The Regulation and Quality Improvement Authority

Review of Quality Improvement Systems and Processes

June 2016

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against three key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

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[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

Table of Contents

Executive Summary

Within health and social care (HSC), improving the quality of services has been ongoing for many years. However, it is only in relatively recent years that HSC organisations have adopted a quality improvement approach, using systematic methods and specific techniques to improve quality.

The review found there is no integrated regional approach to quality improvement (QI), and organisations were at different stages of their QI journey. The development of different individual QI approaches has resulted in numerous QI methodologies, tools and concepts being used. This has contributed to a perception that QI is complex process.

Constraints that are impacting on the effective development of QI include:

- The majority of staff did not have a good general understanding of QI or its benefits. This was limiting the involvement of staff and restricting further development.

- Embedding a QI culture remains a long term challenge.

- Limited capacity for QI work in relation to training and finding the balance between releasing staff to participate in QI initiatives against the need for service delivery.

- Communicating QI initiatives more widely within HSC to share learning and best practice regionally.

During the course of the review, the Minister for Health, Social Services and Public Safety announced the formation of an Improvement Institute, designed to drive forward innovation and QI in health and social care services.

The review team gathered the views of many staff across health and social care, and proposed ten steps that can be taken to enhance QI systems and processes. These steps could help inform the development of the new Improvement Institute.

Section 1 – Introduction

1.1 Context for the Review

The concept of quality embraces a wide variety of viewpoints and approaches. How quality is interpreted will have a significant bearing on its planning, management and success. In Northern Ireland, health and social care bodies have taken many steps to implement quality improvement (QI) initiatives with much important learning identified from each organisation.

Joseph Juran, a pioneer in the field of quality management, described a trilogy of three basic processes: quality planning, quality control, and quality improvement. For organisations to realise the full benefits of quality management, they must ensure these three processes work together.

Whilst there are many well accepted definitions of QI, there is no universally agreed definition and no agreed definition across health and social care. The Health Foundation has suggested QI as "a systematic approach that uses specific techniques to improve quality"[2]. The review team used this definition to guide its approach to conducting the review.

In November 2011, the Minister for Health, Social Services and Public Safety introduced Quality 2020 – A Ten Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland (Q2020)[3]. The strategy outlines the direction for QI in health and social care in Northern Ireland over the next 10 years. Alongside the strategy there is an implementation process whose work streams will deliver a series of products that will support the overall goals of Q2020.

Each health and social care organisation is now required to publish an annual quality report setting out actions which have been taken to improve the quality of services. These reports describe initiatives to support QI which have been taken forward both regionally and within individual organisations.

To ensure that the potential for QI continues to grow, organisations will require robust arrangements to be in place and have access to staff trained in QI methodologies.

RQIA has conducted this review to determine the baseline of the current systems and processes in place within health and social care organisations to deliver improvements in the safety, effectiveness and experience of care. The aim of this report is to synthesise this information to identify the most significant themes which emerged and to inform regional learning.

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[2] The Health Foundation – Quality improvement made simple - http://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

[3] Quality 2020 – A Ten Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/q2020-strategy.pdf

1.2 Terms of Reference

The terms of reference for this review were:

1. To describe and document the current key systems and processes in place across Northern Ireland and within health and social care organisations (individually and collectively), which are designed to improve the safety, effectiveness and patient/ client experience of health and social care.

2. To assess the views of key stakeholders in relation to:
    a. the effectiveness of current arrangements for quality improvement
    b. the current capacity for quality improvement
    c. the arrangements for sharing quality improvement initiatives between organisations
    d. benchmarking quality improvement against other organisations
    e. constraints to be overcome for effective quality improvement
    f. how quality improvement systems and processes could be enhanced

3. To make recommendations for improvement, including possible approaches in relation to assessment of progress in relation to quality improvement across HSC organisations.

1.3 Review Methodology

The review methodology was designed to gather information about quality initiatives and QI work being undertaken by organisations within health and social care. The methodology included the following steps:

- A background review of health and social care organisations to determine their level of exposure to QI and to identify appropriate lines of enquiry.

- Questionnaires which detailed systems and processes for QI, and how they were being taken forward within these organisations.

- Meetings with each organisation to explore the deeper learning about QI in relation to the effectiveness of current arrangements, capacity and constraints, collaboration, and how systems and processes could be enhanced.

- A stakeholder event to present the findings from the review to representatives from each of the organisations. All organisations involved in the review were represented, with 92 delegates attending the event. The findings from the review were discussed, and delegates made suggestions for enhancing and taking the QI agenda forward.

The initial findings from the questionnaires, meetings with organisations and feedback from the stakeholder event were collated, and the information used to inform this overview report.

Section 2 – Findings from the Review

The complex dynamics of the health and social care system within Northern Ireland was clear from the outset of the review. Organisations provide a wide range of services, yet all have a common goal of ensuring people receive safe, effective and compassionate care.

The services provided by organisations can be categorised into two general areas:

- direct services – being provided to patients or service users
- supporting services – being provided to support other organisations including key functions such as education and training

Some organisations provide both direct and supporting services. The organisations involved in the review, details of their size, areas of activity and service delivery are outlined below in Table 1.

Organisation	Number of Employees[4]	Main Areas of Activity	Service Delivery
Belfast Health and Social Care Trust	19,716	Acute Hospital Care Community Care Social Care	Direct services
Northern Health and Social Care Trust	10,694	Acute Hospital Care Community Care Social Care	Direct services
Southern Health and Social Care Trust	9,492	Acute Hospital Care Community Care Social Care	Direct services
South Eastern Health and Social Care Trust	9,013	Acute Hospital Care Community Care Social Care	Direct services
Western Health and Social Care Trust	9,527	Acute Hospital Care Community Care Social Care	Direct services
Northern Ireland Ambulance Service	1,156	Emergency Care Urgent Care Patient Transport	Direct services

[4] HSC Northern Ireland Quarterly Workforce Bulletin – March 2015 Headcount - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hscwb-key-facts-march-15.pdf Note: Figures exclude staff on career breaks, bank staff, Chairs / Members of Boards, Out-of-Hours GPs, and staff with a whole-time equivalent of less than or equal to 0.03.

Northern Ireland Guardian Ad Litem Agency	69 [5]	Safeguarding and advocacy	Direct services
Patient Client Council	30	Advocacy	Direct services
Business Services Organisation	1,438	Regional support functions and specialist professional services	Supporting Services Direct services
Northern Ireland Blood Transfusion Service	193		Supporting Services Direct services
Public Health Agency	335	Public health and wellbeing	Supporting services Direct services
Health and Social Care Board	603	Service Commissioning	Supporting services
Northern Ireland Medical and Dental Training Agency	80 [6]	Training and education	Supporting services
Northern Ireland Practice and Education Council	20	Nursing and midwifery	Supporting services
Northern Ireland Social Care Council	64	Regulation	Supporting Services
Regulation and Quality Improvement Authority	146	Regulation	Supporting Services

Table 1 – Key information about organisations within the health and social care sector in Northern Ireland

The positive engagement of all organisations and their representation at the stakeholder event, demonstrated a collective desire for enhancing QI across health and social care. There was clear evidence that all organisations are seeking to align their QI work with Q2020 work streams and with other regional collaborative initiatives.

Organisations are at different points on their individual QI journeys. There was evidence that they were not always aware of the QI approaches being taken by other organisations within the HSC system who were tackling similar issues.

The definitions of quality offered by each of the organisations were remarkably similar, and closely aligned to the Q2020 strategy. However, the specifics of how QI work was being taken forward varied between organisations.

[5] Information on the number of staff at the time of the review was provided by the Northern Ireland Guardian Ad Litem Agency

[6] Information on the number of staff at the time of the review was provided by the Northern Ireland Medical and Dental Training Agency. The figure does not include the medical and dental trainees working in other organisations.

The need to improve quality is well recognised and initiatives to improve quality have been taking place within and across HSC organisations over many years. However, we found the distinction between service development initiatives and QI work was not always clear. The understanding of QI in relation to quality control and quality assurance varied between organisations.

The mechanisms that support QI, described by the Health Foundation as "a systematic approach that uses specific techniques to improve quality", were not fully evident in all organisations. Some advised that they would like to be provided with a definition of QI, as well as having a standardised approach to QI established across health and social care.

The review team considered that there would be significant benefits if all HSC organisations used an agreed definition of QI. This would help to maximise the benefits of Q2020 initiatives such as the development of training to support the implementation of the attributes framework[7]. Approaches to taking QI forward may differ, but a common language and understanding of core concepts in QI work would be valuable.

