives;
  - f. links to strategic and other developments in Northern Ireland which could potentially expand or extend the roles of nurses in primary care.
4. Explore the potential for placement of pre-registration nursing students in primary care settings.

A project steering group and working group were established to oversee and undertake this work in order to ensure there is a complete picture and understanding of this essential nursing workforce and the contribution to primary care services.

The general practice nursing framework for Northern Ireland, ‘Now and into the future’ provides an overview of the scope and developing role of general practice nurses in primary care. The framework is the output of the partnership working with GPs and a range of key stakeholders.

The recommendations and actions are structured within the following themes:

- **Workforce review** and proposed workforce model based on core general practice nursing activities/skill mix.
- **Core competency framework** based on regionally agreed core activities for general practice nurses.
- **Education** requirements and development planning informed by robust needs analysis.
- **Professional governance** and accountability requirements including systems and support structures for NMC revalidation and appraisal.

The steering group has endorsed the framework which will be considered as part of the DoH review of GP-led primary care services.

The key outcomes will assist with the delivery of high quality nurse-led primary care services that are person centred, delivered by a competent workforce, who are supported and developed professionally within primary care.

### **E-learning and assessment tool pilot**

A new innovative e-learning and assessment tool has been developed and piloted with clinicians in Northern Ireland.

The application tested the interpretation of plain X-rays with doctors in training in radiology and in emergency medicine. Each test consisted of 30 plain X-rays and the clinician was given immediate feedback on the results of each test with educational information on where they had not provided the correct answer. Within the test series each clinician received a bespoke test(s) on the body areas which they had incorrectly answered in previous tests and it was demonstrated that each clinician improved their performance in interpreting these films. Over 100 doctors participated in taking weekly tests and the performance scores identified a statistically significant improvement in performance over the test series.

Another workstream in the pilot developed a cardiotocography (CTG) interpretation algorithm using the NICE Intrapartum Guidance, December 2014. The clinical group from all HSCTs involved obstetricians and midwives in the development of the decision tree interpreting the NICE guidance, and workshops involving 80 clinicians were held to test the methodology, to test the software and inform further development of the system.

A qualitative evaluation undertaken described the significant value of this approach to learning and assessment across all three workstreams with comments that the bespoke tests were equivalent to an individual tutorial for the clinician. This process also identified potential new areas for development of similar applications.

The pilot concluded in 2015/16. Discussions are in progress regarding securing a funding stream to support the mainstreaming of the current applications and the development of new applications on a regional basis.



## Theme three:

# Measuring improvements

### Performance against standards and targets

On an annual basis the Health Minister sets out commissioning plan direction (CPD) targets and standards which represent particular areas of focus for the coming year. The Minister's vision for the integrated HSC system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment care and support. Performance against these standards and targets is reported on monthly basis to the public HSCB meeting. During 2015/16 a number of these areas have represented a significant performance challenge and the HSCB and PHA have worked closely with HSCTs to improve performance by using accredited improvement techniques and ensuring that best practice resulting in high performance in some HSCTs is shared and implemented in others. Examples of this work are outlined below.

#### Cancer

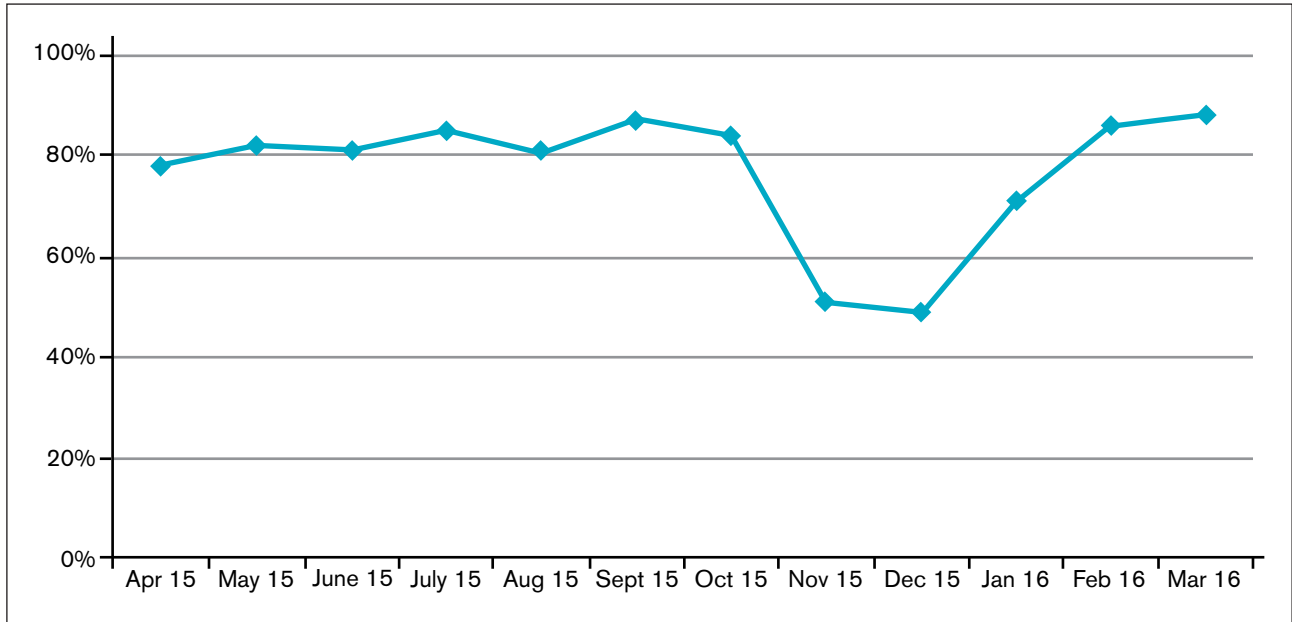
The percentage of urgent breast cancer referrals seen within 14 days deteriorated during the quarter from October 2015 to December 2015. The reasons for the include staffing challenges in a number of HSCTs and a significant increase in urgent referrals for suspected breast cancer, in particular following Breast Cancer Awareness month in October.

In order to respond to this position, the HSCB worked closely with the relevant HSCTs to put a range of measures in place including additional evening and weekend clinics to address the backlog of patients waiting. The HSCB also allocated additional funding to allow the recruitment of more staff to better respond to the higher level of demand.

As a result of this collaboration, performance improved significantly during the final quarter of 2015/16.

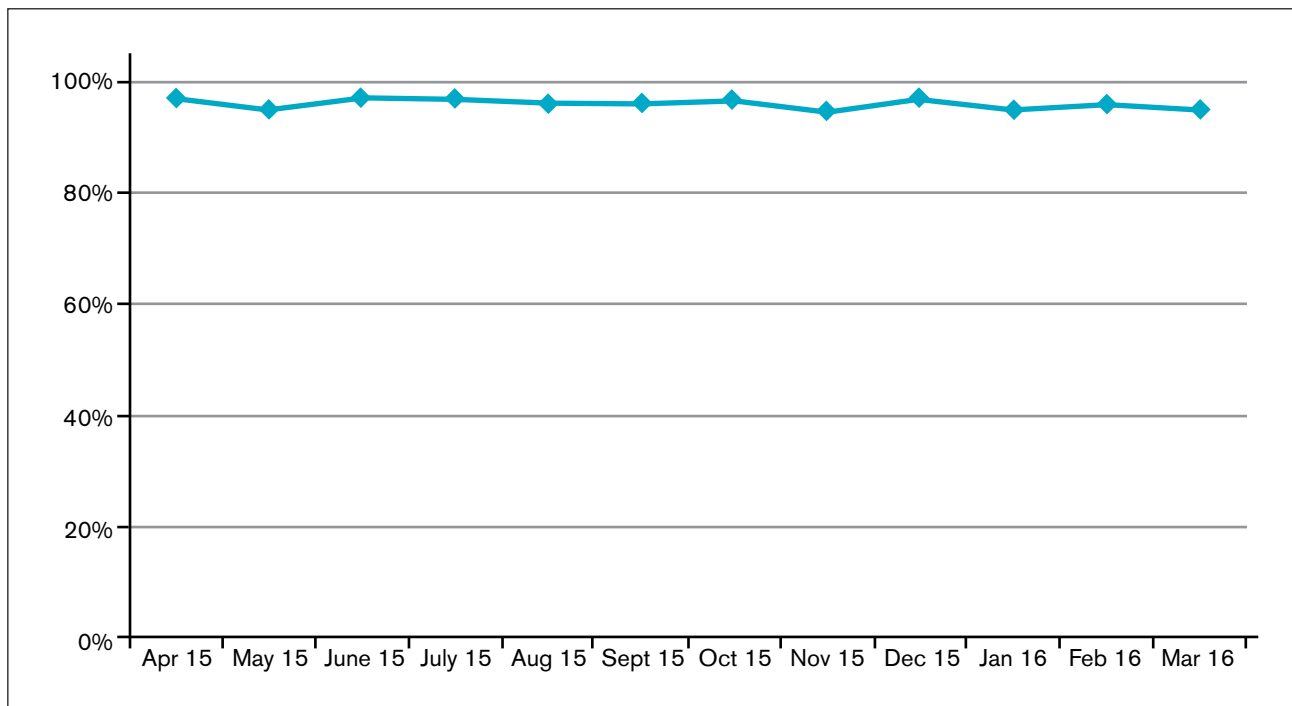


**Figure 1: % of patients seen within 14 days of an urgent referral for breast cancer**



Furthermore, performance against the 31-day cancer access standard has continued to be strong – regionally during 2015/16, 96% of cancer patients commenced treatment within 31 days of the decision to treat (CPD standard: 98%).

**Figure 2: % of cancer patients who commenced treatment within 31 days of the decision to treat**

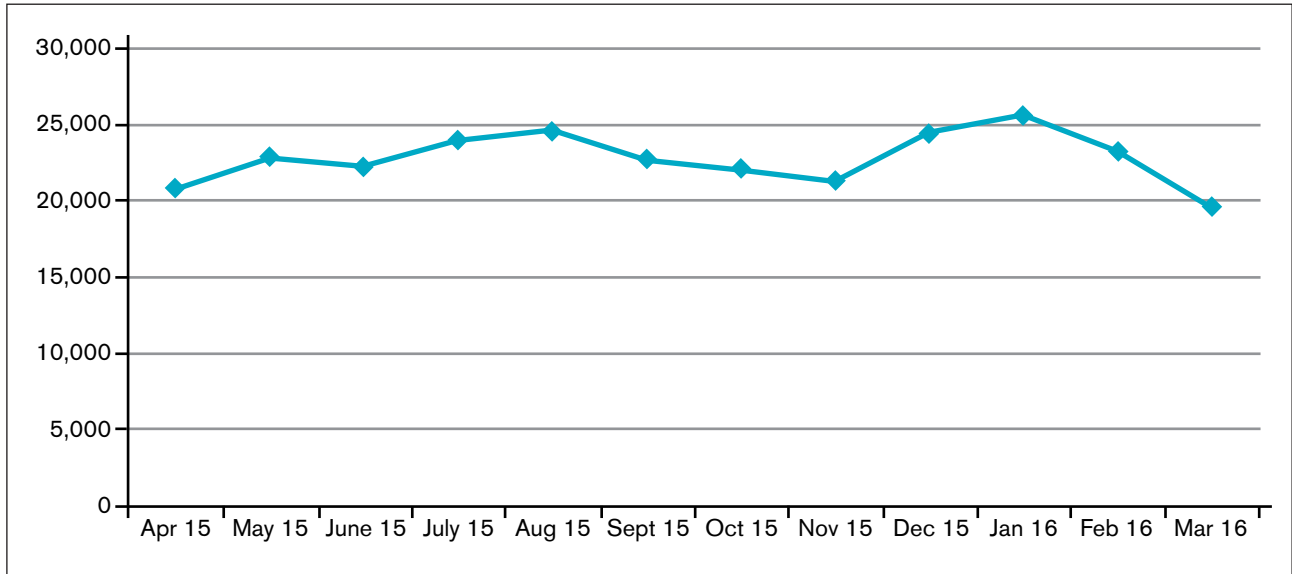


## Diagnostics

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the HSCB prioritised the allocation of the funding available at the start of 2015/16 for elective care for diagnostics. As a result, the waiting time position remained broadly steady during the first eight months of the year.

The length of time patients waited for a diagnostic test improved during the final quarter of 2015/16 as a result of the impact of the additional activity associated with the non-recurrent funding allocated in November 2015. Furthermore, the HSCB has confirmed the allocation of non-recurrent funding to HSCTs to continue to undertake additional activity in the first half of 2016/17 to maintain and, where possible, improve upon the March 2016 waiting time position.

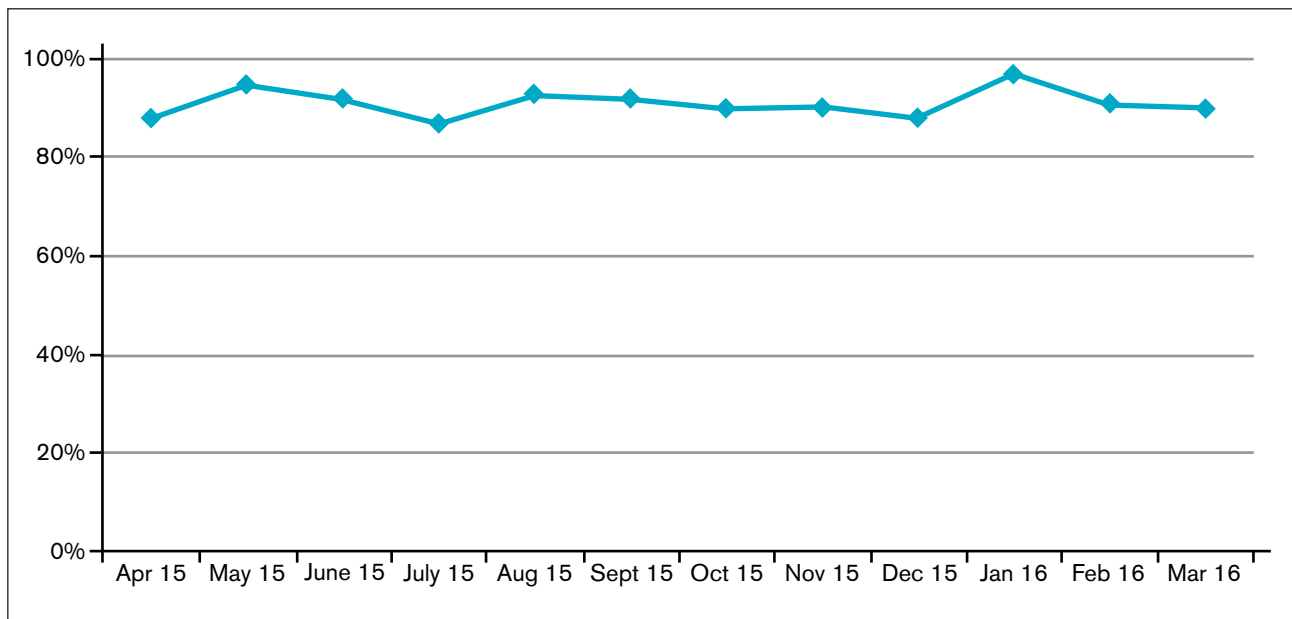
**Figure 3: Diagnostic waiting times**



### Hip fractures

Regionally during 2015/16, 91% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (CPD standard: 95%). This represents an improved position from 2014/15 when 89% of patients were treated within 48 hours.

**Figure 4: % of patients receiving treatment for hip fractures within 48 hours**

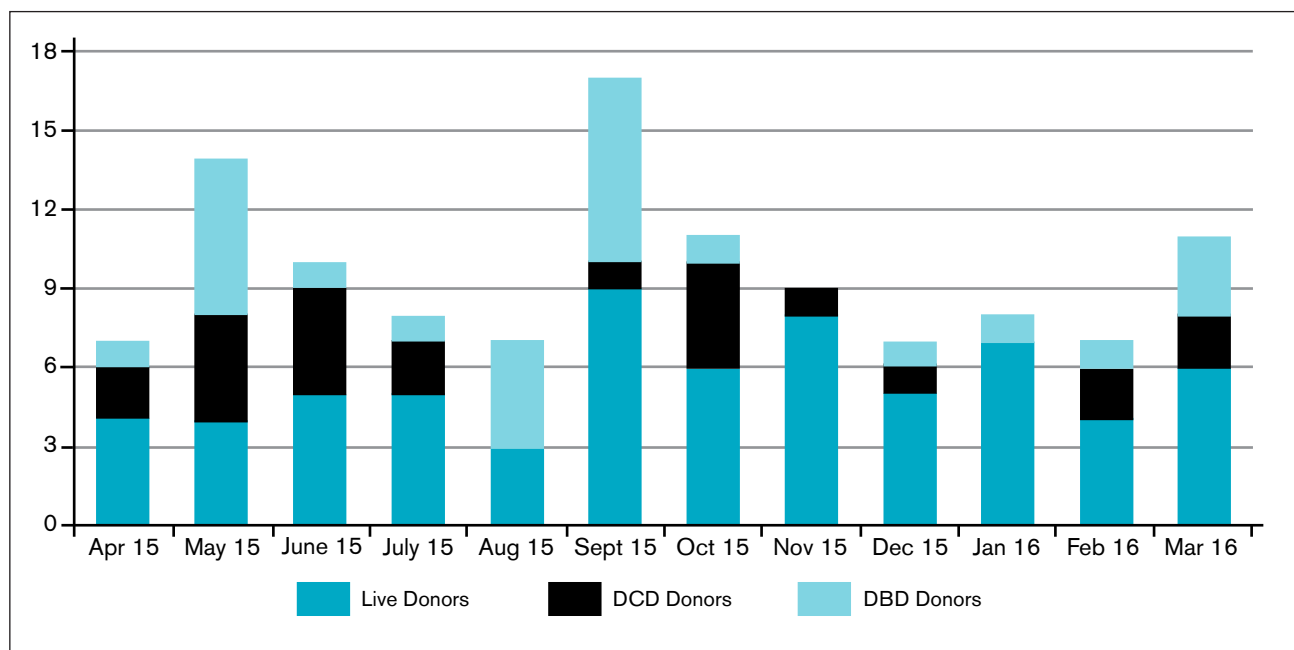


To improve the quality of access for the residents Newry and Mourne area of the Southern LCG, the HSCB has made significant investment in the trauma and orthopaedic team in the SHSCT. As a result of this investment all hip fracture patients in the SHSCT area will be treated locally rather than being transferred to Belfast.

## Organ transplants

During 2015/16, a total of 116 kidney transplants, including live, DCD (donation after cardiac death) and DBD (donation after brain death) donors were delivered in Northern Ireland. This is an increase on the number of transplants delivered in 2014/15 (98).

**Figure 5: Organ transplants**



## Quality assurance and quality improvements for population screening programmes

Population screening actively seeks to identify disease, or pre-disease conditions, in people who believe themselves to be well in relation to the disease or condition being screened for. The aim is to reduce the risk of future ill health through the provision of information and/or treatment.

Population screening programmes are complex systems of care, which comprise multiple elements. These include: policy setting; equipment procurement; staff training; quality assurance; identifying and inviting eligible people; information management; public and professional communication; taking and reading tests; follow-up and failsafe; diagnosis and intervention. Screening is a programme: not just a test.

The PHA is responsible for the quality assurance and commissioning of a number of antenatal, newborn and adult screening programmes. These are listed below.

### **Antenatal and newborn screening programmes:**

- Antenatal infection
- Newborn blood spot
- Newborn hearing

### **Adult screening programmes:**

- Abdominal aortic aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic eye retinopathy

Quality assurance is an integral part of screening because screening can cause harm; as well as benefit. It helps to maximise the benefits and minimise harms. The aim of quality assurance in screening is to maintain acceptable standards and continuously improve the quality of the programmes. Each screening programme has a quality assurance structure which monitors the performance of the service and facilitates continuous quality improvement. This usually takes the form of a quality assurance committee, coordinating group or quality improvement group chaired by a consultant in public health. Examples of quality assurance activity include: regular monitoring of performance against national standards; benchmarking local performance against performance in other UK countries; audit; participant satisfaction surveys; quality improvement activities; multidisciplinary quality assurance visits; the production of quality assurance reports; follow-up meetings; shared learning and training.

### **Quality assurance visits undertaken in 2015/16**

#### **AAA screening:**

- Belfast HSCT - October 2015

#### **Bowel screening:**

- Northern HSCT - November 2015

#### **Breast screening:**

- Belfast HSCT - May 2015
- Western HSCT- December 2015

## Screening programme performance

The following tables indicate that for the majority of screening programmes, key standards and targets are being met or exceeded. Work to promote informed choice about population screening programmes has been taken forward at HSCT level and regionally. This includes work to reduce barriers to accessing screening programmes and promote equality of access.

**Table 2: AAA screening data for 2015/16**

Pathway standard	Acceptable	Achievable	2015/16 position
Uptake (initial screening) Percentage of subjects offered screening who are tested	≥ 75%	≥ 85%	83%
Timely referral Percentage of men with AAA > 5.5cm referred within one working day	≥ 95%	100%	100%
Timely treatment/intervention by specialist (measured from date of referral) Percentage of men with aorta > 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within eight weeks	≥ 60%	≥ 80%	80%
Post-operative mortality (assessed annually) 30 day mortality following elective AAA surgery	≤ 6%	≤ 3.5%	0%

**Table 3: Breast screening data for 2014/15**

Measure	Standard/target/comparative data	Outcome
Uptake	Minimum standard >70%	75.3%
	Target 80%	
Round length	Minimum standard >90% first offered appointments within 36 months of previous screen	97.4%
	Target 100%	
Invasive cancer SDR*	Minimum standard >1.0 Target >1.4	1.3

\* The standardised detection ratio (SDR) measures the ratio of screen detected invasive cancers to the number expected (if the screening programme was detecting invasive cancers at a similar rate achieved by the Swedish two county randomised controlled trial).

