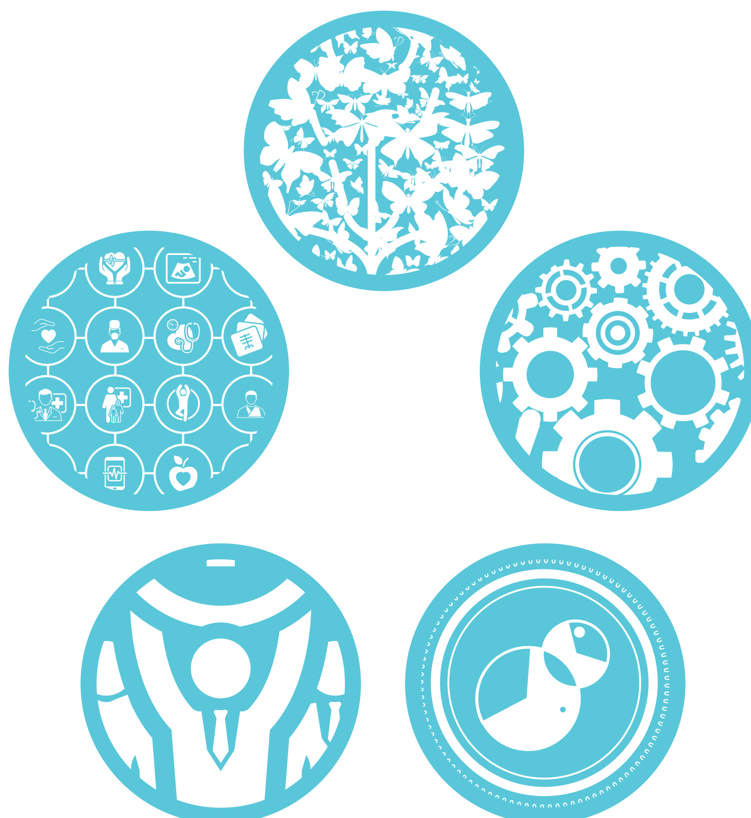
Health and Social Care Board and Public Health Agency



Annual Quality Report 2016/17

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

Chief Executive's foreword

Looking back and taking stock

Welcome to the fourth Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Quality is at the heart of our services and the PHA and HSCB are committed to driving improvement in safety, outcomes, access, efficiency and patient satisfaction. 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.

During 2016/17 there was an important focus on quality improvement within each of our directorates. Using Quality 2020 as our strategic driver, we have seen achievements in areas such as primary care infrastructure through the regional delivery of investment in primary and community care infrastructures. Managed clinical networks have implemented a number of improvements in order to support clinical leadership and share knowledge, good practice and learning. The HSCB and PHA have led the implementation of the dementia strategy which has seen a number of quality improvements over the year including extending domiciliary care to people living with dementia, the introduction of dementia champions and navigators across the HSC.

We have provided opportunities for our staff to engage in quality improvement training at different levels and facilitated a number of regional learning events for the HSC to promote and encourage quality and learn from experiences. I 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.

Looking forward

Looking to the future, we will continue to 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 will remain focused on modernising how our services are delivered, ensuring that they are responsive to the needs of a changing population.

Building on the strong foundations already in place, we will continue to focus on involvement and co-production with patients and clients and through initiatives such as 10,000 Voices. We will use patient and client experience to improve how services are commissioned and delivered. We look forward to identifying new and innovative ways to improve the quality of our work and embedding this into a culture of quality, improvement and innovation.

Valerie Watts

Valerie Watts
Chief Executive

Transforming the culture

Serious Adverse Incidents (SAIs)

During the reporting period the HSCB and PHA reviewed and closed 435 SAIs. The following methods of regional learning were approved:

- **10** reminder of good practice letters
- **6** professional letters
- **2** Learning letters
- Identified **24** newsletter articles and **2** thematic reviews
- **29** were referred to other groups
- **9** were featured at learning events

10,000 Voices

Last year a total of 1,694 stories were collected across a range of service areas from patients, clients, family members and staff bringing the total stories collected to **10,269**. These have been used to inform local and regional quality improvement initiatives.

Strengthening the workforce

By March 2017, approximately **17%** of the HSC workforce reported as being trained at level 1 of Quality 2020 Attributes Framework.

Promoting active travel

The Take the Stairs programme, a simple, effective low cost quality measure, has seen an increase in upward journeys using the stairs by 81% and an increase in downward journeys by 86%.

Delivering Care

Delivering Care aims to develop a tool to determine staff requirements for the nursing and midwifery workforce in a range of major specialities. Phases 1- 4 of this project are complete. The focus is now on the next phases which include mental health, neonatal nursing, primary care nursing and independent sector nursing homes.

Delirium training

By March 2017, almost 1,500 staff have been trained in a programme linked to the roll out of the delirium improvement bundle.

Measuring improvements

NICE

Last year we issued **54** technology appraisals to trusts and we continued to monitor the implementation of **150** clinical guidelines which have been issued to the HSC.

Quality Improvement Plans

Last year the regional quality improvement plan priority areas focused on:

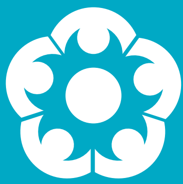
1. Pressure ulcer prevention
2. Falls prevention
3. Venous thromboembolism risk assessment
4. Implementation of malnutrition universal screening tool
5. Escalation of deteriorating patients

Service frameworks

Service frameworks set out, at a strategic level, the type of service that patients and service users should expect. The HSCB/PHA lead six regional service frameworks including:

1. Learning disability
2. Cancer prevention, treatment and care
3. Cardiovascular health and wellbeing
4. Respiratory health and wellbeing
5. Older people
6. Mental health

Raising the standards



Dementia Together NI

Last year the HSCB/PHA Dementia Together NI team developed five short break pilot schemes to support people living with a dementia across different trusts including:

1. Enhanced befriending service and night support service
2. Extended domiciliary care services
3. Emergency support services
4. Enhanced day opportunities
5. Short break opportunities

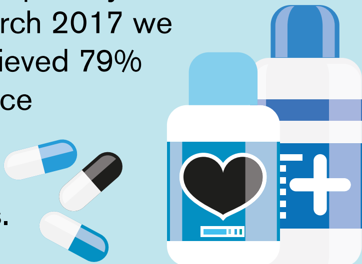
Managed clinical networks

The HSCB/PHA lead the implementation of a range of managed regional clinical networks which provide a platform to achieve regional consistency in care and drive quality improvement. These include:

1. Critical Care Network
2. Neonatal Network
3. Cancer Network
4. Pathology Network
5. Diabetes Network
6. Stroke Network
7. Paediatric Network

Northern Ireland medicine formulary

Ten chapters of the formulary have been published, covering approximately 90% of prescribing choices in primary care. As of 31 March 2017 we have achieved 79% compliance across GP practices.



Self-directed support

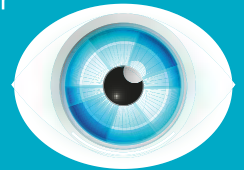
By March 2017,

6,700

staff have been trained across the three SDS levels.

Eye-care partnerships

By March 2017, a total of 6,200 patients have entered the glaucoma/ocular hypertension pathway. As a result of demand-management protocols put in place, 70% of these patients did not need a referral to hospital for diagnostics and assessment.



Integrating the care

Primary care antimicrobial stewardship

Last year 123 practice-based pharmacists, whose role included supporting GP practices with antimicrobial stewardship were recruited. A locally enhanced service was introduced in general practice to support a named antibiotic champion to undertake audit and identify actions, by March 2017 170 GP practices had signed up.

Regional Integrated Support for Education

The Regional Integrated Support for Education, developed and funded in partnership with HSCB, PHA and the Education Authority was launched in May 2017. This provides a range of multi-disciplinary child-focused programmes delivered in primary schools and aimed at helping children to access learning and support their development to reach their full potential.

Contents

Transforming the culture ... 7

Introduction ... 8
Who we are ... 8
Leadership and governance ... 9
Involvement and experience ... 11
Collaborative working ... 17

Strengthening the workforce ... 19

Introduction ... 20
Quality improvement training for the HSC ... 20
Regional learning events for the HSC ... 22
Improving synergy with other bodies ... 25
Training and support for PHA/HSCB staff ... 26
Delivering Care: a policy framework for nursing and midwifery workforce planning in Northern Ireland ... 29

Measuring improvements ... 33

Introduction ... 34
Quality improvement plans ... 34
VTE risk assessment ... 36
The 'Malnutrition Universal Screening Tool' (MUST) ... 37
NEWS (National Early Warning Scores) ... 37
Electronic caseload analysis system for health visiting (eCats) ... 38
Adults with learning disability ... 39
Web-based system for healthcare-associated infection and antimicrobial stewardship ... 41

Raising the standards ... 43

Introduction ... 44
Dementia Together NI ... 44
Managed clinical networks ... 47
Implementation of NICE guidance ... 57
Northern Ireland Medicines Formulary ... 58
Developing eyecare partnerships ... 59
Self-directed support ... 60

Integrating the care ... 63

Introduction ... 64
Integrated care partnerships ... 64
Primary care infrastructure project ... 67
Healthcare–associated infection and antimicrobial stewardship ... 69
Quality improvement: children and families ... 71
Allied Health Professions seven day working ... 72

Theme one

Transforming the culture

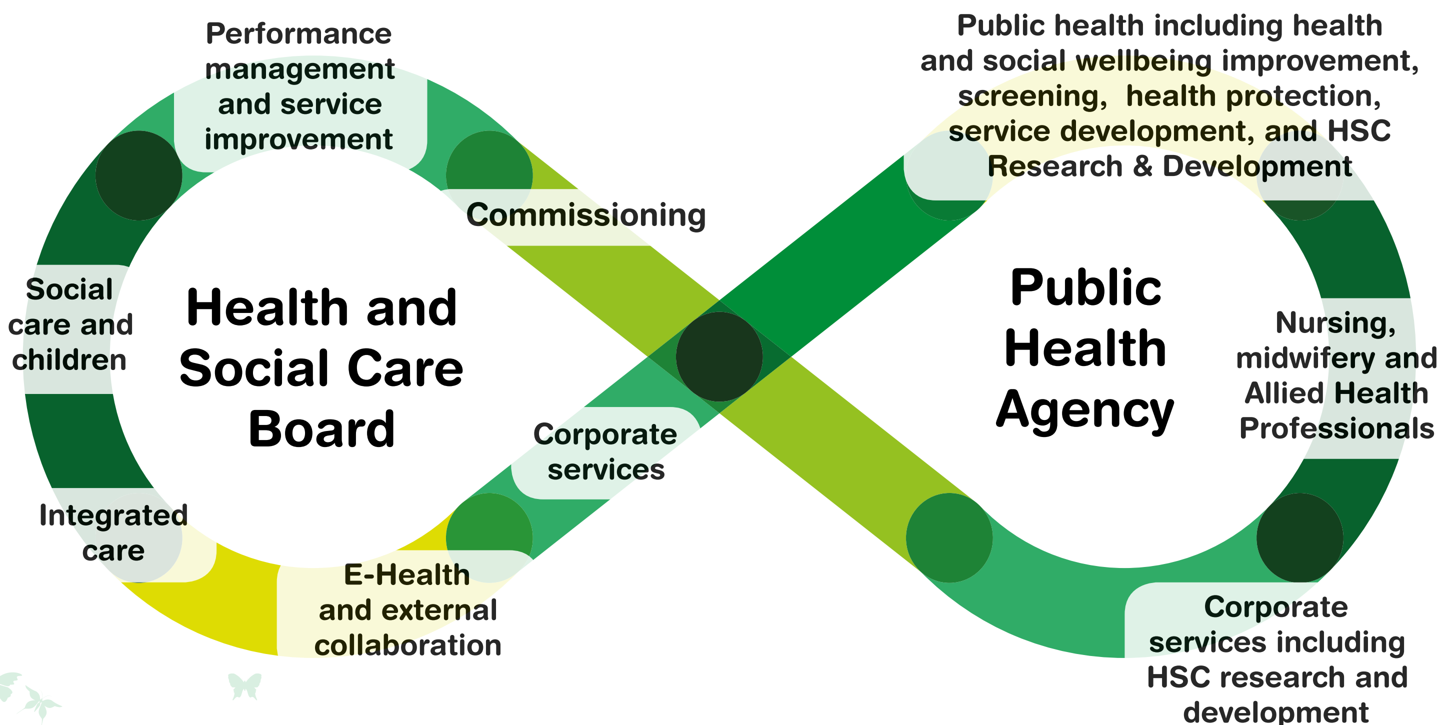
Introduction

The HSCB and PHA recognise that for the quality of care and services to be of the highest level, the culture of an organisation must be open, honest, transparent and, above all, patient and client focused. Key to transforming an organisational culture is the willingness of the senior team to lead from the front in motivating staff, prioritising patient and client care above all else, while embracing change in the rapid moving climate of the HSC.

Who we are

The HSCB and PHA are considered 'arm's lengths bodies' within the HSC. Both organisations have a range of roles and responsibilities and are made up of different directorates. Ensuring that health and social care services are safe, high quality, effective and meet people's needs is a core function of both the HSCB and PHA.

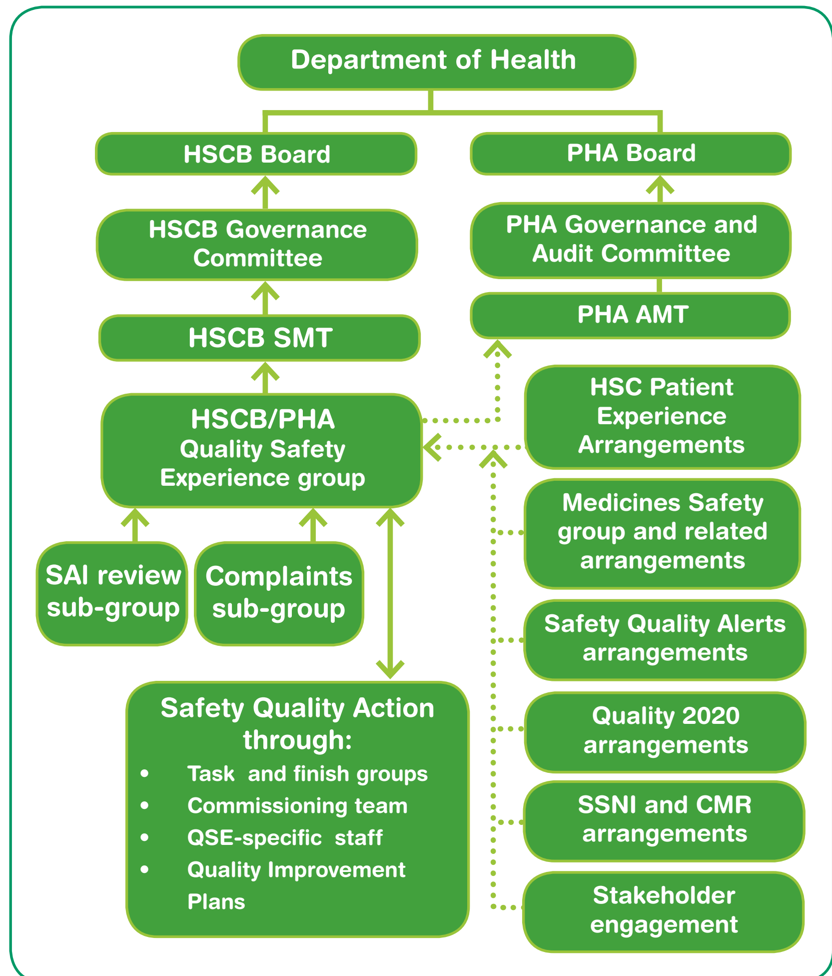
Both organisations work together to improve the quality of services delivered and work towards the Quality 2020 vision "to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in Health and Social Care".