2.1 Leadership and Culture

Leadership

The need to improve quality has been at the forefront of health and social care for a long time. The drive to enhance quality has resulted in numerous initiatives both regionally and locally.

In 2007, the HSC Safety Forum was established to support HSC organisations to drive improvement in safety and quality. At the time of the review, the Safety Forum had six QI collaborative work streams, each working on several QI projects or areas.

In November 2011, the Minister for Health, Social Services and Public Safety outlined the regional Q2020 strategy. This aims to improve quality in health and social care over the next ten years, by providing direction for organisations to build capability and lead quality initiatives. The strategy was accompanied with an implementation plan, and achievement of the strategic goals was to be the combined result of QI work being taken forward by individual HSC organisations and collective engagement in aligned projects.

During discussions with organisations, two common themes emerged in relation to Q2020:

- Senior staff members in organisations had a greater awareness and understanding of Q2020 than frontline staff.
- There is more focus on QI work in secondary care. There were fewer examples of QI initiatives in primary care and social care.

[7] Quality 2020 Leadership Attributes Framework - http://www.knowledge.hscni.net/Topics/Index/510

Q2020 initiatives, together with the work of the HSC Safety Forum through its collaborative work, form the main focus of the current regional approach to QI. Other fora that meet on a regional basis include updates on quality initiatives on their agenda, but this may not be their primary focus.

The development of a strong focus on QI within organisations usually resulted from a concerted impetus from their senior leaders. The Safety Forum has a number of full time staff employed to specifically support QI. In other organisations, staff dedicated to specifically manage QI on a full time basis was not identified. However, there was staff in many of the HSC bodies who have significant roles dedicated to component parts of QI, such as, continuous improvement support and facilitation, acting as patient safety leads, coordinating user involvement and research support. Some organisations had been able to reallocate roles and responsibilities in order to free up time for some staff members to provide dedicated QI support.

The HSC Board has four whole time equivalent staff dedicated to QI work within social care. They also fund five service improvement QI managers within the trusts.

All organisations had built QI into their corporate strategies and business plans. However, the larger HSC bodies also had more clearly defined QI policies and plans to manage the scope of QI initiatives. The review team considered these approaches valid, as QI should be proportionate to the size of the organisation and the number of quality initiatives being undertaken.

All organisations report internally on their QI initiatives to senior management and their respective Boards, as well as submitting an Annual Quality Report to DHSSPS.

The review team identified that a vision for QI was present in all organisations at the senior management level. Drivers typically included: a desire to implement Q2020; a recognised necessity to reduce variation and inefficiency; financial pressures; modernisation of services and development of new services in line with changing needs and regional strategies; or a combination of these factors. External accreditation and recognition, such as Investors in People[8] or the European Framework for Quality Management[9] provided a focus for senior management in how to initiate and embed QI thinking at various levels.

The corporate vision for QI was communicated to staff using a range of methods, such as staff meetings; briefings; newsletters; or emails.

Senior management teams felt that it was not always easy to spread a corporate vision for QI throughout their organisation. This was described as being frequently due to QI being seen as an extra responsibility, additional to normal work.

[8] Investors in People - https://www.investorsinpeople.com/
[9] European Framework for Quality Management - http://www.efqm.org/

Organisations should consider how they communicate their corporate vision for QI to staff. If this cannot be appropriately achieved, the development of QI will not fully progress.

The capacity for supporting and disseminating QI within organisations was described as increasing but not yet adequate. If the scale of QI work increases, organisations advised they would struggle to effectively manage this with their current resources. Whilst organisations were at different points in this process, several indicated that the uptake and implantation of QI was not yet widespread.

Models of how QI could be embedded, including how to sustain dispersed leadership, were shared with the review team. However, one important observation shared by many was their introduction to fundamental QI concepts being a “light bulb” moment or a “conversion” experience.

There was a desire from all organisations to strengthen regional support for QI, although there were wide-ranging views as to what this might look like. In developing regional QI arrangements, consideration should be given to the existing QI resources, such as the Safety Forum and the Knowledge Exchange. Any new arrangements should build on and strengthen existing resources.

There was consensus that constraining QI with overly rigid performance management, bureaucracy, or reporting mechanisms would hinder rather than support progression. There was a shared desire for an approach involving a regional forum that could support QI work by providing a space for sharing and communicating ideas, offering advice and assistance, providing additional training in specific QI methods, and, if necessary, review or commission training needs identified by organisations.

In 2012, the Safety Forum was instrumental in the formation of the Improvement Network Northern Ireland (INNI), which was aimed at supporting QI on a regional basis. The stakeholder event also provided an opportunity for discussion on the future role of INNI within a regional QI framework.

Culture

There are many different aspects of culture, all of which impact on the way people undertake their work. Culture can motivate and encourage, or demotivate and discourage staff. Several cultures can exist within health and social care bodies, even within departments, wards, and offices. This is not unique to healthcare but is found across other industries and countries.

All the HSC bodies mentioned culture as both a key enabler and a barrier to QI. Specific drivers of a QI culture were discussed and included:

- learning from serious adverse incidents (SAI)
- thematic reviews and inspections from regulators
- the need to meet standards for external quality control/assurance
- external accreditation
- the need for restructuring
- the need to make financial and efficiency savings
- the ability to meet key performance indicators
- staff training in QI
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence

Changing and developing culture is a major challenge. Grant (2011)[10] states "cultural change cannot happen at the flick of a switch … and… cannot happen without some form of disruption". Change needs to be gradually introduced and accepted by staff.

Most organisations recognised that an improvement culture was not yet embedded. Many noted the challenges of trying to introduce a QI culture. One described the first year as an "uphill struggle". Those organisations that had been well along their QI journey indicated that it could typically take between three to four years for significant traction for QI work to be realised. This timeframe has been similarly reported in other studies.

The Northern Ireland Ambulance Service identified the need to promote a culture of openness and learning, rather than blame. To achieve this, they have embedded a quality process where paramedic staff discuss a selection of their calls, interventions and patient records with trained peers. Areas for improvement are identified and shared across the organisation, including learning from near-misses, errors and SAIs.

[10] Grant P. Doctors attitudes to a culture of safety: lessons for organisational change Clinical Risk 2011, 17:165-70

Edgar Schein[11], whose work is most frequently acknowledged in medical literature when defining organisational culture, identifies three levels of organisational culture:

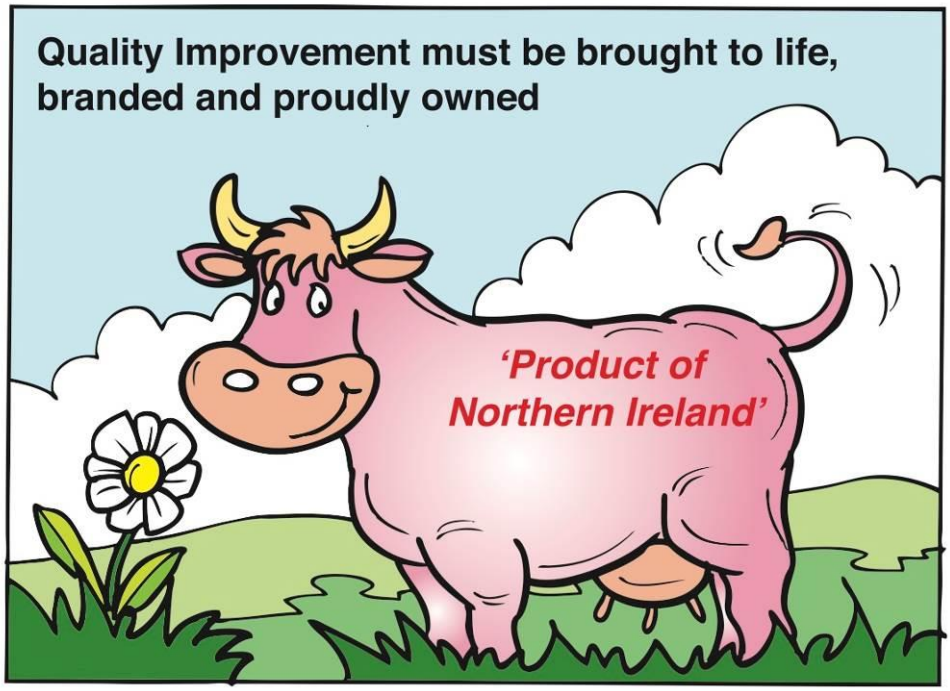
Level 1	Artefacts	these are the most visible manifestations and include things like mascots, dress codes, rituals, rewards and ceremonies
Level 2	Espoused values	these are the values, goals and strategies within organisations
Level 3	Basic underlying assumptions	these are largely unconscious beliefs, values and expectations held by staff

Artefacts

The emergence of artefacts reflecting an evolving QI culture was evident across many of the HSC organisations. In addition to providing a visible focus for QI initiatives, such artefacts may increase staff buy in, add a sense of pride and ownership, and promote the scale and spread of QI initiatives. Ward dashboard displays, run charts, and information on performance targets such as hand hygiene complemented the branding of QI activities. For example, the Belfast Health and Social Care Trust (Belfast Trust) developed a mascot, Daisy the cow, which has become the symbol for QI within the Children's Hospital. Daisy originated as an idea from the team within the paediatric intensive care unit, who wished to improve the quality of handover. She has become a symbol that has energised improvement in other areas.