**Table 4: Bowel cancer screening uptake data for 2014/15**

Measure	Standard/target/comparative data	Outcome
Uptake	55% (2014/15 commissioning directions target)	56.8%

**Table 5: Cervical screening coverage data for 2014/15**

Measure	Standard/target/comparative data	Outcome
5 year coverage	80%	77.1%

**Table 6: Diabetic retinopathy uptake data for 2014/15**

	Total Invited	Total Attended	Outcome
Northern Ireland	60562	45118	74%

**Table 7: Antenatal screening data for 2014/15**

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

**Table 8: Newborn blood spot screening data 2014/15 (most recent data available)**

Measure	Standard/target/comparative data	Outcome
Timely sample collection	95% of first samples taken 5-8 days after birth	98.50%
Timely processing of screen positive samples (PKU, CHT and MCADD)	100% of positive screening results available and clinical referral initiated within four working days of sample	PKU – 100% CHT – 100% MCADD – 100%
Coverage (% of babies, born in and still resident, who have a conclusive test result recorded on CHS by 17 days of age)	Greater than or equal to 95% for all tests	PKU – 99.2% CHT – 98.3% MCADD – 99.2% CF – 99.1% SCD – 99.2%

**Table 9: Newborn hearing screening data for 2015/16 (quarter 2)**

<b>Measure</b>	<b>Standard/Target/comparative data</b>	<b>Northern Ireland</b>
Coverage by 4 weeks of age (the proportion of babies eligible for newborn hearing screening for whom the screening process is complete)	Minimum 95.0% Achievable 99.5%	95.80%
Coverage by 3 months of age (the proportion of babies eligible for newborn hearing screening whom the screening process is complete by 3 months of age)	99.00%	98.70%

## Improving antibiotic prophylaxis in caesarean section

A relatively high proportion of pregnant women in Northern Ireland are delivered by caesarean section (C-section) - 29% of all deliveries in 2013/14 equating to 7,250 women. Up to 8% of women who have a C-section will develop a postoperative infection (580 per year in Northern Ireland). There is a strong evidence base for the use of antibiotic prophylaxis to reduce the risk of postoperative infection in a number of surgical procedures, including C-section. NICE issued an updated clinical guideline, CG 132, on C-section in November 2011. This guideline was endorsed for implementation in Northern Ireland in November 2012.

The PHA established a small working group to review current practice across all obstetric units in Northern Ireland and to guide implementation of CG 132. Using information captured through our regional C-section surgical site infection (SSI) surveillance programme, we completed a baseline audit of practice in provision of antibiotic prophylaxis during C-section delivery. We examined choice of antibiotic used for prophylaxis and timing of antibiotic administration. We used our audit findings to inform and influence change across all obstetric units and discussed and planned change with key service providers. We supported all HSCTs as they refreshed their approach to C-section prophylaxis. Using our regional SSI surveillance programme to inform two further audits of practice, we monitored patient outcomes as CG 132 was implemented over a two year period.

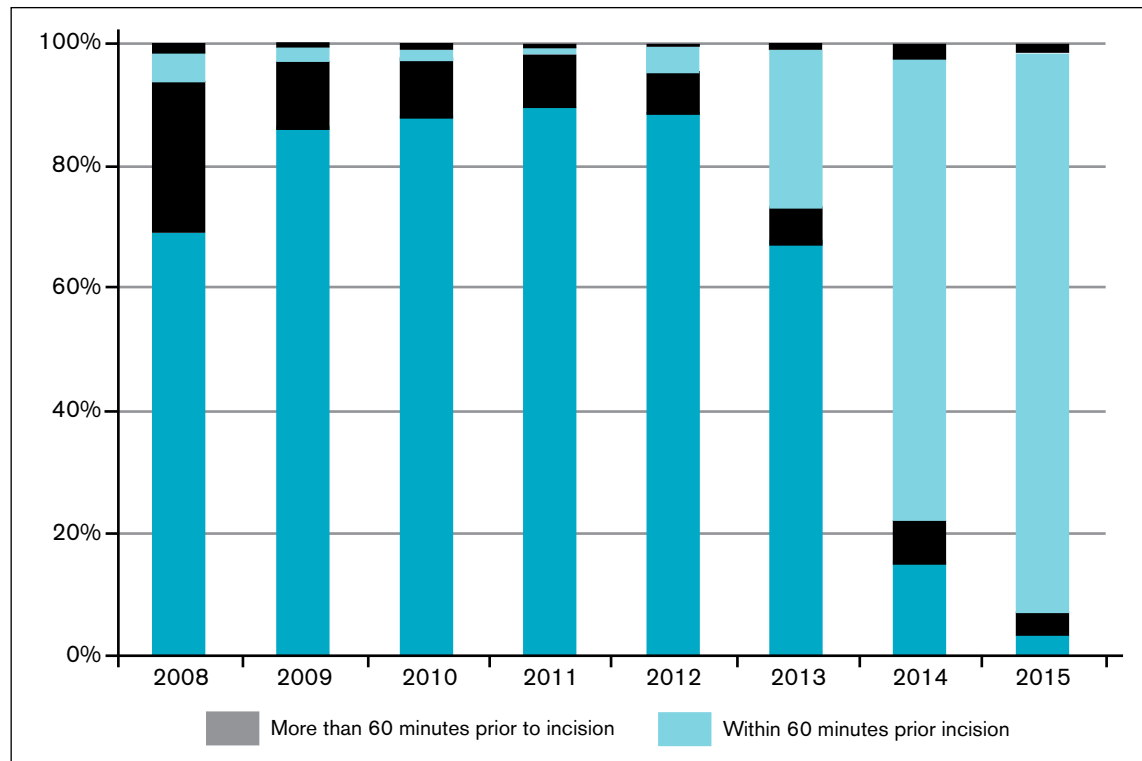
By June 2015 all HSCT hospitals performing C-section moved to implementing the NICE CG 132 (Table 1). In 2013 Co-amoxyclav was the antibiotic of choice for prophylaxis in 65% of C-section deliveries. Timing of prophylaxis was predominantly after cord clamping (65% of C-sections), reflecting the antibiotic of choice (Charts 1 & 2). As we supported all HSCTs to implement CG 132 between 2013 and 2015, we documented (through our regional C-section SSI surveillance programme) a change in practice across all obstetric units. By 2015 we had successfully influenced a change in the antibiotic of choice for prophylaxis, with Cefuroxime used in 90% of C-section deliveries. Linked to this change in antibiotic of choice, we documented a change in timing of administration, with almost all prophylaxis for C-section now administered prior to skin incision (Charts 1 and 2).

Over a two year period all HSCTs implemented NICE CG 132 and changed their practice in antibiotic prophylaxis. Surveillance information captured through our regional C-section SSI programme was key to informing baseline activity and to monitoring changes in practice associated with implementation of CG 132 across all obstetric units. Through our SSI programme we demonstrated this change in practice did not adversely affect patient outcomes. Our regional rate of post-discharge C-section SSI continued to show improvement, reducing from 9.6% to 6.2%. Our regional rate of in-hospital C-section SSI remained low (0.4%).

**Table 10: Hospitals implementing NICE Clinical Guideline 132 on caesarean delivery**

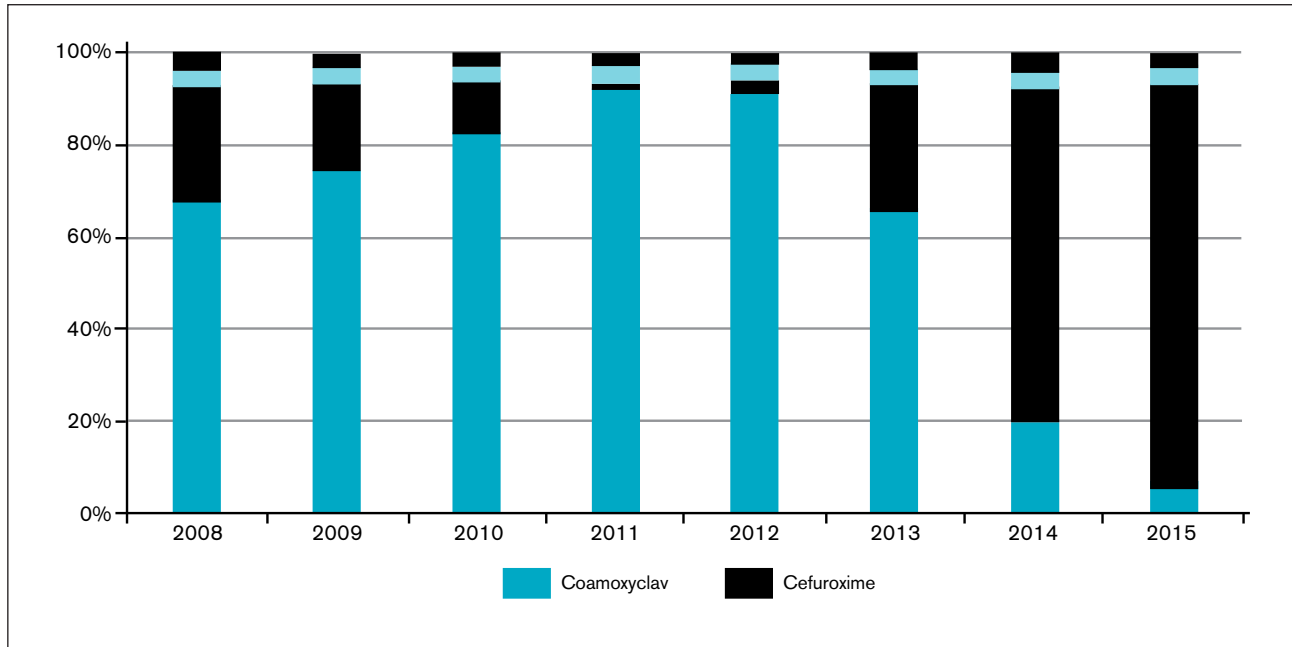
Hospital	Q4 12	Q1 13	Q2 13	Q3 13	Q4 13	Q1 14	Q2 14	Q3 14	Q4 14	Q1 15	Q2 15
Ulster	*	*	*	*	*	*	*	*	*	*	*
Craigavon area				*	*	*	*	*	*	*	*
Daisy Hill				*	*	*	*	*	*	*	*
RUMS					*	*	*	*	*	*	*
Antrim Area						*	*	*	*	*	*
Causeway							*	*	*	*	*
Altnagelvin								*	*	*	*
South West Acute											*

**Chart 1: Timing of antibiotic prophylaxis in caesarean delivery (2008 – 2015)**





**Chart 2: Antibiotic prophylaxis agent use caesarean delivery (2008 – 2015)**



## Quality improvement plans

The quality improvement plans are focused on key priority areas to improve the outcomes for patients/clients. HSCTs report on a number of indicators each quarter to the HSCB and PHA.

Last year we focused on:

1. Pressure ulcer prevention
2. Falls prevention
3. VTE risk assessment
4. The 'Malnutrition Universal Screening Tool' (MUST)
5. NEWS (National Early Warning Scores)
6. Omitted and delayed medications

### Pressure ulcer prevention

While some pressures ulcers are unavoidable, many are preventable. The principal regional focus for 2015/16 was on the reduction of Grade 3 and 4 pressure ulcers. During last year the HSCTs implemented a process for carrying out root cause analysis (RCA) on all Grade 3 and 4 pressure ulcers, in conjunction with the roll out of the SKIN bundle.

**Table 11: Regional rates and numbers of Grade 3 and 4 pressure ulcers, alongside HSCT rates by quarter and the number of avoidable pressure ulcers**

Trust	No. of Grade 3 & 4 Pressure Ulcers					Rate of Grade 3 & 4 Pressure Ulcers per 1,000 Occupied Beddays				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	26	26	15	15	82	0.16	0.16	0.09	0.09	0.13
NHSCT	13	11	11	12	47	0.17	0.15	0.14	0.15	0.15
SEHSCT	9	11	7	9	36	0.12	0.15	0.09	0.12	0.12
SHSCT	3	2	2	8	15	0.05	0.03	0.03	0.11	0.06
WHSCT	5	3	5	5	18	0.07	0.05	0.07	0.07	0.07
<b>REGION</b>	<b>56</b>	<b>53</b>	<b>40</b>	<b>49</b>	<b>198</b>	<b>0.12</b>	<b>0.12</b>	<b>0.09</b>	<b>0.11</b>	<b>0.11</b>

**Table 12: Number of avoidable Grade 3 and 4 pressure ulcers**

Trust	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	9	16	1	8	<b>34</b>
NHSCT	3	4	4	7	<b>18</b>
SEHSCT	2	1	3	1	<b>7</b>
SHSCT	1	0	0	2	<b>3</b>
WHSCT	5	2	3	4	<b>14</b>
<b>REGION</b>	<b>20</b>	<b>23</b>	<b>11</b>	<b>22</b>	<b>76</b>

The reported regional pressure ulcer incidence rates for Grade 3 and 4 ranges between 0.6% and 0.15% per 1000 bed days.

There are a number of individual hospital trusts in England report pressure ulcer incidence rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. In March 2016 the reported pressure ulcer incidence rates for these trusts range between 0 - 1.69% per 1000 bed days. It should be noted that this initiative uses incident rates to compare improvement overtime, but not for the purpose of comparison between trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

## Falls

The 2015/16 commissioning plan requirement stated: "HSCTs will continue to improve compliance with Part B of the 'Fallsafe' Bundle. HSCTs will spread the regionally agreed elements of Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented. HSCTs will monitor and provide reports on bundle compliance, the number of incidents of falls, those which cause moderate or more severe harm and the rate per 1,000 bed days."

**Table 13: Total number of falls recorded, the number resulting in harm of a moderate/severe nature and the moderate/severe rates per 1,000 occupied bed days**

Trust	Measure	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16
BHSCT	No. Falls	566	533	584	646	<b>2329</b>
	No. Moderate / Severe Falls	20	23	13	19	<b>75</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.12</b>	<b>0.14</b>	<b>0.08</b>	<b>0.11</b>	<b>0.11</b>
NHSCT	No. Falls	443	432	424	368	<b>1667</b>
	No. Moderate / Severe Falls	18	20	5	8	<b>51</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.24</b>	<b>0.27</b>	<b>0.07</b>	<b>0.10</b>	<b>0.17</b>
SEHSCT	No. Falls	388	445	403	370	<b>1606</b>
	No. Moderate / Severe Falls	15	17	9	5	<b>46</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.20</b>	<b>0.23</b>	<b>0.12</b>	<b>0.06</b>	<b>0.15</b>
SHSCT	No. Falls	267	251	270	235	<b>1023</b>
	No. Moderate / Severe Falls	12	9	16	23	<b>60</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.18</b>	<b>0.14</b>	<b>0.24</b>	<b>0.33</b>	<b>0.22</b>
WHSCT	No. Falls	328	298	414	388	<b>1428</b>
	No. Moderate / Severe Falls	20	17	11	0	<b>48</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.29</b>	<b>0.26</b>	<b>0.16</b>	<b>0.00</b>	<b>0.17</b>
REGION	No. Falls	1992	1959	2095	2007	<b>8053</b>
	No. Moderate / Severe Falls	85	86	54	55	<b>280</b>
	<i>Moderate / Severe Falls Rate</i>	<b>0.19</b>	<b>0.20</b>	<b>0.12</b>	<b>0.12</b>	<b>0.16</b>

For 2015/16 the reported regional outcome measure for rates from falls resulting in moderate to severe harm are 0.11 to 0.22 per 1000 bed days.

There are a number of individual hospital trusts in England report falls resulting in moderate to severe harm rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. In March 16 the reported moderate to severe harm for falls incidence rates for these HSCTs range between 0.08 – 0.21% per 1000 bed days. It should be noted that this initiative uses incident rates to compare improvement overtime, but not for the purpose of comparison between HSCTs as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

A thematic review of SAIs relating to patients with a fall resulting in moderate to severe harm was carried out in 2015/16. It was evident from the review that there is regional variation in the approach to reporting, investigation, and in identification of learning from these incidents, therefore resulting in potential missed opportunities to prevent harm. In recognition that this is a significant area of risk to patients, there is a recommendation to introduce a different method of reporting which puts in place a consistent regional post falls review evaluation process. This work is being led by the regional falls group which is chaired by the lead nurse for quality and safety and patient experience in the PHA, with a focus on quality improvement, safety and learning.

### **VTE risk assessment**

The 2015/16 commissioning plan states: “HSCTs will sustain 95% compliance with VTE risk assessment across all adult inpatient hospital wards throughout 2015/16.” While all HSCTs have reported progress towards the 95% target for compliance of the VTE risk assessment, no HSCT has met this during any quarter of 2015/16. All HSCTs have reported challenges with achieving this target but there has been a small improvement noted since last year.

The compliance with the VTE bundle from April to March 2014/15 was between 77-88% compliance, whereas the regional compliance range for 2015/16 was between 88-92 % with a small but steady progress noted for each HSCT each quarter. Regionally during 2015/16 there were 27,067 audits undertaken with 24,285 compliant – this equates to percentage compliance throughout the year of 90% for the region. All HSCTs have spread the risk assessment to 100% of required areas.

### **The ‘Malnutrition Universal Screening Tool’ (MUST)**

The 2015/16 commissioning plan requirement states: “% compliance of the completed MUST tool within 24 hours admission to hospital in all adult inpatient wards by March 2016.” By quarter 4 in 2015/16 there was a regional percentage compliance of 94% with MUST.

Spread of the MUST tool has been consistent at 100% for each HSCTs during each quarter in 2015/16.

## **NEWS (National Early Warning Scores)**

The 2015/16 Commissioning Plan requirement states: “% compliance with accurately completed NEWS charts.” Regionally the % compliance has increased each quarter over the year.

Spread of the NEWS tool has reached 100% for each HSCT at the end of the final quarter for 2015/16.

## **Measuring improvements from complaints**

The Regional Complaints Sub-Group (RCSG) meets on a bi-monthly basis and is chaired by the HSCB Complaints and Litigation Manager. Membership comprises professional representatives from HSCB, the PHA and Patient and Client Council (PCC). Improvements have been made in several areas as a result of complaints.

## **Do Not Attempt Resuscitation (DNAR)**

Complaints relating to DNAR and the communication/lack of communication of such decision(s) to patients and/or families continue to feature in monitoring returns received from the HSCTs. A failure around communication on DNAR decisions has also been the subject of a recent Royal College of Physicians Audit. The relevant professional representative on the RCSG reviewing these complaints has ensured that relevant information from the monitoring returns has contributed to informing the development of the Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Operational Policy, which is currently in draft form.

## **Enhancement of communication between Allied Health Professionals and parents**

Relevant information from complaints is discussed at the Allied Health Professionals (AHP) governance meetings. The need for enhanced communication between the health and education sectors and parents has been identified from complaints and within a review of AHP support for children with statements of special educational needs. A plan is in place to revise the format of how therapy programmes will be provided to children requiring access to occupational therapy services.

## **Dementia**

During 2015/16 complaints relating to patients with a dementia have been shared with relevant professionals. The information and experiences of patients and their families derived from complaints demonstrate initiatives that have been undertaken by some HSCTs in relation to the discharge arrangements for patients with a dementia, and the mechanisms in place to enable families and carers to spend more time with their loved ones in hospital. In addition the information has contributed to the development of the Northern Ireland Dementia Learning & Development Framework. The strategy promotes early assessment and diagnosis; helps to raise awareness in providing information and support to families, and has overseen the introduction of ‘navigators’ to work with patients and their families.

## **Family Practitioner Services complaints**

### **General Medical Practice**

- Complaints from patients regarding removal from their GP Practice list due to a breakdown in the doctor/patient relationship, as a result of verbal or physical abuse by the patient towards staff, still feature relatively frequently. While the removal has been justified and in accord with the zero tolerance policy, on occasions Practices have been over-reliant on this policy and failed to fully comply with the GMS (NI) contract when removing the patient. Subsequently, this has resulted in findings of maladministration by the Ombudsman.

When presenting at Practice Managers' Forums, Board complaints staff continue to emphasise the importance of compliance with these regulations and on occasions have re-circulated, to individual Practices, anonymised sections of an Ombudsman investigation report concerning this matter; highlighting the failings that were identified and the specific requirements the Practice is required to fulfil when removing a patient under these circumstances.

- As a result of a complaint regarding, amongst other issues, the lack of contact from the GP Practice with the family following the death of patient suffering from cancer, the GP Practice conducted a Significant Event Analysis. The Practice, while cognisant that time constraints prohibited a home visit in every case, agreed in future to review all deaths within the Practice and seek to respond sensitively and sympathetically in all cases, potentially making use of a standardised 'sympathy card'.

### **Maternity and gynaecology**

- A number of complaints regarding pregnant patients presenting at Emergency Departments (ED) with reduced foetal movements were discussed at the RCSG. Following receipt of an SAI investigation into one of these incidents, a reminder of good practice letter was issued to HSCTs to ensure that patients are assessed by obstetrics prior to discharge.
- A patient complained that she and her unborn baby were not treated with dignity and respect within an Early Pregnancy Unit. She felt that there was poor communication with her, no understanding by staff of what was happening, she was not listened to when she indicated she was experiencing labour pains, and was upset by comments made by a nurse.