Leadership and governance

Within the HSCB and PHA, the **Quality, Safety and Experience (QSE) group** is the strategic group that monitors and reports on overall safety, effectiveness and patient client experience. A number of other groups contribute to the work to improve the safety and quality of services as shown in the overview of the PHA/HSCB QSE governance and assurance structure.

The Safety Quality Alerts Team, Complaints Team, Serious Adverse Incident Group, Designated Review Officer (DRO) professional groups, and the Safety Forum, report to, and support the work of QSE.



Revisions to the regional procedure for the reporting and follow up of serious adverse incidents (SAIs)

During 2016/17 the HSCB, working jointly with PHA, completed a review of the regional procedure for the reporting and follow up of SAIs. The review was carried in consultation with the Department of Health (DoH), the Regulation and Quality Improvement Authority (RQIA) and HSCT professionals and governance leads. The revised procedure was issued in November 2016.

Working in conjunction with other HSC organisations, the procedure provides a system-wide perspective on serious incidents occurring within the HSC and special agencies and also takes account of the independent sector, where they provide services on behalf of the HSC.

The revised procedure offers a consistent approach and leads to clearer, consistent governance arrangements for reporting and learning from the most serious incidents. The procedure supports preventative measures and reduces the risk of serious harm to service users.

The procedure supports governance at a local level within individual organisations to improve existing regional governance and risk management arrangements. It facilitates openness, trust, continuous learning and ultimately service improvement.

Regional learning from SAIs

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

For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. In some cases the HSCB/PHA may also identify regional learning. The table below provides an overview of regional learning by programme of care that has been identified from all SAIs closed during the reporting period.

Serious Adverse Incidents (SAIs)

During the reporting period the HSCB and PHA reviewed and closed 435 SAIs. The following methods of regional learning were approved:

- **10** reminder of good practice letters
- **6** professional letters
- **2** Learning letters
- Identified **24** newsletter articles and **2** thematic reviews
- **29** were referred to other groups
- **9** were featured at learning events

Listed below are four examples taken from the regional learning identified during the reporting period.

- **Safe use of oral bowel cleansing agents**
  This SAI involved a patient with significant co-morbidities who was prescribed oral phosphate bowel cleansing preparation before colonoscopy. The SAI investigation identified that the deterioration in renal function following colonoscopy could have been attributable to the inappropriate use of oral phosphate bowel cleansing preparation. Guidelines for the safe prescription of oral bowel cleansing preparations were not followed. As a result a reminder of good practice letter was issued to the wider HSC asking trusts to review and amend systems as necessary to reflect the current guidance, and ensure staff are aware of the correct procedures.

- **Patient reminder note for special order medicines**
  A professional letter was issued to community pharmacists with a specific patient reminder form for special order medicines. This was developed following an incident where a child receiving a specialist medication for epilepsy was admitted to hospital following a seizure, due to a gap in treatment. A key learning point from the review was to ensure that patients and carers know the importance of ordering their specialist medications well in advance of the end of their supply.

- **Receipt, safe storage, handling and issuing of medicines**
  Following an incident which resulted in the loss of a specialist medication from the reception area of a GP surgery, an article was included in the General Medical Services newsletter reminding practices to have a protocol in place that covers the receipt, safe storage, handling and issuing of medicines and that they have good communication in place between the trust pharmacy, the GP surgery and the patient.

- **Home oxygen and the risk of fires**
  Following two separate incidents involving medical oxygen cylinders which resulted in fires, an article was included in the Learning Matters newsletter reminding healthcare professionals involved in the care of patients using oxygen to ensure that:

  (a) They are adequately trained to advise patients on the safe use of oxygen;
  (b) Patients and carers understand how to use their oxygen safely and are well aware of the risks of home oxygen and fires.

  Patients on home oxygen should expect to receive appropriate education including written information on the use of and risks with handling and operating high pressure oxygen cylinders.

Involvement and experience

Involving patients, clients and carers is core to the effective and efficient commissioning, design and delivery of high quality HSC services. The HSCB and PHA recognise that, through involving patients and service users in our work and listening to their experience, we can make a real difference improving the quality of our services. We have been exploring ways to adopt creative and innovative ways to maximise involvement, moving towards a co-production/co-design model for improvement. Below are some examples of how the HSCB and PHA have led improvements through involvement.

Personal and Public Involvement

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers and the public in health and social care services. The *HSC (Reform) Act (NI) 2009* makes PPI a legislative requirement.

The PHA has responsibility for the leadership of the implementation of this key policy area across the HSC. In addition the PHA has responsibility to:

- ensure consistency and coordination in approach to PPI;
- identify and share best PPI practice across the HSC;
- communicate and raise awareness about PPI;
- build capacity and support training;
- monitor and report on PPI.

Key achievements in 2016/17 include:

HSC Expert Panel

A group of service users and carers met with Professor Bengoa and members of the public. Five key issues were presented and discussed with the panel to advocate for PPI to be integrated into the expert panel's recommendations.

'Involving you, improving care: our involvement story' conference

The PHA, in partnership with Queen's University Belfast (QUB), hosted a major PPI conference, 'Involving you, improving care: our involvement story'. It was attended by some 250 people including the Minister for Health Michelle O'Neill.

PPI Awards

The first PPI Awards were presented by the PHA and QUB to successful PPI projects. The PHA were successfully awarded recognition for Innovation for Involvement for the work with lesbian, gay, bisexual and transgender (LGBT) young people.

PPI and its impact – research launch

The PHA working in conjunction with the Patient and Client Council (PCC) commissioned and launched research to examine PPI across the HSC. The event showcased PPI in practice and provided an opportunity for the lead researchers from QUB and Ulster University (UU) to share the research. Ten recommendations have been developed to advance PPI regionally.

In 2017/18 this will include:

- co-chairing the Regional HSC PPI Forum;
- undertaking PPI monitoring;
- making recommendations for the development of PPI;
- launching co-produced e-learning for service users and carers;
- launching a co-produced web resource 'Engage';
- advising transformation work streams on the practical application of involvement and co-production.

10,000 Voices

The 10,000 Voices initiative continues to provide a platform through which people can have their voice heard and directly influence future planning and delivery of HSC services.

Collaborative working, partnership and co-design have been key to the success of 10,000 Voices , helping to ensure that the patient's voice is heard and at all levels in HSC organisations.

Throughout the period April 2016 – March 2017, a total of 1,694 stories were collected across a range of service areas from patients, clients, family members, carers and staff. This brought the overall total number of stories collected to 10,269 since 10,000 Voices commenced in 2013. The projects included in the 2016/2017 work plan are:

- unscheduled care (patient and staff experience);
- paediatric autism and child and adolescent mental health services (CAMHS);
- process of adult safeguarding;
- eye-care services.

The 10,000 Voices initiative is helping to inform quality improvements within HSCTs, influencing the regional planning of services and contributing to regional and local education and training programmes. The methodology has been used widely in the HSCTs through the use of a 10,000 Voices template which captures and measures experience in relation to the Patient and Client Experience Standards. HSCT facilitators have been engaging with patients/clients and their families at a number of events to ensure that people have the opportunity to "tell their story".

While 10,000 Voices has been evaluated informally by HSCTs as an effective way to obtain patient experience information, a formal evaluation framework to assess the impact of the work is being developed. The regional work streams in the 2017/2018 10,000 Voices workplan includes experience of care in the following areas:

- hospital discharge;
- delirium;
- bereavement;
- neurology services.

Your experience matters

In 2012, the PHA and the HSCB surveyed people across Northern Ireland to assess their experience of mental health services. The *Your experience matters* survey was based on nine questions developed by service users and carers from each HSCT area. In addition, a 'free text' section was included so individual respondents could tell their story and describe their personal experience of using mental health services.

Recovery

Promoting hope, choice and opportunity — Issue 3, Winter 2016

Celebrating recovery

Where do we begin to tell the story of the sterling work around recovery in mental health services, in communities and in the recovery colleges? From recovery cafés and roadshows, to Chairman's Awards and a spring equinox Recovery Awareness Week – the list of achievements is endless.

As we stated in issue one of this newsletter, 'recovery' is more than just a word. It is an ethos; a lifestyle choice; a commitment to wellness, education, ownership and partnership between service users and service providers. And it means different things to different folks. As one service user recently put it: "For me, recovery means needing a diary because I am so busy now. Before that, every day was a Sunday."

In the Northern Health and Social Care Trust (HSCT), it's all go. They are celebrating 2016's commitment to recovery with pop-up cafés, a fabulous recovery choir, the establishment of peer support worker posts and the growing success of WRAP (Wellness Recovery Action Plan) programmes. Recovery is rapidly becoming embedded as the new norm across the Northern HSCT and within our communities.

The South Eastern HSCT's recovery awareness week coincides with the spring equinox, when day and night are of equal length, and is aptly associated with the equal value of lived and learned experience in mental health recovery.

In the Southern HSCT, their recovery college was launched in October 2016 through collaboration between service users and partner organisations, which is the cornerstone of the work of the HSCT and its counterparts across the region.

Health Minister Michelle O'Neill celebrating recovery with the Voice of Recovery Choir

In the Western HSCT, they are proud to boast the enrolment of over 400 students to their recovery college across the five sites and encompassing 45 courses. The HSCT attributes the college's success to its 'experts by experience' who also inspired the recovery college roadshow which saw the recovery college go to the heart of acute inpatient services.

Last but not least, the chest of the Belfast HSCT is swollen with pride upon winning a Chairman's Award in the 'Our People' category, for which the peer trainers beat over 100 entries. And there were more celebrations for two De La Salle pupils in Belfast who won the World Mental Health Day 'Changing Minds' competition 2016.

If there was a soundtrack to the work of the HSCTs and recovery, it may not be Kool and the Gang's *Celebration*, but recovery really is a big hit!

Siobhán Rogan, peer trainer, Belfast Recovery College

In this issue:

- Celebrating recovery
- World Mental Health Day 10 October 2016
- Recovery updates from HSCTs

You can view the Regional Mental Health Care Pathway at www.hscboard.hscni.net/mentalhealth/Regional_Care_Pathway_Mental_Health.pdf

The issues and concerns highlighted in the 2012 survey, for example the need for 'good communication', 'shared care', and 'timely information', were prioritised for improvement. Each HSCT subsequently engaged in service improvement activities to help address these issues/concerns. A key part of this process has been the 'Implementing Recovery through Organisational Change' programme (ImROC). ImROC focuses on staff and service users working together to ensure mental health services become more recovery-focused.

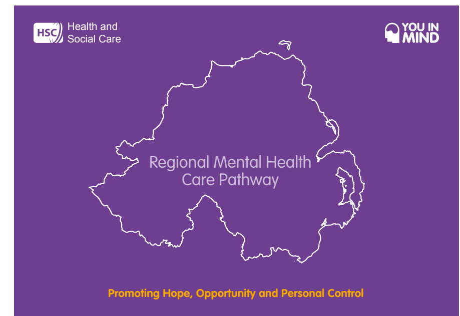
A significant example of how the culture of mental health services is changing is through co-production in the design and delivery of mental health recovery colleges across the region. Recovery colleges offer people with lived experience (including carers), and those working within mental health services the opportunity to learn from each other and to develop skills and confidence to manage their own recovery journey. Recovery colleges are now established and operating very successfully in all five HSCTs.

To assess progress from 2012, a 'second edition' of the regional survey was undertaken between October – December 2015, representing the updated views of service users and carers. A report entitled *You in mind – Your experience matters* was launched in June 2017. Overall, it was really encouraging to report that the findings published in the 2016 report demonstrate a general improvement from 2012 across all the questions asked. Plans are in place to formally evaluate the ImROC programme, with an emphasis on the outcomes for both individuals and the organisation.

The PHA continues to oversee the regional coordination of the ImROC and recovery agenda, sustaining momentum and reinforcing the regional consistency which has been achieved to date. The PHA also develops a bi-annual Recovery newsletter. This newsletter provides a snapshot of peer support working, co-production, recovery college activities and also articles and poems from service users about their recovery journey.

The Recovery newsletter is co-produced with both providers and service users sitting on the group to agree style and content from design through to publication.

Eating disorders pathway to care – a guide for people using services and their family members



This guide for service users and their families was co-produced with carer and peer support groups as a companion document to be published alongside the regional clinical care pathway for the treatment and management of eating disorders. The service users and family members involved in developing the clinical care pathway summarised the information they thought would be most helpful for people newly diagnosed, or for someone worried about a loved one. The guide is a handy sized booklet which also contains contact details for local support groups and useful literature and online resources.

The document is part of the overall 'You in mind' suite of mental health care pathways that provide guidance on the steps of care to be delivered. 'You in mind' is designed to enhance the quality of service experience and promote consistency of service delivery across Northern Ireland.

Co-production in learning disability services

The regional learning disability healthcare and improvement steering group, led by the PHA, continues to make progress through the improvement of the healthcare and health and social wellbeing of people with learning disabilities. One significant piece of work is the development of the HSC Hospital Passport, for people with a learning disability in contact with a general hospital.

The HSC Hospital Passport and guidance notes have been developed for people with a learning disability to complete (with or without help) and present to staff every time they have contact with a general hospital. It gives staff important information on the person and how they prefer to communicate, their medical history and any support they might need while in hospital. Staff can then make any reasonable adjustments in order to provide the best possible care for people with a learning disability.

The passport has been developed and successfully tested in partnership with a wide range of individuals with a learning disability, organisations involved in learning disability service provision as well as family and carers, HSCTs and voluntary and independent care providers. Plans are in place to launch the passport early in 2017.

Easy read health booklets for adults with a learning disability

A series of easy read health booklets on abdominal aortic aneurysm (AAA) screening, menopause and prostate cancer has been developed for adults with learning disability by the HSCB in partnership with the Southern HSCT. A range of service users were involved in the co-production process as well as providing feedback on final content and layout. A DVD promoting the annual health check scheme was also developed with service users and carers, who participated in the production.

