Belfast Health and Social Care Trust
caring supporting improving together

ANNUAL QUALITY REPORT 2023/24

There is an interactive version of the Report HERE

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- Thank You

1. TRANSFORMING THE CULTURE

<u>Introductory Video from Belfast Trust Medical Director: Dr John Maxwell.</u>

As Interim Medical Director of Belfast Health & Social Care Trust I am proud to present our Annual Quality Report for 2023/24. This report reflects our unwavering commitment to delivering the highest standards of care for patients, service users and their families and carers. Our vision remains to continue to create and embed the conditions to

become the safest, most effective, and most compassionate health and social care organisation.

The past year has presented several challenges which have tested our resilience and adaptability. Among these challenges was continual industrial action, which caused significant disruption and impacted on services. Staff worked collaboratively to ensure any industrial action was safe and while ensuring continuity of care and maintaining high standards during these periods has been a challenge, all teams have worked hard and did their best to mitigate the impact on our patients, service users and their families and carers.

During the year 2023/24, Belfast Trust's whole staff body worked to be ready for the implementation of encompass, Health and Social Care's new digital platform and patient record system. Although the Trust's 'Go-Live' in June 2024 is outside the scope of this Report, there is no doubt that the organisation was involved in a herculean effort in the run-up to June, all the while continuing to maintain all commissioned services.

Despite these challenges, we have achieved a great deal. While continuing to deal with operational pressures we have retained our core commitment to continually improve quality. Numerous quality improvement projects have been completed, including initiatives to improve patient flow within our frail and elderly patient group. Collaborative and focused work in outpatient settings has continued to address waiting lists and optimise clinical processes with new, digitally managed pathways – all directly contributing to better patient outcomes and experiences. At the same time, we have been responding to increasing demand in our emergency departments and continuing to care for patients who are medically ready for discharge. We have built on regional relationships with healthcare partners, increasingly making system-wide decisions in the interests of patient care and safety; we have redesigned patient care pathways to make the most of our available resources; and we have worked collectively to always put our patients first. Our commitment to transparency, and our efforts to gain insight and understanding through our learning from complaints and incident processes is also outlined in the report.

In addition to the detailed information regarding the provision of services and quality improvement work across the organisation, our annual

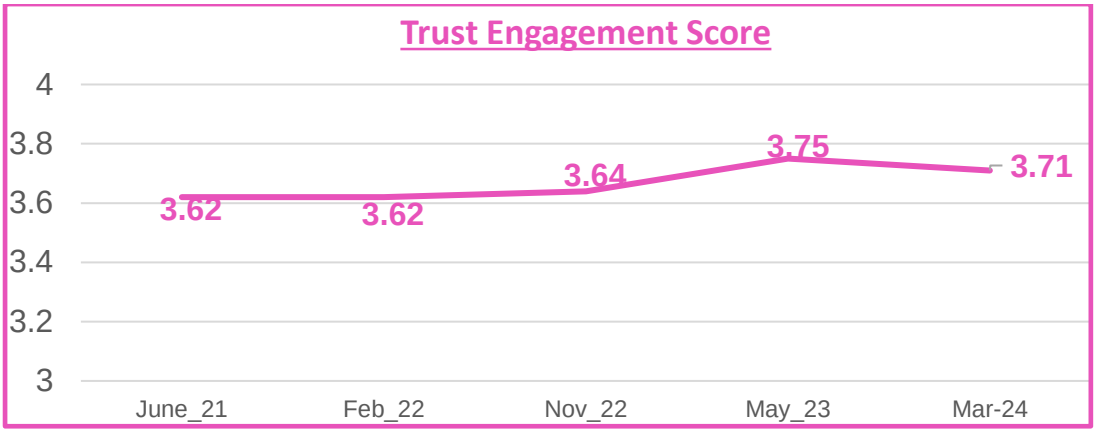
quality report this year centres on providing an insight into the experiences of patients, service users and staff as we know that the voices and stories behind the data will be invaluable in advancing our programmes of service development and quality improvement. This includes our colleagues in Social Work and Social Care.

As we move forward, we remain focussed on the real value of Health and Social Care; its people, not its buildings. Our partners share the same overall priorities, including building capacity in communities and in preventive health care, with a particular focus on health improvement and collaborative healthcare with community and third sector partnerships, in order to reduce inequalities. We remain committed to listening to and learning from the experiences of people who use our services in order to provide feedback to our staff so that we can reflect and improve where necessary but also respond to the positive experiences that so many of our patients and services users take the time to share with us.

HSC Staff Experience Survey

The Staff Experience Survey captures staff experiences of working in the Belfast Trust. The survey provides feedback and data to assist the Trust in better understanding and improving staff experience: measuring, guiding and informing culture initiatives to ensure they are targeted in areas of most need and where the impact will be greatest. Improving organisational culture change is not a “nice to do” but is vital because we know that any improvement in staff experience results in an improvement in patient experience, staff attendance and retention.

The survey also measures staff engagement levels across the organisation, and at local level. The overall Trust Engagement score was 3.75 (out of 5) in 2023, almost back to pre-COVID-19 levels (3.77 in 2019), however declined in the survey conducted in March 2024 to 3.71. The trust target is to achieve a score of 3.80 by December 2025.



Graph showing Trust engagement score (3.71 out of 5).

In 2023/24 two surveys took place with 5663 staff participating in May 2023 and 5764 in March 2024: achieving our highest participation levels to-date. The findings from both surveys were analysed and reports generated and shared at Organisational, Directorate, Service and team level.

Patient and Client Experience

Care Opinion

Patient and Client Experience feedback is important to the Belfast Health and Social Care Trust. Hearing service users experience about health care services we provide, gives us valuable information we use to celebrate services that deliver person centred care well and make improvements when required. In 2023/24, the Trust used ‘Care Opinion’ to receive feedback.

Care Opinion is an online system used by the Belfast Health and Social Care Trust, which gives patients, service users and carers an accessible and easy way to share their experience, when it feels right for them.

Data and responding well

In 2023/ 24 our service users shared 1,033 stories about their experience of care in the Belfast Trust through Care Opinion.

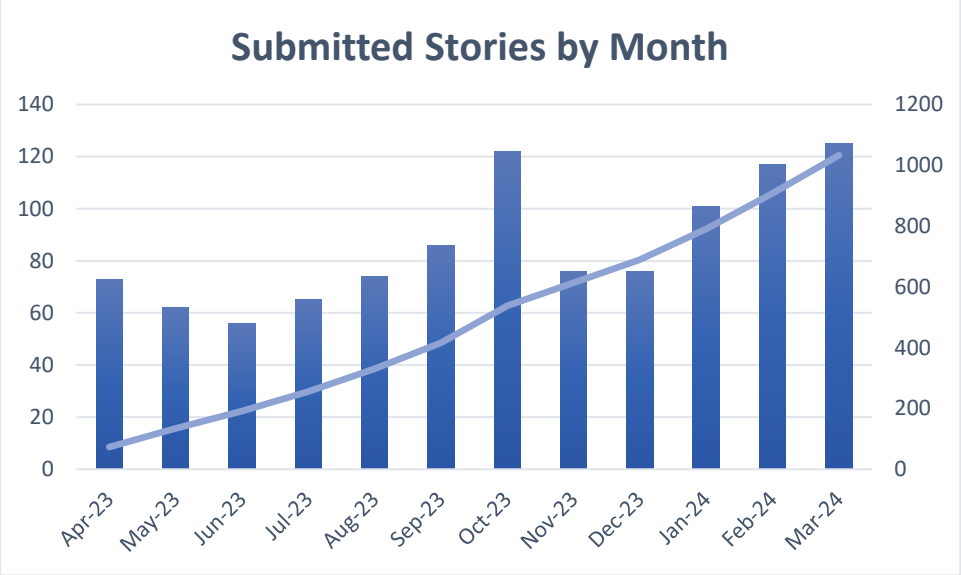
- **756** stories related to acute hospital services and
- **277** stories related to community services.

The expected timeframe for responding to any feedback shred on Care Opinion is 7 days. The Trust are committed to timely responses to Care Opinion feedback and has increased the number of trained responders by 115 to ensure this happens. The Trusts average time to respond to feedback is 11 days.

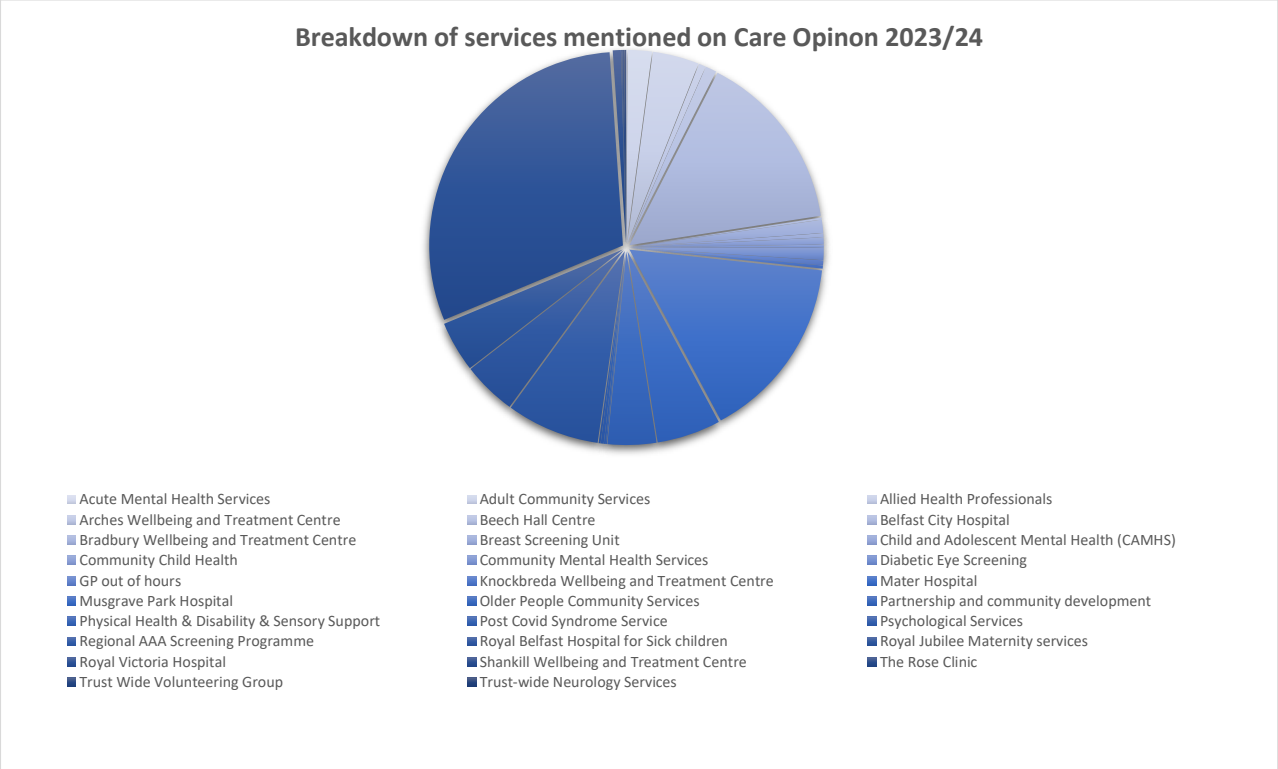
Feedback can include a simple written response, an explanation of how we have used the information shared to make a change or in some instances (were the feedback is considered critical or unsafe) we ask for a meeting with the individual to try to understand better their experience and inform the actions we need to take forward.