As a result of this complaint a number of improvements have been made by the HSCT. These include additional training for staff when caring for a patient who has had a miscarriage, including bereavement care. In addition (early pregnancy) baby pouches, blankets and 'Moses' baskets have been introduced within the unit to preserve the dignity of the baby. Arrangements are also in place to ensure that community midwives are aware of circumstances when they receive referrals following miscarriage.

## **Stroke assessment**

A patient was discharged home following attendance at an ED having had a neurological assessment undertaken, which was normal. The patient returned to the ED later that day with similar symptoms. As a result of this complaint, the HSCT has advised ED staff that where a FAST assessment has been undertaken, and a normal neurological assessment presents, should symptoms persist, it is important not to rule out the possibility of a further CVA event by undertaking a repeat FAST assessment.

## **GP out of hours**

A complaint was received from a relative of a patient who attended GP OOHs with cardiac symptoms. The patient was assessed by the doctor but unfortunately died less than two hours later. Guidance was issued to doctors within the OOH Practice to ensure ECG tests are undertaken, when a patient presents with/advises of a history of chest discomfort

## **Service frameworks**

### **Respiratory**

The original respiratory service framework underwent a formal revision process in 2014, and following consultation, the revised version of the framework, which covers the 3-year period 2015/16 – 2017/18, was formally approved by DHSSPS in September 2015.

The revised RSFW recognises that several diseases can co-exist, share common risk factors and can adversely impact on prognosis; therefore the revised service framework includes both standards for specific respiratory conditions, as well as standards relating to all respiratory conditions, and also generic standards relating to a range of conditions. There are a total of 46 standards for the whole care pathway for respiratory diseases from prevention through diagnosis, treatment, ongoing care, rehabilitation to palliative and end of life care. Each standard is supported by a number of key performance indicators (172 in total), which set levels of performance to be achieved over the three-year period.

Implementation of the revised RSFW is overseen by the Regional Respiratory Forum. The membership of the Regional Respiratory Forum and the terms of reference have both been revised to meet the need of the implementation of the revised Respiratory Framework. A detailed implementation plan has been developed which sets out arrangements for how the revised respiratory framework will be implemented across the region.

A baseline assessment exercise has recently been completed, which assessed each HSCT's ability to be able to measure progress and report against the framework standards. This exercise was then followed up with HSCT visits to each of the five HSCTs in May 2016, where key HSCT respiratory clinical and managerial leads were able to meet with PHA/HSCB colleagues to discuss implementation of the framework and any issues and concerns with regards to performance and information systems. The Respiratory Forum in collaboration with HSCTs and all other stakeholders is working to gather information to develop a formal end of

year 1 report which will be submitted to DoH by September 2016. The revised Framework will continue to be subject to regular review and refinement, to ensure it provides a sound basis for continued improvement in the quality of health and social services.

## **Cancer**

The *Service Framework for Cancer Prevention, Treatment and Care* (abbreviated to Cancer Service Framework) was published in 2011. It set out 52 standards for cancer that specifically focussed on prevention, diagnosis, treatment, care, rehabilitation and palliative care and outlined the anticipated levels of performance over a three year period.

The framework standards have been substantially achieved and the framework document is currently being revised to take account of the latest evidence base and advances in diagnostic and treatment technologies.

The revised document will build on the existing draft and will explicitly identify standards and indicators. This amended document will be a 'Cancer Services Indicator Framework' and is expected to be published by the PHA/HSCB by October 2016.

## **Cardiovascular**

Following an extensive review, a revised Cardiovascular Service Framework was published in 2014. The framework comprises 42 standards and over one hundred key performance indicators, in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of the individuals and communities who currently have, or are at greater risk of developing, cardiovascular disease. A Cardiovascular Service Framework Implementation Group was convened in 2014 and 6 Section Leads appointed for each of the condition-specific sections: vascular; renal; cardiology; stroke; research & development and medicines management. Progress reports are produced annually, with an interim report produced mid-year. The progress report for year 1 of the framework (2014-15) was issued to DoH in autumn 2015. As with many of the frameworks, problems have been encountered with developing data sources, difficulties with IT systems and gaining access to datasets.

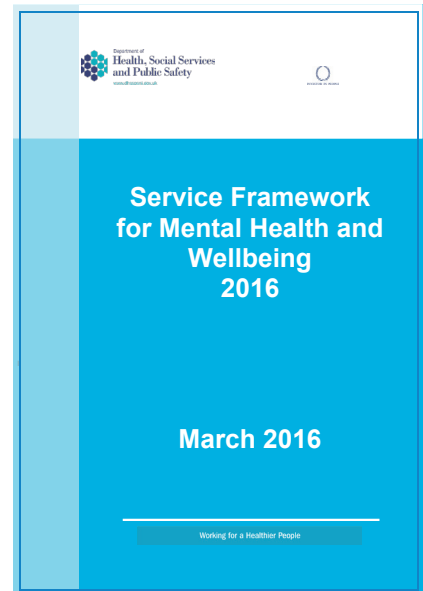
Although data could not be provided for all the anticipated indicators, key achievements include:

- Targets were exceeded for the indicators relating to peripheral artery disease in terms of management with anti-platelet medication and blood pressure readings and cholesterol levels within acceptable levels.
- An e-alert system is now in place, which flags inpatients at potential risk of acute kidney injury requiring clinical review and intervention as appropriate.



## **You In Mind mental health services framework**

The aim of the revised Service Framework for Mental Health and Wellbeing (draft) is to provide guidance on the steps of mental health care to be delivered by HSCTs. It is designed also to enhance the quality of service experience and promote consistency of service delivery across Northern Ireland. The *“You in Mind Mental Health Service Framework”* was the first framework to be co-produced with people with lived experience alongside carers, professionals, voluntary sector agencies, HSCB, PHA and DoH staff. The new framework sets out the standards of care that individuals, their carers and wider family can expect to receive from the HSC system. It is an agreed way of providing care which enables the development of a whole system model for mental health care delivery across the North of Ireland. The new framework enables mental health services to profile need, sets out the range and scope of evidence based interventions provided across mental health services and facilitate the systematic measurement of clinical and care outcomes of citizen experience.



The revised Service Framework for Mental Health and Wellbeing 2016 reflects the principles and values of the 'You In Mind' Regional Mental Health Care Pathway and contains 10 key standards which are supported by 25 Clinical Care Indicators and 21 Citizen based indicators. The framework not only provides a mechanism to audit the 'You in Mind' care pathway but represents a key reference point for all staff in the implementation and promotion of quality across mental health care services. The framework has also led to the establishment of The You in Mind Mental Health Informatics Project for Northern Ireland. This has resulted in the development of an innovative managed care data framework based on the Institute for Healthcare Improvements' Triple Aim Quality Indicators. The aim of the project is to design and test electronic solutions for mental health care which when implemented will deliver routine evidence for the HSC system in Northern Ireland which will allow us to know how we are doing in delivering mental health care.

## **Learning disability**

The aim of the Learning Disability Service Framework (LDSFW) is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion and reducing inequalities in health and improving the quality of care. There are 34 standards and 85 KPIs in the Service Framework for Learning Disability

Year 1 focused on establishing a baseline for the indicators using a range of audit tools. An excel sheet outlining the baseline position as of 31 March 2015, for each of the five HSCTs, HSCB and PHA is complete. Monitoring templates are currently with the five HSCTs to provide data for 2015-2016. The monitoring data being gathered will allow performance levels for 2016-2017 and 2017-2018 to be agreed and developed with the HSCTs. The monitoring data will also help identify areas where change in practice is required.

Key outcomes to date:

- 77% of the files audited during case note review demonstrated evidence that people with a learning disability, their families/carers have been involved in making choices or decision about their individual health and social care needs.
- 93% of the files audited during case note review were able to demonstrate a preferred form of communication if the service user did not use speech as their main form of communication; this is an improvement from last year.
- There is evidence of transfer to directed enhanced services, where appropriate, for health checks for children on transition to adult services ie all GP practise run a search on date of birth and ensure those eligible are invited for health check.
- Regional guidelines on sexuality and personal relationships have been developed as well as an operational protocol developed by five HSCTs.
- Guiding Principles for Personal Relationships and Sexual Health Training (for Adults with Learning Disability, Parents, Carers and staff working with Adults with Learning Disability) have been developed. The guiding principles define values that underpin relationship and sexuality education, to ensure best practice relationship and sexuality training is being developed and delivered.
- Funding is currently being explored with PHA to facilitate the delivery of appropriate training this year for staff to support the implementation of the personal relationships and sexual health operational protocol.
- The HSC Board and HSCTs have provided evidence that they have plans in place to extend the range and scope of self-directed support including how they will develop skills and expertise in relevant staff.

## **Older people**

Older People Service Framework has benefitted from a range of initiatives in relation to person centred care, safeguarding, carers, transitions of care, re-ablement and self-directed support. These have all lead to the provision of more person centred, individualised support to older people and their carers.

Key areas of progress are:

### **Person centred care:**

- There will be a person centred care module and advocacy awareness in the training programme for the Dementia Champions (currently being recruited). Person centred care is also one of the themes of the Northern Ireland Dementia Learning and Development Framework
- As at April 2016 56, 740 assessments using eNISAT were completed and 3009 staff registered as users on the system. eNISAT has now achieved full technical implementation in older people teams regionally.

## Safeguarding:

- NIASP and LASP annual action plans include prevention plans.
- Information cards on how to access safeguarding are being distributed to service users and their carers.
- Provider organisations ensure staff are trained on how to recognise abuse and access safeguarding services.

## Conditions more common in older people

- The Northern Ireland Dementia Learning and Development Framework was developed following an extensive regional scoping exercise which collated the type and volume of training currently available to staff in Northern Ireland which included the cost and accessibility of training programmes and existing levels of accreditation. This framework outlines the core themes in terms of the knowledge and skills that health and social care staff require in order to interact and respond sensitively to the needs of people living with a dementia and their carers.
- A delirium best practice bundle has been developed by Dementia Together NI project team. A training programme has been developed and delivered to more than 500 hospital staff.
- A regional tool has been developed to record screening, assessment, diagnosis, prevention and management of delirium. Use of tool began in February 2016 in pilot wards.

## NICE

NICE is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE produce different types of guidance, including Technology Appraisals (new drugs, medical treatments and therapies), Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions) and Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

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

During 2015/16, the HSCB issued 41 Technology Appraisals to HSCTs and continues to monitor the implementation of 130 CGs and which have been issued to the service. The implementation of NICE guidance can often be the driver for changes in service in a wide range of areas, as it provides commissioners, clinicians and health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found on the HSCB NICE webpage. (<http://www.hscboard.hscni.net/nice/>)

## Using data to measure improvements in primary care

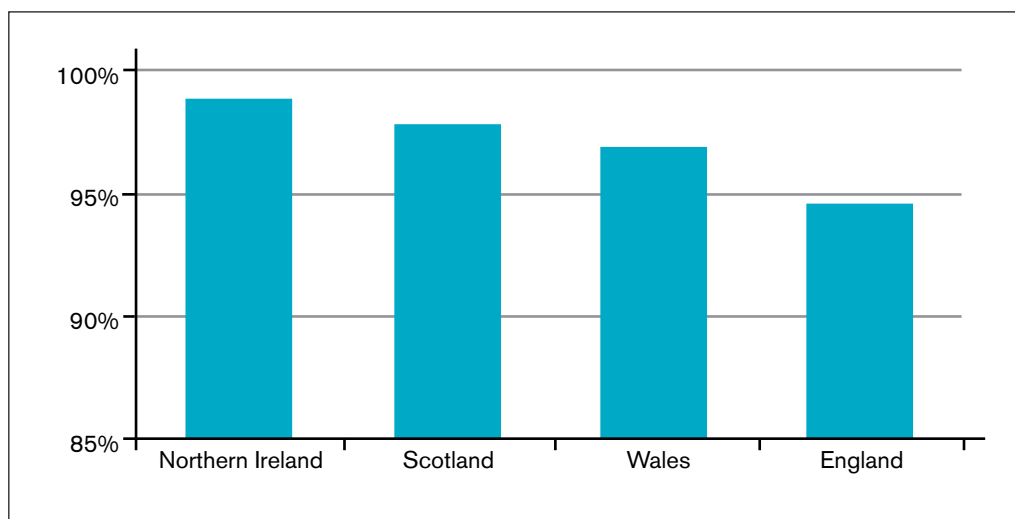
### Quality and outcomes framework

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

Based on this evidence, the Quality and Outcomes Framework (QOF) was introduced for GPs across the UK in 2004 to measure achievement against a range of clinical indicators, with points and payments awarded according to the level of achievement. Although participation is voluntary, all 349 practices in Northern Ireland have chosen to participate.

GP practices in Northern Ireland have always achieved high QOF Clinical outcomes compared to their colleagues in the other countries. 2014/15 shows that GPs in Northern Ireland achieved 99% of available QOF points.

**Figure 6: % QOF achievement 2014/15**



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

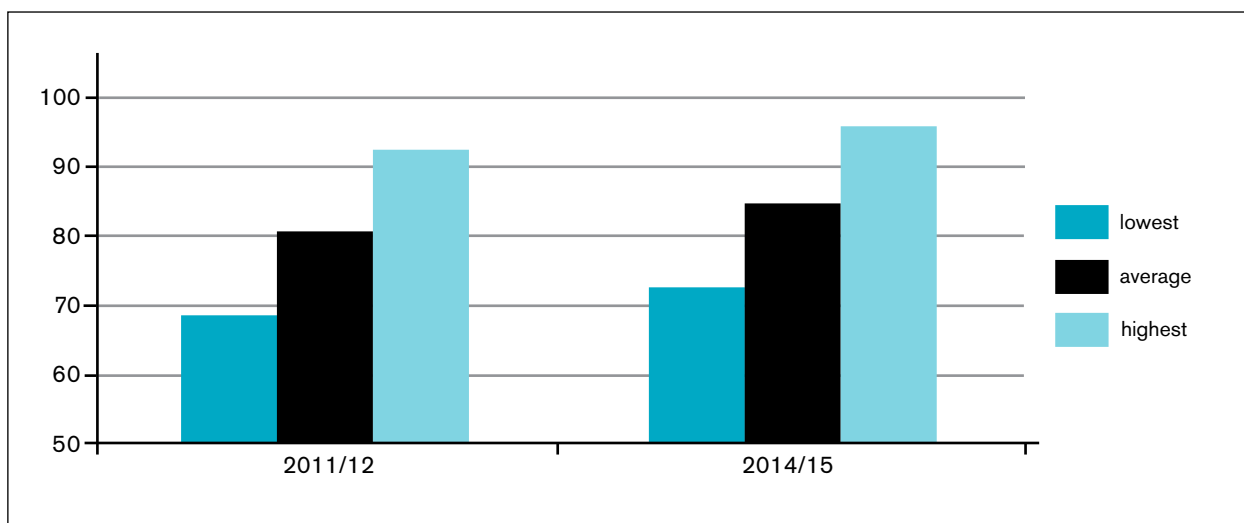
Each practice is provided with an annual report allowing them to compare each clinical outcome with other practices across Northern Ireland. Medical Advisors and practice support staff from the Directorate visit each practice every three years to discuss their achievements and share good practice to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

This focus on measurement and improvement through the combined efforts of individual GP practices and the HSCB has resulted in gradual improvement in the control of some long term conditions, for example in April 2016, 26,058 more people had good control of their blood pressure than in April 2011.

It is really important that everyone has the best possible control of their long term condition, regardless of where they live. If a practice shows lower than average outcomes for management of several conditions they will have a focused visit by Integrated Care (HSCB) staff who will agree an action plan with the practice to improve their outcomes. The practice will then receive annual visits until their outcomes have significantly improved. This focus helps to reduce any inequality between practices.

The graph below shows the indicator for the control of high blood pressure to less than 150/90 (In 2011/12 this was based on QOF indicator BP5, in 2014/15 this was based on QOF indicator HYP002NI). As well as overall improvement, the lowest performing practices have improved the most, therefore reducing the gap between lowest and average performance.

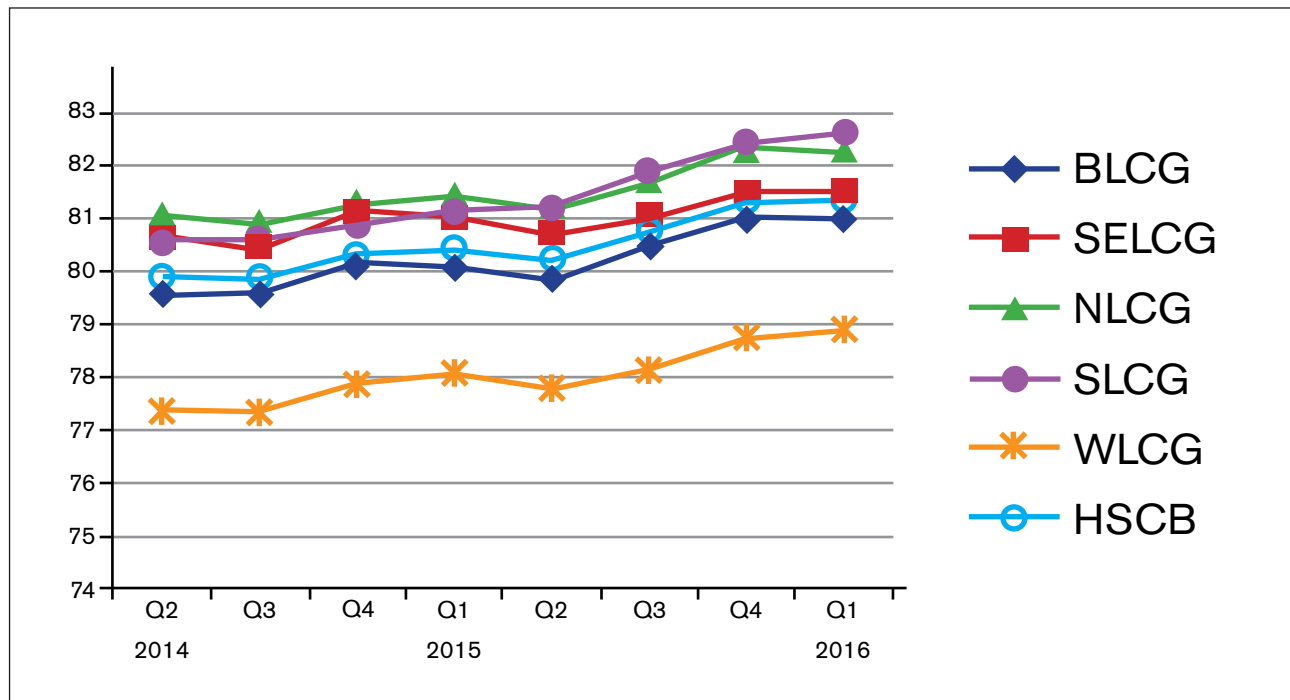
**Figure 7: Control of high blood pressure to less than 150/90**



### Prescribing in primary care

In 2014/15, the Northern Ireland Audit Office published its report on Prescribing in Primary Care. This was followed by a review by the Public Accounts Committee. Later in 2015/16, RQIA published its Review of Medicines Optimisation in Primary Care. In each of these reviews there was recognition of the good work of the HSCB pharmacy and medicines management team. There were also consistent themes in respect of prescribing variation, costs and medicines utilisation in primary care. It was highlighted that in Northern Ireland, we spend comparatively more on medicines in primary care than other countries in the UK. Conclusions based upon comparisons based solely on cost in one sector are not valid given the structural differences in health and social care between countries eg in Great Britain, there is much more dispensing of medicines from hospital outpatients. One of the factors that can be considered is generic prescribing frequency and over the years, primary care prescribers have made steady progress in utilising generic medicines where this is appropriate to do so. The graph below still highlights a degree of variability in certain areas and work is ongoing to maximise the use of generic medicines in order to free funding up for use for patient care in other parts of the HSC.

**Figure 8: Generic prescribing rate (%)**



## Measuring improvements in PPI

The PHA has completed the second annual PPI monitoring process in HSCTs. The PHA has a responsibility for monitoring PPI across the HSC system, but has particular responsibility for providing assurances to the Department of Health (DoH) in relation to the compliance with and progress of PPI in HSCTs. This process was initiated for the first time in 2015.

The monitoring is undertaken using mechanisms and arrangements co-designed with members of the Regional HSC PPI Forum including service users and carers. Service users and carers are also an integral part of the review team. HSCTs are measured against the PPI Standards and associated Key Performance Indicators (KPIs), to help assess progress against compliance with PPI.

In each HSCT there has been considerable progress in many areas while others require additional actions to imbed PPI. All HSCTs have received a PPI Monitoring Report detailing recommendations to support the development of PPI across their organisation

## Measuring improvements in social care

### The personality disorder regional network audit programme

The personality disorder regional network audit programme team (comprising staff from the HSCB, HSCTs and PBNI staff, service users and family carer representatives) has developed an audit framework to test the implementation of the regional personality disorder care pathway and identify areas for service improvement.

Two service audits have been completed:

- specialist functions for personality disorder services identified in NICE guidelines;
- key performance outcomes identified by service users and family members.

A third audit of triangle of care standards is underway.

Each HSCT service has developed an improvement plan and commissioning/resource priorities have been identified for future service development.

### **Case note review**

The HSCB is responsible for providing updates to the DoH on the performance of the HSCTs against the standards and indicators in the Service Framework for Learning Disability. An objective baseline for the indicators has been established for 2014-2015 in partnership with the HSCTs using a range of audit tools. The main outcomes is to provide robust qualitative measures that can be monitored and reviewed to ensure standards improve over an agreed timescale delivered against key performance indicators. The audits also identify areas where change in practice is required.