Physical and sensory disability support

The Physical and sensory disability strategy and action plan (2012–2017) was extended in xxxx which provided the opportunity to refresh the membership of the strategic implementation group. This included new and additional service users as well as DPULO (disabled people user led organisations) representation on the group. During 2016/17 the refreshed implementation group, led by the HSCB, undertook a range of improvements which resulted in co-produced support for service users and staff.

These improvements included:

- Consultation on the review of communication support services
  The HSCB co-produced all of the consultation materials with the British Deaf Association (BDA), including signed video clips in both British Sign Language and Irish Sign Language and commissioned easy read versions of documents from CAN, another user-led voluntary group. The consultation involved regional engagement events in collaboration with the BDA and statutory partners to ensure that the deaf and hard of hearing community were fully involved in the consultation process as well as inclusion at the HSCB Board meeting.

- Making communication accessible – a guide for HSC staff.
  The HSCB coordinated the regional launch of this guide to highlight the need for professionals to communicate to service users in all media that meets their needs.

- Re-investment in the 'My journey, My voice' national campaign
  This campaign highlights communication around disability, led by the Royal College of Speech and Language Therapists.

- Sensory e-learning awareness module
  This initiative is now available across five HSCTs to help staff become aware of the particular communication difficulties facing sensory service users and what staff should be aware of in their day to day interactions with them.

Collaborative working

The HSC Safety Forum provides leadership through collaborative working with HSCTs and other organisations to bring about sustainable improvements in care.

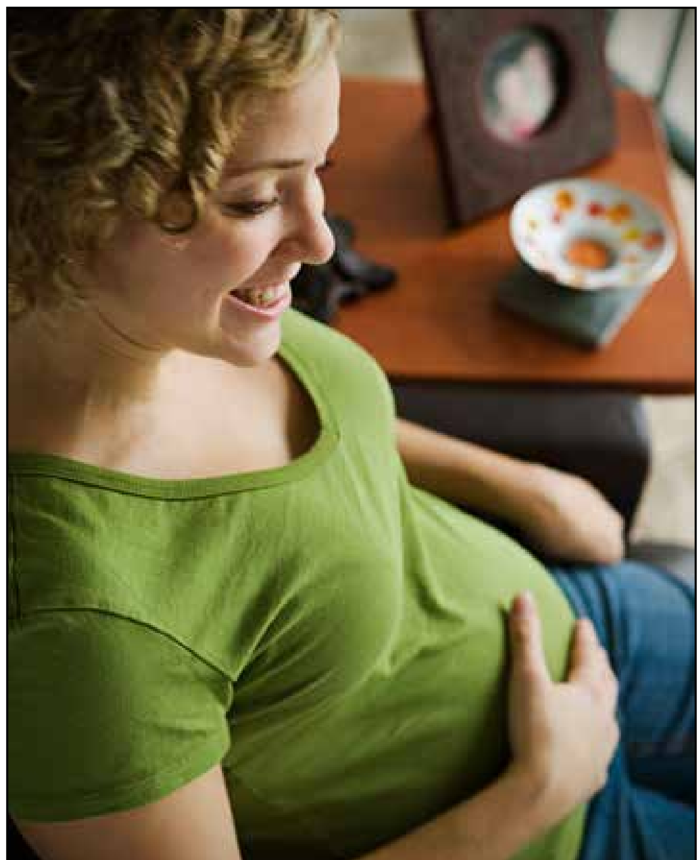
During 2016-17, the HSC Safety Forum brought together teams to address specific areas of service and address gaps between best practice and actual practice.

"The broad theory behind collaboratives is that, by comparing practice, professionals and teams will be motivated to do things differently, which in turn improves patient outcomes and ultimately improves service use and costs." (Health Foundation, 2014)

Examples of collaborative working

a) Maternity collaborative

In 2016/17 the maternity collaborative has sought to broaden its links with other groups to ensure integration with the work of other related groups. With the Northern Ireland Maternal and Child Health (NIMACH) team the collaborative has engaged with the Perinatal Institute to introduce a Standardised Clinical Outcome Review (SCOR) tool to all maternity units in Northern Ireland. This software tool and process allows for unit-based comprehensive reviews of all perinatal deaths. It helps to foster a blame-free culture and objective assessment, identifies substandard care and system failures and facilitates multi-disciplinary learning. To support implementation of this approach and ensure consistency the collaborative are also developing standardised operating procedures for review structures, engagement with parents and record keeping/data protection.



This is being introduced in parallel with a series of confidential enquiry panels run by NIMACH and funded by the Guidelines and Audit Implementation Network (GAIN). In addition, the collaborative has also engaged with the GB-based Practical obstetric multi-professional training (PROMPT) team to facilitate the first all-Ireland training day. This brought together 18 maternity teams to work on interactive drills and workshops that allowed hands on experience of practical and decision-making skills required to manage simulated obstetric situations in both low and high risk maternity settings.

b) Paediatric collaborative

Working with teams from across all paediatric units in Northern Ireland, the paediatric collaborative has focused on communication, early detection and rescue of the sick child and medication safety.

HSCTs continue to progress work on handover and all are now using structured communication tools to assist with the effective transfer of information. In line with one of the key recommendations in the Department of Health's Strategy for Hospital and Community Paediatric Services (2016), the collaborative is also working in partnership with colleagues who are designing the proposed paediatric network.

The collaborative has also retained its links with the professional colleges. Members co-designed and delivered a workshop at the Royal College of Paediatrics and Child Health (RCPCH) 2017 National conference in association with Wessex paediatric quality improvement collaborative teams.

Theme two

Strengthening the workforce

Introduction

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

Together they employ over 800 staff, working in areas such as nursing, medicine, social care, allied health professionals, finance, family practitioner services, commissioning and corporate services. This diverse range of responsibilities, coupled with the current demographic changes and economic climate, requires a sustained focus on improving quality. Thus it is crucial that we train our staff in recognising and implementing quality improvement techniques.

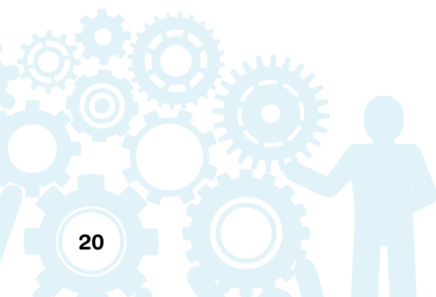
Quality improvement training for the HSC

- **QI ECHO**

  During 2016/17, the PHA HSC Safety Forum led the QI ECHO programme, consisting of eight online ECHO and two face to face sessions. Projects included:

  - Sepsis6;
  - early warning scores;
  - looked after children;
  - safer maternity care;
  - reliability of paramedic care;
  - improvement in Child and Adolescent Mental Health Services (CAMHS).

In total there were 14 teams involved. Feedback from participants has been very positive and the HSC Safety Forum plan to submit an application for future programmes.



- **Scottish Quality and Safety Fellowship**
  In 2016/17 six Northern Ireland applicants were successful in gaining places on cohort 9 of the Scottish Quality and Safety Fellowship (SQSF). This programme aims to develop clinical leaders capable of improving the quality and safety of healthcare. The programme is designed to enhance knowledge of the science and methods for improvement among clinicians who have the enthusiasm, experience and skills. Interviews for cohort 10 took place in June 2017.

- **Building capacity for the future**
  A medical student select component (SSC) 12 week module entitled 'How to save lives and provide quality healthcare' was facilitated by the HSC Safety Forum from February – May 2017. The 24 participants received training on the factors which compromise safety and contribute to adverse events in healthcare, strategies that may be employed to make patient care safer, the use of specific improvement techniques and the practical experience on how to design a project that utilises the improvement model.

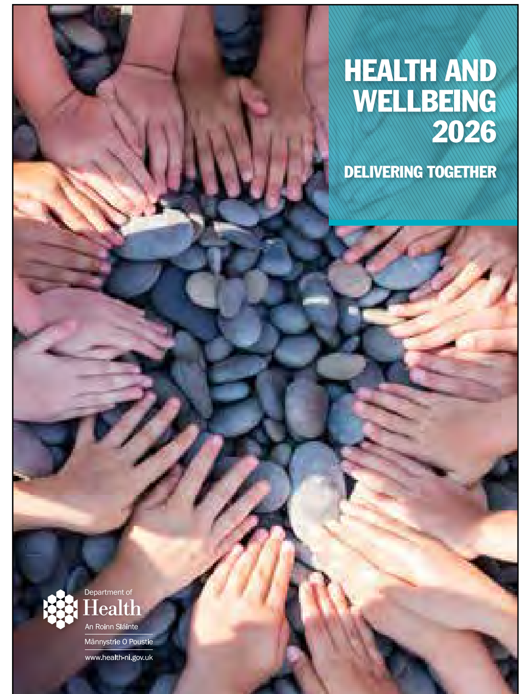
- **Improving and safeguarding social wellbeing**
  The DoH are responsible for the implementation of the *Strategy for Social Work in Northern Ireland* in partnership with the HSCB. A core part of this implementation are quality and service improvement programmes to develop social workers at all levels as leaders and ambassadors for the profession. These programmes include:

  - Social work innovation scheme;
  - Leader as coach;
  - Leading social work stronger together;
  - Improvement advisor professional development programme;
  - Leading quality improvement in social work.

This is supported by the Staying Connected Forum, a regional network for quality improvement in social work. These various initiatives and programmes are designed to develop a culture where practice improvement in the social work profession in Northern Ireland is everybody's business.

Regional learning events for the HSC

Delivering safer care together conference



The 'Delivering safer care' together conference was held on 3 March 2017 with 184 delegates from across all areas of health and social care in Northern Ireland and representatives from the Republic of Ireland. Opening remarks were delivered by Mary Hinds (Director of Nursing and AHPs, PHA). This was followed by Melissa McCarter, who bravely shared the story of her son Aaron who tragically died from Sepsis. Melissa's plea was for better awareness and training for staff in the recognition and management of this illness. The delegates then heard from a range of speakers including Kath Evans (Experience of Care Lead, NHS England), Maria Somerville (service user), who spoke on partnership working to improve care delivery, Dr Dan Cohen (Medical Director of Datix) and Dr Stephen Webb (Consultant, Papworth Hospital), who delivered a session on human factors. Charlotte McArdle (Chief Nursing Officer) and Dr Anne Kilgannon (Deputy Chief Medical Officer) discussed the recently published report *Health and Wellbeing 2026: Delivering Together*. The day concluded with sessions delivered by Dr Steve Tierney and Dr Michelle Tierney who discussed the model of care in Alaska, and Mr Matthius Van Alphen who discussed the model of community nursing in the Netherlands.

A series of satellite events were held in advance of the conference on 2 March 2017. These included workshops on human factors, community nursing and system redesign in Alaska. Previous Scottish Fellows also used this opportunity to meet and link with colleagues from the Republic of Ireland.

Third annual Learning from complaints event

During 2016/17, the HSCB hosted its third annual Learning from complaints event, which focused on the theme of 'Privacy, Dignity and Respect'.

Against a backdrop of reviews, quality reports, and media articles about a lack of privacy and dignity in the HSC, the HSCB noted, in its monitoring role, that these issues consistently feature in a significant number of complaints received across both primary and secondary care. The complaints can include failings in personal care, and how a patient, client or family member is spoken to, both in life or following the death of a loved one.

In context, during 2015/16, the trusts received 6,181 issues of complaint. While only 42 of these were specifically categorised as complaints regarding privacy and dignity, these factors featured in many other complaints, such as those relating to communication, lack of or incorrect information, attitude and behaviour, treatment and care, environment and discrimination. During this timeframe, the HSCB received 289 complaints regarding family practitioner services, 35 related to staff attitude and behaviour and 48 to communication and information.

Approximately 115 persons were in attendance at the event, with representation from across the HSC. The event had two keynote speakers; Dr Melissa McCullough, (Non-Executive Director, HSCB) and Tony Stevens, (Chief Executive, Northern Trust).

Key messages from the day included improvements in practice following the lack of dignity and respect shown to a lady and her baby following miscarriage, how privacy and dignity is maintained within emergency departments, the role of the trust bereavement coordinators in preserving dignity at the time of death, and the implementation and key principles of the regional dementia strategy. In addition, the audience heard and reflected on some very powerful messages from two service users, both of whom discussed the treatment provided to their recently deceased mothers, one of whom was a dementia patient, and the obstacles they experienced ensuring that they received appropriate and timely communication and care.

To raise awareness of these issues and to highlight learning and good practice, feedback from this event was compiled and disseminated to the wider HSC, including trusts, the PHA, the PCC, the DoH, the Northern Ireland Medical and Dental Training Agency, the RQIA, the Northern Ireland Social Care Council and family practitioner services. (http://insight.hscb.hscni.net/resources/learning-from-complaints/).

Second annual SAI event

In keeping with the values of Quality 2020, the HSC Safety Forum and HSCB hosted the second annual SAI event in March 2016. The workshop provided an opportunity for learning across health and social care to drive forward improvement in quality and safety of care, building on feedback and learning from past events.

The aim of the event was to use collaborative learning and an open and transparent approach to:

- share learning from a number of SAIs and identify themes to drive improvement;
- improve the ability to disseminate learning across the system;
- develop and agreed a high quality, robust, insightful approach to investigations of SAIs across the HSC.

Case studies were presented by trusts and integrated care across a wide range of programmes of care. A member of staff also shared his experience of the process and the impact it had on him and his family.

Elder abuse and financial abuse of vulnerable adults

In 2016-17, the Northern Ireland Adult Safeguarding Partnership (NIASP) identified significant learning from investigations of allegations of financial abuse and fraud, and hosted a regional event in conjunction with the HSCB to share this in October 2016.

The event was opened by the Commissioner for Older People and included contributions from trusts, RQIA, Action on Elder Abuse and the Centre for the Protection of Older People, Dublin. The event was attended by representatives from across the HSC and the guest speaker was Dr Amanda Phelan, Associate Dean of Global Engagement at University College Dublin School of Nursing, Midwifery and Health Systems, who presented research findings on elder abuse and financial abuse of vulnerable adults. The event concluded with participants working in small groups to develop their own action plans outlining how the learning identified would be put into practice. This was the second sharing learning event to be hosted by NIASP and

the first to focus on a specific topic. The event was very positively evaluated by participants and provides a blueprint for future learning opportunities.

Celebrating Recovery, transforming lived experience

The Celebrating Recovery conference was held to mark World Mental Health Day on 10 October 2016. For the first time, people with lived experience led the event, from inception to delivery, an example of meaningful co-production. Health Minister Michelle O'Neill opened the event. She said: "My priority is about transforming health and social care to deliver better outcomes…the best way we can do that is to be serious about co-production. It's about listening to patients, carers and families and to relatives. It's about listening to clinicians, and it is about us all coming together co-designing, co-producing the best care pathways which we possibly can produce. I think if we can do that, everybody can feel ownership of the service that they need and everybody can feel ownership of health and social care."