The Daisy brand has been incorporated in badges, pens, logos and in the construction of a life-size fibreglass cow, now residing in the foyer of the Children's Hospital. The team responsible for Daisy comment on these physical manifestations as evidence that, with regards to QI, "it's possible!".

[11] Schein, EH. Organisational culture and leadership 1st Edition San Francisco: Jossey- Bass, 1985



Other examples of QI branding in use included:

- SQE (Safety, Quality, Experience) – the South Eastern Health and Social Care Trust (South Eastern Trust).
- SAFEtember – this approach was used by the Belfast Trust.
- QSE (Quality, Safety & Experience) – the Northern Health and Social Care Trust (Northern Trust).
- Best Care Best Value – the Southern Health and Social Care Trust (Southern Trust)
- Quality – Safe, Effective and Person Centred – Southern Trust
- Quality 2020 – DHSSPS

A physical space or area can also be considered an artefact of culture. Examples of this include the QIIC (Quality Improvement and Innovation Centre) within the South Eastern Trust, the Education and Innovation Centre within the Northern Trust, and the Leadership Centre (Business Services Organisation - BSO).

Staff discussed the practical benefits of having these dedicated spaces that were removed from their immediate workplace.

Rewarding staff for achievements is key to generating and sustaining enthusiasm in QI. Many organisations recognised this and had reward and recognition programmes in place. These were both internal and external to the organisations, with the most common being:

- Chairman's awards
- Guidelines and Audit Implementation Network (GAIN) Awards
- QI Recognition Awards
- Regional Safety Forum Awards
- QI showcasing events

The use of artefacts has had a positive impact in several organisations. Examples were shared with the review team where new QI thinking and initiatives were started as a result of staff being exposed to the artefacts.

<u>Espoused Values</u>

Espoused values – are the values and goals within organisations. The development of a QI culture will be influenced by the values of organisations. Identifying the importance of QI by integrating it into organisational goals and strategies will demonstrate commitment. Aligning QI work with an organisation's strategic aims can lead to increased staff motivation and enthusiasm.

Commitment to QI through the development of specific values and behaviours arising from staff engagement included:

- Culture Charter – in RQIA
- Caring supporting improving together – in the Belfast Trust
- CORE (Compassion, Openness, Respect, Excellence) values – in the Northern Trust
- Vision and Values – in the Southern Trust

Assumptions

Changing or developing culture requires a deep understanding of the largely unconscious beliefs, values and expectations held by staff. While these cannot be measured, they do make a difference to the culture of organisations. The scope of the review meant an in-depth analysis of each organisation's culture was not possible.

There was evidence in several organisations that QI culture had permeated down through several levels. In the South Eastern and Northern trusts, QI values had been recognised and embraced by frontline staff across various disciplines, including domestic and catering services, car parking services and clinical coding. The HSC Board had embedded QI methods into strategic planning.

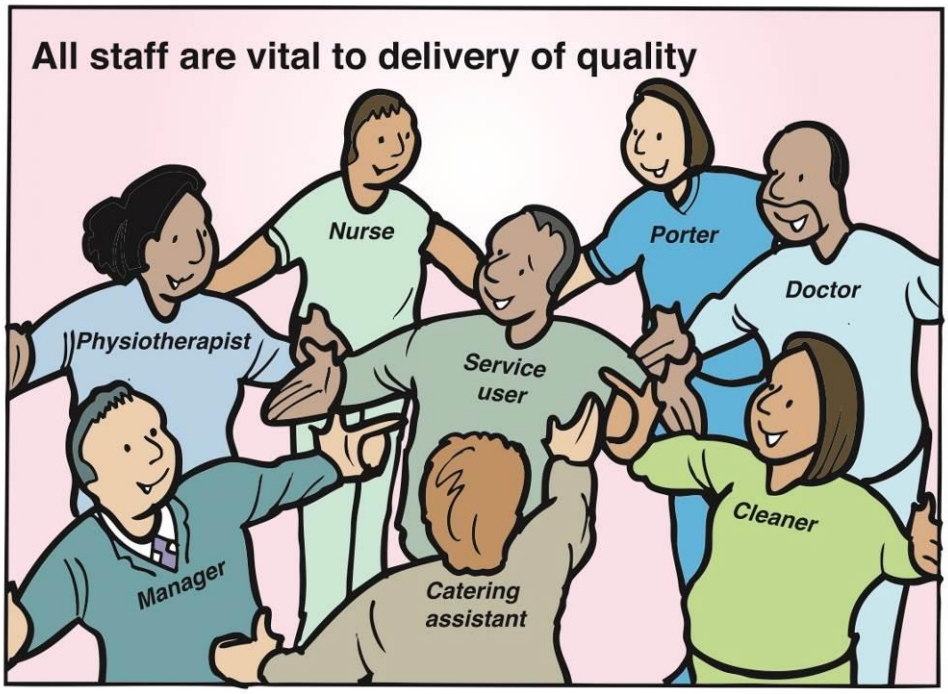
The level of support management teams offered for QI initiatives appears critical to the promotion of a positive culture amongst staff. While there may be a vision for QI at senior management level, the review team were advised that it is a significant challenge to ensure this is embraced across organisations.

It was noted that overall, there was much greater support and resources allocated for service delivery than for QI. Senior management teams spoke about the challenge of balancing service delivery and QI.

Some HSC organisations demonstrated evidence of direct and personal approaches through the implementation of leadership walk rounds, which connect senior staff with frontline staff on the ground. A further example includes the Chief Executive from the Northern Ireland Social Care Council hosting town hall meetings with staff. The Southern Trust used the strapline "No improvement too small" to reinforce improvement work, which was further supported by senior management. These promote an ethos of inclusivity and positive beliefs amongst staff.

Staff Involvement

For QI to be successful the involvement of staff is vital. Staff are key at all stages: defining fundamental values and beliefs, identifying problems, suggesting solutions, engaging in and conducting QI work, and sharing the benefits. The Northern Trust used the analogy of a cartwheel to highlight the vital interconnectivity of their staff.



Frontline staff are uniquely placed by virtue of their constant interactions with patients, clients and customers to identify problems and issues with the care or services provided. They are also ideally situated to make informed suggestions for achievable and effective solutions.

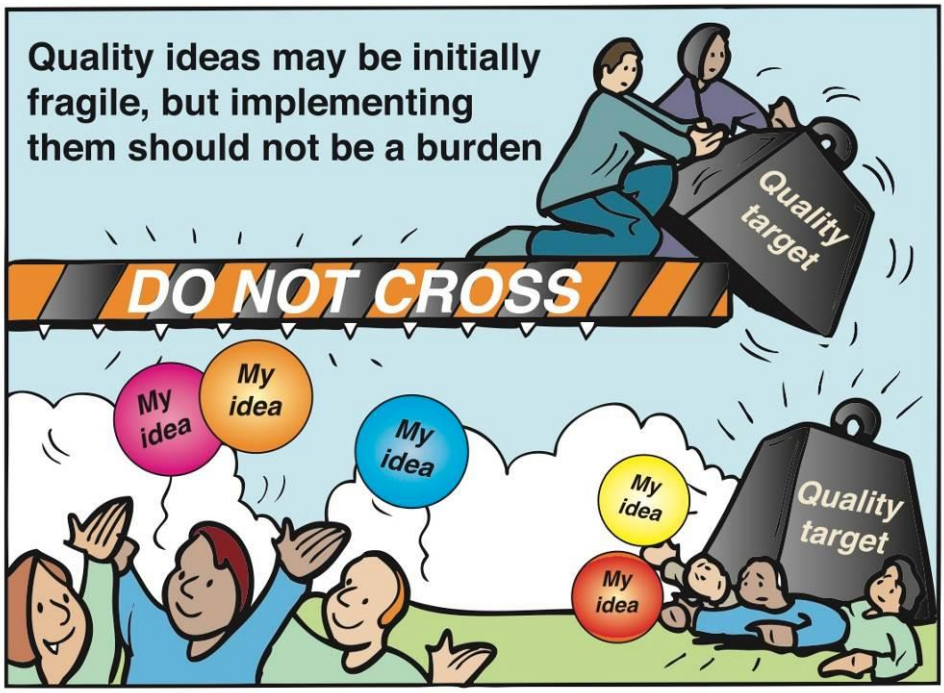
All organisations advised that they had formal processes for developing QI ideas, which were generated by staff. These processes were not reviewed to determine their effectiveness. However, it was recognised that initial ideas may be unformed and "fragile" and there were several hurdles to practical implementation of frontline ideas.