This is important as it acknowledges and reinforces that the feedback has been heard and is being used well.

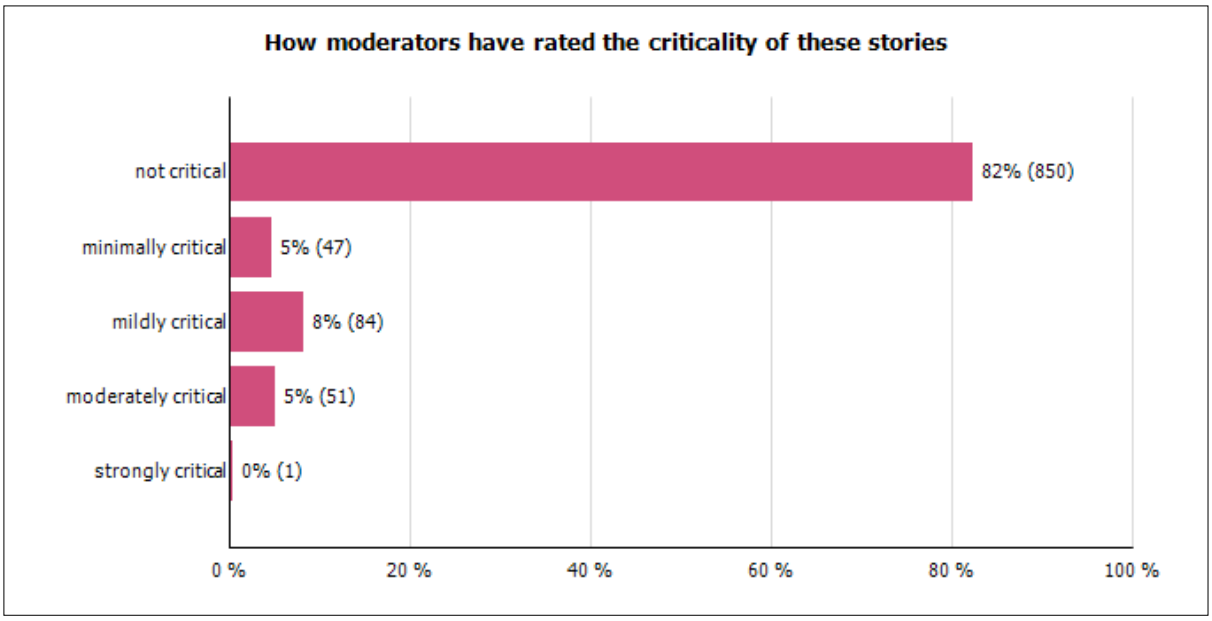
This was an increase of 125% in stories received through Care Opinion from 2023/24. These Care Opinion stories were viewed over **200,000** times by the public on the Care Opinion site in the last 12 months.



Graph showing increase in Care Opinion stories 2023/24.



Pie chart showing breakdown of all services mentioned on Care Opinion 2023/24.



Bar chart showing **82%** of stories shared through Care Opinion had a criticality score of zero. These stories are recorded by the Trust as compliments.

Has Care Opinion Driven Change?

The feedback we have received through Care Opinion has influenced **18** key changes in practice and service delivery in the Belfast Trust within the last year.

An example of a key change has been that correct information and the inclusion of directions on all appointment letters from the Endocrinology department. This resulted from a story that highlighted the out of date information relating to Covid on an appointment letter as well as a lack of directions to the clinical area. Out of date information was removed from the template appointment letters and directions to the site and clinical area were agreed and included in all subsequent communications to patients and service users.

Priorities for 2024/25

- By 31 March 2025 we will increase the number of stories shared through Care Opinion by 25%

- By 31 March 2025 we will decrease the average response time from 11 days to 7 days
- By 31 March 2025 we will increase the number of stories shared through Care Opinion from a community setting by 10%

Unscheduled Care

- Unscheduled Care (USC) TEAm Time Initiative launched October 2023 to improve communication and engagement with staff. Focusing on creating opportunities for staff to pause and reflect on achievements, share learning and provide updates on key organisational matters
- Compromises of a quarterly shared learning event with representation from the Unscheduled Care Collective leadership Team and Director; and additionally a monthly TEAm Brief with invites shared to all staff across Directorate to attend.

10,000 Voices Survey: My Experience of Social Work Services.

Commissioned by the Department of Health Office of Social Services and led by the Public Health Agency in partnership with the five Health and Social Care Trusts.

The aim of 10K voices survey: First measure of social work services have impacted service users and family's lives over the past 10 years. The survey report was published in September 2023. A total of 552 stories were collected from across the region. 30% of the stories related to BHSCT (this was the highest of the returns)

The experiences of social work rated between:

- Strongly positive 34%
- Positive 21%
- Neutral 12 %
- Negative 9%

- Strongly negative 24%

The survey findings have been shared with social workers and service users during Trust engagement sessions. Five key themes have been developed into a regional action plan:

Theme 1 The importance of Core values & standards of conduct and practice

Theme 2 The role and purpose of the social worker

Theme 3 Effective Communication

Theme 4. Ongoing learning from Service users Families and Carers

Theme 5 Workforce

The Regional Action Plan sets out the key themes for action, the desired position/aspiration, and the actions to support an improved experience for service user, family and or carers, of Social Work services.

It is recognised learning is ongoing, and the need to continue to engage with the service users, families and carers, is part of all actions to improve services. This is explicit in the Regional action plan, which also ensures a consistent approach to learning from people who use social work services.

Complaints and Compliments

We recognise the importance and value of service users' opinions regarding the treatment and care we provide. As such we have worked to put effective processes for managing comments, concerns, complaints and compliments about any aspect of care or treatment provided or commissioned by the Belfast Trust in hospital or community settings.

We strive to ensure that all patients have a positive experience of our services, however there may be times when treatment or care do not

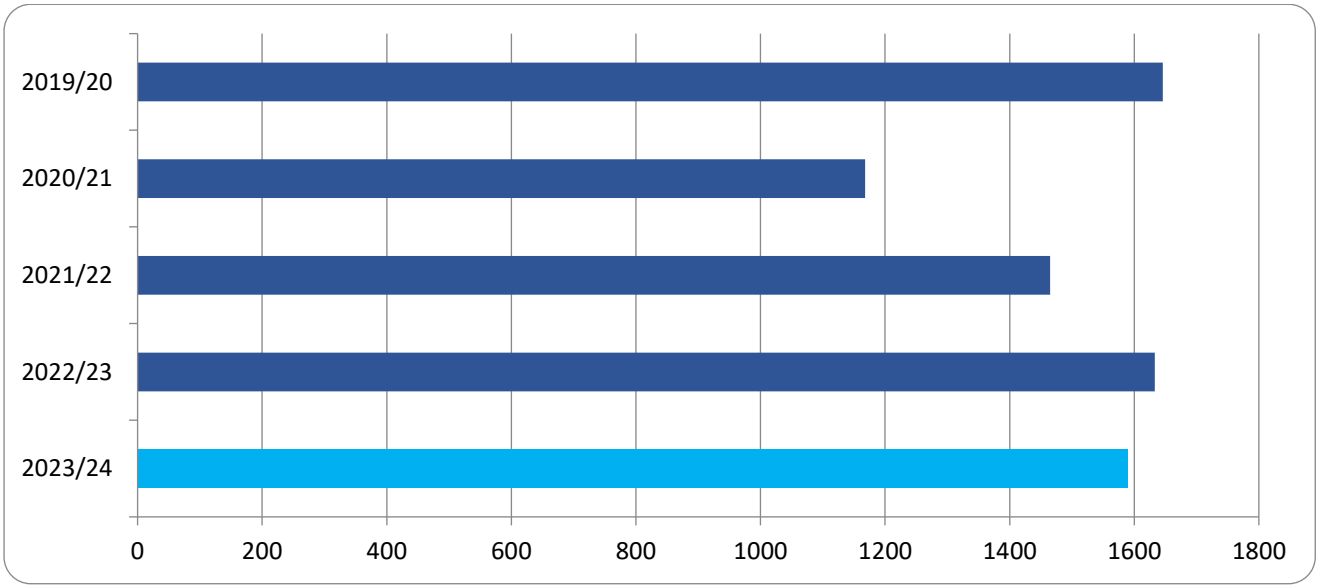
meet expectations particularly when something has gone wrong or fallen below standard.

By listening to people about their experience of healthcare, the Trust can identify new ways to improve the quality and safety of services and prevent similar problems happening in the future.

We place a real focus across the Trust on making sure that lessons from complaints are taken on board and followed up appropriately, sharing these lessons across other Service Areas and Health and Social Care Trusts where the learning can be applied in settings beyond than the original ward / department.

Facts and Figures

1,590 formal complaints were received in 2023/24 representing a 2.6% decrease on the previous year's figure of 1,633.



Graph showing Formal complaints received 2019 – 2024.

Formal Complaints - Top 5 Subjects 2023/24

The most frequent reasons for complaints about our services this year were:

- Communication / Provision of Information
- Quality of Treatment and Care
- Staff Attitude / Behaviour
- Quantity of Treatment and Care
- Waiting lists / delays / cancellations of Outpatient Appointments

The most frequent issues and concerns raised in complaints throughout 2023/24 remained largely consistent with those identified in previous years however “Quantity of treatment care” is newly represented in the top issues raised in complaints. This relates to the amount of treatment and care provided or available, e.g. someone receiving good quality home help but feeling they are receiving inadequate number of hours.