A case note review was one of the audit tools completed across the five HSCTs to determine 2014-2015 baseline position for several of the KPIs. Between November 2015 and December 2015 the case note review was repeated to determine performance for several of the KPIs in the Learning Disability Service Framework. The case note review process involved the development of a set of questions in consultation with the HSCTs, which was then transferred onto an excel sheet to allow the audit to be completed electronically. The sample was agreed using the sample calculator tool provided by GAIN. The case note review audit carried out file checks on 450 files across the region, 90 per HSCT, 30 files per locality. The findings of the case note review have determined a series of recommendations for the HSCTs to implement in the next year in order to ensure improved practice and systems of care.

### **Key observations:**

- 77% of the files audited during case note review demonstrated evidence that people with a learning disability, their families / carers have been involved in making choices or decision about their individual health and social care needs.
- 93% of the files audited during case note review were able to demonstrate a preferred form of communication if the service user did not use speech as their main form of communication; this is an improvement from last year.
- The HSC Board and HSCTs have provided evidence that they have plans in place to extend the range and scope of self-directed support including how they will develop skills and expertise in relevant staff.
- There was marked improvement in the presentation of files which included layout and content from last year, as well as evidence of more up to date reviews; service user and carer participation; and carers' needs assessments completed.

## Theme four: Raising the standards

### Improvements in patient and client experience

Patient and client experience has been recognised as a key element in the delivery of quality health and social care in a number of high profile reports. The evidence is that organisations that focus on patients have higher quality and efficiency, a safer patient environment, as well as greater employee engagement. Therefore the HSCB and PHA support the HSCTs in their implementation of quality improvements by using use both quantitative and qualitative information to ultimately improve the patient experience.

### Implementation of the patient and client experience standards

The PHA in collaboration with the HSCTs have embedded a comprehensive Patient and Client Experience programme which uses a range of methodologies to gain the 'patient' experience of the health and social care to drive quality improvements, enhance the patient and client experience and monitor the implementation of the DoH Patient and Client Experience standards (Respect, Attitude, Communication, Behaviour, Privacy & Dignity).

These include:

- patient stories;
- observations of practice;
- questionnaires;
- 10,000 Voices initiative;
- complaints;
- SAIs.




Through this methodology the PHA gains a comprehensive overview of Patient Client Experience (PCE) in Health and Social Care and this information is used to affect and inform change by driving quality improvements.



During 2015/16 it was agreed that HSCTs would focus on improvement work. The following four Patient Client Experience Regional Priorities were identified as a result of patient feedback and HSCTs have monitored these in 2015/16:

1. **Develop a process to reduce 'Noise at Night' in hospital;**
2. **Raise the profile of "Hello my Name is..." in community and primary care settings;**
3. **Monitor the availability of meals and drinks in EDs;**
4. **Work with HSC Trusts to implement and sustain improvements in relation to mixed gender accommodation.**

# **hello** my name is...  


HSCTs have submitted updates to the PHA on each regional priority detailing implementation progress for 2015/16 associated with same and it is recognised there is a considerable amount of work being carried out in relation to these four regional priorities.

In addition HSCTs also agreed to focus on some local improvements based on their individual HSCT feedback and have submitted details of a number of areas they are working on to improve patient experience examples include:

- BHSCT has introduced a 'Ward Entrance Patient Information Notice Board' in (Adult Acute In-patient Wards) – the board highlights key patient experience and safety and quality indicators, 'meet the team' and 'Ward Sisters Commitments'. Post boxes are being added to these to enable patients and carers to 'post' their feedback.
- BHSCT held a 'SAFE-tember 2015'– Programme of events during the month of September which focus on patient, client and staff safety and quality.
- The NHSCT has introduced 'Dementia Champions' - Reflective Learning and annual updates in best practice with ward based Dementia Champions and Facilitators. This included the development of reminiscence folders for acute care wards where patients with dementia may be cared for. Work has commenced to re invigorate the 'Butterfly Scheme' with awareness sessions and lunch and learn sessions.
- Within the NHSCT the Macmillan Unit Antrim Hospital, Patient Care Survey has been introduced – findings have been presented to all cancer MGMs and action plans been developed to take forward recommendations for improving patient experience.
- SET Patient & Client Experience Programme has completed analysis of numerous acute wards, community-based services and hospital based services. Reports and posters have been produced and supplied to the local managers for development of action plans designed to make progress against all items rated at <90% compliance.
- SET has a 'Volunteer-Led Survey Programme' – This programme involves volunteers going around the wards to patients and helping them complete surveys. The volunteer-led programme currently has three types of survey running (General inpatient, Night-time, introductions) and recently supported data-gathering regarding the Smoke Free Site initiative.

- The WHSCT has engaged with community activities and minority ethnic groups including hard to reach groups. Member of Chinese Community has agreed to join local HSCT patient and client experience working group. Representatives from RNIB attended HSCT Board to provide experience journeying through the health care system.
- The WHSCT have implemented the award winning purple toolkit on dementia care across the acute hospital sites. A care bundle has been developed and will be used to evidence and determine if the patients with an underlying dementia diagnosis are receiving safe, effective and consistent care.
- Within the SHSCT four Directorates have identified, Top five Patient Client Experience Quality Improvement Initiatives (QIIs)
- Quality Improvement Leadership initiatives specific to PCE activity has been included as part of SHSCT specific leadership programme the 12 participant action learning activities need to include a person-centred focus

## **10,000 Voices**

The PHA and HSCB commissioned the '10,000 Voices' Initiative to provide a vehicle which listens to and acts upon patient and client experience using story methodology to affect, inform and influence rapid changes in the way services are commissioned and delivered. The 10,000 Voices initiative has focused on a range of areas throughout 2015/16 including unplanned care, staff stories, care in the home, care delivered by NIAS and autism and CAMHS services.

During 2015/16, based on feedback from 10,000 Voices a number of tangible improvements to patient experience have been implemented across all HSCTs in Northern Ireland including:

- review of pain pathway for orthopaedic patients;
- provision of timely and appropriate pain relief in EDs;
- review of cleaning regimes;
- review of security arrangements;
- care of babies and young children in EDs;
- information for patients about waiting times and what will happen during their episode of care;
- improved signage to provide information for patients;
- Improvements in the provision of food and drinks in EDs.

### **Influencing regional policy and strategic direction/commissioning priorities**

The patient experience information received through the 10,000 Voices has informed a number of regional work streams, for example:

- patient stories from unscheduled care areas are integrated into the regional unscheduled care programme team;
- regular feedback is presented to the local commissioning groups;
- findings in relation to time allocation and timing of calls for those who receive care in their own home were recognised and will be addressed as part of the review of domiciliary care in Northern Ireland;
- stories which describe the isolation and loneliness experienced by people who live alone will be addressed by working collaboratively with individuals, communities and partner organisations through the implementation of Making Life Better (DHSSPS 2013);
- the 10,000 Voices team is working in collaboration with the Regional Dementia Strategy Implementation Group to address a number of emerging issues in relation to the care of patients with dementia, including support for carers, knowledge and skills of staff and long waits in unscheduled care areas;
- the findings from the experience of women and their partners have been integrated into the regional guidelines for Midwifery Led Units (GAIN 2016);
- through 10,000 Voices, the patient voice is integrated into specific programmes of care and thematic reviews, for example acute oncology care, regional work in relation to long term conditions and thematic reviews on pain and nutrition.

### **Informing education and training programmes**

Patient experience information provides a rich source of evidence on which staff can reflect and learn. Through the 10,000 Voices model opportunities for learning and development have been embraced through a number of ways, including:

- local awareness training in the care of patients with dementia;
- development of a person centred programme for Band 2/3 nursing staff;
- development of a patient experience DVD for staff induction and training, based on patient stories;
- development of a teaching session for undergraduate nurses, doctors and Allied Professionals.

## Enabling staff and building capacity

A number of specialist teams are now progressing patient experience programmes by gaining skills in using the 10,000 Voices methodology. Through these programmes, teams are developing and enhancing skills to engage meaningfully with and work in partnership with people to improve experience in specific areas, such as Paediatric Autism and Child and Adolescent Mental Health, eye care services and adult safeguarding.

## **You in mind - your experience matters. Sensemaker Reaudit December 2015**

The report presents analysis of data collected 2015 and offers comparison (where applicable) to data collected in 2012. A total of 665 and 720 narratives and self-signification data were collected in 2015 and 2012 respectively from the users of mental health care services, informal carers, and other respondents in five HSCTs.

There is a comparable data distribution across both capture periods, with 82% of data collected from health care services users, 13-14% - from carers, 1% - from informal carers, and 4% - from other respondents.

In summary, in 2015, compared to 2012:

- There was an increase in the respondents who said that they received the right service at the right time.
- More health service users suggest that the information provided by staff in mental health services was useful and relevant.
- There is no difference in how many respondents said they received no information in both periods.
- The proportion of people reporting that staff in mental services communicated in respectful and considerate manner has increased.
- Fewer respondents felt that they were ignored when their treatment was being planned.
- There was an increase in respondents who said they were fully involved and respected in both treatment processes respectively.
- More respondents reported that mental health services left them feeling stronger.
- Fewer respondents reported that everyday living, social, and leisure facilities were impacted most.
- More people reported that relationships with family and friends, everyday living, or both were impacted most.

- More respondents reported that they had made positive progress and fewer people said that there was no change after using mental health services.
- More respondents suggested that practical support would have made the biggest difference to them.
- Marginally fewer respondents reported that receiving useful information and being treated with compassion and sensitivity would have made the biggest difference to them.
- More respondents (and more users of services) in the current period said that their journey within mental health services was smooth running and the overall number of people reporting that their journeys within mental health services were confusing decreased.

Also, in 2015:

Approximately one third of all respondents say that they are hopeful for the future and a little less than one third are still working with others to plan the future.

To the majority, recovery has been an important part of their treatment.

More than two thirds said that their physical health care needs were discussed in detail

## **Carers survey**

A Carers survey which aimed to capture the experience of informal carers aged 16 years and over of the carer assessment process has been established. To measure if the Carers Support and Needs assessment process introduced as a component of NISAT in 2011 delivered a person centred assessment to carers as was its intent. A number of completed surveys, demographics (age and gender) and location of carers, number of persons they care for, circumstances of person they care for, timeliness of assessment, choice in location and time of assessment, written information/support available to carer. Themed responses on what is important to carers in terms of how assessments are conducted. These included being listened to, recognition of the caring role, receiving support, carers health and flexibility in professional visits/timing of assessments.

## **Learning from complaints**

### **Health and Social Care learning from complaints annual event**

During 2015/16, the HSCB hosted its second annual learning from complaints event in June 2015. The event focused on the theme of 'communication' as this issue features in a significant number of complaints regarding Health and Social Care services. To illustrate this point, from April 2014 to end March 2015, the HSCTs received 7,015 issues of complaint, of these 877 related specifically to communication and information. If complaints regarding staff attitude and behaviour are included, this number rises to 1,989, which is greater than the number of complaints received regarding treatment and care. In addition, of the 230 returns received by the HSC Board regarding Family Practitioner Services (FPS), 59 related to communication. If complaints about staff attitude and behaviour are added to this amounts to 115 complaints of which communication plays a part. Furthermore, the HSC Board has heard directly from service

users of the importance of communication at focus groups, and therefore decided to take the positive step to dedicate its second Learning from Complaints Event to this theme.

Approximately 100 persons were in attendance, with representation across the HSC. The event had two keynote speakers; Ms Marie Anderson (Deputy Commissioner for Complaints, Northern Ireland) and Mr Hugh McCaughey, (Chief Executive, South Eastern Health and Social Care Trust).

Key messages from the day included, the importance of making an apology; continually learning from mistakes and from patient interactions; the importance of creating a culture within organisations whereby staff identify situations which could have been handled better, thus improving the overall service provided to service users; and barriers to communication and how to overcome these. In addition, the audience heard and reflected on some very powerful messages from two service users who described their complaint and outcome via a pre-recorded video.

Feedback from this event has identified that the quality of communication and information provided to patients and families, is at times sub-optimal, which subsequently leads to further upset and distress of service users.

### **Service user focus groups**

As part of the ongoing evaluation of the effectiveness of the HSC Complaints Procedure, the HSCB also hosted a service user focus group during November 2015, specifically for older persons and carers. This focus group also fulfilled the objectives set out in the 'HSCB Audit of Inequalities Action Plan' (2013 - 2018), which states that work should be conducted to, 'Identify and overcome barriers which prevent service users from making complaints and ensure that the HSC Complaints Procedure is accessible for everyone in Northern Ireland, regardless of characteristic'.

Feedback from this focus group, demonstrated that privacy and dignity, to include communication, remain major issues of concern. It was noted that these issues are embedded within the majority of complaints within primary and secondary care. Therefore to acknowledge and address this issue, these topics will be reviewed in greater detail at a Complaints Learning Event in 2016. In addition, a further workshop specifically for those persons with a disability will be organised during 2016/17. The outcomes of which will help inform the HSCB, how the public perceive their experiences of health and social care services, how to improve the complaints process and how to address the reluctance on the part of some service users to raise a complaint, possibly due to fear of impact on their, or their relative's on-going treatment and care.

## **Raising the standards for older people**

### **Building a vision for nursing in older peoples' services**

The Northern Ireland Education Commissioning Group for Nursing & Midwifery Education hosted a regional workshop in September 2015 which aimed to review the changing perspectives for older people's services including the impact for nursing workforce within older peoples caring environments; and inform pre and post registration training with models of good practice.

During the discussions at the workshop a set of draft regional and local actions were produced. In addition, a recommendation was to host local engagement events in each HSCT area to further develop local action plans and recommendations for improving services and career pathways for nurses in older people's services.

The PHA agreed to take this work forward and to provide guidance and assistance to appoint a temporary Band 7 lead nurse. The PHA provided a further funding allocation to each HSCT to engage with Age NI to facilitate an engagement exercise aimed at including the voice of service users, carers and their advocates in the development of a vision for nursing in older people's services

The PHA, HSC and Age NI worked together to co-design a model of engagement to ensure that the expertise, knowledge and experience of staff, service users and carers were captured to inform good practice, improvement and the future development of training and services in care of older people's services. This model has been further developed as a product of the project.

A total of 1100 people responded to the surveys, focus groups, questionnaires and interviews. As a result, the older and often frailer people who are predominantly those mostly in receipt of nursing care, were given the opportunity to drive and influence real change, which will benefit not only them, but older people in the future.

The implementation of the Regional Action Plan is being taken forward by the PHA in partnership with other HSC organisations, agencies and the community and voluntary sector. This initiative also promoted a call to action from the HSC, encouraging nurses to actively consider a career in the very rewarding and stimulating area that is Older People's Services. This work will be further progressed with nurse education organisations.

The general workstreams and outcomes of this project will contribute to the enhancement of patient user and carer experience to influence service improvement methods and assist in determining the key areas requiring action to ensure the delivery of high quality services that are safe, person centred and outcome focused.

### **RQIA review of the care of older people in acute hospitals**

Throughout this year the PHA and HSCTs have been progressing work in response to the 14 strategic recommendations for improvement across Northern Ireland from the RQIA Review of the Care of Older People in Acute Hospitals (2015). This is a brief summary of the work being progressed.

In terms of improving person centred care, work is underway, in partnership with Age NI and older adults, to agree what older people value in an acute hospital ward environment and what makes a difference to them in terms of their care. Some suggestions from older people are to follow their usual routines where possible while in hospital, eg having a cup of tea when they wish and reading in bed at night.

In terms of safety and risk management, ward managers are receiving formal reports on incident trends so that learning can be identified and shared

The regional Promoting Good Nutrition (PGN) strategy group has implemented a protected mealtime policy and made improvements relating to the identification of people, who need assistance with eating in the acute settings. This work links with some of the recommendations of the review. Also related to this review, regional work is underway, led by the PHA, to establish normative nursing staffing levels. This includes the agreement and implementation of protected time for management duties. Also relating to the review is the work of the Dementia Together NI project, including the development of a Learning and Development framework targeting HSC staff knowledge and skills in relation to dementia and delirium.

Other progress continues in relation to this ROIA review including, for example, work in relation to accurate completion of fluid balance and prescription charts and work is underway looking at procedures that are put in place if de facto detention is ever used (de facto detention was referenced in the review to describe patients not being able to freely leave the ward without permission). HSCT and PHA colleagues are considering relevant policies and procedures currently in place with the aim of promoting freedom of movement whilst maintaining safety. Some hospitals have a wanderguard technology system in place in appropriate wards, e.g. for use with patients with dementia. The system facilitates freedom of movement whilst providing tracking security to promote safety.

## **Raising the standards for people with a disability**

### **Regional day opportunities**

The vision set out in the Bamford Review and confirmed in Transforming Your Care was to enable people with a learning disability to lead full and meaningful lives in their communities. This ensures that there is a consistent regional framework, and full and meaningful engagement with service users, and their families and carers, and with staff. A group has been established by the HSCB to oversee the coordination and implementation of the regional day opportunities model for people with learning disabilities across Northern Ireland. This group is made up of cross departmental representation, HSCTs, local councils as well as service users and carers. Service users and carers have the opportunity to feed back to local carer's groups in their respective HSCTs as well as critically review the Implementation of the Regional Day Opportunities Model at local trust level citing best practice and making recommendations. Each of the HSCTs have also established Local Day Opportunities Implementation Teams where local service users are involved.



## **Easy read health booklets**

A series of easy read health booklets on AAA screening, menopause and prostate cancer have been developed by health care facilitators in the SHSCT for adults with learning disability. A range of service users inputted into the design as well as providing feedback on final content and layout.

## **Physical and sensory disability action plan**

During 2015/16 the HSCB has continued to lead on the ongoing progression of the physical and sensory disability action plan 2012-2015 through the Strategic Implementation Group and Regional work streams and partnership working with Disabled people, statutory services and community and voluntary groups:

1. Deafblind report- A regional deafblind needs analysis report was completed and key findings of this review were launched at a workshop in autumn 2015
2. Specialist deafblind training for staff commenced in September 2015. Regional Sensory Care Pathways for hearing and sight loss have been developed and implemented by HSCTs
3. A Regional Sensory Training Framework was developed
4. A level 1 e-learning Sensory Awareness raising programme for hearing and sight loss was developed in 2015 and will be launched on 1 July 2016
5. Regional Review of Communication Support Services and an Equality Impact Assessment was completed in 2015-16. The recommendations of this Review and EQIA assessment opened for public consultation on 6 June for 13 weeks
6. My Journey My Voice, a multisensory interactive exhibition highlighting the needs of people with communication impairment was funded by HSCB in partnership with RCLT and Disability Action
7. Making Communication Accessible - A Guide for all HSC Staff was developed and will be formally launched on 27 June 2016

All of the following were co-designed with service users and community/voluntary sector

1. Deafblind report
2. Regional Sensory Care Pathways
3. Regional Sensory Training Framework
4. Level 1 Sensory awareness e-learning tool
5. My Journey My Voice - a multisensory interactive exhibition highlight the needs of people with communication impairment was funded by HSCB in partnership with RCLT and Disability Action.

## **Self-directed support**

The self-directed support (SDS) initiative introduces personalisation and co-production across all programmes of care including children with a disability.

SDS requires fundamental culture change in social care assessment, support planning, and practice as this is a strength based/outcomes focused approach working in partnership with Service Users and Carers.

To support the changes to practice and mainstream the ethos of SDS training on three different levels is provided within HSCTs.

These are:

- Level 1: Awareness Raising
- Level 2: Assessment, and
- Level 3: Support Planning.

Training level 2 and 3 are PiP accredited. Training is provided to first-line staff and management levels to embed change in practice and systems.

Currently in HSCTs across the three levels of training over 3,300 staff have been trained.

The SDS initiative introduces the Adult Social Care Outcomes Toolkit (ASCOT) across all adult programmes of care on a phased approach.

The ASCOT measure is designed to capture information about an individual's social care related quality of life (SCRQoL).

The aim is for the measure to be applicable across as wide a range of service user groups, and care and support settings as possible.

Evidence from consultation with Service Users, experts and policy-makers, as well as focus group work and interviews with Service Users, indicated that the measure captures aspects of social care quality of life that are valued by Service Users.

The background work with Kent Innovation & Enterprise (KIE) and the Personal Social Services Research Unit (PSSRU) has taken place, licences agreements have been agreed and signed for the region and training has been provided to HSCT staff. The initial trial of ASCOT's practical use with practitioners and the data capture and reporting mechanisms will begin with SEHSCT in late August/ early September 2016 and other HSCTs will follow soon after.

Work is ongoing to streamline and improve the activity monitoring within SDS.

This is built upon previous data capture tools eliminating fields of data that are no longer required by social care. This new data return has been co-produced in partnership with appropriate HSCB, HSCT and Department of Health staff.

This work is progressing alongside the regional review of information.

Service users and carers are involved in every level of the SDS project from local HSCT levels to regional and strategic level. Good practice examples are shared and podcasts have been recorded with Service Users. Numerous focus groups and events have also taken place to involve and engage service users and carers in the development of SDS and help drive culture change.

To date in excess of 120 people were involved in the EQIA and approximately another 120 at various events across the province. Service users and carers have been involved in developing other resources such as the SDS user guide, practitioner guide and the revised direct payments guide.

Work is currently on-going regarding the development of an easy read service user guide and a specific guide directed at carers.

## Allied health professional care pathways

The PHA has been working with AHPs across Northern Ireland to agree AHP Professional Care Pathways. The Care Pathways clearly outline the approaches professional staff take when working with service users and carers. This work, across 6 of the AHP Professions and 5 HSCTs, will work to reduce variation in elective AHP Pathways and deliver consistency of approach across those areas that constitute their greatest areas of demand within elective. This work is unique to Northern Ireland and supports improvements in the quality and consistency of services for service users and carers.