Some innovative solutions to overcome these difficulties were shared with the review team, which included:

- Dragon's Den – staff had the opportunity to present QI initiatives to senior management within the South Eastern Trust, in an attempt to secure funding to take forward their initiative.
- Dare to do Differently – the Southern Trust established a fund to help staff to realise ideas that will improve safety, quality, effectiveness, or make the best use of resources.
- Staff frustration boards – different organisations had put up notice boards in the workplace that allowed staff to note specific frustrations. These were reviewed by management.
- Opportunity Knocks competition – staff within the Northern Trust were given the opportunity to present their quality improvement projects to senior management team.

Despite these streamlined channels one trust expressed surprise as to the conservative nature of some frontline suggestions. They had expected more 'risky' proposals to have been presented.

It is not clear whether this relates to the perception of a formal submission, or the expectations of frontline staff as to how suggestions for QI projects may be received and implemented.



To engage effectively with staff it is important to enhance their connectedness. This can be strengthened on multiple levels by linking them with:

- the ultimate product of their work, i.e. enhancing patient safety and experience
- their colleagues within and across disciplines and
- support from senior teams with ready two way channels of communication

Organisational structures

Organisations with more developed QI cultures and structures permit information and ideas to be readily communicated from staff up through the organisation.

Having listened to how QI was described across HSC bodies, the review team saw many similarities despite variations in size and scope of work. Figure 1 is a reflection of current structures for QI within most HSCNI bodies. It is not intended to represent the QI cycles within organisations or the services provided by those bodies but to illustrate the relationship between important components of QI activity.

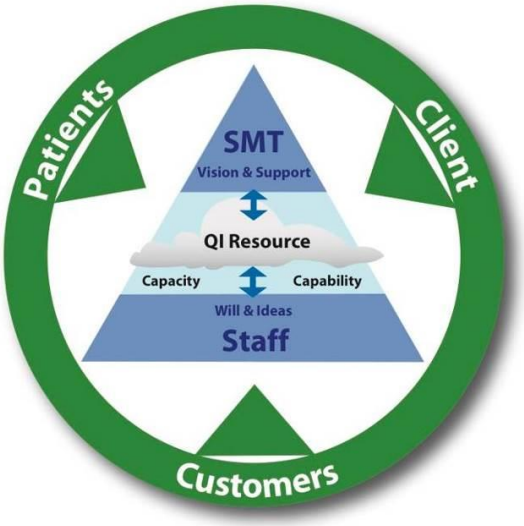


Figure 1 – A representation of organisational structure

In general, it was found that senior management teams provide the vision and support for QI, while staff provided the will and ideas. The review team noted that no organisation has a dedicated QI department or team.

Staff with training and experience in QI are dispersed throughout organisations. This group of staff are represented as a cloud. In organisations with minimal QI resources, their cloud could represent the external organisations brought in to facilitate QI initiatives. All organisations are subject to the voice of the customer/ client/ patient, which is represented as the outer layer on the diagram, surrounding and informing everything we do.

The diagram provided an effective stimulus for delegates at the stakeholder event to discuss both the implications for QI capability, and the voice of service users in each organisation. Many comments and suggestions proposed for changes, modifications and improvements. Although the diagram was not intended to be used beyond providing a simple representation of an organisational structure, the review team considered organisations may wish to use it as a starting point for further discussion.

2.2 Quality Improvement Systems and Processes

At the time of the review, there was a reluctance from some organisations to fully engage in many regional initiatives, as it was perceived that a regional approach could slow things down. This resulted in some duplication of work and QI initiatives. The review team considered that organisations should be more open to adopting and adapting existing work that has already been developed elsewhere, rather than trying to develop their own.

Many organisations felt a regional approach to QI systems and processes could be further developed. Whilst organisations were able to undertake QI work at a local level, there was an aspiration for a regionally aligned framework that could link the QI work of all the HSC bodies. However, the format and remit of any such regional framework was unclear. Due to the complexity of health and social care across Northern Ireland, and the previous organisational changes within the sector, the development of a regional approach may present challenges.

Each organisation's QI journeys are shaped by several factors including:

- the size of the organisation
- the focus of their work
- the previous exposure and training in QI of those leading the development

The review team observed that the trusts tended to have more defined QI systems and processes in place. Along with regional collaboratives, they were undertaking a greater number of initiatives and tended to be further along a QI path.

Systems, Processes and Overcoming Barriers within Organisations

Organisations developed systems and processes around their needs and capabilities for delivering QI. These varied between organisations in relation to their complexity. Although systems and processes were in place, QI activity was distributed in pockets within organisations. The review team considered that a lack of widespread training in QI and the resulting lack of understanding of its benefits hindered further growth of QI.

The review team was advised that the HSC Board has a defined QI programme within the Social Care Directorate. This incorporated a discrete service improvement plan and team, which utilised a range of methodologies, such as QI systems science and implementation science.

Capacity: All organisations felt that they had insufficient capacity to take forward systematic QI. Capacity constraints included staff time, training, and methodological support. Enhancing workspaces to be conducive to QI changes was a further capacity challenge. Several organisations were now starting to explicitly address these resource issues and making positive advances in doing so. Examples included:

- reallocation and redefining of staff roles and job plans to reflect the importance of QI
- rolling out further bespoke training
- providing tailored support to teams and individuals
- building QI into daily work activities, such as lunchtime training sessions and by displaying ward-owned data dashboards
- linking QI activity to appraisal and other human resources processes

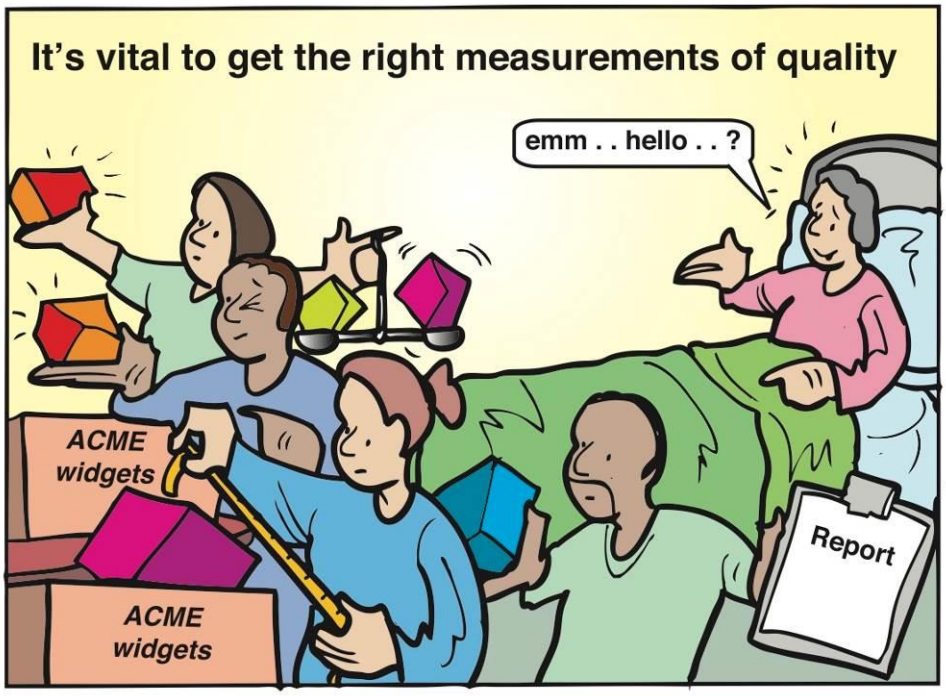
Communication: Organisations advised of having processes for reporting and communicating QI activity, initiatives and successes. Again, the larger organisations had more formal structures in place for reporting. More details about communication are outlined in Section 2.5.