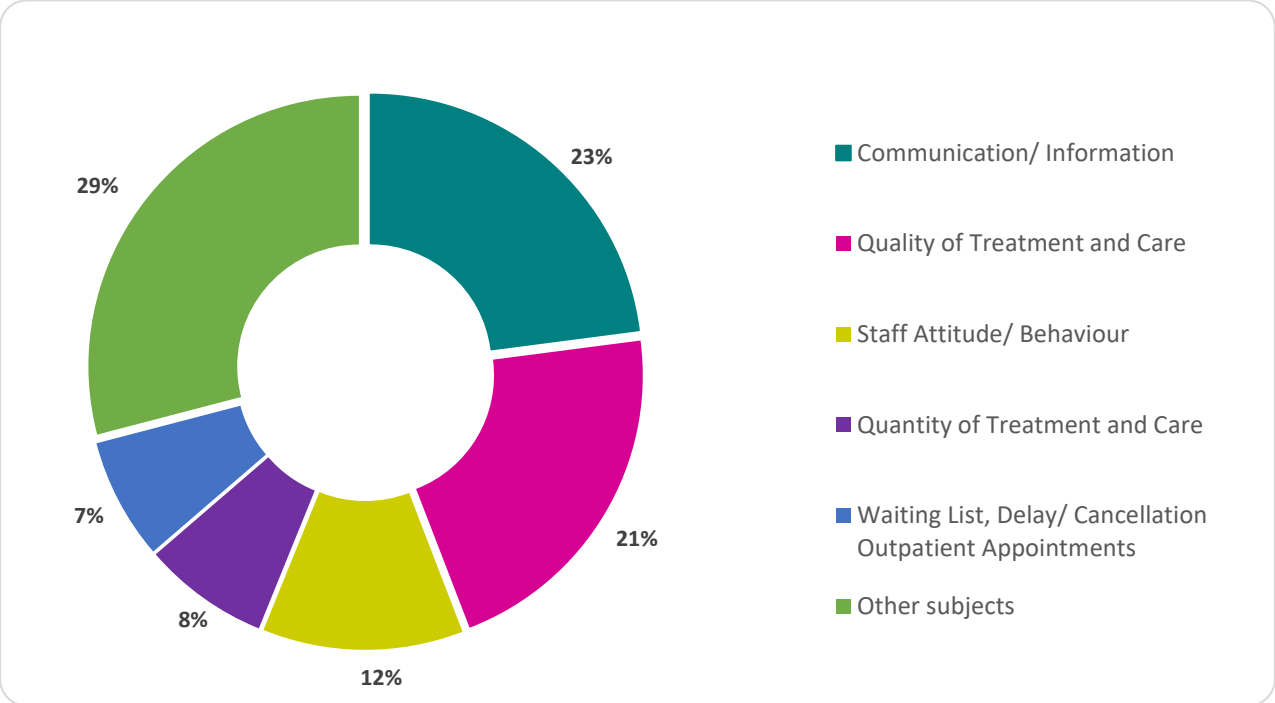
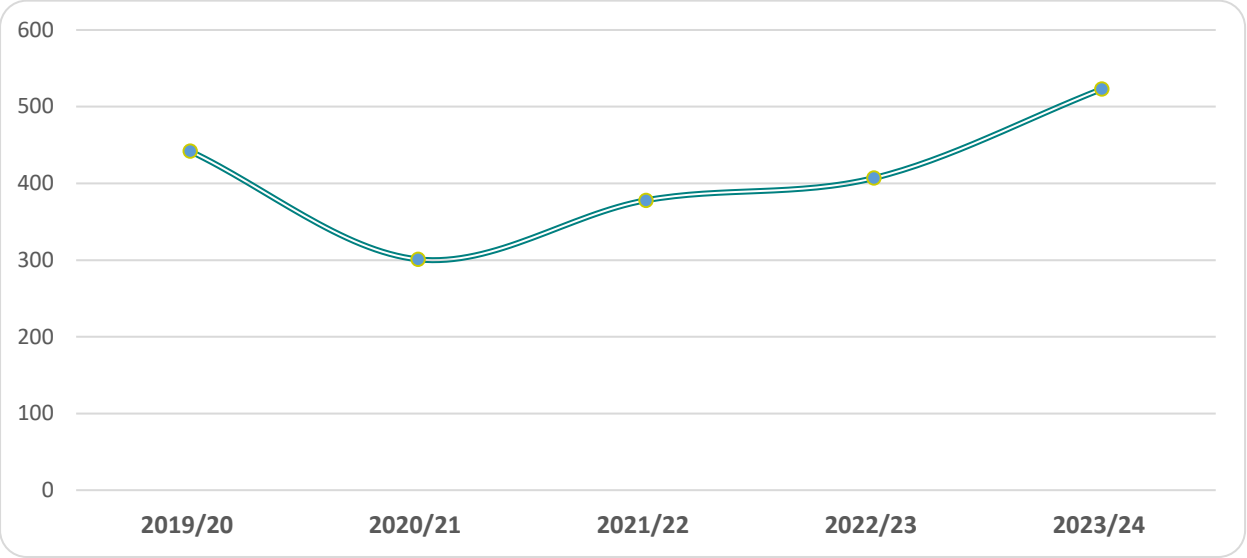


Chart showing the 5 most common complaint subjects during the year:

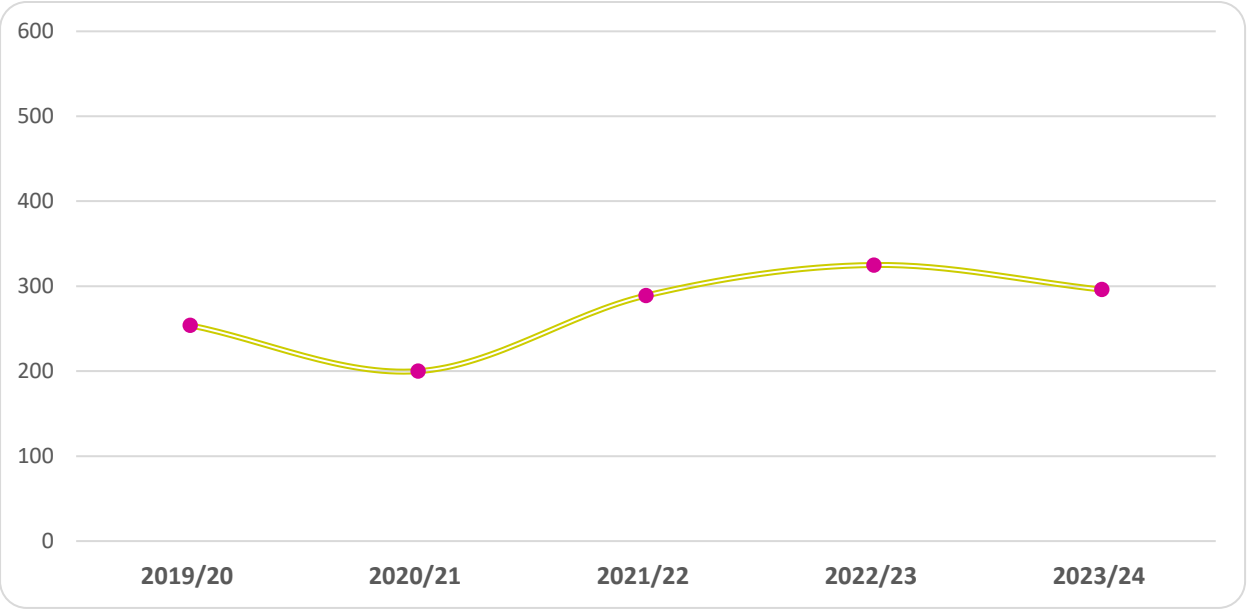
QMS Focus – Safety

Graph showing numbers of complaints about Quality of Treatment and care received:

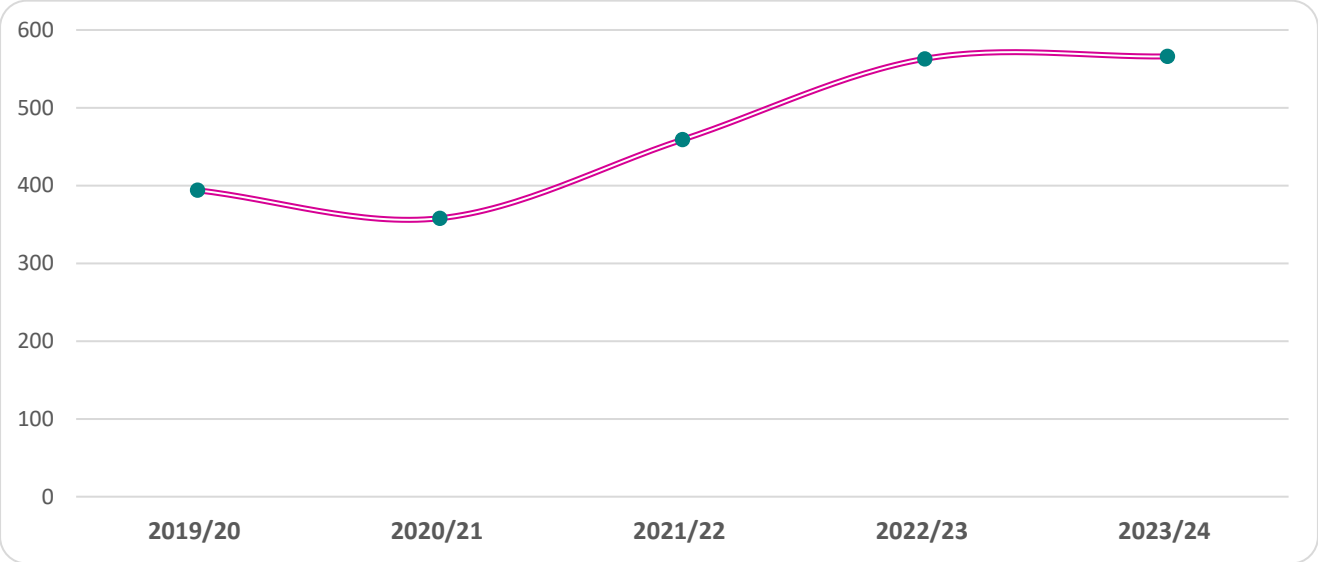


QMS Focus – Experience

Graph showing numbers of complaints about Staff attitude and behaviour:

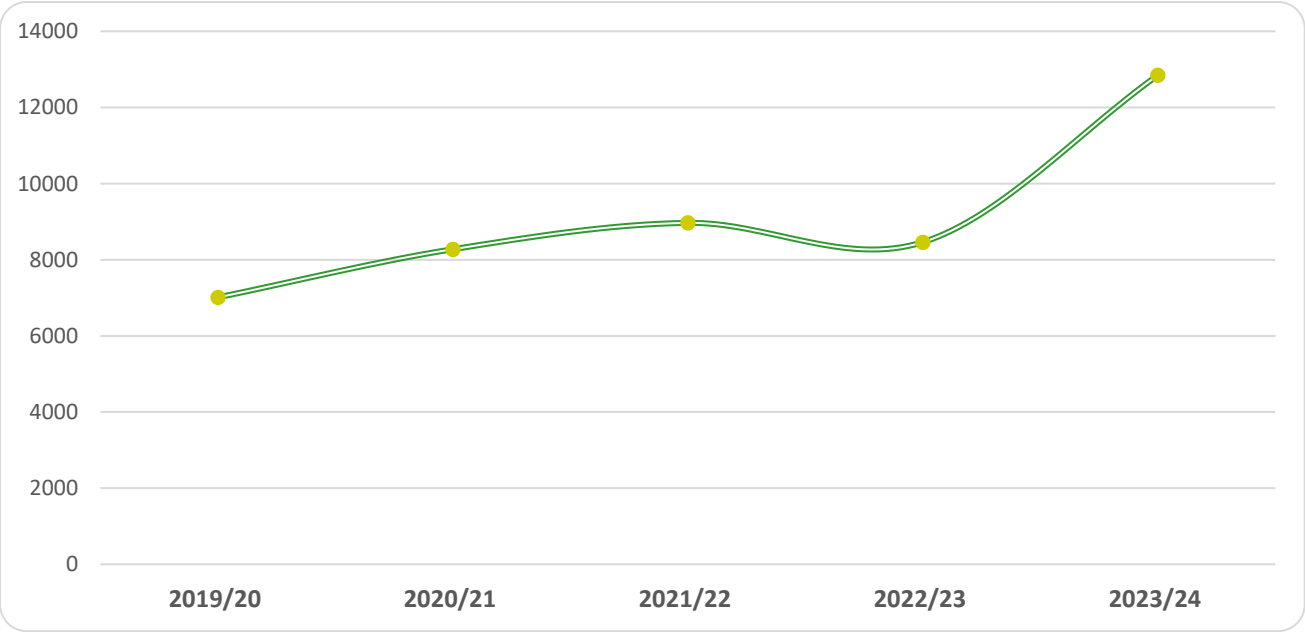


Graph showing numbers of complaints about Communication / Provision of Information:



QMS Focus – Experience

Graph showing numbers of compliments received about our services:



QMS Focus – Timeliness

The Complaints Department supports our managers and staff working in wards and departments to help ensure that comprehensive and full responses are provided to all complaints in an appropriate and timely way.

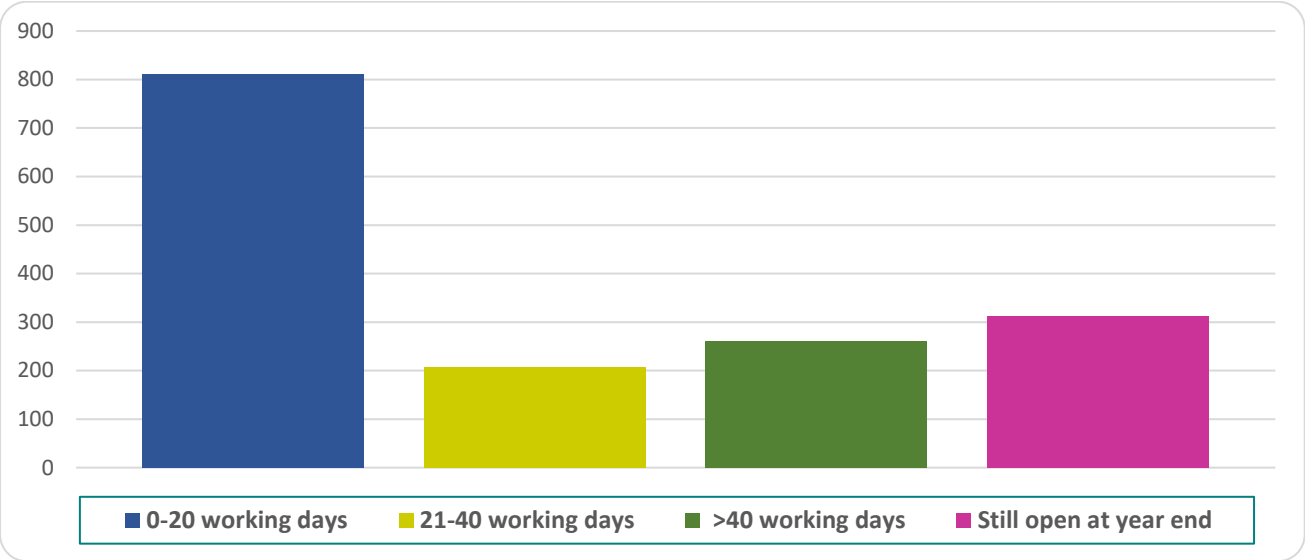


Chart showing an overview of how long we took to respond to complaints this year.

Although the Trust aims to respond to complaints within 20 working days, complex complaints (particularly those that involve a range of services / departments / organisations, or where independent expert opinions are sought) can require additional time to investigate.

Acknowledgement of complaint within 2 working days	99%
Complaint response within 20 working days	51%
Complaint response within 40 working days	64%

Table showing the response times for the Trust for complaints received during 2023/24.

In order to improve the timeliness of our response to complainants, the complaints department introduced an enhanced escalation procedure to

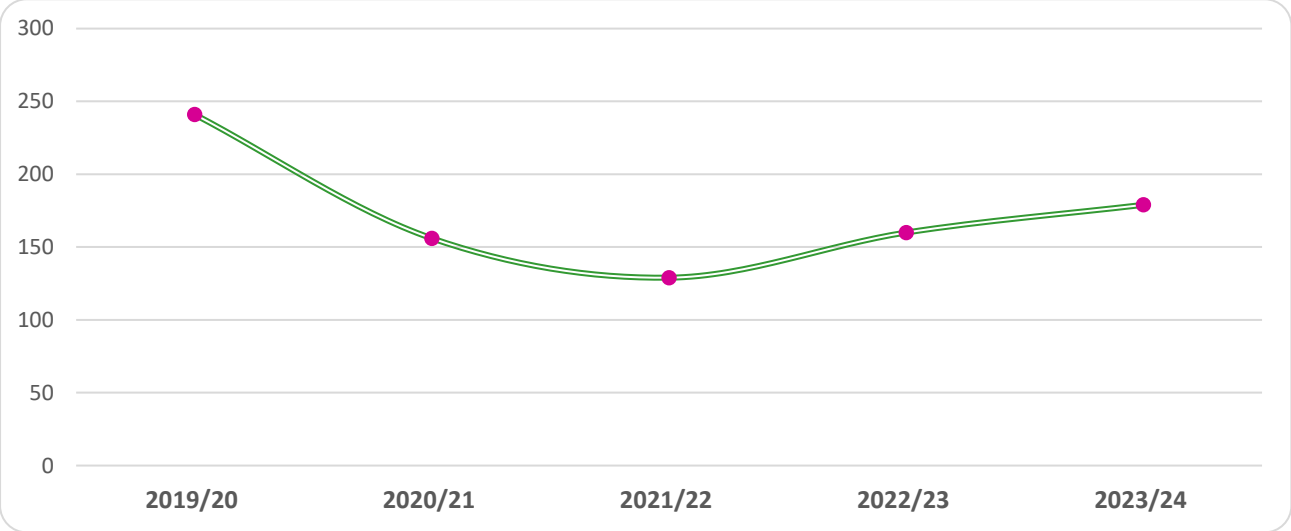
highlight complaints where responses were outstanding for prolonged periods.

Regular reports continue to be shared with services throughout the year including formal reports identifying all complaint cases in each service area where a response was awaited for > 40 working days.

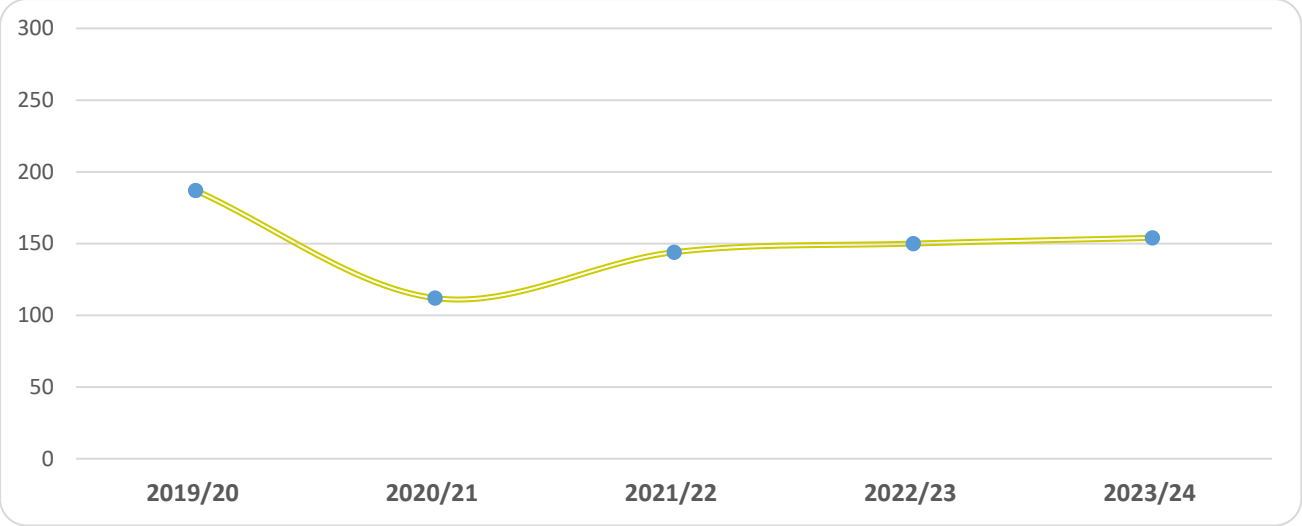
The Trust also continues to encourage and support staff to resolve complaints on the frontline - increasing the numbers of complaints addressed informally within wards and departments, and also increasing the numbers of formal complaints addressed within 5 working days.

QMS Focus – Timeliness

Outpatient Appointments:



Graph showing numbers of complaints received about waiting lists / cancelled services.



Graph showing planned Hospital Admissions.

Learning from Complaints

The Trust continuously seeks to ensure that where any patient has an experience within our care that did not meet the standards that we expect, this experience is reviewed and any learning is identified and used to inform changes in the way that we deliver our services. This learning is shared across Trust wards / departments where relevant to help avoid other patients experiencing similar issues in the future.

How complaints have led to improvements within the Trust for the top subjects of complaints during 2023/24.

A patient was admitted to hospital and regrettably suffered a fall in the ward environment and sustained a spinal fracture. The family complained in respect of the patient's care and treatment in particular asserting that more could have been done to prevent the patient's fall.

As a result of the complaint investigation a number of shortfalls were identified, and actions undertaken to address these including:

- Staff were reminded of the importance of ensuring all patients have a moving handling assessment and falls plan in place when

assessment demonstrates this is required and/or when prompted by a change in the patient's mobility
- Staff must assess the suitability of footwear on admission as well as suitability of any alternatives provided, and record same within the nursing documentation. Family to be asked to provide suitable alternatives if required
- Staff must ensure that care plans have been reviewed and that any mobility/ assistance requirements have been accurately identified

A family complained that they had received conflicting information from staff about a surgical procedure performed on their loved one who was seriously ill and required significant clinical intervention. The apparent inconsistency in information provided to the family was, in the circumstances, very distressing to them.