## Choose Well campaign

This Northern Ireland-wide public awareness campaign was developed to inform the public on the range of healthcare services available from self-care, pharmacy, GP and GP out of hours services, Minor Injury Units, Emergency Departments and 999 services as well as providing information on mental health support.

The campaign aims to empower the public and to encourage people to think about the service that best meets their healthcare needs and to choose appropriately. By choosing the most appropriate service, people will be seen in a timelier manner and this will also help ensure emergency services are available for those patients who need to use these services.



The campaign, now in its third year, is led by the HSCB in partnership with the DoH, PHA, HSCTs, British Medical Association, Community Pharmacy NI and the Patient Client Council.

The Choose Well campaign was shortlisted in the Chartered Institute of Public Relation Pride Awards, 2014.

## **New services procured**

### **Drugs and alcohol**

The PHA, in collaboration with the HSCB, drew up a framework for commissioning alcohol and drug services in response to the New Strategic Direction (NSD) Phase 2 – 2011/16. The framework aimed to provide clarity and direction on the commissioning of the NSD resource allocation post March 2014 and identified the need for a regional Drug and Alcohol Commissioning Strategy. In line with this guidance and with the support from colleagues, the PHA Health and Social Wellbeing Improvement Division developed a Strategy for the procurement of Drug and Alcohol Services.

Business cases on each of the seven service areas identified within the commissioning framework were developed. In April 2014, PHA issued a formal notice informing the drug and alcohol sector that seven services to support the implementation of the NSD 2011-16 would be subject to public procurement. Total contract value was approximately £5.5m per annum. Seven separate public procurement tenders for services to support the implementation of the NSD 2011-16 were issued during 2014/15.

A number of measures were taken in order to enhance the procurement processes including:

- assessment of need and budget allocation;
- researching the evidence;
- consultation with the market/stakeholders;
- development of service specifications/contract adjudication groups;
- links across the PHA and HSC.

Quality improvement is a common goal and is central to the development of health and social care services. The procurement process has significantly addressed three main areas integral to the modernisation and reform agenda:

- setting of minimum standards;
- improved governance arrangements;
- improved accountability.

Also, as a result of the work in developing the regional Drug and Alcohol Commissioning Framework, drug and alcohol service provision across Northern Ireland has significantly changed. Regionally consistent services and models of delivery are now in place across the seven service contract areas. This has made a significant improvement to the range of services available to the population and has responded to the previous perception of a “postcode lottery” landscape of drug and alcohol service provision.

Seven drug and alcohol services are now available in each locality and/or regionally delivering consistent services and models of delivery to agreed standards including:

1. Drug and Alcohol Co-Ordination Team Connection Services
2. Prevention and Harm Reduction life-skills programmes for vulnerable young people
3. Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services)
4. Regional Workforce Development Programmes
5. Community-based services for young people who are identified as having substance misuse difficulties
6. Community based intervention services for adults and family members affected by substance misuse.
7. Therapeutic services for children, young people and families affected by parental substance misuse

### **Self-harm Intervention Programme (SHIP)**

A new service for people who self-harm has been commissioned by the PHA following open tender. The service is referred to as the Self-harm Intervention Programme (SHIP).

SHIP offers counselling services in line with NICE guidance to those who self-harm. It has been available to people aged over 18 years from Oct 2015 and is expanding to provide service to under 18 year olds during 2016 . The service is provided by community and voluntary sector providers and operates in partnership with the mental health services offered by HSCTs in order to provide a more joined-up service for people who self-harm.

There is regional branding and patient literature for consistency. The service is provided in non-stigmatising community setting to maximise engagement and uptake, as it is well recognised that people who engage in self-harm often experience barriers to engaging with services.



SHIP is a Tier 2 level intervention aimed at those who may be at risk of further self-harm in the context of personal and social problems but without major psychiatric morbidity. An assessment by

HSCT mental health practitioners is required to ensure suitability and that any serious mental health issues have been excluded before stepping down into this service. If more serious mental health issues are identified, on-going care is provided by the local HSCT. SHIP can also provide support to people who self-harm who have some issues with alcohol or drug misuse if it is deemed appropriate and more intensive services are not required. The assessment in some cases can involve a telephone call with the patient and GP to confirm eligibility in order to prevent lengthy waits for HSCT assessment.

Self-harm within a family context can be very stressful for the entire family. Taking a preventative and upstream approach SHIP, also offers a parent/carer a short period of education and support regarding how to support someone who self-harms and how to take care of their own mental wellbeing. This element of the service can be provided to parents/carers even if the client does not wish to engage with the service as people who self-harm can sometimes be reluctant to engage in services.

Outcomes are being monitored using the CORE Outcome Measure which scores clients pre and post involvement with the service. Pilot work with this client group has demonstrated significant clinical improvements in CORE Outcome Measures however outcome data is not yet available for the SHIP service. Early indications are that the service is becoming well established but it has been slow to get off the ground in some HSCT areas. It is a good example of collaborative working and development of formal cross-sectoral care pathways.

## **Raising the standards in primary care**

### **Enhanced services**

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

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

Below is an example of an enhanced service which has been well received by patients, their carers and GPs in 2015/16.

### **Medical care planning for patients with long term conditions**

The increasing number of patients living with long term conditions is one of the biggest challenges facing Health and Social Care and represents over 50% of the current GP workload. As people live longer the incidence and prevalence of long term conditions will increase. Many elderly patients live with more than one long term condition adding to the complexity of management.

This enhanced service aimed to target groups of patients with long term conditions and complex care needs including multiple sclerosis, Parkinson's disease, stroke, nursing and residential home patients and patients with multiple co-morbidities. This enabled an annual planned comprehensive

medical review of these patients in order to agree an individual medical care plan and allowed early diagnosis, problem recognition and appropriate referral as well as adequate social support to be put in place. It also facilitated early identification of palliative care needs for some patients and appropriate management. Proactive management of long term conditions can help to ease the burden on primary care. It can also improve the patient's quality of life and reduce the number of unplanned hospital admissions.

### **Improving patient information returns from the community dental services**

An analysis by the HSCB of the information returns by the Community Dental Service (CDS) from the five HSCTs revealed significant inconsistencies as to how patient contacts are recorded against some of the programmes of care, particularly POCs 3 and 8. The lack of comparability of patient contacts across the POCs has implications for accurately measuring clinical activity and financial expenditure and needed to be addressed.

Dental staff from the HSCB led on the project to develop a standardised community dental return for the CDS and agree common definitions across the five HSCT CDS teams. This work was completed in April 2015 and signed off by the Central Returns Group DHSSPS in May 2015. The new information returns commenced in 2015/16 and now provide standardised data on:

- **Oral health improvement programmes and disease prevention**

An important metric to inform key policy documents such as the Programme for Government and Bamford Learning Disability Action Plan and address enquiries such as Assembly questions, Assembly correspondence and media queries.

- **General anaesthetic dental extractions in young children**

An important measure of oral health in one of the most vulnerable patient groups.

- **New and review patient contacts against relevant POCs**

Provides standardised activity information for patients with special care needs as defined in the Department's CDS Scope of Practice (March 2011).

### **Developing eyecare partnerships**

Through the collaborative work of Developing eyecare partnerships the HSCB has raised the standards in eyecare through investment in enhanced training for primary care optometrists to enable the provision of enhanced services by optometrists. Work across two eyecare pathways, the acute eyecare pathway and glaucoma care pathway, has resulted in significant service developments supported and underpinned by optometric workforce training and development.

#### **1. Acute eyecare pathway**

Optometrists were supported with additional training in acute eye conditions to allow patients in the Armagh/Dungannon locality of the Southern Local Commissioning Group area to access an enhanced optometry service in the community for the management of acute eye conditions. The Southern Primary Eyecare Assessment and Referral Service 2 (SPEARS) has provided patients with prompt, safe and appropriate eyecare, tailored to their needs closer to home.

This innovative service has meant that patients with sudden onset/acute eye conditions can be assessed, examined and managed by optometrists without the need to access hospital based eye services. In the small number of instances where patients do need to be referred to hospital for treatment the optometrist can arrange for this to happen. Patient experience reports over 80% of patients describing their experience as excellent. The SPEARS service will be extended to the entire Southern LCG area during 2016/17 with additional investment in training and extension of the service provision.

**Patient A . . .**

**“It’s good to know if you have an eye problem that you can get it sorted straight away rather than having to wait maybe two weeks to see your doctor”**

**Patient B . . .**

**“This is an excellent service. The optician had removed the foreign body in minutes and relief was immediate. If she was unable to help me I would have had to attend the Royal Hospital in Belfast almost an hour away”**

**Patient C . . .**

**“It’s brilliant. Advice and re-assurance (and treatment if necessary) provided right away- no waiting and wondering and worrying about the condition”**

## **2. Glaucoma eyecare pathway**

The HSCB has invested in training for optometrists working in the community in the detection and case finding for glaucoma and ocular hypertension. These conditions in combination are estimated to affect 5-6% of the population and detection of the condition requires specific clinical tests and skilled examination of the eyes and visual fields. Over 380 optometrists in the community already provide a service to reliably measure the intra ocular pressure (pressure within the eyes) which is one indicator for glaucoma and ocular hypertension. In addition in 2016/17 HSCB will implement plans to support enhanced higher training for optometrists for a further enhanced service. The enhanced service will enable more detailed and repeated testing of the eye and visual fields for patients who may show some initial signs of glaucoma and ocular hypertension.

This advanced case-finding training will help and support community optometrists in service provision, and in deciding if a patient does require referral to the hospital eye service. The impact will be a reduction in unnecessary referrals, reduced patient worry and anxiety and optimum patient experience.

## **Antimicrobial stewardship**

Resistance to antibiotics has been recognised as the most significant public health challenge facing our generation. The fact that there is increasing resistance to common antibiotics, with few if any new antibiotics coming to market means that without a change in the way that antibiotics are prescribed, we may see illnesses re-emerge that will not be amenable to treatment and the

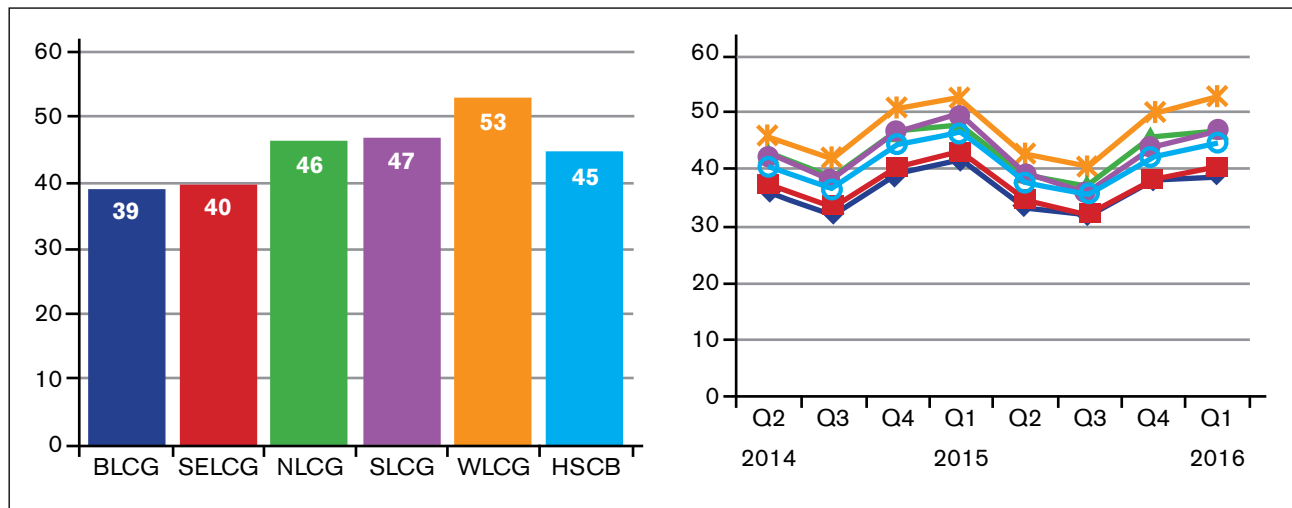


delivery of health services will have to be radically changed as common surgical procedures may not be possible.

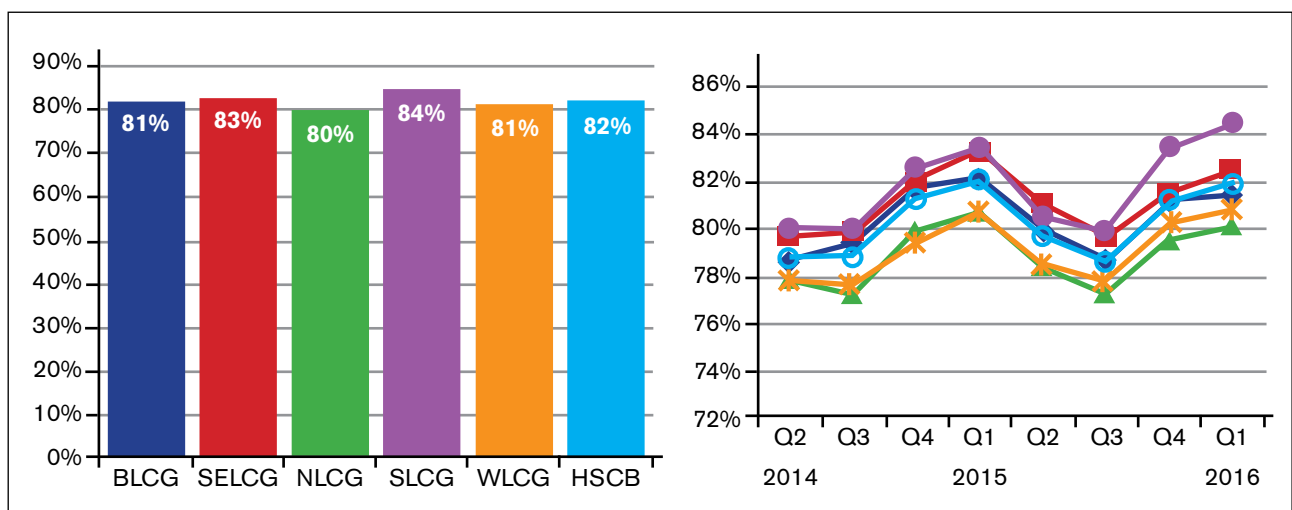
HSCB and PHA have been working jointly throughout the year to support the changes required to antimicrobial prescribing. Aligned with European Antibiotic Awareness Day in November, the revised Antimicrobial Guidelines for Primary Care were published. For the first time, these guidelines were made available in App form and prescribers have provided positive feedback. It is recognised that concerted work in this area is required in 2016/17 and beyond.

The quantum of prescribing per weighted head of population (NIPU) shows that the overall volume has not changed markedly despite rising demand. On a positive note, there have been changes to the types of antibiotics in use with a decrease in the broader spectrum antibiotics (eg cephalosporins, co-amoxiclav and quinolones) often associated with healthcare associated infections such as C.difficile.

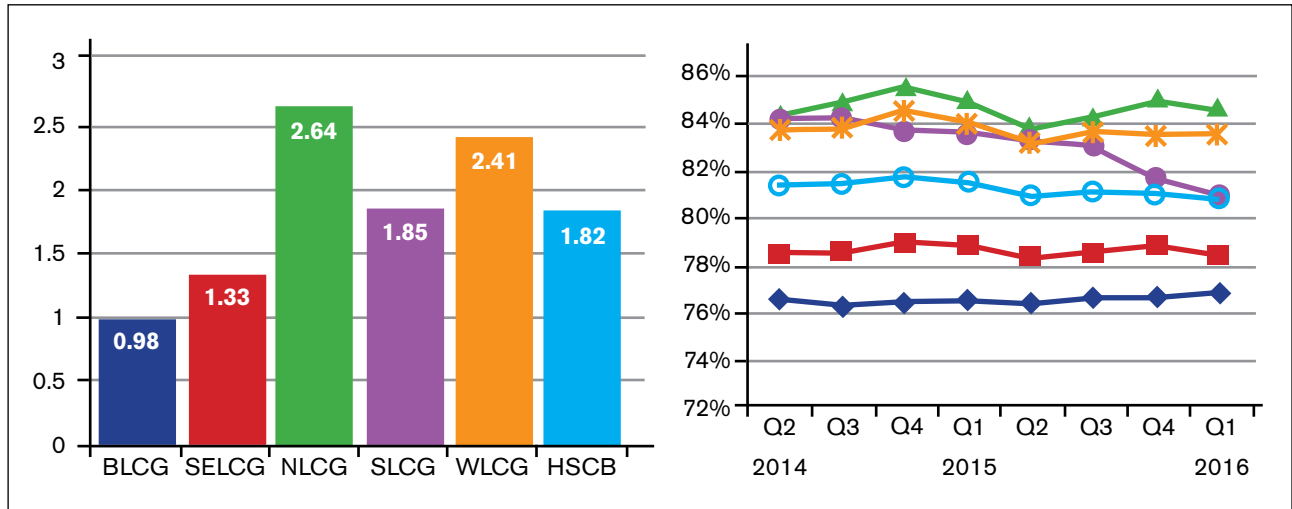
**Figure 9: Antibiotics, items/1000 NIPUs**



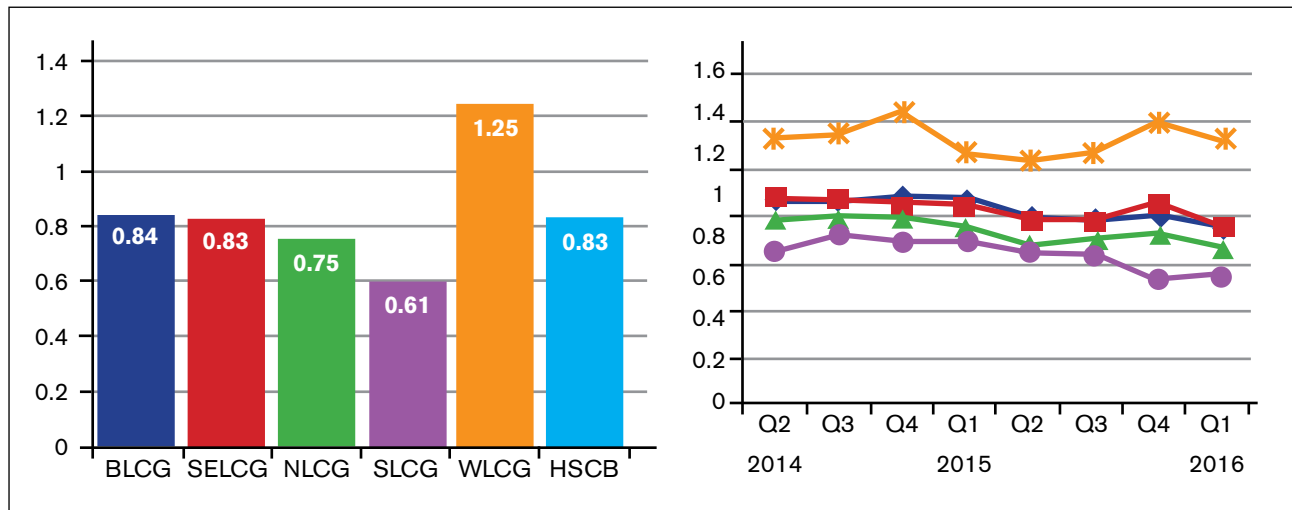
**Figure 10: Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin and clarithromycin, % items**



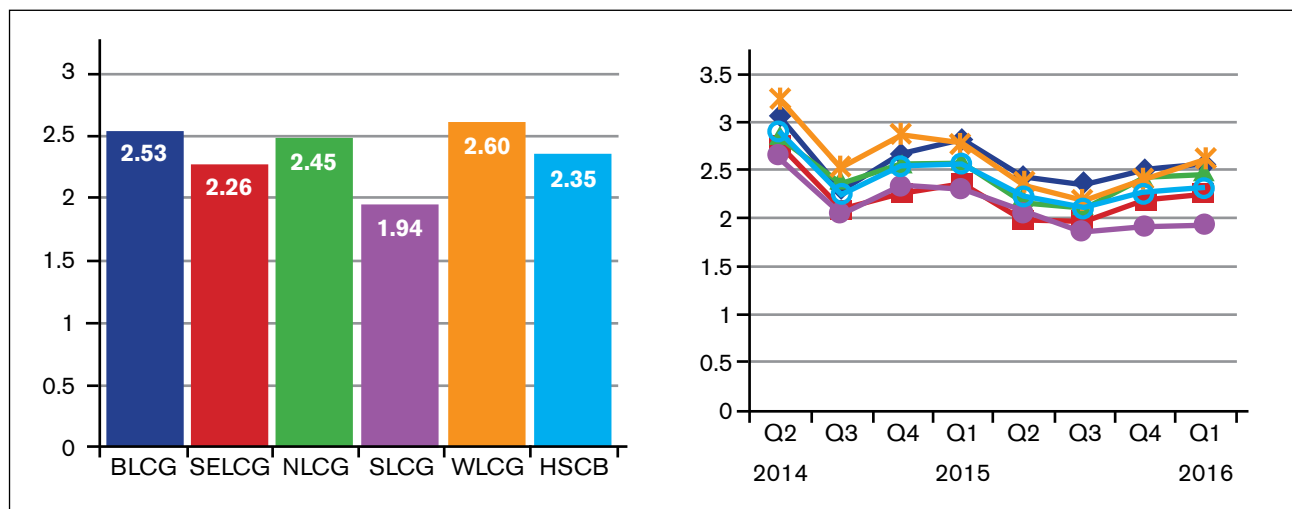
**Figure 11: Cephalosporins and other beta-lactams, items/1000 NIPUs**



**Figure 12: Quinolones, items/1000 NIPUs**



**Figure 13: Co-amoxiclav, items/1000 NIPUs**



**Controlled drugs**

Controlled drugs are designated under Misuse of Drugs legislation and due to their nature have specific requirements associated with their possession and supply. Following the Shipman Review, legislation has been enacted throughout the UK to increase the governance associated with the

management of controlled drugs. Designated bodies must have nominated Accountable Officers to ensure appropriate governance arrangements are in place. Since 2015, HSCB has been tasked with an additional legislative responsibility in convening the Local Intelligence Network (LIN) of Accountable Officers for Northern Ireland. During 2015/16, under the chairmanship of the HSCB, the LIN has provided a unique forum for sharing intelligence around the use of controlled drugs in Northern Ireland. One specific project that has been referenced at the LIN has been the development of a controlled drugs supply chain database. This has provided the facility for reporting of 'leakage' from the controlled drugs supply chain and highlighted areas where inspection and enforcement activities are needed in order to prevent diversion for illicit means.