Relationship of QI to other quality processes: A potential conflict was identified in some organisations in relation to their understanding of quality assurance/ control and QI. Some organisations felt that QI may be inconsistent with other regulatory and quality processes. A clear example of how such processes can interlink effectively so that quality control and assurance mechanisms can drive QI is illustrated by The Northern Ireland Blood Transfusion Service (NIBTS).

The work of NIBTS is tightly regulated and subject to strict requirements for quality assurance and control. Despite these requirements, NIBTS staff are able to successfully incorporate QI initiatives into their work. They have developed and sustained a regional programme for staff competency assessment in safe blood product transfusion. This recurring three year programme was introduced for 26,000 healthcare staff across NI, including doctors, nurses and portering staff.

Performance Management: Some organisations discussed tensions in relation to the type and amount of measurement associated with performance management. Organisations considered some measurement activity to be non-value added for the patient/ client/ customer. Being held accountable for such targets was utilising considerable resources which, otherwise, could be devoted to QI.

Realigning some measurement activity with patient/ client/ customer centred outcomes could raise the focus and attention on the value of QI.



2.3 Quality Improvement Methodologies

Organisations were using a range of different improvement methodologies. The approaches adopted often reflect previous awareness and experience of their application to the nature of the process in which improvement was sought. Organisations advised that there was limited regional capacity to support and train in QI methods. It was also noted that resource issues sometimes contributed to organisations being unable to release staff for QI training.

Figure 2 shows, as reported to the review team, the frequency of methodologies, improvement tools, and QI concepts across the HSC organisations surveyed. These were diverse in number and application, with a mixture of methodologies, methods and tools.

Staff noted that the profusion of jargon, abbreviations and terminology was often overwhelming and off-putting, sometimes leading to disengagement. The review team considered that simplifying language and concepts to make them relevant to inexperienced staff was vital. Staff from Northern Ireland Guardian ad Litem Agency shared their experiences of having to overcome these early hurdles.

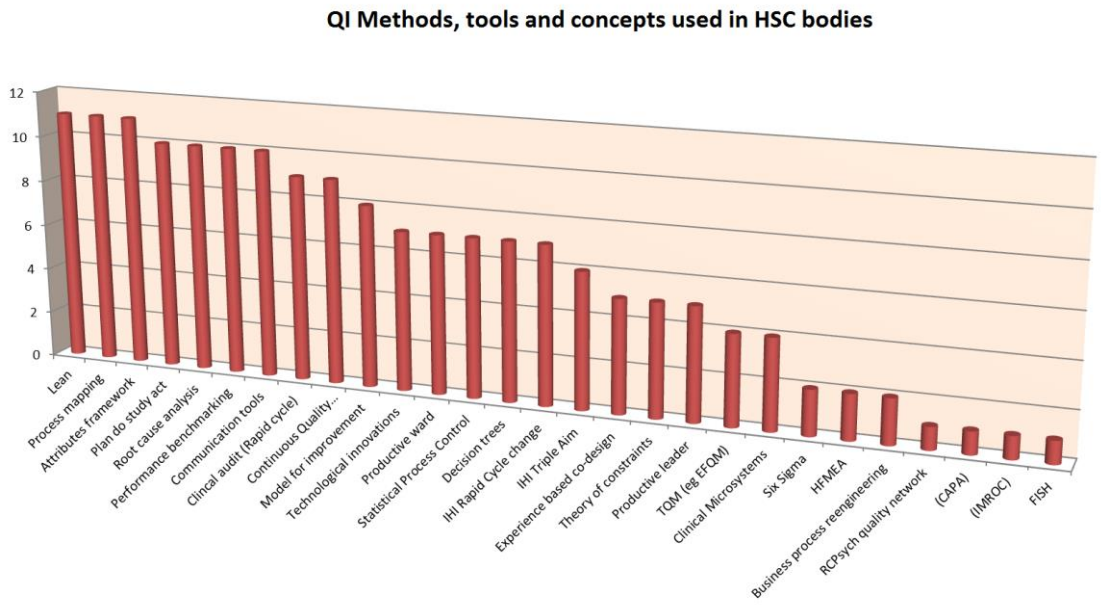
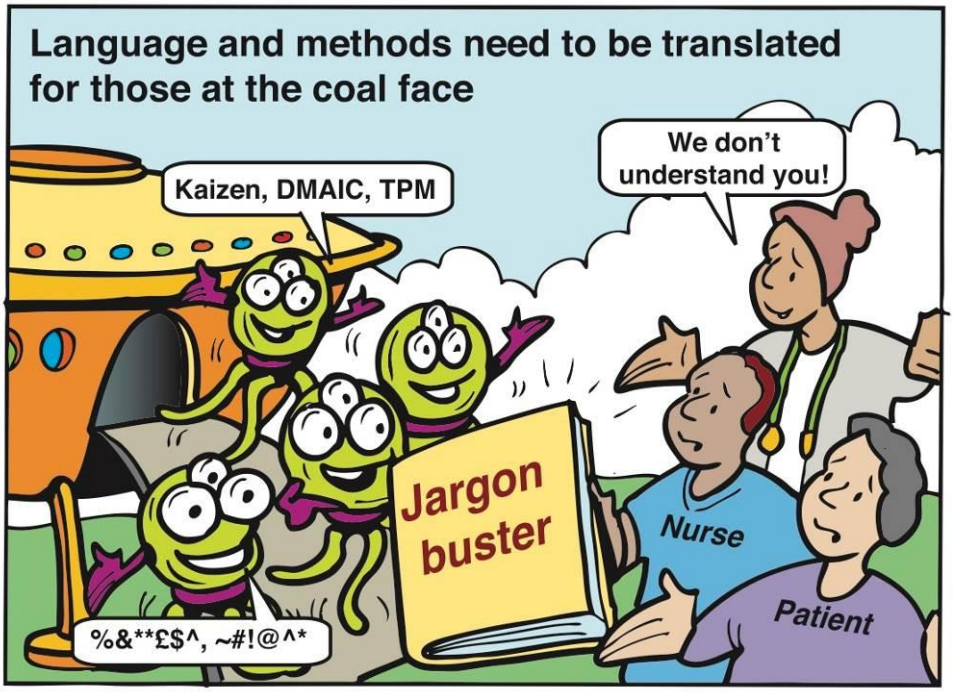


Figure 2 - QI methodologies, tools, and concepts used by HSC bodies

Previous experience in QI was often a factor in the selection and use of particular methodologies. However, this may not necessarily have represented the most effective or appropriate methodological approach. Staff should have an understanding that there are a range of tools and methods that can be applied to various problems.

Some organisations had chosen to adapt and simplify methodologies to suit their application, rather than apply the approach in full.

While this may have been appropriate and led to successful outcomes in particular cases, there is a risk that elements vital to the successful application of a particular approach are omitted. In such cases the benefits of the QI work may not be optimised or sustained.



Many organisations indicated that QI needs to be demystified in order for staff to identify with it and see its role in addressing important workplace issues. While QI should be kept simple it is important that appropriate and tested methodologies are used. Serial measurements always need to be taken to monitor changes and evidence the impact of the QI initiative. The review team consider that a toolkit of appropriate methods could be agreed on a regional basis. Staff could be trained to apply these methods and a body of knowledge built up within and across organisations. It is important to 'keep things simple' for all staff involved in QI.

Benchmarking

Benchmarking can be used as a useful tool in QI, helping organisations identify where they fall short of best practice, and identify what action is needed to improve. Organisations provided evidence of the use of benchmarking; although examples shared related more to benchmarking for performance management and service improvement rather than for QI.

With the exception of the trusts, the diversity of the services provided by different organisations made it difficult for them to appropriately benchmark against each other. For organisations such as NIBTS, NIGALA, RQIA, BSO and NIPEC, they had to benchmark services against comparable organisations at a national level. Some examples included:

- BSO departments use a range of benchmarking techniques, including the Chartered Institute of Public Finance and Accountancy's service benchmarking scheme which covered human resources, purchasing and logistics, finance, and legal services.
- NIGALA benchmarked their services against similar organisations, such as Children and Family Court Advisory and Support Service.
- RQIA benchmarked aspects of regulation and enforcement systems and processes with those used by other health and care regulators, such as the Care Quality Commission and the Care Inspectorate Scotland.

Although the trusts provided similar services, it was noted that there were differences in how some data was collected. This complicated benchmarking and direct comparison between services.