Co-hosted by the PHA and HSCB, the event was attended by people with lived experience and health and social care professionals from the statutory, community and voluntary sectors, including trusts and the carers' charity CAUSE.

Delegates heard stories of mental health recovery from people with lived experience and their carers, participated in recovery activity taster sessions, viewed Recovery College stands and learned from the experience of the Scottish Recovery Network.

This theme is also reiterated in the Minister's recently launched 10 year vision statement, *Health and Wellbeing 2026: Delivering Together*, which gives specific mention to recovery colleges and how these are an excellent example of how co-production can make a big impact on services.

Improving synergy with other bodies

- The HSC Safety Forum have facilitated a number of train the trainer sessions on quality improvement methodology with Queen's University Belfast medical tutors, to enhance knowledge and skills and ensure consistency in messaging for the undergraduate curriculum.
- The Health Foundation "Q" Programme is an initiative which connects people with improvement expertise across the UK. Northern Ireland currently has 28 members. It seeks to create opportunities for people to come together as an improvement community, sharing ideas, enhancing skills and collaborating to make health and care better. The PHA HSC Safety Forum has submitted an application to the Health Foundation for participation in Cohort 4 of the Q Programme.

- The HSC Safety Forum participated in the ADEPT Leadership ® programme during 2016/17. In conjunction with the BSO Leadership Centre, the programme focused on 'Improving communication with patients and their families'. As part of this programme a teaching module for trainee doctors was developed which focused on person-centred communication skills.

Training and support for PHA/HSCB staff

Quality 2020 attributes level one

In July 2016, an attributes framework e-learning programme was launched by DoH to raise awareness of the importance of quality improvement, whether in a caring or other role. This training is essential for all staff and covers the attributes described in Level 1 of the framework, offering a strong foundation to support quality improvement throughout the organisation. Last year, the HSC was set a goal for improvement that by March 2017, 10% of the HSC workforce should have achieved training at level 1 in the Quality 2020 attributes framework. The PHA was responsible for collating the information relating to this goal across the HSC.

During 2016/17 approximately 17% of HSC workforce reported as being trained at level 1.

Work is ongoing to further engage and promote the programme within organisations.

Designated Review Officer workshops

Each SAI notified to the HSCB is assigned to a Designated Review Officer (DRO), a senior professional/officer in the HSCB/PHA with relevant knowledge of the care/service area where the SAI occurred.

A series of DRO workshops, in each of the four HSCB/PHA localities, were held in February 2017 to provide training to DROs in respect of changes to the regional SAI process. The workshops also provided an opportunity to update the DRO protocol which has now been aligned to the revised SAI procedure.

Promoting health and wellbeing in the PHA as a workplace

The Staff health and wellbeing working group (SHWWG) was established in July 2014 under the auspices of the Organisational workforce development group (OWDG). The purpose of SHWWG is to act as a focus to improve the health and wellbeing of all staff in the PHA/HSCB and the work of the group reinforces the organisations' commitment to this goal. The process of working together across all divisions has been important to building understanding and sharing perspectives. The group has led a programme of action which recognises the importance of the workplace as

a setting to improve health and wellbeing. During 2016/17, the group led the implementation of a number of programmes to assist in promoting health and wellbeing for staff such as:

(a) LGBT forum

A forum for lesbian, gay, bisexual and transgender (LGBT) staff continues to provide confidential support for LGBT staff and students in the health and social care workplace. An e-learning facility has been developed and widely promoted within HSC settings and a website to support LGBT staff has been recently launched. Staff also participated in annual PRIDE events.

(b) My mood matters/Living life to the full

A range of courses has been made available to staff in the PHA/HSCB in relation to ‘My mood matters’ and ‘Living life to the full: life skills’, both of which have evaluated very positively. The courses have been offered to each locality and have been well attended in each area.

(c) Physical activity

PHA/HSCB staff have been encouraged to increase physical activity during the working day by promoting active travel to and from work, the use of stairs, lunchtime walks and on site gym facilities in each PHA site. An upgrade to the gym facilities in Linenhall Street and the introduction of the Take the Stairs initiative also helped boost opportunities for physical activity. The Take the Stairs programme, led by Dr Damien Bennett and Leanne McMullan, saw an increase in upward journeys using the stairs by 81% and an increase in downward journeys by 86%. It is now planned

to develop a toolkit that can help other workplaces introduce this simple, effective and low cost measure. A short video was also developed as part of awareness raising about the scheme.

(d) Staff wellness day

A fun wellness day for staff was held in October. The event was highly popular with a whole range of groups, activities and advice on hand, including:

- cookery demonstrations;
- Jumping Clay;
- Carecall;
- Cancer Focus;
- Belfast City Council bike scheme;
- men's sheds;
- Active travel and Sustrans;
- Zenbu Chair Massage;
- tapestry forum;
- trade unions;
- Pure Gym;
- Aware (mental health and wellbeing);
- Lighthouse Financial Advice;
- HERE NI and Rainbow.

Delivering Care: a policy framework for nursing and midwifery workforce planning in Northern Ireland

What is it?

Delivering Care: a policy framework for nursing and midwifery workforce planning in Northern Ireland aims to support the provision of safe, effective and high quality care in hospital and community settings.

The policy lead for the framework is the Chief Nursing Officer for Northern Ireland. The PHA are tasked with taking forward the development and implementation of each phase of the framework in partnership with HSC organisations, Executive Directors of Nursing and senior nursing workforce leads.

The framework sets out principles for commissioners and providers of health and social care services for planning nursing workforce requirements in a range of settings.

Why are we doing it?

- To promote a shared understanding between professionals, management, finance and human resource colleagues of the essential components to set and review nurse staffing requirements and when establishing new services to provide safe, effective and person-centred care.
- To support general and professional managers in presenting clearly the need for investment in nurse staffing within a changing service profile particularly in response to incremental service growth.
- To design a reference document for safe nurse and midwifery staffing levels in Northern Ireland.

Project aim

Delivering Care aims to develop a tool to determine staff requirements for the nursing and midwifery workforce in a range of major specialities.

This framework will support general and professional managers in presenting clearly the need for investment in nurse staffing with a changing service profile particularly in response to incremental service growth.

Who are the partners?

- PHA
- Trusts
- DoH
- HSCB
- Human resources
- Staff side
- PCC

What methods are used?

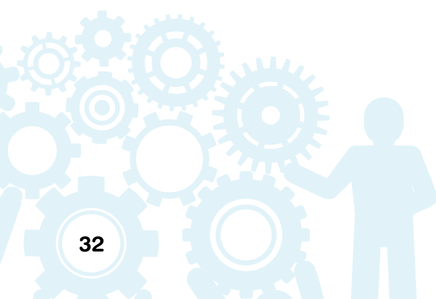
- Academic literature reviews
- Robust project governance arrangements
- Data collection of current workforce intelligence and including baselines and benchmarks across the UK
- Engagement with key stakeholders
- Application of best evidence
- External critical review
- Influencing factors that contribute to professional judgement
- Quadruple Aim

What areas have been looked at?

Phase	Staffing model	Status
Phase 1: Acute medical and surgical wards	Normative staffing range	In the process of implementation. £12m allocated
Phase 1A: Elective care treatment environments	Recommended range for 24/7 wards including day and short stay wards	Guidelines being scoped in trusts
Phase 2: Type 1 emergency departments	1:700-1:800 nurse to annual attendance ratio	Recommendations endorsed by CNO. No recurrent funding aligned as yet.
Phase 3: District nursing	Population based model	Recommendations endorsed by CNO. Proposals submitted to DoH
Phase 4: Health visiting	Population based model – caseload weighting	Recommendations endorsed by CNO
Phase 5: Mental health	Acute – nurse/bed ratio	Ongoing
	Community – caseload and population based model	
Phase 6: Neonatal nursing	Based on level of activity	Ongoing
Phase 7: Primary care nursing	Population based model	Ongoing
Phase 8: Independent sector nursing homes	Workplan being agreed with CNO and Director of nursing	TBA

What have been the key achievements so far?

- Developed a work plan for nursing workforce planning, which was a corporate priority.
- A regional partnership approach has been taken between the key stakeholders: (PHA/HSCB/NIPEC/trusts/DHSSPS/BSO/RCN)
- Increased the skill mix and funded new Band 6 staff in each trust to address recruitment in older people's environments.
- Influenced the success of the Burdett Grant award for recruitment and retention project.
- Influenced training and Educational Commissioning Group priorities for Health Visiting (41 student places in 2017/18), District Nursing (36 student places in 2017/18) and 200 new student entrants pre-reg places (100 in 2016/17 then 100 in 2017/18). Nursing Student places = 901 across the universities in Northern Ireland; 90 Open University; 287 Ulster University; 524 Queen's University Belfast.
- Have secured £12 million for Phase 1 - Acute Medical and Surgical Wards;
- £850,000 of Funding has been secured for staff as part of Phase 3 – District Nursing/Phase – Health Visiting for 2017.
- Proposals have been made to Department of Health for recurrent funding for Phase 3/4 and Phase 7 up to 2019/20.
- Proposals have been made for Phase 2 within unscheduled care
- Established a regional General Practice Nursing Network. This provides a forum for discussion of professional issues, sharing best practice and contributes to CPD.
- Have developed a foundation education programme for general practice nurses.



Theme three

Measuring improvements

Introduction

The HSCB and PHA recognise that gathering information and examining data is important in identifying the performance of an area of work. However, in doing so they also recognise that it is vital that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. During 2016/17, the HSCB and PHA have continued to promote the use of accredited improvement techniques to drive improvements and have worked with trusts and other HSC bodies to provide support to improve outcome measurements in a range of quality indicators.

Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support trusts on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout the region.

In 2016/17 QIP target areas were:

- pressure ulcer prevention;
- falls prevention;
- venous thromboembolism (VTE);
- the implementation of the Malnutrition universal screening tool (MUST);
- national early warning scores (NEWS);

Pressure ulcer prevention

Recording and measuring for improvement

NICE guidelines recommend that pressure ulcers of grade 2 and above are reported locally as incidents. This ensures that information is gathered about the circumstances of the pressure ulcer to promote learning and prevention of future incidents.

The higher the grade of pressure ulcer, the more severe the injury to the skin and underlying tissue. Grade 3 or 4 pressure ulcers can develop quickly, for example, in susceptible people, a full-thickness pressure ulcer can sometimes develop in just one or two hours. However, in some cases, the damage will only become apparent a few days after the injury has occurred. During 2016/17 the focus was on reducing the number and rate of grade 3 and 4 pressure ulcers and continuing the spread of SKIN bundle throughout all adult inpatient wards.

SKIN Bundle

The SKIN Bundle (see diagram below) is an evidence based collection of interventions proven to prevent pressure ulcers. SKIN is an acronym that prompts nurses to remember four key elements of good skin care: **S**urface selection, **K**eep moving, **I**ncontinence management, and **N**utrition.

The PHA supports trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN in all hospitals in Northern Ireland, through face-to-face collaboration and facilitation of sharing and learning across organisations.

The promotion of the use of the pressure ulcer safety cross within trusts to measure incidents of pressure damage has facilitated understanding and learning in relation to the prevention of pressure ulcers.

Falls prevention

Falls are among the top five most frequent adverse incidents reported within trusts. Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls. Frequently the cause of a fall is related to:

- footwear;
- lighting;
- activity;
- medication;
- eyesight.

Falls prevention involves managing a patient's underlying fall risk factors (for example problems with walking and transfers, medication side effects, confusion, frequent toileting needs) and optimising the hospital's physical design and environment. A number of practices have been shown to reduce the occurrence of falls.

Trusts are committed to ensuring falls prevention is a priority. A Regional In-Patient Falls Group, led by the PHA, has been established to provide multidisciplinary advice and support across the HSC in preventing harm to

patients who fall while in hospital and share regional learning across Northern Ireland. It focuses on sustainable strategies for falls prevention and management across trusts.

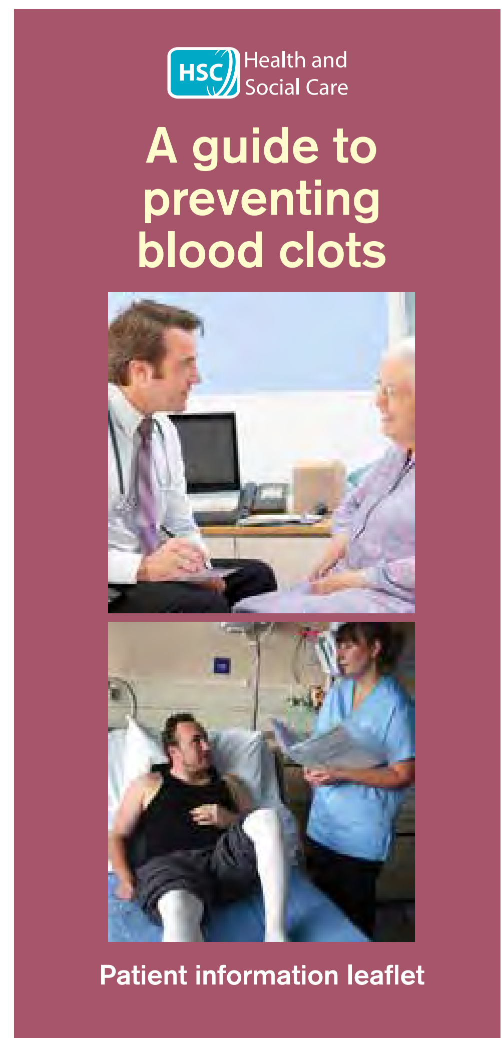
During 2016/17 the PHA worked closely with HSCB and trusts to continue to implement the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings. The falls bundle contains a number of regionally agreed elements, which are evidenced to reduce falls.

VTE risk assessment

What is Venous Thromboembolism?

Venous thromboembolism (VTE) is a blood clot in the vein. It's related to two life-threatening conditions:

- Deep vein thrombosis (DVT) is a clot in a deep vein, usually in the leg.
- Pulmonary embolism (PE) is a DVT clot that breaks free from a vein wall, travels to the lungs and blocks some or all of the blood supply. Blood clots in the thigh are more likely to break off and travel to the lungs than blood clots in the lower leg or other parts of the body.



VTE prevention is, above all, about saving lives and reducing long term ill-health. This is a common and often avoidable circumstance. There is extensive evidence including the NICE guidelines to assert that the patient must be assessed for their risk of a VTE and where appropriate should receive a form of prophylaxis suitable to their personal risk and existing conditions. The measure being used by the trusts is compliance with the completed VTE risk assessment

The 2016/17 Commissioning Plan requirement stated: "Trusts will sustain 95% compliance with VTE risk assessment across all adult inpatient hospital wards throughout March 2015." Regionally during 2016/17 there were 26,960 audits undertaken with 24,577 compliant – this equates to percentage compliance throughout the year of 91% for the region. All trusts have spread the risk assessment to 100% of required areas.