Investigation of the complaint found that that details regarding the intended surgical procedure were not clearly communicated to the patient or the family.

Communication detailing the learning points and safety message relating to this complaint was circulated throughout the Trust, highlighting in particular that:

- Planned surgical procedures must be clearly communicated to patients and documented in the patient's medical records.
- Planned surgical procedures should also be clearly communicated to the patient's family/next of kin, with the patient's consent, as soon as is practically reasonable.

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman.

An example of learning and improvement arising from a complaint that was investigated by the Ombudsman in 2023-24 is detailed below:

A complaint arose from sensitive and difficult circumstances where children were removed from the care of their parents. The family raised concerns in relation to delays in establishing kinship care arrangements and that the Trust's decision-making regarding was based on inaccurate information. In cases such as this, Trust social services are required to assess potential of family members as carers, and their potential to provide kinship care.

In this instance, the Trust's decision not to deem an individual as suitable led to the complaint which was investigated first by the Trust and then by the Northern Ireland Public Services Ombudsman.

An agency external to the Trust is routinely consulted when these circumstances arise. Investigation of the complaint identified that in this case the information provided by this agency was inaccurate.

NIPSO found that the Trust had failed to take timely action when the inaccuracy was identified and as a result the assessment process for suitable placement of the children had been delayed. NIPSO found also that there had been insufficient record keeping regarding the Trust's engagement with the external agency and investigation of the initial complaint.

As a result of NIPSO's investigation and recommendations the Trust implemented an action plan to ensure that the required standards were being maintained for this challenging area of service.

This included:

- Reminding relevant staff of the importance of keeping proper and appropriate records

- Undertaking an audit using a random sampling of records to assess:

a. Documentation relating to conversations between Social Workers and the external agency
b. Documentation relating to obtaining consent for criminal records checks
c. The making and retention of records of complaint investigations.

The Trust documented its learning from this case and have raised this learning for consideration for regional dissemination to other Northern Ireland HSC Trusts.

Compliments

Throughout the year the Trust continued to receive compliments about many aspects of our services. A total of 12,847 compliments were formally recorded during 2023/24.

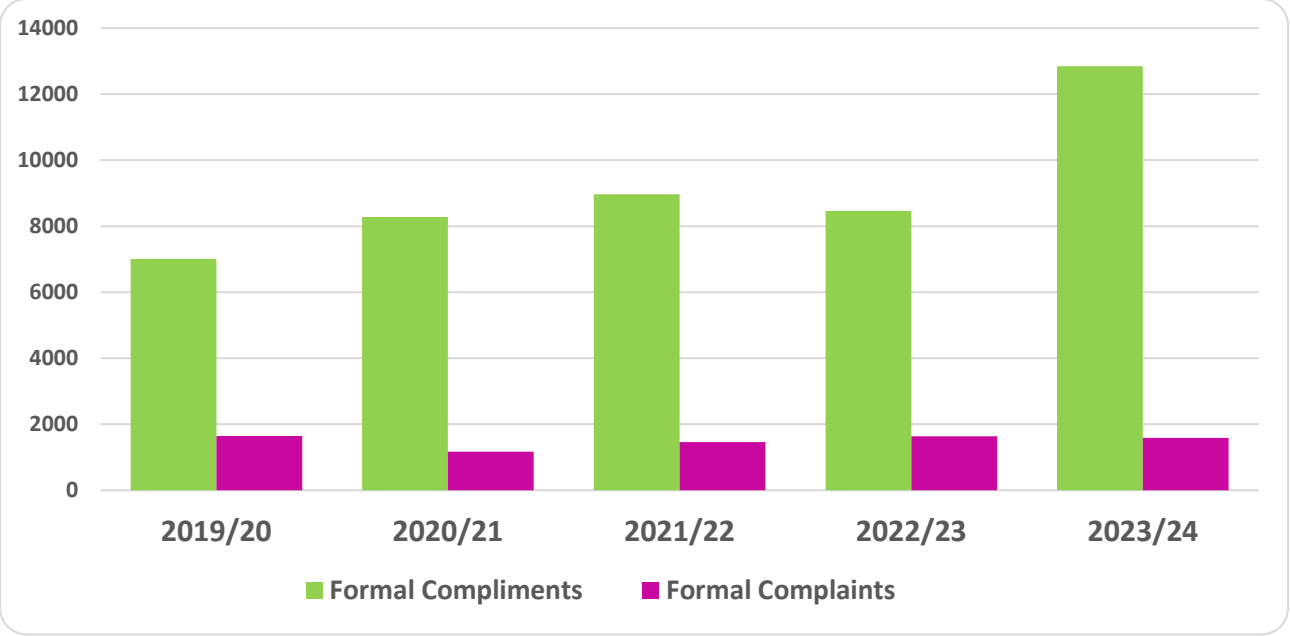


Table showing the numbers of compliments received over the past 5 years.

Serious adverse incidents (SAIS)

Serious Adverse Incidents (SAIs) form a very small proportion of all adverse incidents across the Trust each year, with approximately 1 SAI for every 250 Adverse Incidents.

Due to their potential seriousness and often complex nature, the process of a SAI review provides the opportunity for important learning to be identified to prevent reoccurrence and increase safety across the Trust and wider Health & Social Care.

Of the 57,971 incidents[1] reported in 2023/24, 171[2] met the criteria for reporting as SAIs. This equates to 0.3% of the total incidents reported throughout the Trust.

Approved incidents as at date of report completion. This report does not include incidents reported by Independent Sector Providers (ISP). For this reporting period there were also 10,555 ISP Incidents.

Excludes 3 SAI Notifications that were subsequently withdrawn following further consideration.

Outstanding SAI Reviews and Actions Taken to Address

Reviews outstanding in relation to Serious Adverse incidents continue to be a challenge to the Trust. Additional processes have been brought into the Trust to raise awareness of what was outstanding, identify bottlenecks in the review processes and providing support / guidance to Commissioning Directorates to try and move complex SAI reviews on to completion.

Internal processes include weekly discussions at the Trust Governance call; monthly discussion at SAI Group, SAIG (Trust Assurance Group), generation of monthly Quality Management System (QMS) data shared within the organisation and specifically shared as part of the Executive Team Safety Huddle arrangement; quarterly review of SAI data by Assurance Committee of the Trust Board, divisional meetings co-

ordinated between members of Directorate Collective Leadership teams and Medical Director's Office with a focus on outstanding SAI reviews.

External to Trust processes, SPPG has supported a bi-monthly Trust performance meeting that includes a specific focus of the SAI reviews outstanding and the stage these outstanding reviews are at, as well as covering outstanding SAI queries and Terms of reference.

SAIs with Catastrophic Severity

Unfortunately, some of the SAIs conducted concern incidents that resulted in a patient death or an incident leading to death (graded as Catastrophic).

Directorate	Level 1	Level 2	Level 3
Adult Community, Older Peoples Services & AHPs	5	1	
Anaesthetics, Critical Care, Theatres, Sterile Services (ACCTSS) & Surgery	2		
Child Health & NISTAR, Outpatients, Imaging & Medical Physics	5		
Children's Community Services	1		
Mental Health, Intellectual Disability & Psychological Services	20	1	1
Trauma, Ortho, Rehab, Maternity, Dental, & Sexual Health	5		
Unscheduled Care	11	2	

Table showing a breakdown of these cases by Directorate in 2023/24 by level of review undertaken.

SAI Type Tier

Type Tier	Count	%
Diagnostic Processes / Procedures	41	24
Behaviour	40	23

Table showing the Top 2 Most Commonly Reported Types of SAI.

Learning from SAIs

Every week new SAI notifications and SAI recommendations from completed reviews are presented at the Trust Weekly Governance call. Any learning (including immediate) identified by the relevant Directorate would be discussed as part of this call.

Learning is also a specific focus on Directorate reports at the monthly SAIG meeting. A summary of Learning Themes from completed SAI reviews continues to be brought every 6 months to this meeting. Of the 216 reports submitted during the reporting period 01 April2023 to 31 March 2024, 212 reports had learning themes confirmed. This identified a total of 440 themes. The table provides a breakdown of sub-group learning themes for the top 2 learning theme groups.

Work is underway to potentially add some additional learning themes to the current list to assist some services accurately capturing their key themes, for example Social Work.

Table showing some additional learning themes.

Learning Theme	Count
C: Deficient Checking & Oversight	**155**
C1: Medication error	10

Learning Theme	Count
C2: Misinterpretation/mishandling of test results	16
C3 Unexpected perioperative death (within 24hrs)	9
C4: Wrong - site/implant/procedure/patient	8
C5: Risk management failure	35
C6: Staff Training not up to date	11
C7: Related to checking aids e.g. tick box	11
C8: Failings/errors in documentation	64
P: Failure of Prevention	**120**
P1: Inpatient falls	4
P2: Healthcare-associated infections	7
P3: Pressure sores/decubitus ulcers	1
P4: Suicides	22
P5: VTE/pulmonary embolus	2
P6: Cardiac / respiratory arrests	1
P7: Staff Training/ skills deficiency	20
P8: Infant/Child Death	2
P9: Failure to prevent self-harm/assault/homicide	5
P10: Other (specify)	56

Shared Learning from Incidents and SAIs

The importance of identifying learning at an early stage and ensuring all services who may need to know about this is continually highlighted, whether this be via the Weekly Trust Governance call arrangements or by one of the established groups that sit within the Assurance

Framework that actively look at incident and SAI data or as part of the regular Divisional huddles completed.

For the reporting period 2023 to 2024 there were 15 Shared Learning Letters re Incidents, 29 Shared Learning Letters re SAIs issued and 2 Safety Message of the Week (SMOTW) formally issued. All of which are available on the LOOP Learning Library within the Trust. Please ref below for one example issued within this time period

Belfast Health and Social Care Trust
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SHARED LEARNING

Reference No.	Date Issued:
BHSCT/SAI/22/110	05 March 2024

SAFETY MESSAGE:

Due diligence must be taken by radiography staff when applying automated reports to X-ray examinations.

Summary of Event:

A patient presented to Emergency Department where a chest X-ray was requested and completed. The X-ray was accorded an automated report in error resulting in no formal radiological evaluation for the chest X-ray. The patient was discharged with no X-ray report.
Following subsequent separate hospital attendances and imaging investigations, the patient was diagnosed with lung carcinoma, which was present on the initial chest X-ray.
This resulted in a delay to the patient's diagnosis and treatment.

Learning Points:

- Radiography staff to ensure automated reports are appropriately assigned in compliance with protocols.
- Imaging services must have robust auditing processes to minimise the risk of incorrectly assigning an automated report, potentially resulting in a delay to a patient's diagnosis and treatment.