## **Improving dementia services in Northern Ireland**

### **Delivering social change project**

During 2015/16 the Delivering Social Change Project team developed a Northern Ireland Dementia Learning and Development Framework, steered by an expert group.

A series of regional workshops were held to identify the thematic subject areas which were considered to be central to the content of this Framework.

This Framework presents an illustrative model which encapsulates the value base for all encounters with people living with a dementia, their families and carers. It is based on the concept that living with a dementia is not a linear journey nor indeed one where people fit into clinical categories such as early, middle or late stages of dementia and in fact people will enter the journey at different stages.

At the centre of the model is the key objective that the framework strives to ensure that the person living with a dementia, their family and carers, can live well with dementia. The key points in a person's journey pertains to finding out it's dementia, making changes and planning for the future.

There has been wide engagement across a number of organisations and a formal launch by the Health Minister is planned for autumn 2016.

### **Dementia Together NI delirium workstream**

***'For every 48 hours delirium remains undetected, mortality increases by 11%'***

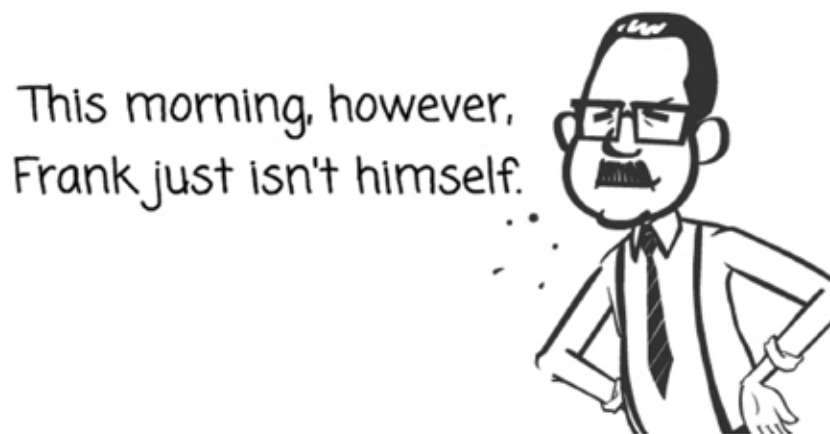
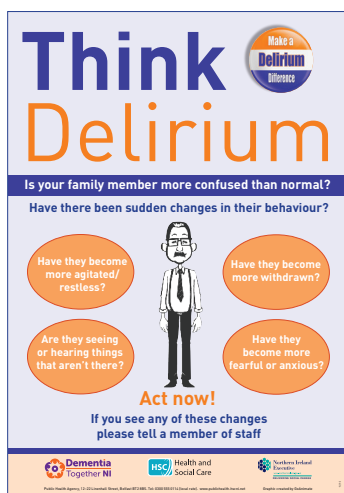
Delirium is an independent risk factor for poor outcome - increased mortality and increased risk of adverse incidents such as falls and prolonged length of hospital stay. It is commonest in those over 65 years, with conditions such as acute infection, hip fracture or pre-existing dementia.

In order to address difficulties in prevention, recognition and management of delirium within the acute setting, the HSC Safety Forum facilitated a regional quality improvement collaborative. In support of the regional dementia strategy, the collaborative, working with front line staff, patients

and their families/carers explored ways to improve care for those suffering from (or at risk of developing) delirium.

The work of the collaborative involved development of a screening tool and care bundle designed to embed best care, based on NICE guidance, for people who are at risk of developing delirium.

It was also imperative to (i) highlight the increased risk for certain populations of patients and (ii) improve communication between staff and those who are at risk, their families and carers. Materials were developed to engage with these groups and emphasise the importance of improved engagement; posters for use in public areas, under the theme 'Think Delirium' outlining signs and symptoms; information leaflets to reassure family/carers in relation to delirium experience; staff posters to re-enforce care pathway and use of tool. A delirium awareness animation was developed to share information on delirium far beyond HSC organisations.



Tailored delirium training was developed to provide staff with additional knowledge in relation to identifying, preventing and managing delirium. This training module has been provided to over 700 staff on site, and will be available on the HSC eLearning platform to ensure spread and sustainability of best practice.

## Saving babies' lives campaign

Saving babies' lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

These elements were identified as such by experts through a process of engagement and consensus building over a 12 month period since 2014. Each HSCT in Northern Ireland has mapped their current work against all four elements and have plans to take forward improvements in each area in collaboration with each other in order to reduce stillbirth rates in Northern Ireland.

## Family nurse partnership programme

Quality is at the heart of the Family Nurse Partnership Programme. The Family Nurses aim to provide the highest quality service for our young people's wellbeing. Following the publication of the Building Block Randomised Controlled Trial, the Family Nurse Partnership Programme in Northern Ireland has embarked on a Quality Improvement programme focusing on five key areas:

- smoking cessation in pregnancy and parenthood;
- improving breastfeeding in initiation rates;
- improving access to a flexible sexual health and pill planning services for teen parents;
- initiation of the revised perinatal mental health pathway;
- improved access to home safety equipment.

A service improvement methodology will drive this quality improvement bundle. The regional database will inform whether the programme adaptations are improving the outcomes for young parents on the programme

## Service developments

### Early pregnancy assessment services

Early pregnancy assessment services (EPAS) play a crucial role in treating and supporting women and their families during what can be a very distressing and frightening time in their lives. In 2012, NICE published guidance on ectopic pregnancy and miscarriage, including a specific recommendation on seven day access.

Over the last year, the PHA has worked with HSCTs and patient groups to consider issues of variation across early pregnancy services in Northern Ireland. In November 2015, the PHA hosted a regional multi-professional workshop examining criteria for referral, models of service delivery, links with bereavement services and seven day access. Following further engagement, including the Maternity Strategy Implementation Group and Emergency Department Clinical Engagement Group, a common direct referral pathway and commissioning intention for early pregnancy assessment services were developed and shared with HSCTs and primary care in June 2016. The common referral pathway specifies when women who experience vaginal bleeding/pain in early pregnancy should be referred from community or emergency department triage settings directly to early pregnancy assessment services. The commissioning intention also outlines the regional approach to referral, access, models of care, ultrasound scanning and bereavement care within early pregnancy assessment services.

These will be implemented by the HSCTs and primary care sending a consistent message to referrers and aiming to improve experience for patients their families and staff. This is an

important area for the Maternity Strategy Implementation Group and updates on progress within HSCTs will be sought in six months.

### **Acute oncology service**

An acute oncology service (AOS) was created and introduced to improve the care of people with acute cancer-related symptoms requiring hospital care. This innovative development led by the HSCB, working with the PHA and Macmillan means that Northern Ireland leads the way in the UK in introducing services on a regional basis.

AOS will ensure that people requiring unscheduled hospital admissions with complications of cancer will have improved access to oncology support. Northern Ireland patients receive excellent cancer care, but when requiring unscheduled admissions they do not necessarily have access to oncology advice. A bed census, undertaken in autumn 2013, identified an unmet need for AOS with 368 people in hospital with acute cancer-related complications.

The introduction of acute oncology services is a response to national advice. The service was developed drawing on this advice and bringing together local expertise from many disciplines to ensure a rigorous and consistent patient centred care. Importantly, we developed an integrated approach across all HSCTs, across clinical disciplines and across the statutory and voluntary sector.

Through collaboration with HSCT clinicians and managers, service users and Macmillan Cancer Support, a service model was developed, patient pathways mapped and a service specification developed. Subsequently an evaluation framework was created and tested against the specification, and a database developed to ensure consistency in monitoring across all HSCTs. Quarterly reports are shared at the steering group at which the service impact can be assessed. The development of a mobile APP provided access to the guidelines for all health care professionals. Guidelines and APP details were disseminated through HSCTs, made available on HSCT intranets and shared through social media channels.

The service commenced in 2016 and outcomes are assessed utilising the evaluation framework (table 2). Early results have shown services provide rapid access to the service which often negates the need to attend ED, reduces 30 day mortality and length of stay, all improving patient safety and quality of care for people with acute cancer related complications.

Developing the acute oncology service through a collaborative approach with primary, secondary and community care, service users and the voluntary sector representation meant that engagement and commitment of stakeholders was secured.

With limited funding, by necessity the service will develop in a phased manner, an approach instrumental in developing key priorities and securing agreement for a robust evaluation which will help provide the evidence of effectiveness and facilitate service expansion.

Recruitment has been slower than anticipated and on reflection, we could have potentially utilised a central recruitment process which may have expedited the appointment of medical and nursing staff.

## Improvements in reducing health care associated infections

During 2016 the PHA Health Care Associated Infection team carried out two pilot projects focused on care home settings. These projects aimed to improve the knowledge of MRSA colonisation; and improve the diagnosis and management of urinary tract infections in these settings. Improvements in the management of these issues have the potential to reduce the burden of resistant bacteria in the community and contribute to the reduction in health care associated infections.

### 1) Educational intervention to improve knowledge and management of MRSA in a sample of care homes in Northern Ireland

MRSA carriage in care home residents has been found to be disproportionately high in admissions to acute HSCTs. It has been reported that MRSA colonisation levels among residents in care homes in the UK were >20%.

Given the disproportionate incidence of MRSA colonisation in care home settings, the team identified one care home in each of the five HSCTs in Northern Ireland and arranged three visits to each selected home in order to ascertain the knowledge and management of MRSA/antimicrobial stewardship before and after an educational intervention. The visits consisted of a range of methodologies including audits, feedback and improvement techniques.

First visit	Second visit - the intervention	Third visit
<ul style="list-style-type: none"> <li>• Hand hygiene audit</li> <li>• Personal protective PPE audit</li> <li>• MRSA questionnaire</li> <li>• Antimicrobial stewardship</li> <li>• Questionnaire</li> </ul>	<ul style="list-style-type: none"> <li>• Presentation on general IPC (with HH glow machine)</li> <li>• Presentation on MRSA and management (with scenarios)</li> <li>• Presentation on PPE (with practical donning and removal)</li> <li>• Presentation on Antimicrobial stewardship</li> <li>• Questionnaire</li> </ul>	<ul style="list-style-type: none"> <li>• Re-audit hand hygiene</li> <li>• Re-audit PPE</li> <li>• Repeat MRSA questionnaire</li> <li>• Repeat antimicrobial stewardship questionnaire</li> <li>• questionnaire</li> </ul>

Following the intervention, hand hygiene practice improved for all members of staff. With hand hygiene being the single most important factor in the onward spread of most infections, not just MRSA, it is hoped that the quality of care and safety of residents improves also.

PPE usage is an important factor in infection prevention control practices. It is, however, only effective if used properly. The practice of donning, removal and disposing of PPE improved in all the homes participating.

Antimicrobial resistance is a major treat to everyone especially the elderly and infirm. The knowledge of virus/bacteria, first and second line antibiotics for specific infections, dangers of prescribing without examination or lab result and Kardex review all improved following the intervention for each participating home.

MRSA knowledge improves the management of residents either colonised or infected within the care home environment. Subjects covered included isolation, decolonisation, outbreak management, transfer to other healthcare facilities and terminology. In all participating homes the repeat questionnaire proved that knowledge levels had increased.

## **2) Educational intervention to improve the diagnosis and management of urinary tract infections (UTIs) in a sample of care homes in Northern Ireland**

HALT (2013) raised concerns about the diagnosis and management of UTIs in care homes in Northern Ireland. The aim of the pilot was to review the impact of a decision aid (adapted from Scottish Consortium's decision aid) and educational package in improving the diagnosis and management of UTIs in care homes. The team took a range of steps to assess the impact including:

- adopting the Scottish Consortium's decision aid for use in Northern Ireland following consultation with a wide range of experts and clinical staff;
- developing an educational package for both care homes and GPs;
- selecting five care homes (one from each of HSCTs) and invited them to take part in the pilot;
- carrying out semi-structured interviews with staff in care homes to determine how UTIs were diagnosed and managed prior to the pilot;
- providing care home based training on UTI diagnosis and management in each of care homes and provided GPs with hard copies of training packs and decision aids;
- asking care homes to collect information on residents receiving antimicrobials for UTIs/ uroprophylaxis for a two month period following the educational intervention;
- collecting feedback from care homes and GPs on training and decision aid.

The information collected during the semi-structured interviews confirmed the findings of HALT (2013). Signs and symptoms of infection were not used appropriately to diagnose UTIs and dipstick urinalysis was often used as a diagnostic tool for UTIs in the absence of signs and symptoms of infection. This resulted in inappropriate antimicrobial prescribing. In addition to this most of the care homes referred to feeling pressured to initiate treatment for UTI because of requests from relatives, even in the absence of clear signs and symptoms of infection. The G.P. often initiated treatment based on a laboratory result and relied on the care home to send samples at appropriate times.



The feedback from the educational intervention and decision aid was positive and both care homes and GPs agreed that they were easy to understand and improved diagnosis and management of UTIs. The care homes reported that antimicrobial prescribing was reduced during the two month period of the pilot.

The pilot highlighted that more work is required in educating the general public on the need to treat UTIs in > 65 year olds based on signs and symptoms of infection. This may require PPI work to ensure effective communication. In addition to this the pilot highlighted the need for training to be rolled out to staff outside of the care home setting, including community psychiatric nurses, district nurses and out-of-hours staff.

## **Centre for Connected Health and Social Care**

The Centre for Connected Health and Social Care (CCHSC) continue to work in partnership with HSCTs and HSCB to participate in EU initiatives. The European Innovation Partnership on Active and Healthy Ageing aims to achieve its overarching target to increase the average healthy lifespan by two years by 2020.

By bringing together key stakeholders (end users, public authorities, industry); all actors in the innovation cycle, along with those engaged in standardisation and regulation the partnership provides a forum in which they can cooperate, united around a common vision that values older people and their contribution to society, identify and overcome potential innovations barriers and mobilise instruments. Currently the PHA and HSCB participate in the work of Action Groups. Action Groups formulate collective plans to take forward work in their respective areas such as Personalised health management, starting with a falls prevention initiative; prevention of functional decline and frailty; Integrated care for chronic diseases, including remote monitoring at regional level; development of interoperable independent living solutions, including guidance for business models; innovation for age friendly buildings, cities and environments and prescription and adherence to treatment. Participation in the action groups raises the profile of Northern Ireland and the many excellent initiatives and models of service that we have in place; provides a means to benchmark against other European regions and to discuss, explore and learn from the experience of others. Participation also allows for relationships to be formed that may lead to consortia that would be well placed to bid against future calls for EU funding.



## Theme five: Integrating the care

### **Integrated care partnerships (ICPS) in primary care**

Seventeen Integrated Care Partnerships (ICPs) were established in June 2013 as collaborative partnerships of providers tasked with designing, implementing and monitoring services within their locality. Each ICP Partnership Committee has representation from primary care, secondary care, community pharmacy, NIAS, voluntary and community sectors, local council officers as well as service users and carers. The initial clinical priority areas that ICPs have been asked to focus on are frail elderly, respiratory disease, diabetes, stroke and end of life care as it applies to those clinical areas.

Through the collaborative work of ICPs, services are now planned and delivered in partnership between all providers involved in the frontline delivery of care. This has created a shift in culture from providers working in relative isolation of each other to an open and transparent partnership to deliver patient centred services. New models of care have been developed across the region that have driven integration amongst providers and have also brought a focus to establishing the promotion of wellness and use of community and voluntary services as a core part of new models of care. Belfast ICPs are working to implement a chronic disease prevention hub as an integral part of all redesigned care pathways and South Eastern ICPs are currently developing a proposal for a similar service, both commissioned by the respective Local Commissioning Group.

Western ICPs have successfully implemented a social prescribing pilot to help older people to address social, emotional or practical needs by linking them to sources of support and activities within their local community. The pilot involved Aberfoyle Medical Practice and Eglinton Medical Practice and was delivered by Bogside & Brandywell Health Forum, in conjunction with Rural Area Partnership in Derry (RAPID).

Older people referred to the service by their GP were visited by a social prescribing coordinator to discuss suitable options including: social clubs, physical activity, self-help groups, and volunteering, learning, counselling, and advice and guidance services. The coordinator then supports the older person to access the necessary services and remains in contact with the client to review progress. The majority of people referred were for long term physical conditions, emotional resilience and social isolation. Most referrals were made to exercise opportunities or older people's social clubs.

From April 2015 to May 2016 106 people were referred to the programme with 66 people going on to participate in social activities delivered by the community and voluntary sector. Feedback from patients shows that the programme has had a positive impact in changing health behaviours through losing weight or stopping smoking, in integrating the new activities into their daily routine, increased confidence and willingness to try other activities, and fewer visits to their GP.

Since their establishment in June 2013, ICPs have been focusing on delivering integrated care pathways with providers working in partnership to deliver the right care, in the right place, at the right time. Belfast ICP, Southern and South Eastern ICPs have developed or helped refine acute/enhanced care at home models aimed at treating elderly patients in their own home for certain conditions where they would previously have presented at ED or been admitted to hospital.

The average length of stay in the acute care at home service is six days, compared to an average 11 day stay in hospital for older people in Belfast.

In 2015/16 274 elderly people were provided with care in their place of residence and therefore avoided a hospital admission, saving 3014 bed days. All patients have reported 100% satisfaction with the service.

Each ICP Partnership Committee is responsible for service redesign and implementation, the monitoring of services across the clinical priority areas and demonstrating the improvement they have made. ICPs are held to account by their respective Local Commissioning Group for the services they deliver, against a range of regional and local metrics set out in a formal Local Accountability Agreement (LAA). The LAA is in place to demonstrate value for money and facilitate ongoing improvement by facilitating evidenced based rapid cycles of change. The Northern ICPs' 'Nursing home in-reach' project focuses on very frail older people living in nursing homes, who commonly experience a high level of attendance at EDs.

The aim is to develop and deliver a specialist education, training and development programme for staff working in nursing homes in the Antrim/Ballymena area to enable them to provide care for their residents in the home, rather than in hospital.

Two staff from each of the 20 participating nursing homes took part in training including: long term conditions management; dementia care; recognising/managing the deteriorating patient; medicines optimisation; end of life care; catheter management; PEG tube management; syringe driver management and venepuncture. The staff then cascade this learning to their colleagues. A practice development facilitator provides a 'case finder' function to track patients who do attend ED, to determine the appropriateness of that attendance, and then to provide follow up support to the home, such as additional staff training, to avoid a re-attendance.

The increased knowledge and skills of nursing home staff in the pilot has resulted in a 25% reduction in the number of visits from Marie Curie staff out of hours; a 21% reduction in the number of calls made to district nursing services compared to the same period in the previous year; a 48% reduction in the number of calls to the hospital diversion nursing team relating to PEG tube issues.

The numbers of elderly people attending the ED from nursing homes in the NHSC area has reduced by a third due to the enhanced skills of nursing home staff, down from 1016

attendances in 2014/15 to 706 in 2015/16, and avoiding 1624 acute bed days. Unfortunately, the further roll-out of schemes, even where the emerging evidence of improvement is strong, is often impeded by a lack of ring-fenced funding for reform projects.

A number of initiatives aimed at allowing patients to be cared for in their own home by appropriate specialists were developed in 2015/16. Examples of two such initiatives are described below.

### **The enhanced care at home service – South Eastern HSCT**

In 2015 the enhanced care at home service was commissioned by the South East LCG and launched in a locality (North Down and Ards) of the South Eastern LCG area. Patients age 65 and over could be referred by their GP or district nurse to the Enhanced Care at Home service. This service allowed these patients to receive, within their own home environment, assessment and treatment from a team of specialist professionals coordinated through their own GP and District Nurse. This service, an excellent example of joined up and innovative working, is designed to enable health and social care providers to work more closely together. Enhanced care at home delivers seamless care, providing a better experience for patients, their families and carers whilst reducing pressure on hospital services. This initiative keeps people well in local communities while responding to each individual's needs.

Between September 2015 and April 2016, fifty patients were admitted to the service with conditions such as COPD, cellulitis, congestive cardiac failure, UTI, dehydration and asthma. As the service rolls out across the SE LCG area, numbers are anticipated to rise significantly.