The 'Malnutrition Universal Screening Tool' (MUST)

The Promoting Good Nutrition Strategy (PGN) (DHSSPS, 2010) identified the Malnutrition Universal Screening Tool (MUST) (BAPEN, 2003) as the screening tool of choice to identify those adults who are at risk of malnourishment or who are malnourished. Nutritional screening is the first step in the identification of malnutrition. The screening process enables detection of significant risk of malnutrition and supports the implementation of a clear plan of action, such as simple dietary measures or referral for expert advice. Nutritional screening should be undertaken using a validated screening tool. MUST has been validated for all health and care settings in Northern Ireland and for use by a range of professionals.

Since the initiation of the PGN Strategy in 2011 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. The Regional Promoting Good Nutrition Steering Group carried out an evaluation of the strategy in April 2016. It was noted that progress has been made in acute hospital settings on implementing and improving including key characteristic 9, 'MUST is embedded in acute areas of health and social care' .

Trusts are committed to ensuring the implementation and compliance with MUST is a priority. By quarter 4 in 2016/17, 16,158 audits undertaken with 15,113 compliant, giving a regional percentage compliance of 94% with MUST. Spread of the MUST tool has been consistent at 100% for each Trust during each quarter in 2016/17.

The 5 'MUST' Steps

Step 1 Measure height and weight to get a BMI score using chart provided. If unable to obtain height and weight, use the alternative procedures shown in this guide.

Step 2 Note percentage unplanned weight loss and score using tables provided.

Step 3 Establish acute disease effect and score.

Step 4 Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5 Use management guidelines and/or local policy to develop care plan.

NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of the National early warning score (NEWS), including appropriate escalation arrangements to improve care of the deteriorating patient, in all trusts. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating HSCTs to clearly define their expectations regarding intervention when NEWS is abnormal. Trusts are committed to ensuring escalation of NEWS is a priority and worked with the HSCB and PHA to measure compliance with accurately completed NEWS charts.

Electronic caseload analysis system for health visiting (eCats)

The enhancement of the electronic caseload analysis system (eCAT) for the health visiting service has been led by PHA with the full support and engagement of managers and practitioners from the trusts.

An extensive literature review was completed to examine the evidence in relation to health visiting caseloads. However, although there were a number of articles there was a paucity of evidence on determination of the optimal caseload size. The initial plan in Northern Ireland was the determination a reasonable caseload size that would be acceptable to practitioners, managers and commissioners and could be used to inform the DoH Delivering Care staffing model for health visiting.

This work has been led by the Public Health Agency with the active collaboration and engagement of practitioners and managers; a caseload measurement system has been developed and tested. It accurately reflects the demands of the caseload across the four Hardiker thresholds of need and provides a 'weight' measurement for the optimal caseload size. Planned and unplanned absence allowances are considered within this weight measurement. This IT software solution provides live and up to date data which informs on individual and team pressures and supports transparency across individuals, teams and trusts. It supports improved workforce planning and trust practitioners and managers are committed to a regionally consistent approach to service delivery and service improvements. Caseload content is robustly quality assured by the trust managers in partnership with PHA.

Health visiting eCAT outcomes

- Objective health visiting caseload measurement
- Accurate workforce information
- Improved practice consistency across individual caseloads, teams and trusts
- Workload equity and transparency
- Supports practitioners with caseload analysis
- Fairer workload allocation and reduced workforce stress
- Informed resource allocation and commissioning

eCAT for district nursing

An electronic caseload analysis tool (eCAT) has been developed over the past few years and has been rolled out across all trusts. With the assistance of the regional eCAT user forum and the software developer Yarra in contract with PHA/HSCB further developments and improvements have been made.

District nurses can input information against an agreed standard definition data set to produce an in-depth analysis of caseload content. It is driven by the caseload holder, which in turn enables them to bench mark and review their caseload content within and across local teams. District nurses are

now supported electronically to describe the patients on their caseloads by age, visiting patterns, presenting primary need and dependency on nursing or other services. eCAT provides professionals with caseload analysis which informs workload equity, patient dependency, clinical need prevalence and workload throughput of referrals and reviews. It highlights areas for action in relation to presenting clinical need and rationale for visiting patterns, thus targeting training resources. For example higher occurrence of pressure ulceration on caseloads prompts further analysis for review of training and ensures skill mix is targeted appropriately to improve care outcomes.

A caseload analysis information report will be provided on an annual basis.

Adults with learning disability

The Regional Health Care Facilitator Forum has been working on a range of initiatives to develop quality systems and improve measurement as follows:

Data collection following annual health check for adults with learning disability

The data systems health care facilitators (HCFs) use to collate information and data recorded by the GP during the annual health check and this data was reviewed. This led to the development of a revised spreadsheet, which has been implemented regionally and managed locally by the HCFs. All of the HCFs have participated in effective use of spreadsheets so they are 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 and present findings from the data collection. It is anticipated the spreadsheet will provide key information to support future commissioning of services for adults with learning disability.

Service Framework for Learning Disability

The Service Framework for Learning Disability is one of six frameworks; the others include Cancer Prevention Treatment and Care, Cardiovascular Health and Wellbeing, Mental Health and Wellbeing, Respiratory Health and Wellbeing and Older People's Service Framework.

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 a range of standards and Key Performance Indicators (KPIs) along with quantifiable measures that assess and measure the extent to which each standard is implemented.

The HSCB is responsible for providing updates to the DoH on the performance of the trusts against the standards and indicators in the Service Framework for Learning Disability. An objective baseline for the indicators was established for 2014–2015, in partnership with the trusts, using a range of audit tools. The main goal 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.

Case note review

A case note review was one of the audit tools completed across the five trusts to determine 2014–2015 baseline position for several of the KPIs. Between November 2015 – December 2015 and November 2016 – December 2016 the case note review was repeated to determine performance for several of the KPIs in the Service Framework for Learning Disability. The case note review process involved the development of a set of questions in consultation with the trusts, which was then transferred onto a spreadsheet 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 trust, 30 files per locality. The findings of the case note review have determined a series of recommendations for the trusts to implement in the next year in order to ensure improved practice and systems of care.

Self-Assessment Audit Tool (SAAT)

A Self-Assessment Audit Tool (SAAT) and supporting guidance has been developed to assist with the collection of monitoring data and provide baseline figures against which HSC services can be further audited. This should be completed by trusts on an annual basis until 2018. The trusts have completed three returns of data to date – year 1- baseline- year 2 and year 3 data provided against performance and indicators.

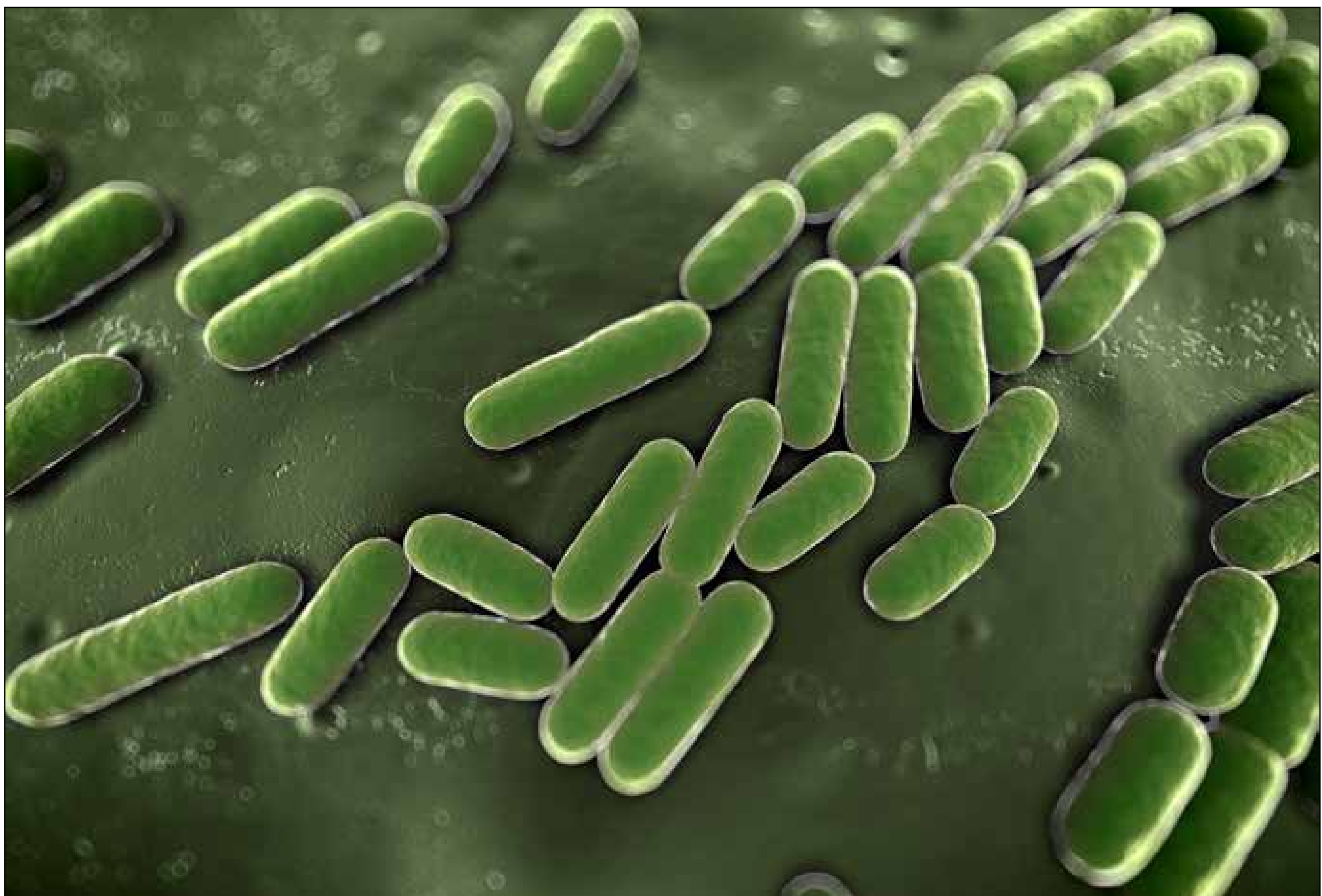
Impact on improving quality

The standards developed by the Service Framework provide a model which current services should adhere to. It is important to note that in the absence of an objective baseline which ascertains the present status/performance of services it is difficult to determine progress against the standards (ie how services improve or decline with the introduction of the framework). Establishing a baseline has allowed the HSCB to identify service areas where service improvement is required as well as improving quality.

Web-based system for healthcare-associated infection and antimicrobial stewardship

Receiving healthcare, such as having surgery or being admitted to hospital, can be necessary to investigate and treat an illness. However, sometimes people who are treated for illnesses can be harmed by the treatment itself or get an infection when being treated, even though the intention of the health professionals is to help improve people's health. For example, the use of antibiotics by people who don't have a serious infection can cause more harm than good. When antibiotics are used, they do not kill all bacteria, and the surviving bacteria can cause infections that are more difficult to treat with antibiotics. This is why we want to try and reduce the use of antibiotics when they are not necessary.

The PHA health protection service is leading an initiative to produce an interactive reporting system to provide intelligence to healthcare professionals about incidence of healthcare-associated infection, antibiotic use and resistance of bacteria to antibiotics. The aim of this initiative is to help healthcare teams direct their efforts to improve the quality of care by identifying opportunities for preventing infections and reducing use of antibiotics. The web system will also provide an integrated suite of high-level measures of healthcare-associated infection incidence and antibiotic use in trusts, allowing comparisons to other trusts and over time.



The healthcare-associated infection and antimicrobial resistance surveillance team has been engaging with stakeholders from across the HSC to understand their information needs and to develop new reporting systems. An interim regional dashboard that displays key measures of antibiotic use and incidence of MRSA and MSSA blood-stream infection and *Clostridium difficile* infection has been implemented and is being tested by a small user group. Feedback from this will be used to inform the development of the next stage of the project. Over the next year, HSC professionals will be able to access better information about healthcare-associated infections and antibiotic use to help direct their quality improvement initiatives.

Theme four

Raising the standards

Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which are used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and services delivered. Below are a few examples of where, through a number of interventions, quality improvement in outcomes is recognised.

Dementia Together NI

The HSCB and PHA lead the Dementia Together NI (DTNI) team. During 2016/17 the team have implemented a number of improvement initiatives which have resulted in quality outcomes for patients, clients and service users. Some examples are illustrated below.

Short breaks

Working with people with a dementia and their carers, the DTNI team developed five short break pilot schemes. These have been piloted across the region and are currently being evaluated with a view to extending them (or some hybrid model) from April 2018 when the DTNI project comes to a conclusion.

The pilot schemes are as follows:

(i) Home support (SEHSCT area)

Enhanced befriending service and night support service, including the provision of personal care services to people living with a dementia, for a period of two to four hours once per week.

(ii) Extended domiciliary care (all five trust areas)

Extended domiciliary care services to people living with a dementia, including the provision of comprehensive care services for a number of periods, including overnight, up to a maximum of four consecutive 24 hour periods. Services are provided primarily to the person with a dementia in their own home. However they can include support services outside the home, (eg shopping, attendance at religious services, other routine social events).

(iii) Emergency support (NHSCT area)

Emergency support service for people living with a dementia and their informal carers that includes the provision of personal care services between 9am and 5pm, for periods of one hour up to eight hours for a maximum of three consecutive days (24 hours in total)

(iv) Enhanced day opportunities (WHSCT area)

Enhanced day opportunities service including personal care services to people living with a dementia and their informal care givers, for periods from four to six hours, once per week.

(v) Holidays (all five trust areas)

Providing opportunities for people with a dementia to have short breaks for a few days either on their own or accompanied by a close friend/carer.

Carers' training

A six week information and training programme was developed by DTNI in collaboration with informal carers. This has been rolled out across all five trusts and is currently being evaluated with a view to extending all or part of the programme after the end date of the DTNI programme. During the course of the programme, significant modifications were made to allow greater flexibility in content and delivery to make it more accessible and relevant to individual carers.

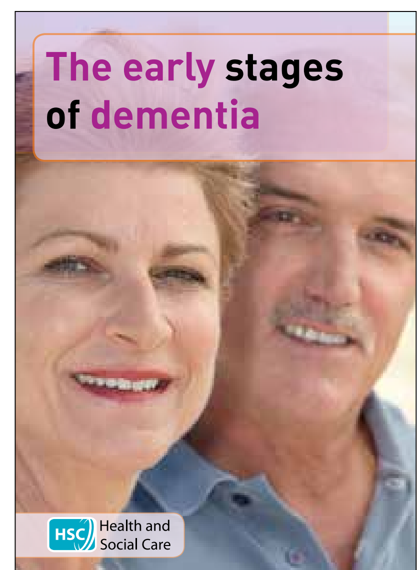
Dementia Champions training

The DTNI team, in collaboration with key stakeholders, developed a six month Dementia Champion training programme which was delivered by a local care service provider/training consortium. More than 250 students graduated from the programme which was closely aligned with Tier 3 in the Learning and Development Framework (Informed Practice). A unique feature of the programme was that participants had to undertake a change/ improvement project within their workplace, thereby directly enhancing service and practice within dementia care.