The trusts provided examples of general benchmarking, which included:
- Monitoring compliance with commissioning targets across all trusts by the HSC Board and PHA.
- Participation in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), National Early Warning Score (NEWS) studies as well as GAIN audits.
- Benchmarking with other trusts on the Catering Controls Assurance Standards and the Catering and Domestic Services Risk Registers.

Although benchmarking specifically for QI was limited, there were a few specific examples identified. These included:
- The use of CHKS[12] as a regional and national (UK) benchmarking tool, which was used by the trusts.
- The benchmarking of specific actions outlined in the Regional Allied Health Professions Strategy.
- In mental health and learning disability, benchmarking of QI is carried out through the Royal College of Psychiatrists' network accreditation programme.

Many organisations recognised the potential for developing an overarching strategy relating to QI that would incorporate benchmarking to facilitate the measurement of organisational progress.

2.4 Staff Training and Support

Training

Across the health and social care sector, relatively few people have received formal training in QI or have a recognised qualification. One of the work streams from Q2020 was to develop an attributes framework to identify the training needs for staff in relation to QI.

[12] CHKS is a leading provider of healthcare intelligence and quality improvement services - http://www.chks.co.uk/

The framework was released in 2015, and, during the review, many organisations were noted to be already using it to identify training needs.

Organisations have approached staff training in different ways, and this appears to have been influenced by the size and role of the organisation.

Broadly speaking, larger organisations, including trusts, are more likely to have invested in external formal QI training, with a general expectation of a return on this investment. The knowledge gained can be reinvested into training staff internally.

Key staff are trained as QI champions with expertise to lead and advise on projects, and to develop internal capability. Other staff received basic QI training or coaching in specific methodologies. The SQE QI programme (developed by the South Eastern Trust) has delivered training to over 500 staff within the South Eastern Trust and across Northern Ireland.

The Southern Trust had developed an e-learning module, aimed at providing training and understanding of QI. Its development was aligned to level 1 of the Q2020 attributes framework. It was advised that this had been shared with the regional task group, and was available for use by other organisations.

Smaller organisations are less likely to have invested in external training and only limited numbers of staff had received formal training in QI. Several of the smaller organisations mentioned the external support received from the HSC Leadership Centre and Safety Forum.

External Training received by staff was diverse and from a range of sources, some of which was commissioned by the HSC Board and also funded by the PHA. External training included:

- Institute for Healthcare Improvement courses
- The Health Foundation Fellows training
- Safety Forum Scottish Fellows training
- FISH (Foundations of Improvement Science in Healthcare)
- LEAN

Examples were identified to show how this training was being implemented in various health and social care projects.

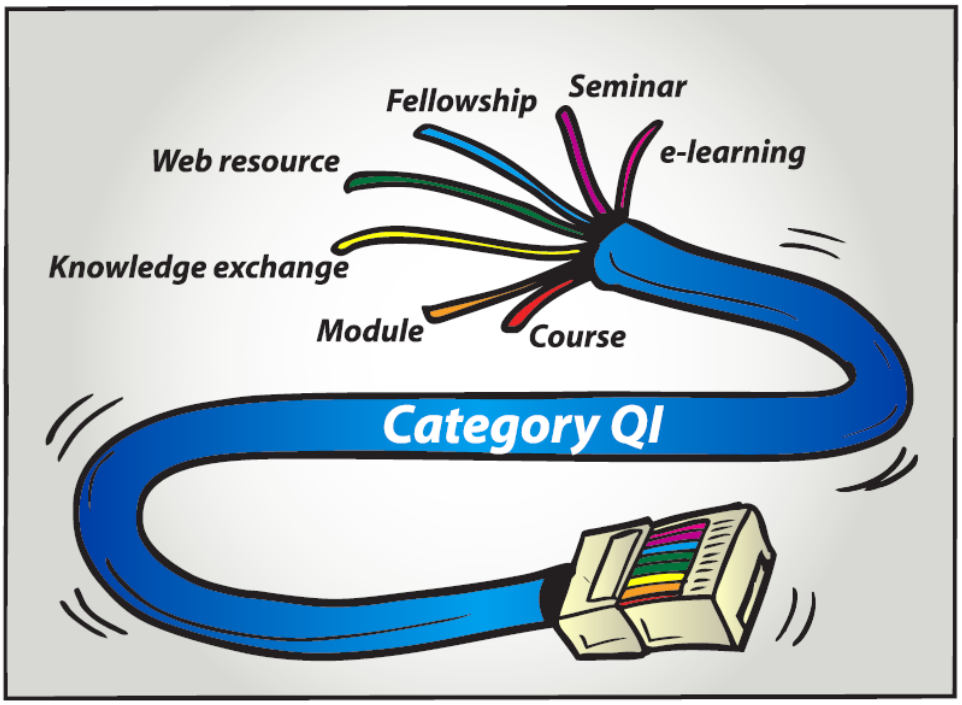
Training can often be time and resource intensive for local organisations to avail of, which remains a significant challenge within a resource-limited health and social care system. The review team found little evidence of structures that can facilitate access to other sources of funding for training, such as the Health Foundation.

Internal training provided must be proportionate to the level of involvement of the staff, with training matching their particular needs. Examples of internal training included:

- Incorporating training into daily routine – Lunchtime master classes, drop in sessions, and breakfast seminars.
- Availing of local opportunities – Western Health and Social Care Trust (Western Trust) and Southern Trust participation in the Cooperation and Working Together training programme on patient safety.
- Offering multiple platforms and modalities for learning - Bespoke e-learning packages, developed in both the Southern and South Eastern trusts, based on local examples and case studies. The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) created a roadshow video for the introduction of nursing revalidation.
- Catering for a range of needs – multilevel training for staff in the Belfast Trust.
- Building on academic resources and linkages – Northern Trust pharmacy partnership with a Swedish University.
- Responding to feedback – development of iQUEST programme by NIMDTA.

It was recognised that undergraduate QI training across all disciplines is very limited. Innovative partnerships with local universities have already been established in order to develop and deliver postgraduate training in QI.

The review team welcomed the training that was being developed and delivered, but identified that there was little regional alignment. Training that is bespoke to specific organisations represents potential benefits to those organisations; however, there may be duplication of effort. Improvements to regional alignment may reduce this.



In developing QI within organisations, some mentioned uncovering hidden talent, including, individuals working within organisations that had previous experience or training in QI methodologies. Recognising this, the Northern Trust has developed a directory of staff with experience and training relating to QI. This was noted by the review team as an example of good practice to support a QI network.

Support

Completing QI training is a necessary but not sufficient factor to enable staff to take forward a project. They must also have the appropriate workplace environment to undertake the QI work, support to carry it out, time out to think, and formal management support.

It was found that such resources were frequently difficult to provide.
Time was a significant constraint for staff working on QI initiatives, as there is constant pressure to meet the demands of daily work in delivering care and services. The amount of time available to work on QI was limited in all organisations.

Staff felt they were unable to take a step back and have time to analyse problems and brainstorm ideas for improvement. The review team was advised of many specific instances where staff were working on QI initiatives in their own time.

Organisations advised of innovative ways to address resource challenges, including time, money and availability of staff. Several examples of collaborative working within departments were presented to the review team. Staff reorganised time off, daily tasks, and workloads to release time for colleagues to attend training or work on QI initiatives. It is this type of support that brings teams together and delivers success.

There was recognition that successful QI activity often increases productivity and can offer a cost saving and return on investment, although the release of resources and support did not always match this. In the current economic climate, the benefits of QI were carefully weighed against other workplace priorities.