Type of Learning:	Specify learning details: (include details of actions by HSCB/PHA)
☒ Specific Directorate(s) **Radiology**	Key learning covered in report shared with SPPG on 16/11/2022.
☐ Trustwide	
☒ Regional*	Modernising Radiology Clinical Network
☐ Other	

***If learning is regional then completion of HSCB/PHA Regional Learning Notification Template should be considered.**

Action Required: (*For discussion and agreement at the relevant Assurance Framework Group – if learning is to be progressed sooner, other approval processes may need to be completed to ensure learning is disseminated in a timely manner)*

Shared learning to be disseminated to all Imaging departments for information and to action if appropriate.

Approved by:	Designation:	Date Approved
SAI Group		20 February 2024

LOOP LEARNING LIBRARY | Please note that this Shared Learning Letter and other learning is also available to view & download via the BHSCT LOOP Library from the following link
https://bhsct.sharepoint.com/sites/medical/SitePages/Learning-Library(1).aspx

Image showing an example of shared learning.

In addition to this the Trust would continue to receive external learning from the SPPG that has arisen from SAI reviews completed across HSC Trusts. Any learning relating to SAIs would be formally shared and noted at the next SAI Group.

Shared learning outside the SAI process is also considered for reporting through as per regional procedure to PHA / SPPG for their consideration.

Work is underway in the review of learning and how this is presented on the Loop to identify any improvements.

Work is also currently underway within Northern Ireland in the update of Regional Guidance with this expected to be issued early 2025. The new guidance will look to support the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

Adverse Incidents / Serious Adverse Incidents (SAIs)

An **Adverse Incident** is defined as “Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service.”

Adverse Incidents happen in all organisations providing healthcare. Belfast Trust meets this challenge through the promotion of a culture and system of reporting all incidents when they occur to learn from them and to prevent re-occurrence. “To err is human, to cover up is

unforgivable, to fail to learn is inexcusable" – Sir Liam Donaldson, former Chief Medical Officer, England.

The objective of the incident reporting system is to encourage an open reporting and learning culture, acknowledging that lessons need to be shared to improve safety and apply best practice in managing risks. It also provides feedback on high-level analysis and themes arising from reported incidents.

Incidents reports are provided to a number of specialist groups e.g. the Trust Assurance Committee, Invasive intervention group, Health and Safety Group, Management of Aggression Group, Safety Improvement Team, to help identify trends and areas requiring focus and to allow measurement of the impact of incident reduction projects within the remit of these groups.

A **Serious Adverse Incident (SAI)** is a classification of incident that is subject to Department of Health procedures for reporting and investigation. SAIs will include 'an incident where there was a risk of serious harm or actual serious harm to one or more service users, the public or to staff.'

Facts and Figures

In the year 2023/24 there were a total of 57,971 adverse incidents reported and, of these, 171 were reported as SAIs. 80% of adverse incidents affected patients or service users, 13% affected staff/contractors/vendors with the remaining 7% affecting the organization as a whole or public/visitors.

Top 5 Incident Types 2023/24

1. **Behaviour (23,371 reported incidents)**

Examples of actions to reduce re-occurrence:

- The Trust has a zero tolerance approach to violence and aggression towards Trust staff.

Safety Intervention Team

- Deliver Safety Intervention training programmes throughout the year to Trust staff at varying levels, following completion of a zero tolerance risk assessment and training needs analysis.
- Support the Trust in the development of policies and procedures pertaining to this area of expertise.
- Provide advice to staff and managers on restraint reduction, restrictive practices and minimising the risk of violence and aggression.
- Monitor and review all incidents involving the use of physical interventions. This is to recognise trends and hotspots and provide additional support and guidance for service areas on reducing occurrences of incidents and learning from incidents.

Safety Intervention Training Benefits:

Recognise & Respond to Escalating Behaviour:

Staff learn to recognize signs of distress and gain a broad range of tools to help them intervene early and a clear understanding of using the right skills at the right time to effectively de-escalate when conflict arises, so that behavioural crisis doesn't occur. The training incorporates trauma-informed and person centred approaches.

Recognise & Respond to Crisis Behaviour:

When faced with a behavioural crisis that places staff or others at risk of injury, staff learn to focus on the least restrictive physical intervention to ensure the Care, Welfare, Safety and Security of those in our care.

Recognise & Respond to Higher Risk Crisis Behaviours:

Offering a wider array of verbal, non-restrictive and restrictive interventions to manage risk behaviour

Best Practice Learning:

All verbal and safety intervention training is based upon the latest principles of learning with an emphasis on strategies that can be used by staff. Physical interventions within the Crisis Prevention Institute (CPI) have been independently risk assessed, following published research which demonstrates that they maximize safety and minimise harm and follows international standards of best practice.

Evidence Based & Fully Accredited

All courses are based upon the latest research and include approaches that have a proven track record of effectiveness. Safety intervention training is fully compliant with current statutory and legal requirements. Nationally and internationally accredited by Restraint Reduction Network Training Standards.

Mental Health Services

- All incidents graded as moderate and above severity, as well as incidents graded minor or insignificant, but with a potential of a medium or above consequence are reviewed by the Collective leadership Team (CLT), at the weekly governance huddle and feedback returned to the appropriate service area with comments or further action if required.
- Incidents of violence and aggression are discussed locally at Ward/ Department level during team meetings and at monthly Patient Safety Meetings.
- Within Mental Health Services a Physical Intervention (PI) report produced on a weekly basis is distributed to the service areas within Mental Health Services for review and escalation. The Divisional Nurse (CLT) also has oversight of this report. The PI

report includes all aggressive and self-harming behaviour incidents. The service monitor the use of Physical Intervention, Prone and Supine restraint, IM rapid tranquilization and seclusion.

- All Mental Health Incidents are discussed at monthly Divisional Governance Meetings. Trends and patterns are collated for wider discussion. When themes are identified, these incidents are grouped and reviewed collectively to identify any possible learning.
- It should be noted that often when a peak arises within a Mental Health inpatient facility, it can relate to an individual or a small cohort of individual patients who have been admitted and who are very unwell.
- Support for staff involved in incidents of violence and aggression is provided as and when necessary.

Intellectual Disability Services

- All incidents of aggression are reviewed daily during safety huddles at both hospital and community levels and discussed in live governance meetings. Inpatient aggression incidents are specifically addressed at ward-level clinical improvement meetings.
- The Monthly Divisional Governance Meeting reviews these incidents using collated weekly safety reports, these include data trend and pattern analysis. These findings are presented to the management team to embed proactive crisis management and protection plans within the Division.
- A review of patient placements and co-location at the MAH site has led to relocating some patients to environments better suited to their needs, such as individual PODS or annexes. These settings promote increased independence and prepare patients for community living.
- Delayed discharges of some children at Iveagh have been escalated with respective Trusts. We currently have one over-18-year-old residing at Iveagh, with ongoing joint efforts to find a suitable placement.
- The focus on accelerated resettlement is being revised, recognizing the potential harm to individuals. Some inpatients, who

do not wish to remain in the hospital, are at risk due to factors such as personal frustration, low staffing levels and boredom, which may lead to dysregulated behaviours.

- The trends from 2023 to 2024 indicate a decrease in behavioural incidents among inpatients and across all ID services. This decline reflects the effectiveness of robust governance arrangements and careful consideration of environmental impacts.

2. Accidents / Falls (8,943 reported incidents of which 81% were Falls)

- Falls Incidents. See Falls Data section in Theme 3 of the Annual Quality Report.

3. Medication / Biologics / Fluids (6,729 reported incidents)

Medication Incidents:

- Teaching to final year medical, nursing and pharmacy students at QUB and UU has been updated to include an awareness of potential medication risks related to encompass.
- Incidents related to bladder irrigation has led to an order panel being developed and available in encompass.
- QI work undertaken in Ward 6D in relation to reducing omitted doses that has resulted in a reduction in the ward incidents and an improvement in the ward medication thermometer for omitted doses for 2023.

4. Other (3,070 reported incidents)

- Some incidents recorded as ‘Other’ may be able to be coded more appropriately
- Actions are being taken to improve the coding of incidents.

5. **Service Disruptions (environment, infrastructure, human resources) 2,808 reported incidents, 71% of which relate to lack of staff / non availability of beds)**

- These incidents occurred throughout the Trust with particularly high numbers in the Emergency Depts. (Royal and Mater sites), the Mental Inpatient Centre (Belfast City site) and Maternity Service (Royal Jubilee Maternity Hospital)
- Incidents are reviewed on an ongoing basis via the live Governance arrangements in each of the relevant Directorates. Regular review and update of business continuity plans would be key
- Communication with Site Coordinators and escalation to senior management would occur when required to ensure appropriate action is taken to minimise impact on ongoing service delivery. This can sometimes require actions being taken throughout the Trust. These issues require entire HSC system review to resolve

How the organisation learns

Quality Improvement

April 2023	Unscheduled Care Learning Lunch
May 2023	STEP Celebration Event 42 Graduates 400 Total
May 2023	ScIL Graduation 18 Graduates 116 Total
June 2023	SQB Graduation 858 Trained in eSQB/SQB
September 2023	Safetember 2023
March 2024	March to Safety 2024

March 2024	Emergency Department QI Celebration
Ongoing	Since 2021 286 staff have had EQI Training.
Ongoing	STEP/STEP-UP
Ongoing	35 Shared Learning Documents on BHSCT Learning Hub https://bhsct.sharepoint.com/sites/medical/SitePages/Learning-Library.aspx
Ongoing	BeST
Ongoing	Schwartz Rounds
Ongoing	QI Project Surgeries

Belfast Support Team (BeST)

The BHSCT is committed to supporting staff and recognises the emotional impact of incidents or unexpected events. We want to support staff in providing safe, effective and compassionate care by making available both practical and emotional support when these events occur. Any member of staff who has experienced the emotional impact of an unexpected event can confidentially be put in contact with a trained peer supporter. The peer supporter will provide reassurance and support and can also offer practical advice on coroner's, inquests, complaints and SAI's etc. There are **127** trained peer Supporters across all directorates, professions and bands in the Belfast Trust. Since **2019** there have been **17** requests for BeST Support.

Schwartz Rounds

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing

care, not to solve problems or to focus on the clinical aspects of patient care.
During a Schwartz Round three members of staff (story tellers) present short accounts of their experiences of delivering patient care. They either present an experience of a particular patient case that is shared collectively, or present a set of individual experiences based around a theme (*'A patient I'll never forget'* or *'What keeps me awake at night'* for example). This is followed by a facilitated discussion with contributions from the audience. The Round lasts for one hour and is usually held at lunchtime.

'I feel these sessions are so beneficial and allow a safe space to discuss issues within work that are not always made vocal'.

'Relly excellent and can't wait for the next one'

Between the periods of April 2023 – March 2024 there has been 3 face to face Schwartz Rounds held across the RBHSC and RJMS sites. These Rounds totalled more than 53 members of staff in attendance. Feedback received has been extremely positive.
Click **HERE** for further information

QI Project Surgeries
QI Project Surgeries are for teams currently involved in quality improvement (QI) projects but who are not part of a current QI programme.