The need for training across all sectors and disciplines is still recognised as a priority and proposals in relation to the continuation of the Dementia Champions programme beyond the lifetime of the DTNI project have been submitted to the DoH for consideration.

Delirium training

A programme of training linked to the roll out of a 'delirium bundle' has been successful across 12 pilot sites, with almost 1,500 staff trained. A programme to 'Train the trainers' has been developed and will be delivered to 25 key staff



(five per trust) within the lifetime of the DTNI project, thereby leaving a legacy within this area of work.

Public awareness

Building on earlier work by the DTNI project team, two new publications have been made available for people with a dementia and carers: (i) Eating, drinking and swallowing - A guide for carers of people living with a dementia and (ii) Dementia and care of natural teeth and dentures. Further publications on (i) choosing a care home, (ii) palliative care, (iii) risk communication and (iv) relationships, sexuality and dementia are underway.

A new public awareness campaign is being developed for launch in September which will build on the earlier campaign 'Still Me', which was aimed at tackling the stigma attached to dementia.

The dementia website www.NIDirect.gov.uk/dementia is a work in progress but is already proving popular as a source of information for the public and professionals alike.

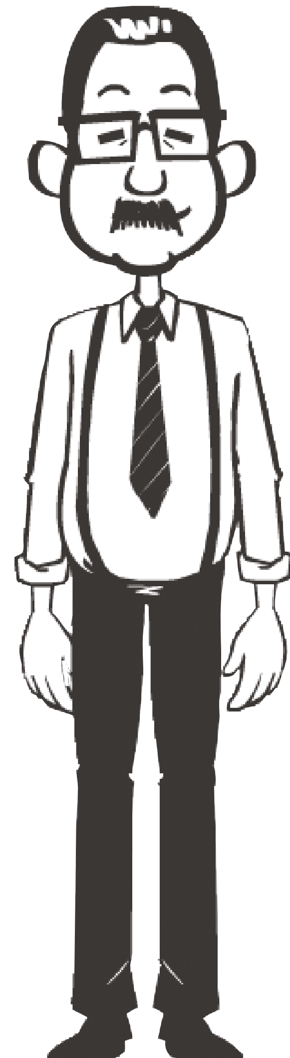
Dementia Navigators

Ten Dementia Navigators are now in post (two per trust). The role was developed following extensive consultation with people with a dementia and their carers.

Dementia Navigators work as members of a multi-disciplinary team across the range of memory services and other programmes of care as necessary. They provide a highly responsive, individualised information and signposting service to people with a diagnosis of dementia, their carers, families and friends.

Navigators act as a link between service users, professionals and other services, such as the community and voluntary networks, to ensure continuity of care and support throughout the dementia journey.

The current two navigators per HSC would be regarded as a minimum and this service needs to be developed and expanded further, not just in line with the regional job description but also to facilitate the implementation of the out-workings of the regional dementia collaborative (re-design of memory services and dementia care pathway).



Frank character created by goanimate.com

Other initiatives

(i) Training

The DTNI project has funded a number of training programmes, some of which were initiated by individual trusts and after evaluation have been rolled out across all five trusts. These initiatives include (i) CLEAR assessment, (ii) virtual training and (iii) social services training packages.

(ii) Dementia Companions

Following the evaluation of an initiative in one trust, the DTNI project team has funded the appointment of Dementia Companions

Dementia Companions are based in acute hospital wards and their role, under supervision of nursing staff, is to support people with a dementia with activities of daily living, create a safe, person-centred environment and enhance the experience of the person with the dementia and their carers. An evaluation showed had the introduction of the model had led to reduced falls, reduced episodes of 'violence and aggression' and reduced security costs.

The deployment of companions along with other developments in hospital care including (i) John's Campaign, (ii) roll-out of the Butterfly scheme, and (iii) the application of the 'delirium bundle,' developed as part of the DTNI project, will help deliver proposals for the improvement of dementia care in hospitals.

Managed clinical networks

A managed clinical network (MCN) is a linked group of health professionals and organisations across different sections of the health service (including community, hospital and specialist care) working together in partnership with social services, voluntary organisations and, most importantly, patients and carers.

The aim of the MCN is to bring these different health professionals and organisations together and help them work in a more coordinated manner without restrictions. This will ensure that the same high quality care is delivered to all patients living in Northern Ireland. Below are some examples of where clinical networks have improved quality and raised the standards through standardisation and implementation of best practice

Critical Care Network Northern Ireland

The Critical Care Network Northern Ireland (CCaNNI) works with all HSCTs and with commissioners to support the delivery of adult and paediatric critical care services. CCaNNI facilitate ongoing standardisation of policies, guidelines and processes, and provide comprehensive data on critical care activity and capacity. A significant role of the network is the development

of the critical care workforce. Over the past year, the CCaNNI senior nurses committee have worked with colleagues from across the UK in the further enhancement and development of Core Critical Care Competencies for nursing staff, both new and experienced. These competencies are now standardised across the induction programmes for new staff nurses to critical care and are embedded within our locally commissioned critical care nursing short course. To support the inclusion of the competencies in the commissioned course, annual training events are now delivered in the autumn for the staff nurses who support nurses undertaking the course.

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. Close working with individual units, the PHA and GP practices ensures that accurate data relating to influenza within critical care is available.

A significant project has commenced this year to initiate the development of a CCaNNI website which will provide information for patients and relatives, as well as an area for professionals working within critical care to access clinical and educational resources.

Given the increased level of threat faced within the United Kingdom, CCaNNI are engaged in multi-agency and cross-HSCT work in developing rigorous plans in the event of Northern Ireland having to respond to a mass casualty scenario.

Neonatal Network Northern Ireland

The Neonatal Network in Northern Ireland (NNNI) is committed to maintaining safe, high quality, family focused and sustainable neonatal services. Resources and energy are focused on achieving regional consistency in care and driving quality improvement initiatives across the region. The network also supports the development of clinical leadership and provides a forum to share knowledge, good practice, expertise and learning.

During 2016/17 the NNNI:

- Developed and implemented regional guidance to:
    - standardise the prescription of antimicrobials used in the prevention and treatment of nosocomial infections;
    - support the management of infants who are at risk of early-onset sepsis (EOS).
- Provided input to the development of regional guidance on placental pathology.
- Worked collaboratively with the DoH on the development of neonatal resources to reduce the risk of harm due to hyponatraemia.
- Standardised processes for screening for retinopathy of prematurity.
- Supported ongoing projects to improve thermoregulation in neonates and increase rates of breastfeeding in neonatal units.

- Standardised data collection on network activity and participated in network discussions to optimise capacity at times of increased demand.
- Updated emergency planning contingency plans for neonatal services.
- Collated and analysed findings of a regional discharge questionnaire which is provided to all families when their baby is discharged from a neonatal unit.
- Undertook a detailed analysis of the neonatal workforce and established neonatal nursing as phase 6 of the normative nursing process.
- Provided input to the PHA/HSCB review of neonatal services including the review of national guidance in the context of service provision in Northern Ireland.
- Shared and discussed learning from adverse incidents related to neonatology.

In addition funding has been secured to appoint Allied Health Professional (AHP) staff in neonatal wards and to assist in driving innovation in this area through an established AHP Neonatal Network. As a result an integrated service model has been developed and AHP services will be delivered through the appointment of dietetics, occupational therapy, physiotherapy and speech and language therapy staff located in all neonatal units. Their key function will be to provide advice, support and specialist interventions to the children, working closely with other members of the multi-disciplinary team alongside community and voluntary sector colleagues. This model of intervention will assist in timely and safe discharge of the child from the hospital setting and a seamless pathway of care will be delivered which includes post-discharge support and review. Ultimately this work will significantly contribute to the more timely and appropriate interventions and discharge of the child from hospital settings.

Northern Ireland Cancer Network

The Northern Ireland Cancer Network is a partnership of HSC organisations, academia, charities, cancer specialists and service users who, working in collaboration to deliver safe and effective care, improve cancer clinical outcomes and enhance patients' and carers' experience and quality of life.

Some of the key achievements during 2016/17 were:

- Coordination of the development and implementation of the Northern Ireland TYA cancer service delivery model. Funding for this model has been secured through five local and national charities: Cancer Fund for Children, Children's Cancer Unit Fund, CLIC Sargent, Friends of the Cancer Centre and Teenage Cancer Trust.

- Continuation of the national cancer peer review process. Four additional tumour sites underwent review in 2016–17 and recommendations arising from the reviews are being progressed.
- Establishment of an acute oncology clinical reference group to support implementation and monitoring of the regionally agreed acute oncology model.
- Supported implementation of Year 1 of the clinical nurse specialist workforce expansion plan.
- Development and agreement of a regional pathway for the management of patients with gastro-intestinal consequences of pelvic radiotherapy along with written information and protocols.
- Development of regionally agreed service specifications for head and neck cancers and skin cancer.

Paediatric network

The HSCB, PHA, Belfast HSCT and Department of Health 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 to, 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 within the Royal Belfast Hospital for Sick Children (RBHSC) at Belfast Trust has continued to lead on the following three main objectives:

(1) Formalise selected paediatric networks in Northern Ireland

The following networks continue to build on excellent working and partnership arrangements to support clinicians and families throughout Northern Ireland:

- Paediatric epilepsy network;
- Paediatric respiratory and allergy network;
- Paediatric endocrine network;
- Paediatric neurodisability network.

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

In 2016/17 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. A number of specialist in-reach services were delivered in 2016/17 for a total of 281 patients including:

- Specialist urology surgery and outpatient clinics;
- Liver disease clinics;
- Metabolic bone clinics;
- Metabolic lysosomal storage disorders clinics;
- Specialist endocrine clinics;
- Bone marrow transplant failure clinics;
- Spasticity intervention assessment clinics;
- Craniofacial assessment clinics;
- Epilepsy surgery clinics;
- Metabolic LSD clinics;
- Specialist Diamond Blackfan clinics;
- Specialist sleep clinics;
- Specialist ENT surgery;
- Specialist surgery;
- Thoracic surgery.

In 2016/17 the Belfast Trust 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 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 2016/17 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.

Stroke network

During 2016/17, the stroke network has held over 30 meetings with key stakeholders from the voluntary sector, service users, stroke staff from trusts, the DoH and the HSCB and PHA. Already a number of benefits have been achieved that will result in improved patient experience and recovery following stroke.

Stroke national audit

All five trusts in Northern Ireland participated in the Stroke national audit which has facilitated local service improvement activities. The audit scores individual stroke teams between an A and E grade and has shown that a number of trusts have moved up a grade.

Additionally, for the first time, one trust in Northern Ireland scored a B. Northern Ireland stroke units appear to compare well to UK peers in terms of provision of clot busting treatments though there is still room for meaningful improvement. However, the audit also highlighted a number of opportunities to deliver better care throughout the stroke pathway.

It also demonstrates that trusts in Northern Ireland continue to successfully implement quality improvement projects to improve against the key target of getting stroke patients admitted to a stroke ward within four hours of arrival. An overview of the national audit results is outlined below.

Target		National	Royal Victoria Hospital Belfast	Antrim Area Hospital	Causeway Hospital Hospital	Ulster Hospital	Craigavon Area	Daisy Hill	Altnagelvin Hospital	South West Acute Hospital	A SCORE Requires
SSNAP Level		**C**	**E**	**E**	**D**	**D**	**D**	**E i**	**Bh**		
Scanning within 1 hour	%	51	54	41	31	39	39	41	39	53	48%
Scanning within 12 hours	%	94	90	82	79	85	75	95	85	87	95%
Stroke Unit	%	78	77	50	36	54	67	58	45	86	90%
Stroke Units on admission (4 hours)	%	57	36	15	9	25	32	26	25	67	90%
See consultant before 24 hours	%	81	86	89	65	50	79	80	54	96	95%
MDT 72 hr Care Bundle*	%	63	41	28	18	36	27	33	19	49	60%
Percentage receiving clot busting treatment	%	12	18	12	11	13	8	12	15	18	20%
Median door to needle time	min	52	42	50	77	54	56	42	39	26	40 or less

Northern Ireland is one of a limited number of UK regions with access to 'mechanical thrombectomy', a new clot retrieval intervention which is suitable for a small percentage of stroke patients. It is provided by the Royal Victoria Hospital on weekdays from 9am to 5pm. Over 70 patients benefitted from thrombectomy in 2016/2017. The stroke network is working in partnership with the Belfast Trust 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 service. This new treatment is one of the most effective known in modern medicine and can reverse the effect of some of the most severe debilitating strokes. In addition to work undertaken in previous years, this year, the network has focused on the development of patient repatriation processes to ensure as many people as possible can be admitted for thrombectomy at the Royal Victoria Hospital.

Reshaping stroke services

The HSCB and PHA, in collaboration with all HSC organisations, have established a task and finish group to redesign stroke services. The reshaping stroke services group is gathering information from stakeholders during a 13-week pre-consultation exercise and is co-designing a new model for the provision of stroke services in Northern Ireland.

Seven proposals and a number of supporting materials have been developed, such as animation and patient videos to help communicate the need for change to as wide an audience as possible. In addition to stakeholder events with survivors and staff groups, public meetings are scheduled in September to ensure that everyone has an opportunity to be part of the design of a new model of stroke care for the population.

MAGIC project

Northern Ireland, through the stroke network, is a partner in a €3 million, Horizon 2020 EU procurement project. This year the project has funded eight companies in Europe to develop new ideas and products to support stroke rehabilitation in the community. The stroke network is now working with key experts in technology and research to develop prototypes that will be tested within our services in 2018. This has involved a number of exciting events where stroke clinicians and service users have partnered with product developers to design solutions that will assist in stroke recovery.

Diabetes network

Burden of disease

There were 88,000 adults (aged 17+) and 1,200 children in Northern Ireland living with diabetes at the end of March 2016. Type 1 is an autoimmune disease that cannot be cured and that most often presents in childhood and is present for life. Type 2 diabetes accounts for 90% of all cases of diabetes in adults and the recent increase in Type 2 cases is notable and can be explained to some extent by rising levels of obesity and an ageing population. There are many factors such as ethnicity,

other conditions and family history that can place individuals in a higher risk category than others. Women can also experience diabetes in pregnancy. In each of the different diseases prevalence is continuing to rise year on year.

While the treatment costs of diabetes are difficult to quantify precisely, it is estimated that in Northern Ireland they amount to over £400 million annually. This equates to over £1 million per day, or 10% of the total health and social care budget. The costs of treating diabetes-related complications are particularly high, and may account for up to 80% of overall healthcare spend on the condition. At any one time in Northern Ireland, one in five people in a hospital bed will have some form of diabetes and every day 10 people will receive a diagnosis of diabetes.