### **The acute care at home team – BHSCT**

This is an innovative new service which was commissioned by the Belfast LCG and launched in Belfast in October 2015. It provides older people with expert medical and social care in their own home. GPs can refer older people living within BHSCT Community team catchment area whether they are living in their own home or in residential or nursing homes. The 'acute care at home' team is led by a consultant geriatrician and includes nurses, pharmacists, social workers, occupational therapists, physiotherapists and community psychiatric nurses. GPs are an integral part of the team, provided through a local enhanced service with Belfast practices working together through GP Federations to provide 20 GP sessions per week to the team.

Since the service was officially launched in October the team have treated 260 older people with conditions such as chest infections, urinary tract infections, cellulitis and dehydration who would previously been referred either to ED or admitted to hospital. The average length of care with the acute care at home team is one week, and around 75% are managed without the need to be admitted to hospital.

### **Developing eyecare partnerships**

A core tenet of developing eyecare partnerships (DEP) is the integration of eyecare services across primary and secondary care through a pathway approach to service provision. Eye conditions are sometimes life-long but can also be of sudden onset with rapid resolution;

however, irrespective of how quickly they take to present or how long they are present, it is important that the management of the condition and the outcomes are consistently good. Patients with eye problems often attend both optometrists in the community and doctors and other ophthalmic professionals in the hospital eye services. It is essential for good patient outcomes that primary and secondary eyecare services are integrated and connected. Through DEP the HSCB has introduced several initiatives to allow better integration of care.

*How we did this, what did we do and what difference has this made and will continue to make to patients?*

### **1. Project ECHO for optometry/ophthalmology**

During 2015/16 Optometry services in HSCB established a 'world first' Project ECHO® 3 Ophthalmic Knowledge Network supported by the Northern Ireland Hospice. Project ECHO is an innovative tool using interactive digital communications to facilitate engagement between ophthalmic specialists and optometrists in the community. Through regular ECHO sessions, knowledge is shared and clinical experience and skills are enhanced. ECHO has enabled the establishment of a culture of engagement and support for learning and a mutual understanding of the challenges faced in care provision across primary and secondary care. In 2016/17 the HSCB plans to establish a second ophthalmic knowledge network. Patients will benefit from Project ECHO in that the clinicians who engage will have direct access to expertise and peer support resulting in enhanced knowledge and skills to support their provision of generalist clinical care.

### **2. Electronic referrals**

In 2015/16 the HSCB has established the mechanisms and infrastructure to enable optometrists in the community to refer patients to secondary care using electronic referral via the HSC Clinical Communications Gateway. This significant project will ensure that patient referrals are sent directly to secondary care in a timely and direct manner and that feedback directly to the optometrist is enabled. Electronic referrals will ensure that the patient journey 'in' to secondary care is efficient and safe and that the essential feedback on the patient outcome, that is the journey 'out', and is advised to the primary care professional who will provide ongoing care in the community. 3 Project ECHO® (Extension for Community Health Outcomes) Northern Ireland <http://echonorthernireland.co.uk>

## **Building the community pharmacy partnership**

The Building the Community-Pharmacy Partnership (BCPP) is a partnership between the Community Development and Health Network (CDHN) and the HSCB with strategic direction offered by a multi-agency steering group.

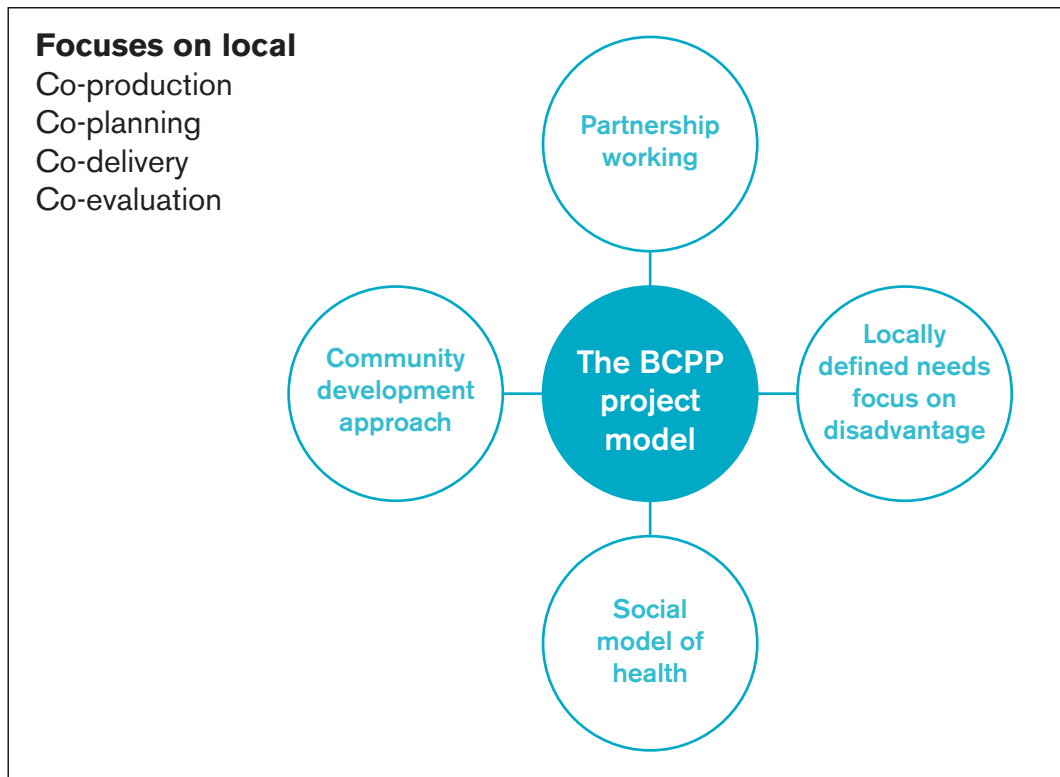
The programme aims to promote and support local communities to work in partnership with community pharmacists to address local health and social wellbeing needs using a community development approach.

The programme works towards:

- increasing local people's skills, encouraging community activity and self help;
- increasing local people's understanding of health issues;
- encouraging local people to play a role in promoting health.

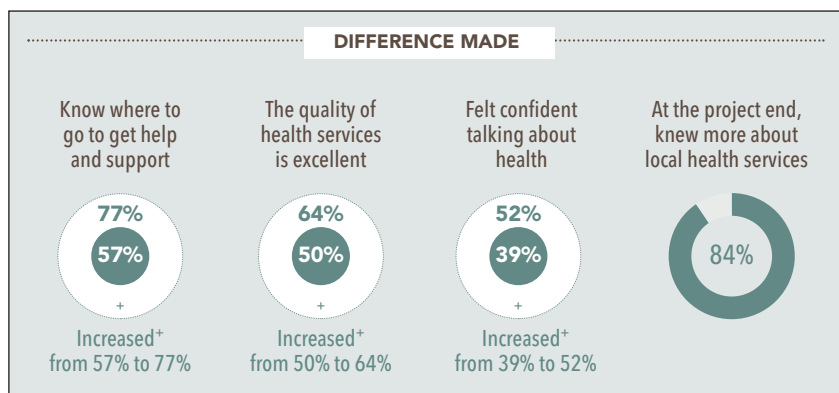
The project model is summarised as follows:

### Project model

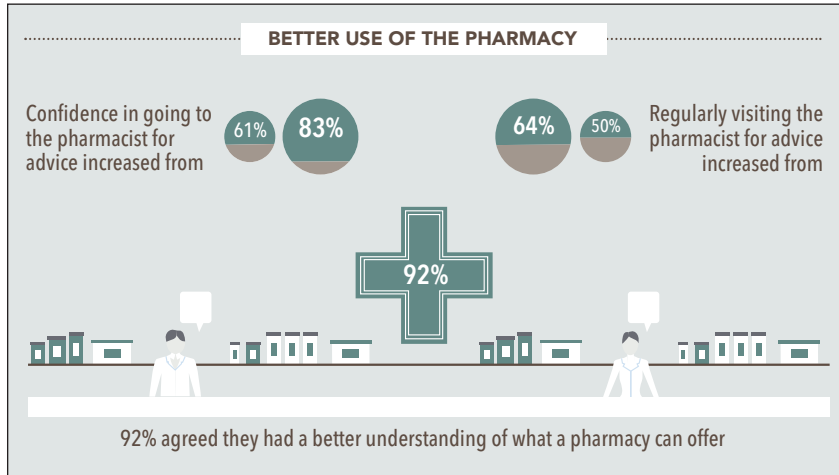


#### ADDED EXTRAS

Over the course of the year £360,000 funding is typically invested into over 60 projects which engage over 1600 core participants. Projects are delivered to some of the most deprived communities in Northern Ireland and cover a broad range of health and social care issues as well as wider determinants of health eg housing, poverty, employment. The programme is continually being evaluated and details of the impact of the project are given on the CDHN website: <http://www.cdhn.org/bcpp-resources> In summary there has been an improvement in confidence and knowledge in participants in relation to healthcare:



There have been improvements in the utilisation of pharmacies:



There have been improvements in self-reported health status of participants:



The HSCB will continue to commission CDHN to deliver this programme in 2016/17 and seek ways to build on what is a very positive programme.

## Wasted medicines in primary care

In 2014/15, the Northern Ireland Audit Office published its report on Prescribing in Primary Care. This was followed by a review by the Public Accounts Committee. Later in 2015/16, RQIA published its Review of Medicines Optimisation in Primary Care. In each of these reviews there was recognition of the good work of the HSCB Pharmacy and Medicines Management Team. There were also consistent themes in respect of prescribing variation, costs and medicines utilisation in primary care.

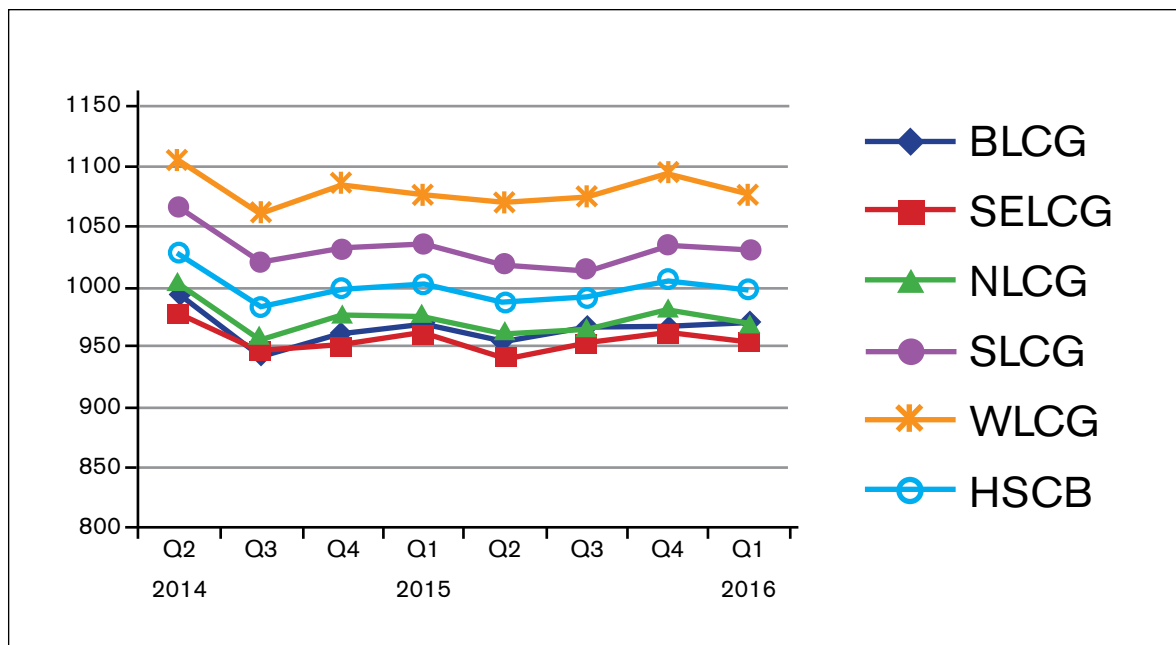
With respect to the demand for prescriptions and use of medicines, HSCB has embarked on a social media campaign which highlighted that:

- Medicines wasted in Northern Ireland have an estimated value of £18m each year;
- Over 70 tonnes of medicines are returned to community pharmacies each year with an estimated value of £6.5m each year.

The target group for the campaign was women aged over 40. The campaign was supported by LCGs and had good reach on social media with 34000 people in the target group on Facebook, 53000 people on Twitter with a total exposure of over 100,000 impressions.

The direct impact of this campaign is difficult to measure. It is noticeable that the overall prescribing frequency as measured by the number of prescriptions per weighted head of population (NIPU) has shown a slight decrease. This is against an increasing demand for health and social care services.

**Figure 14: Items/1000 NIPUs**



## Pharmaceutical clinical effectiveness (PCE)

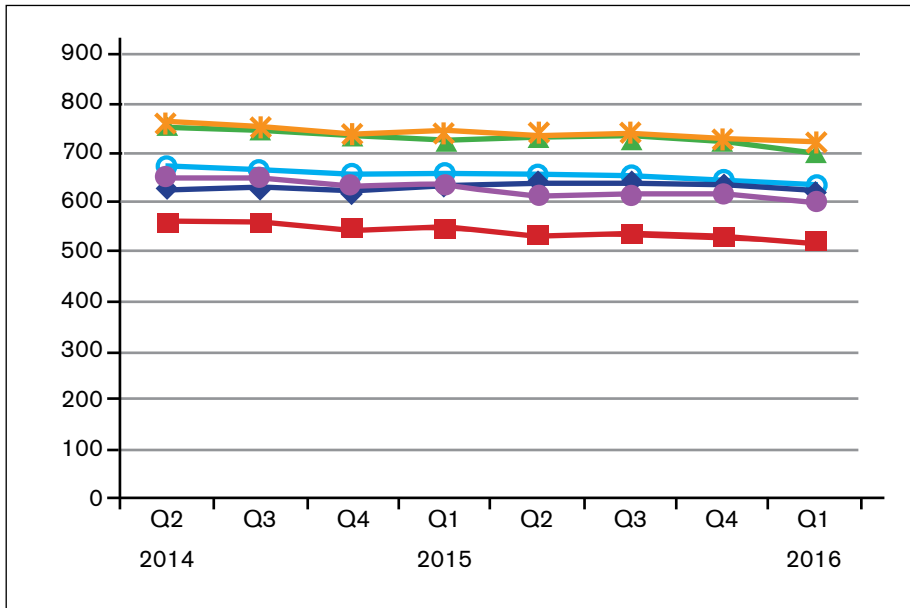
Each year, the HSCB is tasked with delivering the PCE programme. The ethos for PCE is that by focusing on quality and safety in prescribing and use of medicines, we can derive efficiency and health gain. While there is a financial target for PCE, and in 15/16, this was £20m which will ensure budgetary breakeven, it is of critical importance that this drive for efficiency does not supersede quality and safety. In 2015/16 there was work undertaken in all therapeutic areas and integration of work in primary care with secondary care and with the community and voluntary sector has been and continues to be important. By way of example, in Northern Ireland we issued **4,201,874** prescriptions for analgesics (pain killers) costing **£36,089,876**. We have recognised that simply issuing guidance to general practice in relation to the best medicines to prescribe simply does not address the underlying issues with management of pain. There is a requirement for a whole systems approach:

- prescribing guidance that is jointly owned by practitioners in primary and secondary care;
- support for patients and carers in respect of how they manage chronic pain;
- access to specialist advice and support;
- access to therapists such as physiotherapy.

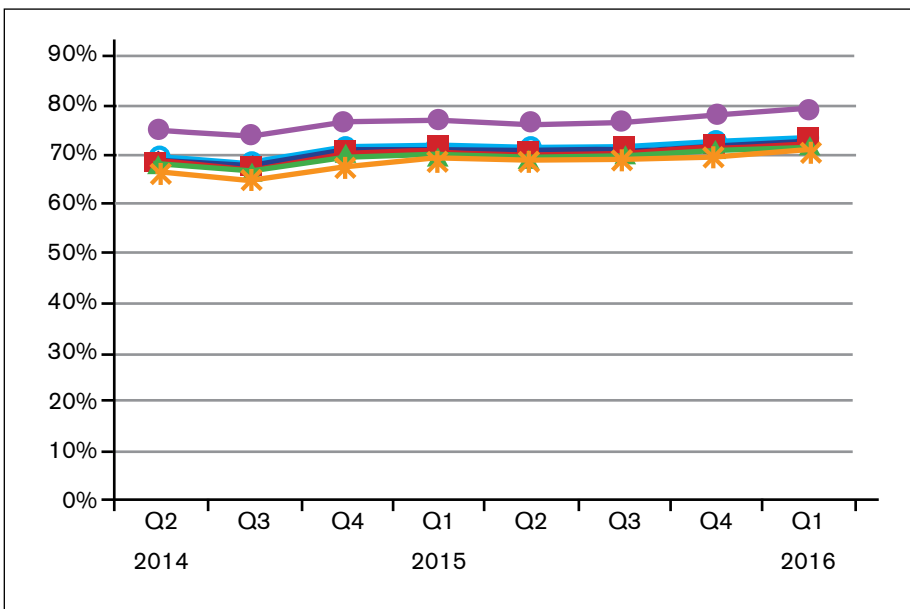


In 2015/16 chronic pain was recognised as a Long Term Condition and further work is underway to consolidate the actions that have been undertaken thus far. HSCB continues to monitor progress in this area through a range of prescribing indicators which shows progress is being made:

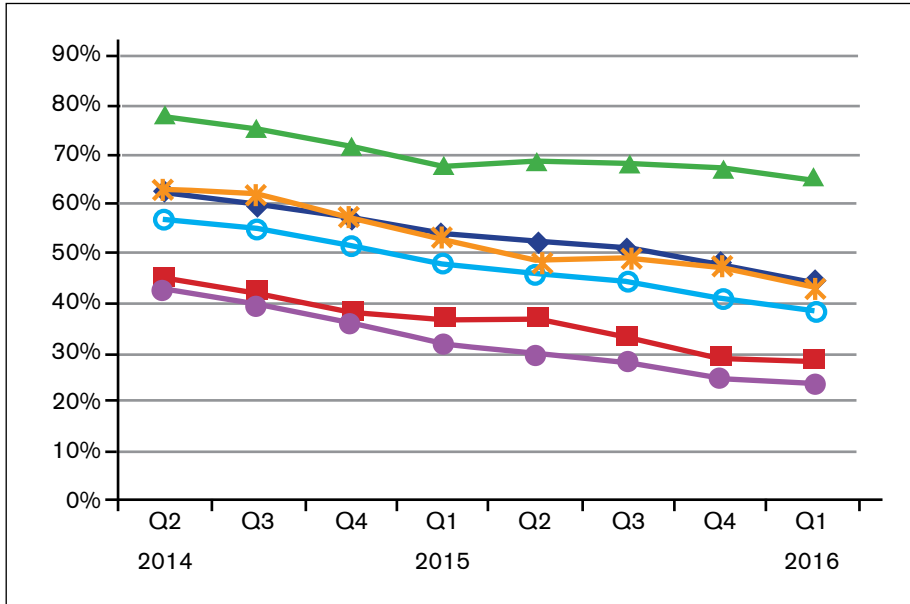
**Figure 15: NSAIDs DDs/1000 NIPUs**



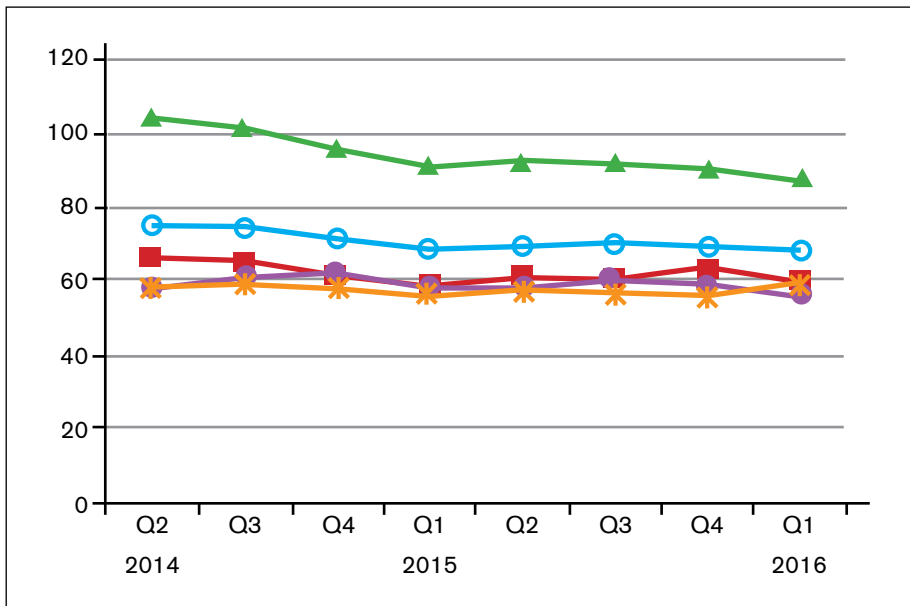
**Figure 16: % ibuprofen and naproxen of all NSAID items**