These surgeries can be booked in 1hr slots and will be facilitated by two level 3 QI trained mentors. Teams can book one of these slots by emailing: **qualityimprovement@belfasttrust.hscni.net**
And coming along to discuss their QI questions. Small teams can join virtually via MS Teams or face to face at the QI Hub in Elliot Dynes, RVH.

Between the periods of April 2023 – March 2024, **19 teams** have attended project surgery slots.

A Full breakdown of the QI Project Surgeries can be viewed by clicking **HERE**

Safetember 2023

The overarching theme for Safetember 2023 was 'Engaging Patients in Patient Safety' in line with the theme for WHO's world patient safety day on 17th September.

Click here to find out more about World Patient Safety Day

Throughout Safetember staff are encouraged to think how they can elevate the voice of; patients, service users, their families and carers and recognise the crucial role they play in the safety of health care. A range of teams shared their experiences and held information sessions which were published on the corporate calendar.

Other key themes that were highlighted as part of Safetember included:

- Medication Safety
- Keeping staff safe and well
- Learning from experience

Click **HERE** to view the interactive Safetember Calendar from 2023.
Image of Safetember Calendar.

March to Safety 2024

March to Safety is a month-long programme of events where staff are encouraged to take time to refocus on the safety of our services by taking part in various events. It aims to support a culture which prioritises the safety & quality of care above all else through sharing learning from when things go wrong as well as from quality improvement projects and learning from experts in their fields to inspire new ideas.

Staff will hear from experts in their fields and have the chance to engage in discussions around the key focuses of this year's March to Safety programme. March to safety aims to build on Safetember's programme of events to focus on ensuring a safer system by looking at safety in its variety of forms allowing staff to engage with experts in their field, share learning and take away key messages from the session which will inform their own practice going forward.

Click **HERE** to view this year's interactive March to Safety Calendar

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Corporate Calendar - Events open to all staff

Please Note: The falls e-learning programmes have now been published on LEARN.HSCNI and are available in the CEC portal

March to Safety

Belfast Health & Social Care Trust
STAFF EXPERIENCE
Have your say: Live from 4th - 29th March

Monday	Tuesday	Wednesday	Thursday	Friday
Theme 1: Place the person clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation	Theme 2: Ensure a relentless focus on safety and quality improvement through the implementation of our Quality Improvement Plan aligned to our corporate objectives and assurance framework	Theme 3: Ensure that we are an open, transparent and supportive organisation that is continually learning and sharing both within and beyond the organisation	Theme 5: Enhancing our will, our capability and structures to undertake quality improvement consistently, everywhere and every day	1 Refocus on Safe Systems
4 Online Stress Control Class Nursing Registration Roles and Responsibilities 11:00 - 11:30 Ergonomics (Sit to Stand Hoist Demonstration, RVH)	5 Yellow Card Awareness Session, 10:00 - 10:45 Ergonomics (Sit to Stand Hoist Demonstration, MPH)	6 Medication Safety Thermometer Presentation Ergonomics (Sit to Stand Hoist Demonstration, BCH)	7 Fallsafe Awareness Session 14:00 - 15:30 Ergonomics (Sit to Stand Hoist Demonstration, MIH)	8 Freedom of Information (FOI) Session 11:00- 12:00 Medication Delay and Omissions Presentation
11 Yellow Card Awareness Stand, 10:00 - 14:00 Mind your Mind Toolkit Session 1 (Staff), 12:30 - 13:00 Measles Presentation, 14:00 - 15:30	12 Deaf Awareness Training, 10:00 - 12:00 Supporting Teams through Organisational Change, 12:30 - 13:15 Cancer Research UK Information Stand (Lunchtime) Fallsafe Awareness Session, 14:00 - 15:30	13 Engage and Involve: Introduction to Co-production for PPI 12:30 - 13:30 Yellow Card Awareness Session, 15:00 - 15:45	14 Deaf Awareness Training, 10:00 - 12:00 Freedom of Information Session (FOI) 12:00 - 13:00 Safety Issues Associated with Agency Staff 13:00 - 14:00 Nursing Registration Roles and Responsibilities 15:00 - 15:30	15 Human Factors (Professor Paul Bowie) 13:00 - 14:00 National Early Warning Score Presentation
18 Bank Holiday	19 Monthly Mover: 15 Minute Desk Yoga, 10:30 - 10:45 BWell Information Session, 12:30 - 13:00	20 Food and Nutrition to Reduce Cancer Risk 10:00 - 10:45 Supporting Carers across the Organisation, 14:00 - 15:00	21 Yellow Card Awareness Session 10:00 - 10:45 Management of opioid toxicity and use of naloxone for adult inpatients on long-term opioids for pain 2024, 11:00 - 11:30 Peer Auditing Presentation, 14:00 - 15:30	22 Post - Fall Matters: Investing in the Provision of Powered Flat Lifting Equipment Freedom of Information Sessions (FOI) 11:00 - 12:00
25 Mind your Mind Toolkit Session 1 (Managers) 12:30 - 13:00 Discover the Recovery College Session, 10:30 - 11:30 Yellow Card Awareness Session, 15:00 - 15:45	26 ~~Yellow Card Awareness Stand~~ CANCELLED Nursing Registration Roles and Responsibilities 11:00 - 11:30 ~~Supporting Teams through Organisational Change, 12:30 - 13:15~~ CANCELLED Schwartz Round RJMS, 13:00 - 14:00	27 Freedom of Information Session (FOI) 12:00 - 13:00	28 Regional Learning from Serious Adverse Incidents/Patient Experience/Complaints ECHO Network 14:00 - 16:00	29 Palliative Care Study Day, 8:45 - 16:00

Crisis Planning – Forward Planning

Belfast Trust welcomed the publication of the Mental Health Strategy in 2021, which focuses on a multi-agency approach to managing the mental health of the population. We continue to engage in all aspects of the Single Mental Health Crisis service work streams led by DoH. We continue to phase out Card Before You Leave (CBYL) where patients

who did not meet the threshold for mental health services in ED received next day follow up phone call.

This has resulted in 14.3% reduction in CBYL and an increase in face to face consultations with these patient groups.

Our Mental Capacity Act Team are also operating at a high level of performance with the Belfast trust MCA Team leading the region for training, implementation of Section 12 and legal compliance. The decision to deprive someone of their liberty is never taken lightly but our team is well trained, expertly staffed and ready to act in the best interests of those we care for.

Waiting Lists across health and social care continue to grow but we are pleased that some initiatives have taken place with a resulting decline in these areas. For example our CAMHS community team were able to reduce their waiting lists by 14% in 2023 through the introduction of a waiting list dashboard.

Our East Recovery Community Mental health team achieved an 8% reduction in caseload. We are hopeful this trend will continue and we have increased our data analytics capability to support these initiative.

As with any service, our staff team are the lifeblood of what we do. It is our duty to ensure they have the resources and training to deliver the care our patients need. This is why steps were taken last year to reduce sickness absence, with our Beechcroft team reducing absence from 16.3WTE in July to 5.5 WTE in December.

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) are legal measures designed to ensure that individuals who lack the mental capacity to consent to their care or treatment are not unlawfully deprived of their liberty. These safeguards, integral to the Mental Capacity Act (Northern Ireland) 2016, protect the human rights of vulnerable adults in care homes, hospitals, and other settings. They provide a legal framework to ensure that any

deprivation of liberty is in the best interests of the individual, necessary, and proportionate.

The importance of DoLS is highlighted by their alignment with the Human Rights Act 1998, particularly Article 5, which guarantees the right to liberty and security. These safeguards protect individuals' rights by requiring thorough assessments and regular reviews of care and treatment arrangements that might amount to a deprivation of liberty. This process includes appointing independent assessors and representatives for the affected individuals, ensuring their rights are upheld and providing access to legal remedies if necessary. In the Belfast Health and Social Care Trust, DoLS are managed by the Mental Capacity Act Service. Key activities from April 2023 to March 2024 included:

- 619 existing DoLS Authorisations: Extended, representing a 47% increase from the period April 2022 to March 2023.
- 1,231 new DoLS Authorisations: Ensured that deprivations of liberty were lawful and in the best interests of the individuals. The assessments were divided into:
    - Short Term Detention Authorisations: 504, a 174% increase from the period April 2022 to March 2023.
    - Trust Panel Authorisations: 727, an 86% increase from the period April 2022 to March 2023.

The Mental Capacity Act Service has closely collaborated with educational settings to ensure that, where required, DoLS Authorisations are in place for young people aged 16 and over. Since April 2023, 40 Trust Panel Authorisations have been completed, compared to none in the previous year. Significant awareness and collaborative work with educational settings has ensured that the human rights of young people deprived of their liberty in educational settings are upheld.

- Conducted 45 training sessions for health and social care staff and independent sector providers.

- Over 900 participants attended these sessions, focusing on legal requirements, best practices for assessments, and the importance of upholding individuals' rights.

- Refinement and updating of policies related to DoLS to align with current legislation and best practice guidelines.
- Development of new protocols and revision of existing ones to ensure clarity and consistency in practice.

- Regular audits and reviews were conducted, with 150 cases reviewed to monitor the implementation of DoLS and identify areas for improvement.
- These audits helped ensure transparency and prompt addressing of any issues.

- Prioritised collaboration with various stakeholders, including families, care providers, and legal representatives, to ensure a holistic approach to safeguarding individuals' rights.
- An established carers and Nominated Persons representative group meets bi-annually to inform and improve practice.
- Feedback from these stakeholders has been instrumental in shaping the service's strategies and policies.

From April 2024 to March 2025, the Mental Capacity Act Service plans to continue these efforts, focusing on enhancing the quality of assessments and further improving inter-agency collaboration. The goal is to ensure that all individuals subject to DoLS receive the highest standard of care and that their rights are consistently protected.

In summary, the activities of the Mental Capacity Act Service play a vital role in upholding the principles of the Mental Capacity Act (Northern Ireland) 2016 and the Human Rights Act 1998. By rigorously applying Deprivation of Liberty Safeguards, the service helps protect some of the most vulnerable members of society, ensuring their care and treatment are always in their best interests.

Least Restrictive Option

ASWs are committed to ensuring the least restrictive intervention possible. Between April 2023 and March 2024, 33% of assessments under the Mental Health (Northern Ireland) Order 1986 resulted in alternatives to compulsory hospital admission. Specifically, 9% of these assessments led to voluntary admissions, with patients who had the capacity to consent opting for inpatient psychiatric care. Additionally, 24% of the assessments resulted in alternative care plans, providing necessary support within the community and avoiding inpatient psychiatric care.