Context of network development

The network approach was launched shortly after the publication of the regional Diabetes Strategic Framework in November 2016. The primary objective is to manage improvements in care for the short, medium and longer term in line with the strategic framework recommendations. The network considers the population of people living with diabetes to include all age groups; children, young people, adults and pregnant women, and all types of diabetes, as well as those who care for people who live with diabetes.

Functions of the diabetes network

There are five primary functions of the network, these are:

1. Regionalisation of improvement: once for Northern Ireland wherever possible, eg care pathway design, workforce planning, audit.
2. Commissioning/planning of services: The HSCB and PHA are working with people living with diabetes and those managing their treatment to develop new services.
3. Integration of care around the patient from all agencies, with a particular focus on community health support.
4. Improvement Leadership: as a member of the Q community and a leader of innovative approaches to leading, sharing and learning.
5. Communication: becoming a voice and an ear for all things diabetes within health, social care and wider civic society.

Oversight is led by the Chief Medical Officer, as unlike other clinical networks the diabetes network reports directly into the Department of Health. Interim leadership by the outgoing Deputy Chief Medical Officer has now ceased and there are plans agreed to appoint a clinical director on a part time basis to take this work forward. People living with diabetes are involved in all areas of the network.

Highlights of work underway in 2017-18

The work programme to manage improvements is vast and sprawling. A few choice highlights are noted here:

- Implementation of an 'end-to-end' foot pathway to reduce the number of amputations of digits and limbs due to diabetic foot disease as well as narrowing the gap between prevalence and incidence of high risk foot disease.
- Developing a regional menu of structured patient education, along with a professional training programme, to increase the capacity of self-management for the newly diagnosed.
- Increasing capacity for expectant mothers living with diabetes in specialist care.
- Launching a regional strategy for the prevention of the onset of Type 2 diabetes by offering a range of interventional programmes and targeting high risk groups.
- Standardising the resources and thereby quality of inpatient care on all wards in Northern Ireland by agreeing one common set of treatment protocols.
- Appraising and investing in new technologies to improve diabetes care and promoting the use of shared, lifelong patient records to support a more integrated approach to management.
- Continuing the excellent work of the Paediatric Network to manage the specialist care and technologies for children and young people living with diabetes.

A network conference event will take place in the Spring of 2018 to highlight service quality and explore patient experience.

Modernising Radiology Clinical Network

The Modernising Radiology Clinical Network (MRCN) is a clinical advisory and implementation collaborative aimed at ensuring high quality, safe and sustainable diagnostic imaging services for the people of Northern Ireland. The network includes all of the clinical directors of radiology, radiology service managers, the NIPACS systems manager, general practitioners and representatives from the PHA and HSCB.

Some of the key achievements in 2016/17 were:

- Working collaboratively with the Department of Health in the recent review of imaging services.

- Securing annual increases in the number of training places for consultant radiologists (from 37 to 46), with plans in place for a further eight places over the next two years.
- Introduction of a region-wide programme to achieve Imaging Services Accreditation (ISAS) for diagnostic imaging services. Currently, there are no ISAS accredited diagnostic imaging services in Northern Ireland. ISAS is a professional quality standard, jointly developed by the Colleges of Radiology and Radiography. Funding was secured to appoint five Lead ISAS Radiographers (one per trust), clinical radiologist time, and regional leadership to support this programme. All of the Leads are in post and the United Kingdom Accreditation Service (UKAS) are delivering a Northern Ireland based training programme for the first time.
- Working with HSCB to secure significant recurrent investment to address demand and capacity gaps and deliver seven day access to services, an increase in the number of reporting radiographers and further development of skill mix opportunities.
- Providing clinical advice to the development of CCG pathways for IBD/BS/coeliac disease/gynaecology/rheumatology.
- Development and testing of model for regional reporting arrangements.
- Commencement of a significant project to review/improve how imaging activity is recorded.
- Shared and discussed learning from adverse incidents relating to radiology.

Implementation of NICE guidance

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

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

In line with Department requirements, 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 2016/17, the HSCB issued 54 Technology Appraisals to trusts and continues to monitor the implementation of 150 CGs which have been issued to the service. Examples of Clinical Guidelines which have been implemented during 2016/17 include:

- CG 37 - Postnatal care
- CG 175 - Prostate cancer
- NG 8 - Anaemia management in people with chronic kidney disease

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. However, the current financial pressures in the HSC have meant that many NICE-related service developments have not been able to progress, particularly those relating to clinical guidelines.

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/)

Northern Ireland Medicines Formulary

The HSCB carries a significant responsibility with respect to how medicines are used across the HSC. Recognising that responsibility, a Northern Ireland Medicines Formulary was launched in March 2014. The formulary is a preferred list of medicines for use by healthcare professionals in Northern Ireland. The scope of the formulary is to provide all prescribers with guidance on first and second choice medicines. The medicines are chosen on the basis of evidence supporting their effectiveness (ability to treat the condition), their safety (reduced likelihood of causing harmful side-effects), patient acceptability and cost. The formulary aims to support prescribers in their decision making so that:

- patients are prescribed safe and cost-effective medicines;
- patients across Northern Ireland are prescribed the same medicines for conditions covered by the formulary;
- healthcare professionals in primary and secondary care will be prescribing medicines in a consistent way.

To date, ten chapters of the formulary have been published, covering approximately 90% of prescribing choices in primary care. A target of 70% compliance with the formulary has been set and we have achieved 79% across GP practices in Northern Ireland. A robust process for the development and review of the Northern Ireland Medicines Formulary has been established and we consult with a wide range of stakeholders in relation to both the clinical content and implementation of the formulary.

2016/17 was a busy year for the formulary team, seeing the publication of two new chapters (nutrition and eye conditions) and a full review of the respiratory and endocrine chapters. We also collaborated with other bodies such as NIDirect and took advice to revamp our patient zone, making

it easier to navigate. We encourage feedback from users, for example, we have acted on feedback to make information more concise.

Formulary implementation is key to success and work is ongoing to raise awareness. It is encouraging to note that usage of the formulary website has increased by over 90% in the last year and the number of new users has increased by over 60%. Moving forward, our key priority is to make the formulary more accessible to users in their daily practice, such as by building on our links with GP clinical systems.

Developing eyecare partnerships

Developing eyecare partnerships, the 2012 DoH strategy, has helped establish the first active partnership of key stakeholders involved in the commissioning and provision of eyecare services. In the five years to 2017 since *Developing eyecare partnerships* was launched, open discussion, creative thinking and the sharing of ideas for quality care has delivered transformation, improvement and integration in eyecare service provision.

Success in raising the standards of clinical care and investment in workforce is demonstrated in the roll out of new higher level of enhanced service for patients who it is suspected have signs of glaucoma or ocular hypertension. These are 'silent' eye conditions which can affect a person's sight and early detection is therefore vital.

This new service is provided in community or high street optometry practices. The service is aligned to NICE and Royal College guidelines and allows patients to access clinical care which will enhance the case finding for glaucoma and ocular hypertension. Patients can undergo appropriate and necessary clinical investigations by community optometrists who have been supported to undergo higher training and are accredited to provide the service. This service is acknowledged as a patient-centred, safe and accessible model of care to assist in managing pressure and demand for hospital eye services and helping to improve the quality of referrals for patients with suspected eye problems.

When communication and patient management systems are integrated, the efficiency of care provision is improved, duplication and waste are reduced and patients and service users have improved experiences and outcomes.

In 2016/17, significant work was undertaken to develop and integrate information technology and communication systems for eyecare provision both in community optometry practices and hospital eye services. A significant proportion of community optometrists are now connected to the HSC secure network, which has enabled them to access secure means of electronic referral to hospital eye services for their patients. This means rather than having to send a paper referral, which takes time to reach the destination, referrals are received by the hospital immediately and securely. Following receipt the referral is reviewed by the hospital eye service staff and the patient is assigned (now fully electronically by 'eTriage') to the appropriate eyecare pathway and clinic. This ensures that there are no unnecessary delays.

The eyecare network which will be established as a follow on from the *Developing eyecare partnerships* collaboration will build on the work which has been completed to date. The network will set and establish a range of indicators for quality and effective eyecare and will use these indicators to measure improvement in service provision as the transformation in eyecare services continues. The work of *Developing eyecare partnerships* has helped a transformation in culture that means that key people in key organisations and bodies recognise the importance of working together for the benefit of patients and service users.

By March 2017, since the inception of optometry-led demand management primary care protocols in 2013, a total of 6,200 patients have entered the glaucoma/ocular hypertension pathway. Prior to the demand-management protocols, all of these patients would have been referred to hospital for diagnostics and assessment. Demand-management has reduced this figure by almost 70%, to 1,950. This reduces patient anxiety, removes unnecessary journeys to hospital, and frees much-needed appointment slots in secondary care.

The roll-out of electronic referral is a game-changer for ophthalmic services, helping to get patients to the right clinic in a timely manner. As the referral also carries provisional diagnostics, including scans, images and visual field plots, the system also allows for electronic triage, and referral-for-advice. Again, this means that only those patients that need to be seen in hospital are offered suitable appointments. Patients, and the system, are better off.

Self-directed support

The self-directed support (SDS) initiative represents a key change across all social care programmes. SDS reflects the shifting expectations of people in society today. SDS aims to embed fundamental change to how social care needs are addressed, changing the landscape of social care across all sectors by giving service users and carers greater control, choice and flexibility as they develop support plans to maximise their independence and meet assessed support needs.

Using best practice, SDS implementation continues to build on established person centred outcomes based practice across all five trusts. A number of significant pieces of work have been completed in the past year.

SDS resource development

Easy read resources to support SDS service users and carers have been co-produced in partnership with various learning disability groups, CAN and other statutory organisations.

The Regional SDS Activity Toolkit was co-produced in partnership with trusts, HSCB, PMSI and CRIT to support accurate data collection across the region.

Training

In line with Programme for Government outcomes measurement and self-directed support, Regional ASCOT Assessment Pathways for Outcome based support planning has been developed for service users and carers.

Training has been developed specifically for Northern Ireland implementation with a number of key staff from each trust trained by PPRSU Kent on ASCOT assessment and statistical reporting management.

The SEHSCT launched the implementation of ASCOT across all POCs in November 2016 with other trusts joining at periodic planned intervals.

SDS training

Bespoke self-directed support training levels:

1. Awareness
2. Assessment and process
3. Support planning

Training continues to be delivered to HSC staff, external organisations and agencies by SDS implementation teams and representatives from service users and carer groups.

Currently over 6,700 individuals have been trained across the three SDS levels. Specific training and audit resources continue to be co-produced in year by HSCB and trusts to support best practice.

Belfast Trust

Like other trusts, the Belfast Trust adopt a co-production approach to self-directed support and work collaboratively with people with lived experience, carers and practitioners on the development and delivery of regional, standardised learning and development opportunities.

In 2016 a unique task and finish team was established to create a user friendly tool that will assist individuals in calculating aspects of their personal budget under SDS arrangements. The small core team, referred to as the ‘scrum’, comprised people with lived and professional experience and

enabled each individual to apply their own unique creative thinking, skills and expertise. The initiative was led by an individual with a high level of expertise in computer programming and experience of receiving support services and was supported by funds from the social work innovation programme.

Almost 1,500 staff, stakeholders, service users and carers have participated in awareness and information sessions, reflective practice groups, process and support planning training. Bespoke workshops have taken place across mental health, learning disability, older people's services, children with disabilities and physical and sensory support services that facilitated managers and practitioners to engage with the lived experience and explore the opportunities and challenges to practice. Evaluations were hugely positive and there was real leadership and ownership demonstrated by the workforce in all service areas. Further work has been completed to support practice in terms of the co-design and co-production of accessible literature and practitioner's guides, and also a range of inspirational podcasts to promote the value base of SDS.

Northern Trust

One page profiles

The one page profile (OPP) is a one page document encompassing the SDS seven step criteria for good support planning, along with the NHSCT's Care plan meets care management standards.

Service user support plan

Service users and staff had expressed difficulty completing profiles. The NHSCT established a group to develop a user friendly resource while still incorporating the SDS seven step criteria, with the aim to improve support planning for service users, carers and staff.

The support plan was co-produced with service users reflecting what matters to them on how their care is to be delivered.

Carers can readily identify from the support plan, service user's strengths, preferences and needs to inform service provision.

Using the 'Plan Do Study' (PDS) model, changes to the document were piloted in two localities for two weeks with service users less than 65 years of age and who have a physical difficulty (PD), and older EC service users. A small survey (Likert Scale) incorporating qualitative comment was conducted to gain feedback from service users.

Following initial processes a larger pilot was undertaken using the two localities and a larger staff group across (PD and EC), for four weeks. The survey data and feedback gathered from both service users and staff provided quantitative measurement and additional qualitative feedback that helped shape appropriate resources and informed best practice.

Theme five

Integrating the care

Introduction

The PHA and HSCB are committed to ensuring the integrated health and social care system in Northern Ireland is effective and that there is seamless movement across all professional boundaries and sectors of care. The HSCB and PHA have led a number of key improvements in this area during 2016/17. This has made a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

Integrated care partnerships

Integrated care partnerships (ICPs) were established by the HSCB in 2013, as a key element of the *Transforming your care* strategy, and are a new way of working for the health service in Northern Ireland to transform how care is delivered.

ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals, local councils and the voluntary and community sectors, as well as service users and carers, to design and coordinate the delivery of local health and social care services.

ICPs have over the last three years worked to review current services and implement more integrated pathways of care. Through the ICP infrastructure, health and social care staff from a range of professional backgrounds and across a number of organisations were able to work together alongside service users and carers, and local leaders from the voluntary and community sectors in a sustained way and at a scale which is not normally feasible.

This work led to the design and implementation of a number of more integrated services, agreed with and funded by the relevant LCG.

The '**Nursing home in-reach**' initiative focuses on very frail older people living in nursing homes, who commonly experience a high level of attendance at hospital emergency departments. The aim was to develop and deliver a specialist education, training and development programme for staff working in nursing homes, initially in the Antrim/Ballymena area. This is now being rolled out using a phrased approach to a further 20 homes in the Causeway and East Antrim area to enable them to provide more care for their residents in the home, rather than in hospital. This equates to 56% of the total NHSCT nursing home population.

Two nurse registrants (nurse champions) from each of the 20 initial 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. These champions then passed on this learning to their colleagues within the home.

A practice development facilitator provides a ‘case finder’ function – to track patients who do attend the emergency department to determine the appropriateness of that attendance. They then to provide follow up support to the home, such as additional staff training, to avoid a reoccurrence where possible.

The increased knowledge and skills of nursing home staff post pilot in 2015/16 has resulted in a reduction in district nursing visits by **43%**; a reduction in hospital diversion visits by **29%** and **25%** reduction in the number of visits from Marie Curie staff out of hours.

The number of older people attending the emergency department from nursing homes in the NHSCT has reduced by up by a third due to the enhanced skills of nursing home staff. In 2016/17,

there were 58 average monthly emergency department attendances from the nursing homes involved in the pilot; this is down from 85 in 2014/15 and 59 in 2015/16.