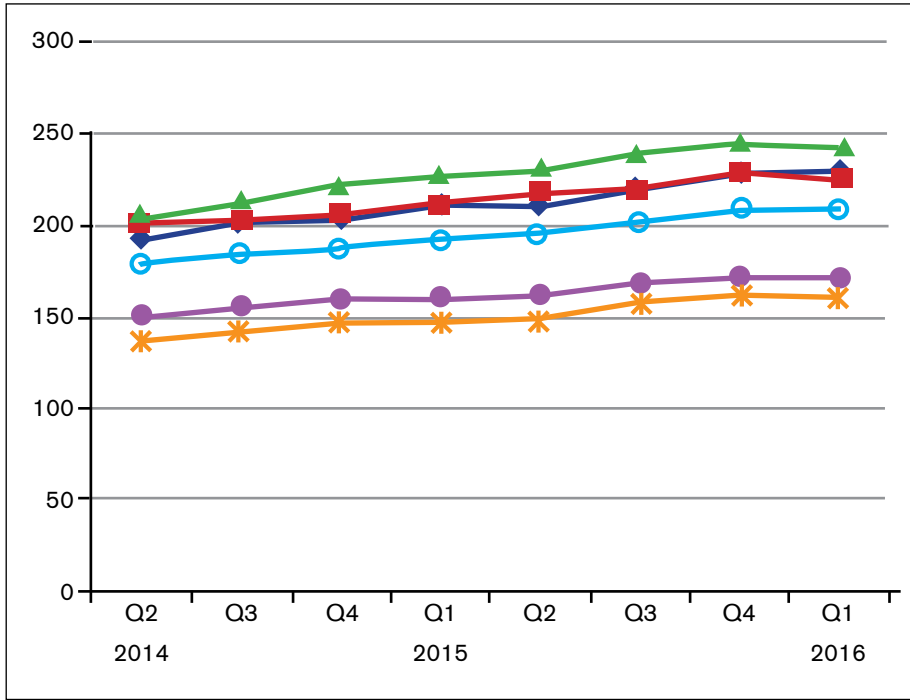
**Figure 17: Diclofenac, DDDs/1000 NIPUs**



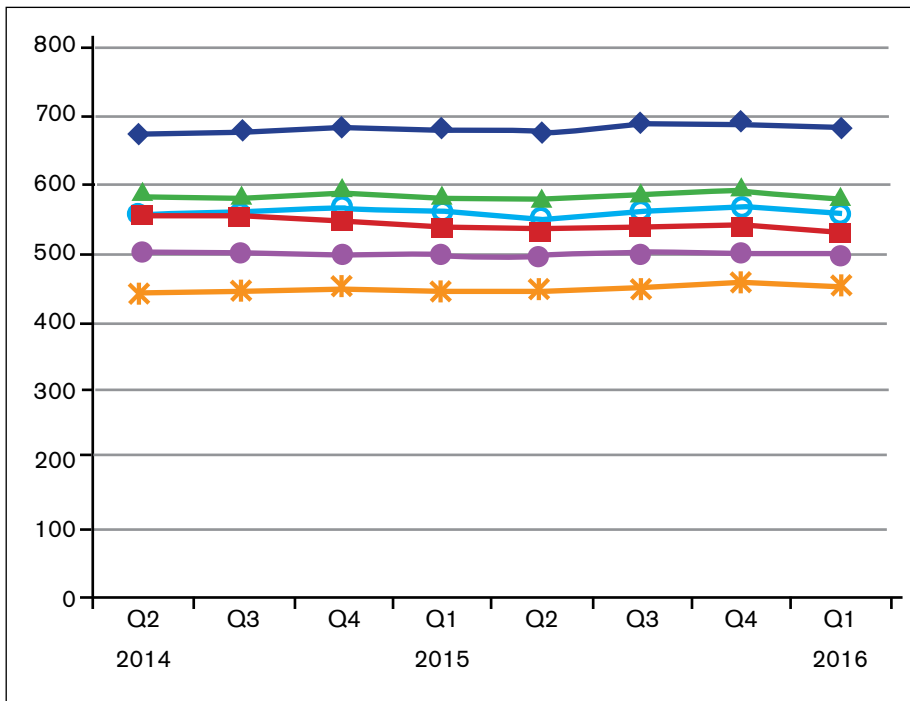
**Figure 18: Cox IIs, DDDs/1000 NIPUs**



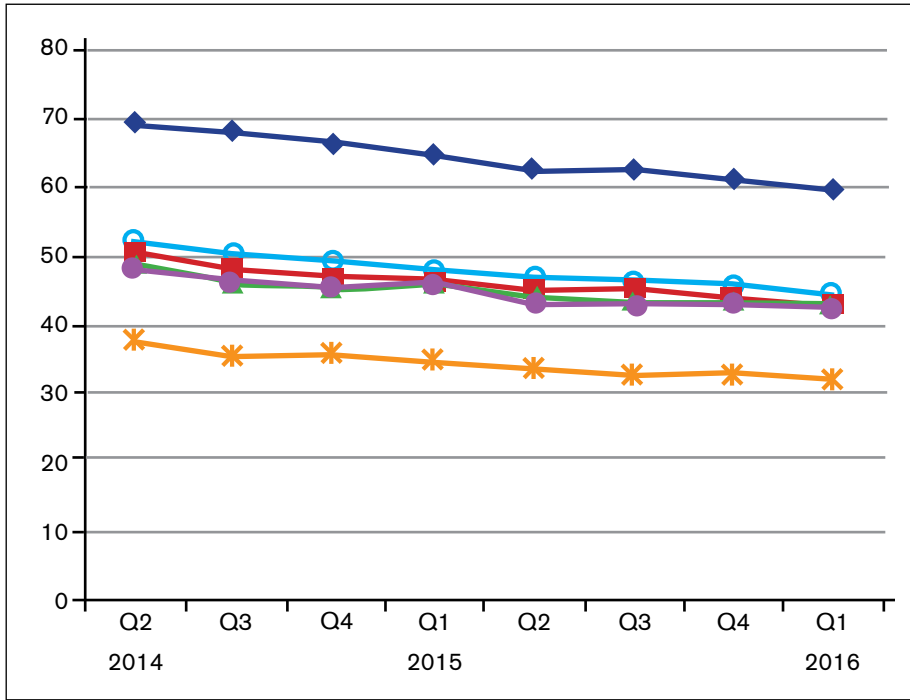
**Figure 19: Pregabalin, DDDs/1000 NIPUs**



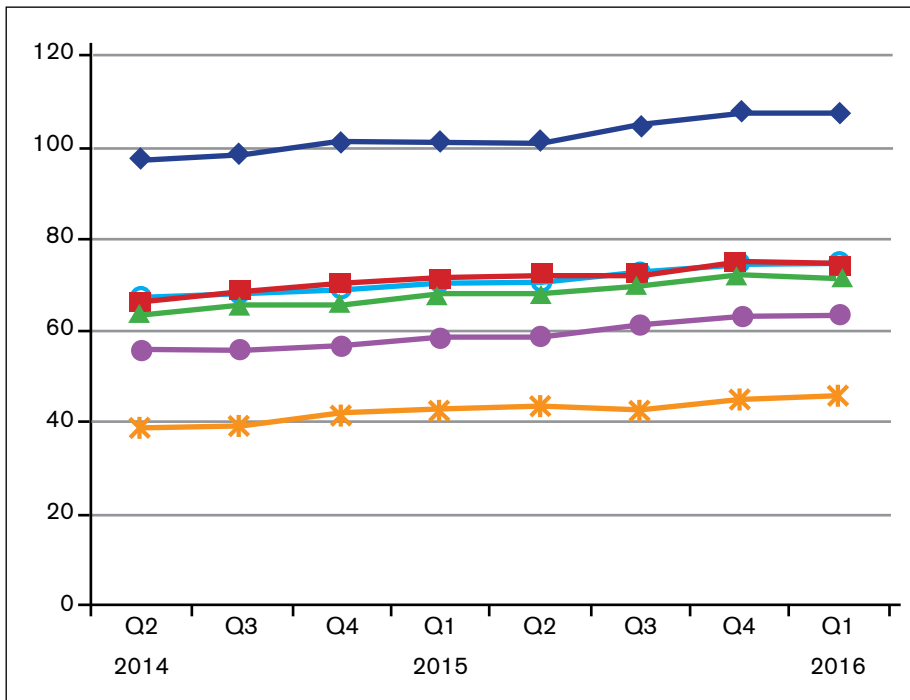
**Figure 20: Paracetamol-opioid compound analgesics, DDDs/1000 NIPUs**



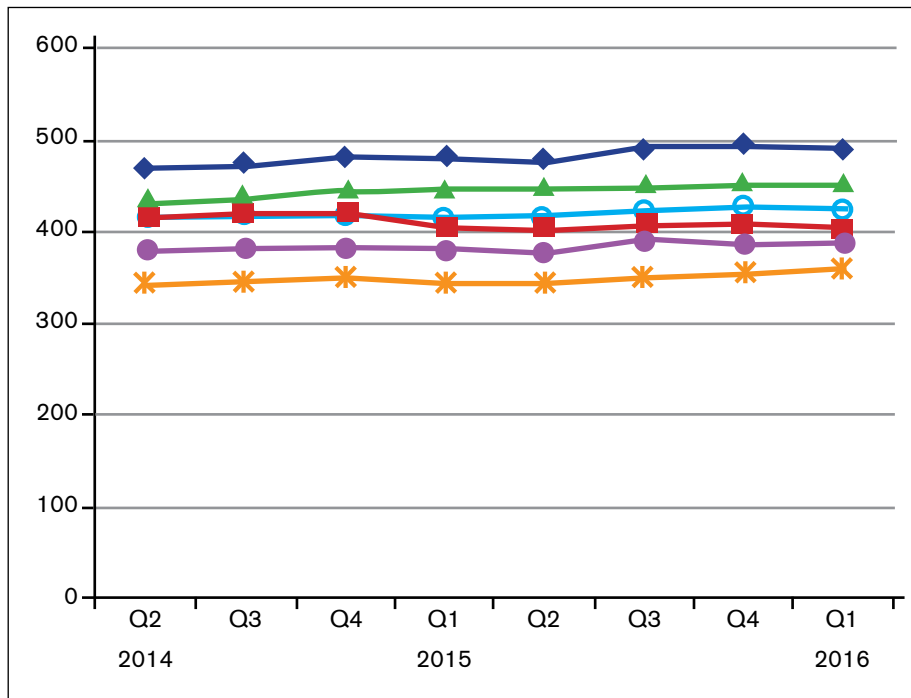
**Figure 21: Co-codamol 8/500 DDDs/1000 NIPUs**



**Figure 22: Co-codamol 15/500, DDDs/1000 NIPUs**



**Figure 23: Co-codamol 30/500, DDDs/1000 NIPUs**



## Integration of quality improvement

### Improved care for children in hospital

In 2015/16, the HSC Safety Forum’s paediatric quality improvement collaborative completed the introduction of age-adjusted early warning scores for all children in hospital to facilitate the early detection of deterioration and timely intervention. This was achieved by evaluating a prototype system in pilot areas and making further minor changes before full introduction – which in turn will be re-evaluated after 12 months.

Medication errors are a significant but preventable cause of harm to children and young people. The HSC Safety Forum in partnership with the Royal College of Paediatrics and Child Health have joined the UK Meds IQ network to bring together tools and improvement projects to address this problem. The vision of the network is that child health professionals will be able to use this resource to support their own improvement work and learn from the experiences of others. Each HSCT has identified champions whose role is to (i) promote the use of Meds IQ in their HSCT and professional groups (ii) share local and regional resources on medication safety and contribute to the content of the website.

In parallel with the above, working in partnership with Northern Ireland Medical & Dental Training Agency, paediatric medical trainee programme, the HSC Safety Forum designed and delivered an introduction to Quality Improvement training package for child health professionals covering basic QI methodologies including the IHI Model for Improvement, PDSA cycles, stakeholder engagement and measuring for improvement. We also shared experiences of successes and failures and look at how we can share good practice. It is anticipated that this will become a standard element of future training programmes.

## Beyond pills - living better with persistent pain

It is challenging for people living and often struggling with persistent and disabling pain to become involved in Health and Social Care service improvements. In 2014 the Patient Client Council published 'The Painful Truth' report based on the personal accounts of 2500 people in Northern Ireland and their experience of living with persistent pain. The majority of the report's ten recommendations were accepted by the health minister, the HSCB and PHA. This led to the establishment of the Northern Ireland Pain Forum in 2015; a collaborative network of voluntary and statutory service providers and service users. The forum seeks to drive pain management service improvements through co design and co delivery, set priorities and influence policy decisions for the estimated 400,000 people, who have persistent pain in Northern Ireland. The forum is built around a service user reference group and has participation from voluntary agencies, community and primary care professionals and all HSCTs. It is supported by the Patient Client Council and the HSCB and convened and chaired by the PHA.

During 2015/16 a number of key service improvements relating to pain management were introduced including:

- development of the first comprehensive five year plan for much needed pain management service improvements;
- participation in the Northern Ireland Pain summit in November 2015;
- development of a Northern Ireland web portal for pain management;
- introduction of a menu for self-management interventions for patients in pain;
- identification of options for improving community and GP services;
- development of a patient pathway for fibromyalgia – a debilitating condition that is difficult to diagnose and treat.

## Integrating the care with AHPs

### **Allied Health Professional support in neonatology**

Recent regional investment has been secured for children with complex healthcare needs to appoint AHP practitioners to work within Neonatal care across the region. This investment ensures standards set within the British Association of Perinatal Medicine is met (BAPM) based on the current cot figuration in Northern Ireland.

The AHP staffing resource appointed within this investment for neonatal care includes Dietetics, Occupational Therapy, Physiotherapy and Speech and Language Therapy. These practitioners will work as part of the wider multi-disciplinary team of medical and nursing staff to strengthen the workforce and professional expertise in neonatal care, which will enhance outcomes for children and their families.

This investment will support the baby's short and long term neurodevelopmental, growth, nutrition, physical, respiratory and bonding with parents in line with the growing evidence of the complex needs of this vulnerable group.

Support provided will include a comprehensive assessment and provision of a developmental focused model of intervention to meet the identified babies and families'.

## **Neuro-disability**

Occupational therapy and physiotherapy support has been integrated within neuro-disability services in both a tertiary and local HSCT basis to address the complex movement disorders associated with Cerebral Palsy and other acquired Neurological conditions.

This integrated model of care with specialised medical support has provided comprehensive innovative interventions to meet the needs of children and young people with a range of neuro-disability disorders. This service model provide intervention to address the difficulties experienced by children within complex movement disorders from a neuro-disability base, eg increased spasticity, muscle stiffness and variable muscle tone.

This model delivers medical intervention such as Botulinum Toxin with intensive therapy to enhance children's independence and performance, ease their management and reduce pain in the following areas:

- children who are GMFCS 4 or 5 and who are experiencing discomfort for dressing and changing due to adductor and hamstring spasticity;
- ambulant children who have diplegia;
- children with upper limb spasticity.

The integrated Medical and AHP model of care has had positive outcomes for children and young people, parents/carers, school staff and clinicians and facilitates early intervention for children of varying levels of spasticity, meeting NICE guidelines. This team was recently runner up at the UK Neurology Team of the year and was a finalist at the 2016 AHP Award for Children's Services.

## **Integrating the care with social care services**

### **Adult safeguarding - new procedures including adults at risk**

Adults in need of protection, Joint Protocol for Working Adult safeguarding is a complex task involving a range of skills and expertise. This is reflected in the wide range of organisations who are members of NIASP. This allows NIASP access to an equally broad range of initiatives and developments across government departments which, in turn, significantly increases opportunities to raise awareness of adult safeguarding. Adult Safeguarding is a key service regionally, both for individual users/carers, but also strategically. Developed to standardise and streamline response to allegations of abuse, neglect and exploitation and improve outcomes for service users. Making Communication Accessible - A Guide for all HSC Staff was developed and will be formally launched on 27 June 2016

## **Regional review of domiciliary care**

Domiciliary Care is a key service regionally, both for individual users/carers, but also strategically. Information flows about the service and marketplace were poor and contradictory, the service user experience not consistently captured. Improved financial and activity information; better understanding of HSCT operating models, workforce pressures and the market regionally; improvement in data definitions. Establishment of a set of recommendations to inform future development of the service, including learning from user/carer experience, improved service interfaces and learning from national/international experiences.

## **Self-directed support initiative**

Introduces personalisation and co-production across all programmes of care including children with disability. Requires fundamental culture change in social care assessment, support planning, and practice as this is a strength based/outcomes focused approach working in partnership with service users and carers. The development of SDS initiative is a key component in personalisation and coproduction. The SDS initiative introduces the ASCOT Adult Social Care Outcomes Toolkit across all programmes of care on a phased approach. The background work with Kent University has taken place, licences are agreed and signed for the region and training has been provided to HSCT staff. The initial trialling will begin with SEHSCT in late August/early September and other HSCTs will follow soon after.

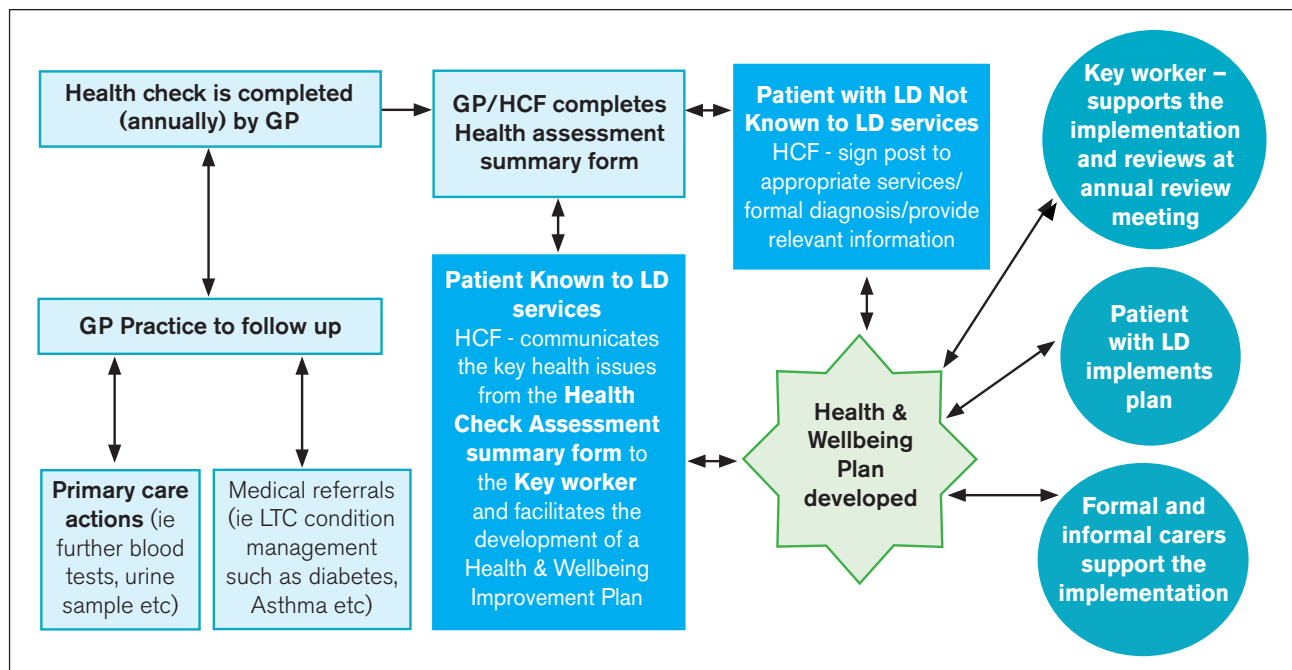
## **Annual health check: patient pathway to support the development of a health and wellbeing plan**

Within the Learning Disability Services Framework standard 21 indicates that people with a learning disability should be supported to achieve optimum physical and mental health. The key performance indicator linked to the standard specifies that each person with a learning disability who receives an annual health check should have a health and wellbeing plan in place. Health and wellbeing plans simply identify the personal health and wellbeing needs of individuals and describe the actions to empower individuals to make healthy choices to improve their health. They will also identify any help and support that might be needed to achieve and maintain good health and prevent ill health.

A patient Pathway has been developed (see below) as well as guidance in order to assist the HSCTs with the implementation of individual Health and Wellbeing plans for adults with a learning disability. The pathway and guidance will facilitate a consistent regional introduction to the development and implementation of Health and Wellbeing Plans by describing roles and responsibilities and will ensure that these plans become integral and routine to existing assessment, care planning and review processes.



## Annual Health Check: Patient pathway to support the development of a health and wellbeing plan



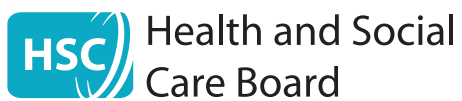
## Beyond silos: learning from integrated eCare practice and promoting deployment in European regions

CCHSC are currently leading a three year EU project in partnership with HSCTs, primary care, HSCB and BSO. Although the provision of collaborative service models bringing together the usual silos of social care, health care and informal support have started to emerge much remains to be done to deliver truly integrated care which meets people's needs.

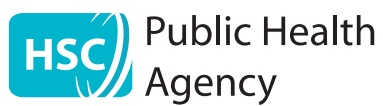
The project is called 'Beyond silos: learning from integrated eCare practice and promoting deployment in European regions'. The overall aims of the project are to enable delivery of integrated care to older people to support them to live independently within the community by providing the ICT tools necessary to join up care pathways across organisations, in particular between social and health service providers.

HSC are using the Beyond silos project to better integrate the care of older people in Northern Ireland. We are building on the Telemonitoring Northern Ireland service by integrating it with the NIECR thereby providing health and social care teams with common access to patient and client data. While interfacing elements of eNISAT with the NIECR will enable the transfer of information, including risk assessments, between professionals and will facilitate a smoother journey for the service user along the care pathway.

Additionally, we are piloting the inclusion of a shared care summary within the NIECR. Care professionals will be able to create and update service user information using a dynamic, interactive and integrated shared care plan. The Beyond silos project will use NIECR dynamic forms and pathway creation technologies to develop a shared care plan reusing information gathered from the community, eNISAT, TNI, and social care integrations, as well as information already known to NIECR.



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