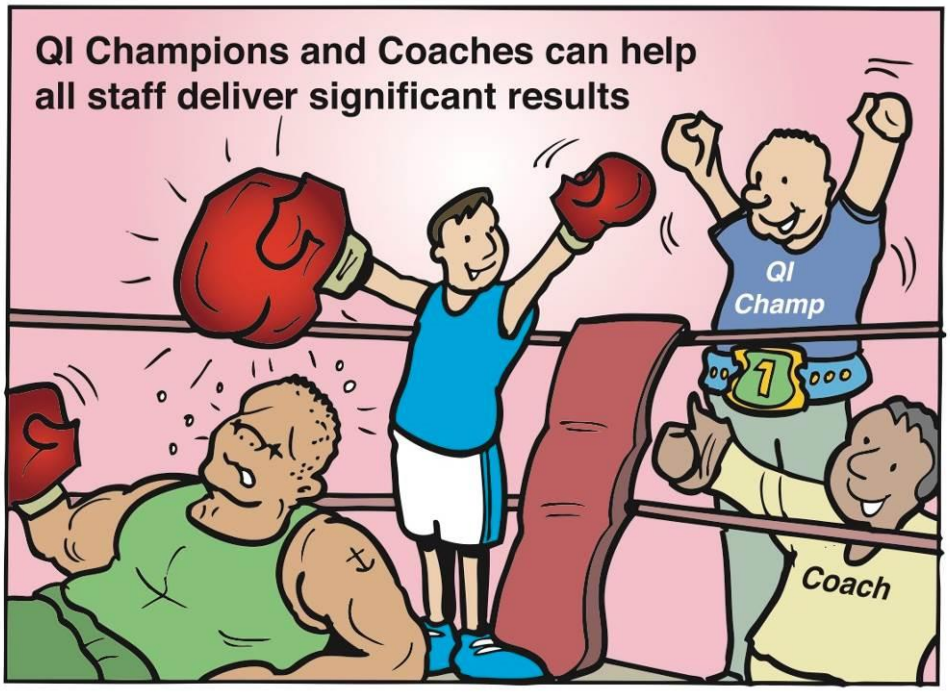
The review team was able to explore the experiences of a group of junior doctors and their Foundation Supervisor in one of the trusts. A ward-based checklist for patient discharge and handover was developed and being piloted by several Foundation Year 1 (FY1) doctors. This was working well and senior consultant staff had actively been using this during weekend reviews.

The FY1 doctors did not have any formal training in QI methods and their Foundation Supervisor, whilst very supportive, had no experience of QI tools either, and felt that the direct support they could offer was limited. Despite this, links with the governance department and other clinicians with QI skills in the trust were made by the Supervisor.

However, three months into the use of the checklist the FY1 doctors had not had any mentoring, review or evaluation of their work. Their project did not appear on a list of current QI projects ongoing in the trust. The Foundation Supervisor was also keen to ensure that the QI work they were doing was in addition to gaining the competencies required by their e-portfolio and not a replacement for this mandatory aspect of their training.

This example raises some very practical issues around supporting doctors in training, particularly at Foundation level. These include: providing on the ground QI method support, registering QI initiatives with the governance and QI leads and ensuring that the generic and clinical competencies that require to be evidenced during Foundation Years training are not adversely affected.

There was evidence of some positive support available across all organisations, in particular, the support from QI champions, and members of management who had developed a better understanding of QI. QI champions were available to provide help and advice on methodologies, measurement, or any aspect of the initiatives.



Staff found the provision of a physical space, such as the QIIC and the Education and Innovation Centre, very supportive.

Coaching and mentoring was another example of support that was available. Staff with more experience of QI, such as the Safety Forum Scottish Fellows, shared their experiences and helped others develop initiatives. In the South Eastern Trust, an informal bi-monthly curry club has been established, where staff could come to share and discuss ideas. In the Belfast Trust the STEP UP programme for specialty registrars in training offers a similar opportunity. In the Northern Trust, lunchtime Quality Improvement 'Drop-in' sessions were offered to clinical staff.

2.5 Communication

Communication is one of the most significant components within successful QI frameworks, as it an integral in every part of the process. Overall, communication was an area that most organisations recognised that they needed to develop further, although areas of good practice were also described.

The Voice of the Customer

The term 'voice of the customer' represents the needs and desires of those people or businesses that are in receipt of the care and services being provided. For different HSC organisations these include: patients, clients, customers and staff.

Customer satisfaction is an important indicator of performance, and should be considered an asset within QI. Customers usually voice their needs or concerns when there was something wrong with the care or services they were receiving. Organisations should be using this information as the trigger to assess any issues and make necessary improvements.

Historically, health and social care organisations have struggled to effectively capture patient experience, i.e. the "voice of the customer". This is improving since the introduction of Personal and Public Involvement standards.

Traditionally, feedback from complaints and SAIs has been used by most organisations to identify problems with care and services. However, this information accounts for only a small percentage of potential QI initiatives that could be derived from patient/ client/ customer feedback.

Some examples where organisations conducted meaningful engagement with patients/ clients/ customers, which are becoming more systematic and widespread, included:

- the development of a renal transplant pathway within the Western Trust
- designing new autism services in the Southern Trust
- the development of a parent poster on communication with clinical teams, designed and delivered by a parent working as part of a regional paediatric QI collaborative
- engagement with service users, carers and families following an SAI is undertaken by organisations, and monitored by the HSC Board
- the 10,000 Voices project, led by the Public Health Agency (PHA), which is gathering trust-wide data on patient experience
- annual customer surveys and regular engagement with customers to agree key performance indicators was undertaken by the BSO
- engagement with patients and clients to gather data to inform improvements in service development was undertaken by the Patient and Client Council (PCC)

Internal Communication

Internal communication within organisations was the most developed area of communication. Existing channels of communication facilitated the exchange of QI information. However, it was noted that there were still opportunities to refine this communication to all relevant staff.

Some staff were unaware of the breadth of QI work being undertaken. This applies to work being undertaken both internally and externally of their organisations. The larger organisations faced more of a challenge in relation to communication.

While there was a need to keep staff informed about QI initiatives, not all QI work was relevant to all staff. Informing staff about all the work being undertaken could overwhelm them and have a negative impact on their perception of QI. Organisations should balance the amount of information delivered against its relevance to staff.

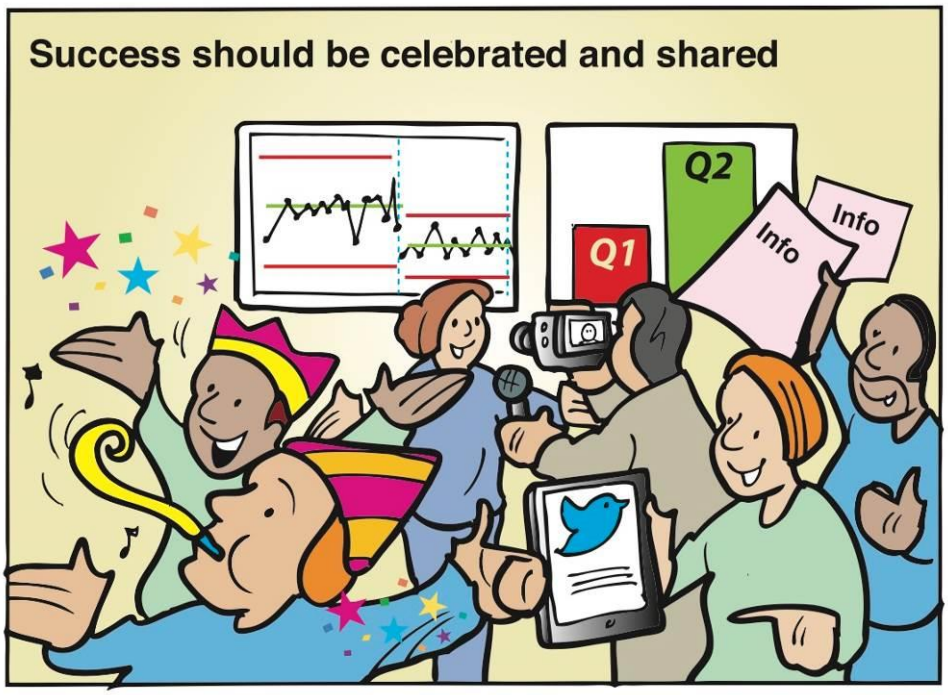
Regional Communication

There are some established mechanisms for regional communication in relation to specifically sharing information about QI. Examples of these include the PHA sharing outputs from SAIs and thematic reviews, including learning letters, and the Safety Forum providing updates on the progress of regional collaborative projects. Other regional communications includes reminders of best practice letters, learning matters newsletters, and Med Safe bulletins.

The Knowledge Exchange Website offers an online platform for further sharing across Northern Ireland. Developments to strengthen communication regionally could build on these cornerstones and consider other options for more widespread dissemination of information.

Communicating Success

Specific mechanisms to communicate success included email, newsletters, meetings, social media, and award ceremonies. The review team considered that communicating success was important, both internally and regionally, as it motivates staff and contributes to the sustainability of QI.



2.6 Constraints to be Overcome

Although all organisations are taking forward QI, there were many constraints that could impact on the effective development of QI. The constraints varied between organisations, due to the progress of development of QI arrangements. Whilst constraints have been identified throughout this report, those that are key, are discussed below.

A Culture of improvement needs to be embedded within organisations if QI is to be developed. Most organisations recognised that they had not yet achieved this, but were actively trying to improve this. More visible demonstrations of commitment to QI throughout the management structures of the organisations would support this. In particular, managers need to increase their understanding of the benefits of QI, and identify ways to facilitate the involvement of staff in QI initiatives. This is going to be a challenge for many due to the reported insufficient capacity to take forward systematic QI.