Qualitative outcomes also showed positive testimonials from relatives/residents highlighted improved patient experience, patients felt there was a culture shift to a more person centred ethos and nurse champions also felt empowered within their workplace

The '**Acute care at home**' service was designed and implemented by East Belfast ICP in May 2015 and was subsequently rolled out across Belfast. The service aims to provide people aged over 75 with expert medical and social care in their own home, to avoid admission to hospital.

An integrated team of healthcare professionals work together to help older people manage conditions such as chest infections, urinary tract infections, cellulitis and dehydration. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients, and receive a consultant-led assessment and treatment.

The average length of stay in the service at home is six days, compared to an average 11 day stay in hospital for older people in Belfast. In 2016/17, 1,862 older people were provided with care in their place of residence and therefore avoided a hospital admission. A further 1,449 patients were triaged by the acute care at home team and redirected to the appropriate pathway, avoiding an emergency department attendance.

Causeway and Mid Ulster ICPs have introduced an **enhanced foot care team** for people with diabetes consisting of a specialist podiatrist, diabetes consultant and a diabetes nurse specialist. The aim is to provide a more integrated foot care service, which supports service users to better manage their condition and their cardiovascular risk and to enable the team to work more effectively with vascular consultants across Northern Ireland.

It is intended that the new care pathway will reduce emergency admissions for diabetes related foot conditions, reduce the risk of amputation and ultimately reduce the number of amputations. Patients can be referred directly by their GP, nurse, emergency department or hospital to the multidisciplinary service and will be seen within 24–48 hours for an assessment and treatment. Treatment can include treating the wound and relieving pressure on the wound, treating any infection and advising on blood sugar control.

From April 2015 to March 2017 **493** referrals were received by the foot care team from. **85%** of patients were seen within 48 hours and 5% of patients were treated by the hospital diversion team and so avoided hospital admission, saving **504** bed days.

The numbers of minor amputations carried out on patients in the Causeway and Mid Ulster ICP areas have been reduced by **90%** from 10 in 2014/15 to 1 in 2015/16.

Primary care infrastructure project

The Primary care infrastructure development (PCID) project is responsible for the regional delivery of investment in primary and community care infrastructure. It is part of the strategy for improving the overall health and wellbeing of the community, and for improving the delivery of integrated primary, community and secondary care services. Primary and community care services are a key element in the delivery of health and social care in Northern Ireland and provide over 90% of all health and social care contacts. The provision of appropriate physical infrastructure in primary care is essential to support this person-centred care. The agreed service model is based on a 'hub and spoke' approach to facilities and supports the co-location of trust and GP-led primary care services, grouped within a single facility for the purposes of delivering integrated care services and patient care.

PCID programme achievements

There is a regional programme plan which sets out details of the proposed 'hub and spoke' schemes in order of priority to be delivered in tranches. Tranche one of the PCID programme is well underway with new hub facilities now operational in Ballymena, Banbridge and Omagh (as part of the local enhanced hospital) and new hubs in Newry and Lisburn in the latter stages of procurement, along with plans to improve tranche one bespoke facilities.

The programme also supports GP practices in either improving their existing premises or relocating to alternative premises. To date the programme has supported capacity improvements to GP-owned premises in Carryduff, Downpatrick and Erne Health Centre in Enniskillen, along with relocations for the Mount Oriel and University Health Centre Practices in Belfast:

Carryduff - The scheme in Carryduff provided a two-storey extension to the existing building incorporating administrative and teaching space on the first floor and the provision of extra clinical space on the ground floor to allow for additional community based services to be provided.

Downpatrick - This scheme included the extension of the existing building at first floor level, together with associated alterations to the existing internal layout to provide two additional GP consultation rooms as well as two fit for purpose treatment rooms. A lift was also installed to enable all patients to access consultation rooms on the first floor.

Enniskillen - In Enniskillen a build project is currently underway to refurbish the first floor of the Erne Health Centre to provide additional clinical and administration space. The facility (which

currently houses five GP practices on the ground floor) will support the co-location of a wide range of trust services, including a clinical intervention suite which will provide facilities for patients who require treatments such as blood transfusions and administration of IV drugs in the community rather than in an acute hospital. This will significantly improve access for patients.

Mount Oriel Practice relocation, Belfast – The PCID team worked closely with the Mount Oriel Practice to negotiate a move to the Belfast Trust's Knockbreda Wellbeing and Treatment Centre. The primary benefit of the move is that patients will be better able to access a broader range of services in a single location. In hours and out of hours GP services are now delivered from within a single facility. The practice provides the full range of general medical services and also supports undergraduate medical student training and medical research. The practice moving into the centre addressed the need for healthcare teams in the south Belfast area to be co-located and so provide greater access to health and social care services in the locality.

University Health Centre relocation, Belfast - The PCID programme provided support to enable the relocation of the University Health Centre GP Practice, alongside the Belfast Trust Psychological Services at the newly refurbished Elmwood Manse building in the heart of the Queen's University campus. It provides fit for purpose accommodation to enable the delivery of core and enhanced GP services including sexual health, minor surgery, minor injuries, sports and orthopaedic medicine surgery, and travel medicine. Within the same facility, the trust provides access for the delivery of around 23 psychological therapy clinics per week, along with dedicated workstation/office accommodation for adult psychological services staff. The unique location also enables close liaison between the GP and trust services located at the student health hub and the Queen's Student Guidance Centre, which provides a range of student support services, including the student counselling service.

Key benefits from the work of the PCID programme

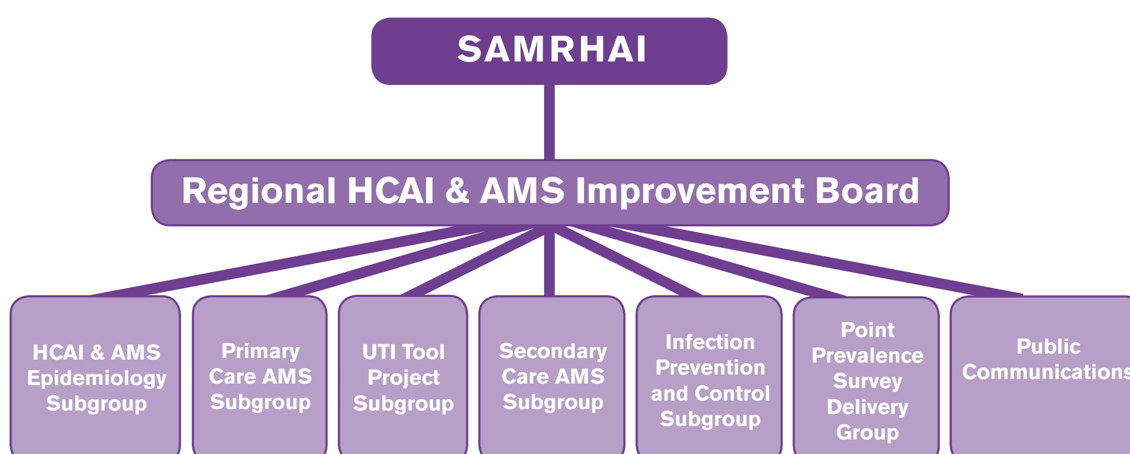
The outcome of this service model provides patients with improved accessibility, within the local community and closer to people's homes, in line with the themes set out in the Delivering Together vision statement. The new and improved facilities delivered under the programme have also engendered improved levels of integrated working, enabling multi-disciplinary primary and community care staff teams to work more closely with GPs and other practitioners in the delivery of services to patients.

Healthcare-associated infection and antimicrobial stewardship

The healthcare-associated infection and antimicrobial stewardship improvement board was established by the PHA in June 2016. Its objectives are to:

- provide leadership and drive progress on reducing and preventing HCAI across HSC settings;
- provide leadership and drive progress on improvement of antimicrobial stewardship across the HSC;
- oversee and lead implementation of regional policy for HCAI and antimicrobial stewardship improvement;
- Agree an annual regional HCAI and antimicrobial stewardship delivery plan, which is aligned with action plans progressing through the strategic committee on antimicrobial resistance and healthcare associated infections (SAMRHAI) and other partner organisations;
- Support HSC organisations to embed processes and systems to achieve required improvement for HCAI and antimicrobial stewardship;
- Support performance monitoring of HCAI and antimicrobial stewardship through provision of high quality data and intelligence;
- Provide expert advice and support for HCAI and antimicrobial stewardship improvement and incident/outbreak management across the HSC;
- Provide expert knowledge and support to the DoH for policy development in relation to HCAI and antimicrobial stewardship;
- Report progress and be accountable to DoH.

Its membership is multi-professional and multidisciplinary and representative of the key stakeholders in HCAI and antimicrobial resistance. The improvement board reports progress to the Department-led strategic committee on antimicrobial resistance and healthcare associated infections (SAMRHAI). The working sub-groups of the improvement board are shown below.



Key areas of achievement in 2016/17

Primary care antimicrobial stewardship

A primary care antimicrobial stewardship group was established as a subgroup of the healthcare-associated infection and antimicrobial stewardship improvement board. In 2016/17, 123 (95 whole time equivalent) practice-based pharmacists, whose role includes supporting GP practices with antimicrobial stewardship, were recruited. A third wave of recruitment will take place in early 2017/18. In 2017, new nursing home/intermediate care pharmacist posts were created. Part of their role will be to support antimicrobial stewardship and appropriate prescribing, linking in with the Northern Ireland regional antimicrobial pharmacists' network. In December 2016, a locally enhanced service was introduced in general practice to support a named antibiotic champion to undertake audit and identify actions; 170 general practices (out of 344) had signed up by the end of March 2017. An antimicrobial stewardship resource pack was developed for primary care, including patient information leaflets, reception staff protocols, posters, e-learning material links, links to guidelines and 'non-prescription pads'.

Secondary care antimicrobial stewardship

A secondary care antimicrobial stewardship subgroup was established in April 2016 under the improvement board to develop and implement a regional antimicrobial stewardship secondary care action plan for 2017/18. This was in response to the UK ambition to reduce inappropriate antimicrobial prescribing by 50% by 2020.

The group includes representation from all trust antimicrobial management teams, and its plans include: implementation of 'Start smart then focus', promoting the importance of antibiotic review on ward round checklists, ensuring antimicrobial usage data is fed back to prescribers in a timely and usable manner, and harmonisation of therapeutic drug monitoring for narrow spectrum antimicrobials across the trusts.

In 2016, a baseline assessment of stewardship (NICE NG15) was undertaken by the Northern Ireland Antimicrobial Pharmacists' Network with microbiologists. The combined assessments will help to prioritise achievable goals for the region and individual trusts.

Residential care antimicrobial stewardship

The PHA piloted an education/information intervention to improve the management of suspected urinary tract infection in five care homes during January 2016.

Surveillance of healthcare-associated infections, antimicrobial resistance, antimicrobial consumption, gram-negative bloodstream infections and surgical site infections

The improvement board established an epidemiology group to design and oversee the processes for collection, analysis and sharing of data and information about healthcare-associated infections, antimicrobial resistance, antimicrobial use, antimicrobial stewardship and infection prevention and control in Northern Ireland and the contribution of information to UK, European and global surveillance programmes.

Communication to professionals

The improvement board organises regional events for health professionals about antimicrobial resistance and stewardship. The PHA organised a regional symposium on 13 March 2017, which had a strong focus on antimicrobial resistance. The event was used as an opportunity to raise the profile of antimicrobial resistance among health professionals and for networking among HSC and wider stakeholders with an interest in antimicrobial resistance, antimicrobial stewardship and infection control.

Behavioural science

Representatives of the Department of Finance innovation lab team are working with the improvement board to develop collaborations with this team to help deliver objectives on specific projects using behavioural science.

Quality improvement: children and families

The HSCB is working with the PHA and other agencies to undertake a number of initiatives to improve quality of services during 2016/17. Below are a few examples.

1. **RISE:** Regional Integrated Support for Education, launched in May 2017, provides a range of multidisciplinary child-focused programmes delivered in primary schools and aimed at helping children to access learning and support their development to reach their full potential.

   The emphasis is on early intervention and involves healthcare professionals from teams within trusts, including; speech and language therapists, occupational therapists, physiotherapists, behavioural therapists, clinical psychologists and therapy assistants. The teams work alongside teachers to run group and individual activities and help transfer the children's skills into the classroom. Teachers and teams work together to identify the areas where children are struggling and provide joint ideas and intervention to support them in their learning. RISE has been developed and funded in partnership by the HSCB, PHA and Education Authority.

2. **Looked after children education project:** delivered under the Delivering Social Change Early Intervention Transformation Programme (EITP), this project aims to improve outcomes for looked after children and young people through embedding early intervention approaches. Its goal is to achieve significant change in how services are delivered to enable organisations to intervene earlier when issues or adversities emerge in the lives of children, and in the educational outcomes of looked after children through improving support at Key Stage 2. It has established a looked after children champion and is working towards the development of models of multi-agency working across social care and education to shift away from what OECD (2016) regarded as a "strongly siloed and fragmented set of institutional structures governing the educational attainment of looked after children".

3. **Review of regional facilities for children and young people:** is a HSCB-led multi-agency collaborative approach to reconfigure and transform high end provision for looked after children, often those with the most complex needs. Nearing completion stage the review has been inclusive of children and young people, practitioners, youth justice, the PSNI, education, CAMHS, commissioners, policy makers and academics and will set the direction for future service provision.

Allied Health Professions seven day working

The background to Allied Health Professions seven day working is within the DoH Unscheduled Care Task Group Work streams (2014). One of the seven key work priorities identified at that time focused on patient flow in emergency departments at the five large acute sites. The PHA team led the AHP element of this through regional unscheduled structures engaging with local commissioning groups and trusts across the region. This resulted in:

- The establishment of physiotherapy input to maximise 'see, treat and discharge' within a dedicated minor injury stream in emergency departments. This complements the role of the emergency nurse practitioner. A physiotherapist is now in place to see treat and discharge in the minor injury streams in each of the emergency departments of the five large acute hospitals (Craigavon, Royal Victoria Hospital, Altnagelvin, Antrim and the Ulster hospital).

- Embedding physiotherapy, occupational therapy, pharmacy and social work support within emergency departments and short stay wards. Both physiotherapy and occupational therapy are embedded as part of a multidisciplinary team in the emergency departments of the five large acute hospitals. The posts have been appointed for all trusts and are now in place in four of the five trusts. These posts will be in place shortly in all five trusts.

Under the new regional unscheduled care structures in Northern Ireland, AHPs are represented on the regional programme team and are working collaboratively with colleagues across the HSC through the workstreams. One of the current workstreams is the discharge workstream. 'Discharge to Assess' principles have been described by NHS England, learning from models across the UK. The key findings of this will be brought to the Northern Ireland Discharge Group with the intention of informing Discharge to Assess in Northern Ireland.