The need to measure and record data for the purposes of performance management was utilising considerable resources that some felt negatively impacted on organisational capacity that could otherwise be devoted to QI. Some data measurement activities were felt to add no value for the patient/ client/ customer.

Training and support were identified as two areas that also required further development. Although some staff had been trained in the various QI methodologies, tools and concepts, a lack of awareness and training for the majority of staff more generally, limited understanding and the potential involvement in QI initiatives.

The lack of training in QI and its potential benefits resulted in the reduced commitment of some managers and staff to QI.

Limited time and opportunity to move away from normal work to participate in QI initiatives, dwindling financial and resource allocations, and lack of encouragement to engage in QI were also mentioned as constraints.

The perceived complexity of QI was highlighted as a constraint to the involvement of many staff. The numerous QI methodologies, tools and concepts sometimes made it difficult for staff to understand which approach was most appropriate to use in their particular context. Some staff noted that they had not progressed a QI initiative for this reason. In others, methodologies were tailored or only partially used to suit the circumstances. Many staff also emphasised that the profusion of jargon, abbreviations and terminology was often overwhelming and off-putting. This had led to disengagement and an unwillingness of some staff to volunteer for QI initiatives.

To overcome this, it was suggested that a streamlined set of QI methodologies, tools and concepts should be adopted. Simplifying the language and jargon used in relation to QI was also a necessity to help staff gain a better understanding of QI.

While many organisations had arrangements in place to identify and generate ideas for QI initiatives from staff and customers, this was not as comprehensive as it could be. Identifying changes to services and improving patient experience, should be driven by those providing and receiving the services. It was considered that the understanding of QI more generally was a constraint to its further development across health and social care.

Communication impacts significantly on the development of QI. While the internal communication within organisations was evident, the external communication between organisations, specifically for QI, were not evident. This restricted the ability of organisations to share information and learning from QI initiatives. In some cases, duplication of work was being undertaken. The limitations of the arrangements for external communications with the media and the public were also identified as a constraint to improving the perception of health and social care.

The review team noted that all of these constraints are interlinked. For effective QI on a regional basis to be realised, all these issues would need to be addressed and overcome in parallel.

Communication with the Media and Public

Despite communicating QI success to the media, it was apparent that the media were not actively reporting on them, thus the public were unaware of successes in these areas. There were few instances of celebrating success in the media.

The lack of promotion of QI activities with media and the public was considered to be in part a consequence of the cultural attitudes within Northern Ireland. The role of the media in reporting stories about health and social care can greatly influence public perception. Reporting has often focused on negative and contentious issues with greatly reduced reporting of positive stories. This can lead to an unbalanced perception of health and social care in the province.

To redress the balance, organisations should consider how they can influence the wider political and cultural landscape to prioritise QI. In some organisations the use of social media was starting to gather momentum, increasing the exposure of QI activity to a wider audience. For the QI agenda to develop and flourish, communication must be improved with all stakeholders by continuing to share success stories with politicians, the media and the public.

Section 3 – Conclusions and Next Steps

3.1 Conclusions

The Health and Social Care system in Northern Ireland is complex, with multiple organisations providing different services, but with a common goal of ensuring people receive safe and effective care.

This review was conducted to determine the level of QI activity being undertaken within health and social care and to derive global themes for regional learning.

All organisations recognised the need to improve quality, and have been improving the quality of their work and practices for some time. However, the mechanisms that support QI were not fully explicit in all organisations.

Senior management teams have largely acknowledged the importance of QI and developed a vision for taking it forward. It was not fully evident that this vision had been embraced at all levels within organisations, as there were examples of competing priorities in relation to delivering care and services.

There was a collective desire for enhancing QI across health and social care.

Each organisation had embarked on their QI journey at different times, and had varied structures to support QI.

Organisations shared a desire for enhanced leadership and support mechanisms at a regional level, which could facilitate their work by providing a space for sharing and communicating ideas, and offering advice and help. However, there was a lack of consensus in relation to what this was, or what form it would take.

The review team considered there are benefits to such a regional mechanism, and would encourage all organisations to take an active role in discussing how to take this forward.

The culture within organisations plays a significant role in the development of QI. Many examples related to the different manifestations of culture, such as artefacts and defined values, were evident in organisations. Whilst these had contributed positively towards the development of QI, changing and embedding a culture of improvement remains a long term challenge.

Organisations' independent development of QI approaches had created a number of different systems and processes.

QI activity existed in pockets throughout all organisations.

Resources, particularly in terms of staff training, time and finance, were substantial barriers in developing and sustaining QI. Relatively few staff have received formal training, particularly in the smaller organisations.

There were tensions in relation to the perceived competing priorities between performance management, quality assurance and QI.

Organisations had adopted different methodologies based on the work or practice being evaluated, and the previous exposure and knowledge of those leading the evaluations.

Although several methodologies are being used, the possibility of streamlining these into a regional toolkit should be considered. A sufficient body of trained staff needs to be available to ensure that the selected approaches are delivered effectively.

Staff training is essential in developing QI and should be proportionate to their level of involvement.

Organisations that have QI champions value them.

Some staff are unaware of the breadth of QI work being undertaken in their particular organisation. Communicating QI projects is an area requiring further development and should build upon existing structures.

Communication with the media and public is an area that could be strengthened, particularly in relation to sharing information about good practice and successes.

The voices of patients, clients and customers are increasingly being heard on both a local and regional level.

This report is intended to provide a baseline of QI activity across health and social care, and outlines ten next steps that could be taken to enhance QI.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review.

3.2 Next Steps

This report sets out the findings of a baseline assessment of the quality systems and processes for QI in health and social care organisations in Northern Ireland. In light of the information obtained, RQIA recommends the following next steps should be considered by all HSC organisations in taking forward the QI agenda.

1. Consideration should be given to agreeing a common definition of quality improvement for health and social care organisations in Northern Ireland.

2. A regional mechanism to support the quality improvement activities of HSC organisations and coordinate the sharing of learning should be defined and agreed. Utilisation and further development of existing mechanisms, such as Q2020 and the Knowledge Exchange, should considered as part of the discussions.

3. Consideration should be given to prioritising the regional alignment of quality improvement training.

4. Consideration should be given to simplifying the terminology of quality improvement and developing a toolkit of key methodologies.

5. Consideration should be given to a review of performance management and quality improvement activity, to establish a balance between the non-value added metrics with more quality and experience based metrics.

6. Organisations should give consideration as to how their corporate vision of quality improvement is delivered to staff and, where issues are identified, make any necessary improvements.

7. Organisations should give consideration to appropriate coordination of quality improvement activity to more effectively use existing resources.

8. Organisations should ensure there is support for staff to carry out quality improvement activities, particularly in relation to providing:
    - an appropriate workplace environment
    - resources to undertake the work
    - time out from normal activities to carry out the work
    - management support

9. Organisations should give consideration to ensuring that information gathered about patient and client experience is effectively used to inform and drive quality improvement initiatives.

10. Organisations should give consideration as to how to improve communication in relation to quality improvement activity, in particular:
    - further developing internal and regional communication
    - promoting and communicating success internally and externally
    - engaging with the media and the public

Appendix 1 - Abbreviations

Belfast Trust	- Belfast Health and Social Care Trust
BSO	- Business Services Organisation
CORE	- Compassion, Openness, Respect, Excellence
DHSSPS	- Department of Health, Social Services and Public Safety
FY1	- Foundation Year 1
HSC	- Health and Social Care
INNI	- Improvement Network Northern Ireland
NIBTS	- Northern Ireland Blood Transfusion Service
NIPEC	- Northern Ireland Practice and Education Council for Nursing and Midwifery
Northern Trust	- Northern Health and Social Care Trust
PCC	- Patient and Client Council
PHA	- Public Health Agency
Q2020	- Quality 2020
QI	- Quality Improvement
QIIC	- Quality Improvement and Innovation Centre
QSE	- Quality Safety Experience
RQIA	- Regulation and Quality Improvement Authority
SAI	- Serious Averse Incident
South Eastern Trust	- South Eastern Health and Social Care Trust
Southern Trust	- Southern Health and Social Care Trust
SQE	- Safety, Quality, Experience
Western Trust	- Western Health and Social Care Trust

Appendix 2 - RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010

Review	Published
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013

Review	Published
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of the HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

Review	Published
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
RQIA Review of Community Respiratory Services in Northern Ireland	February 2016
Review of the Northern Ireland Ambulance Service	March 2016
RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	June 2016

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