Personal and Public Involvement (PPI) - Explaining Key Work

The Trust continues to advance work to embed Personal and Public Involvement (PPI) as a key element of Quality Improvement. The Involvement and Partnership Team work across the Trust to support the implementation of the statutory duty to involve and continue to implement the Department of Health Co-Production guide and the Belfast Trust Involvement Strategy, Involving You – From Them and Us to We, which sets out the Trusts vision, commitment and integrated approach to Patient and Client Experience, PPI and Co-production.

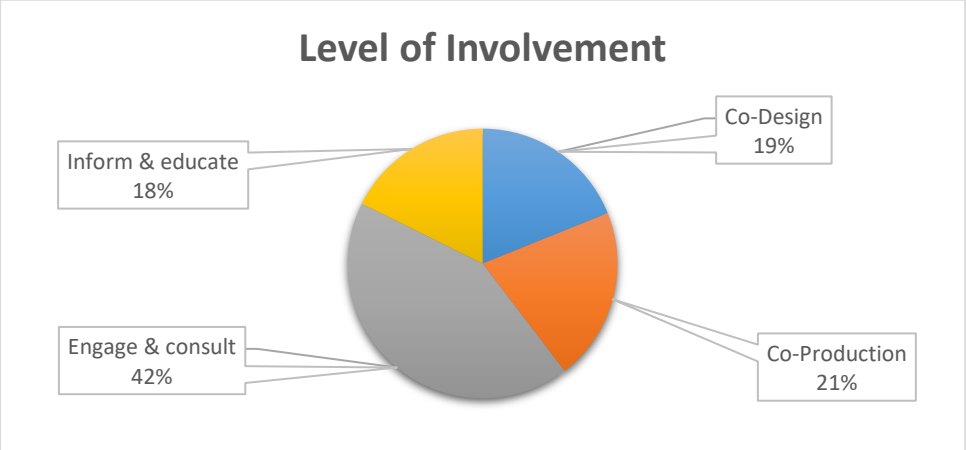
PPI is included in the Trust Assurance Framework committee structure and reports via the Involvement Steering Group. PPI is reflected in the Trust draft Corporate Plan as a key theme ‘listening and involving patients, service users and carers to improve services’ and subsequently included in Directorate and Divisional management plans.

The Trust capture involvement activity taking place across the Trust on a bi-annual basis. During the 2023/24 period, the following involvement work was reported:

Round 3: April – September 2023 – 94 returns submitted

Round 4: October 2023 – March 2024 – 70 returns submitted

Involvement is undertake at different levels with co-production being seen as the pinnacle of involvement. Across the Trust a range of involvement activity is being undertaken across the different levels.



Graph showing level of involvement across Belfast Trust (42% Engage and Consult, 21% Co-production, 19% Co-Design and 18% Inform and Educate).

Belfast Trust historic 'Trust of Sanctuary' Application

Belfast Health and Social Care Trust are on course to be awarded the **prestigious 'Trust of Sanctuary' Award** in recognition of its commitment to providing a safe, welcoming environment for everyone, regardless of background, ethnicity, or origin. No other Health Trust in Northern Ireland or the rest of the UK has received this accreditation. Maternity Services also received the **'Service of Sanctuary'** Award. Belfast Trust will be the first trust awarded when the ceremony takes place September 2024.

The Sanctuary Awards recognise and celebrate the organisations who go above and beyond to welcome people seeking sanctuary. This award is recognition of our staff's commitment to deliver inclusive treatment and care across both hospital and community sites, all of which are shared spaces where everyone is welcome and treated with dignity and

respect. We are working tirelessly to tackle inequalities and make sure that everyone has the best possible opportunity to succeed in life and can feel at home in our society.

Belfast Trust applied earlier this year to become a Trust of Sanctuary and hosted a visit for City of Sanctuary members to see at first hand the high quality, safe and compassionate services we provide.

Some examples of this work include International recruitment and support for international staff, introduction of a Cultural Liaison Midwife in maternity services, our Inequalities and Inclusion Team who support refugee and asylum seekers in Belfast and our continued support for unaccompanied asylum-seeking children.

We are also **the only Trust in Northern Ireland to have a Good Relations Strategy,** which played an integral part in our success with this award and underpins our corporate and social responsibility as the largest Health and Social Care Trust and employer in NI.

2. STRENGTHENING THE WORKFORCE

Staff Induction

In order to build the capability and skill of Belfast Trust staff to manage ongoing change and rise to the challenges that the organisation faces, we recognise the importance of staff undertaking a comprehensive corporate induction. A digital Onboarding approach is in place for staff joining the organisation. This arrangement provides staff with key information to support their understanding of the Trust culture and values. It also provides access to all 10-core elements of their Statutory Mandatory Training supporting the delivery of safe care from the onset

of their employment. From April 2023 to March 2024, 1095 staff utilised the digital Onboarding to compete their statutory mandatory training

Mandatory Training

Statutory training is required to ensure that the Trust is meeting any legislative duties. Mandatory training is an organisational requirement to limit risk and maintain safe working practice.

The table below shows the Trust position of the Core 10 Mandatory Training areas from April 2023 to March 2024.

Statutory Mandatory Training	Position at March 2023	Position at March 2024	Progress
Adverse Incident Reporting	58%	71%	+13%
Corporate Induction	75%	53%	-22%
Data Protection	54%	-*	-
Equality	39%	-*	-
Fire & Environmental Safety	44%	38%	- 6%
Health & Safety Awareness	59%	71%	+12%
Infection Prevention Control	77%	-*	-
Moving and Handling	38%	-*	-
Quality 2020	72%	61%	-11%
Safeguarding Adults & Children Level 0	78%	69%	-9%

*data not available until September 2024

Utilising our new Learn HSCNI system the Trust can prioritise statutory and mandatory training, clearly indicating renewal dates, and ensuring accountability. The "My Learning" function allows staff members and their managers to review compliance levels and instantly choose an

option for resitting the training, streamlining the process and maintaining high standards.

Belfast Trust continues to be committed to providing crucial training and development to all staff in order to empower them to deliver safe, effective, compassionate care. A significant improvement in this provision has been the launch of a new Learning Management System (LearnHSCNI) in May 2023. This has provided a centralised platform for all staff to access training and development. Improved accessibility to learning resources and personalised learning pathways that are tailored to individual needs, has improved user experience for our staff.

The HR People and Organisational Development team is dedicated to developing and supporting managers and leaders to lead collectively and with compassion. Our programmes aim to provide them with the capability, skill and tools to do this effectively. Using the LearnHSCNI platform, a full portfolio of programmes were offered by the team during 2023/24. Programmes were delivered both virtually and in person, enabling accessibility for all staff groups. In total 1,469 staff availed of the portfolio programmes, which were supplemented by customised sessions on HSC Values, Leadership and Management Development, Team Development interventions and coaching which were delivered to a further 1499 staff.

- 75% of staff agreed they would be recommending the skills training to a colleague
- 72% agreed they would be actively able to implement a learning from the skills training.

Vocational Learning

The Trust prioritises its investment in our Nursing Assistant workforce, empowering them to support service delivery in teams and ensure patient safety.

The Vocational Learning Team continues to ensure the mandatory Nursing Assistant induction is delivered in line with the Department of Health's Induction and Development Pathway for Nursing Assistants. Between April 2023 and March 2024, 180 Nursing Assistants (Band 2) and Senior Nursing Assistants (Band 3) attended the Nursing Assistant Induction. The Induction programme provides virtual sessions, E-learning activities, and face-to-face training for In Hospital Life Support.

The Regional Qualifications framework (RQF) enables Nursing assistants and Senior Nursing Assistants to complete accredited vocational qualifications (Level 2 and Level 3 Certificate in Healthcare support) and develop their clinical competencies.

The course ensures nursing assistants, who engage most frequently with patients and service users, possess the essential skills necessary to deliver safe, high-quality, effective, and compassionate care. This includes Level 3 qualifications in the perioperative environment, allowing Nursing Assistants in that team to undertake a scrub role in theatres once the RQF qualification is achieved.

Leadership Programmes

Leadership Development programmes continue to be a focus for the HR People and Organisational Development team in order to both prepare and then fully equip staff to apply for promotional posts and meet their line management responsibilities. The Aspiring Manager (309) , Managing with Care (106), Nursing Leadership Development (533) and Succession Planning(22) programmes allowed 970 staff to enhance their leadership skills, meet key competencies, understand leadership behaviours necessary to foster high performing teams and apply best practise models to their everyday role.

These programmes adopt flexible and diverse learning approaches, including peer-to-peer learning, self-directed resources, bite-size webinars, tailored action learning sets with a focus on business need

and practical toolkits. 84% of staff who completed a leadership intervention agreed it was useful to their current management role.

Our leadership courses cultivate a robust pool of talented individuals prepared for future senior positions, demonstrating the Trust's commitment to providing staff with clear career progression pathways and establishing itself as an employer of choice.

Quotes from participants:

"It's given me heaps of extra knowledge."

"It has allowed me to improve my skills and personal development to potentially allow me to go to a Band 4 in the future."

"I learnt a lot of valuable information that has helped me with my practice."

Supervision, Coaching and Mentoring

Belfast Health and Social Care Trust in line with the Collective Leadership Strategy and our People and Culture priorities has been aiming to develop a "coaching" culture across the organisation. The Institute of Coaching identifies 5 key benefits of coaching;

- Empowering individuals and encouraging them to take responsibility
- Increased employee and staff engagement
- Improved individual performance
- Help to identify and develop high potential employees
- Helping the organisation increase its productivity and achieve its goals

The Trust has invested significantly in coaching in 23/24, through training 33 new coaches and refreshing the skills and confidence of existing trained coaches. This focus on developing the coaching skills of individuals to achieve, maintain and exceed competences outlined by the prominent coaching federations allows our Belfast Trust coaches to support staff of all professions across the organisation.

Staff achievements - Recognition Certificates

As part of the Staff Experience Survey, staff are given the opportunity to anonymously recognise a colleague. The May 2023 survey resulted in **3,177 certificates** being awarded, and in March 2024 a further **3,724** certificates were awarded.

Recognition events with the Chairman and Chief Executive followed with almost 400 staff attending in December 2023. Plans are underway to host further recognition events in autumn of 2024 for those nominated in the March 2024 survey. Feedback from these events was extremely positive as is detailed below:

- *"Everything that was said is what I strive to do and it was really heartfelt to see in writing and much needed at that time"*
- *"In a large organisation it is these type of things that really makes you feel counted"*
- *"I appreciate the time taken to put this event on as much as the certificate itself."*
- *"I work in a very stressful environment and for staff to take time out to nominate me was very humbling- Fantastic session and very heart warming."*

Image of staff receiving their recognition certificates.

Revalidation of Nursing Staff

The Nursing and Midwifery Council (NMC) introduced a model of Revalidation for all nurses and midwives from December 2015 by order of the Privy Council. Taking effect from April 2016,

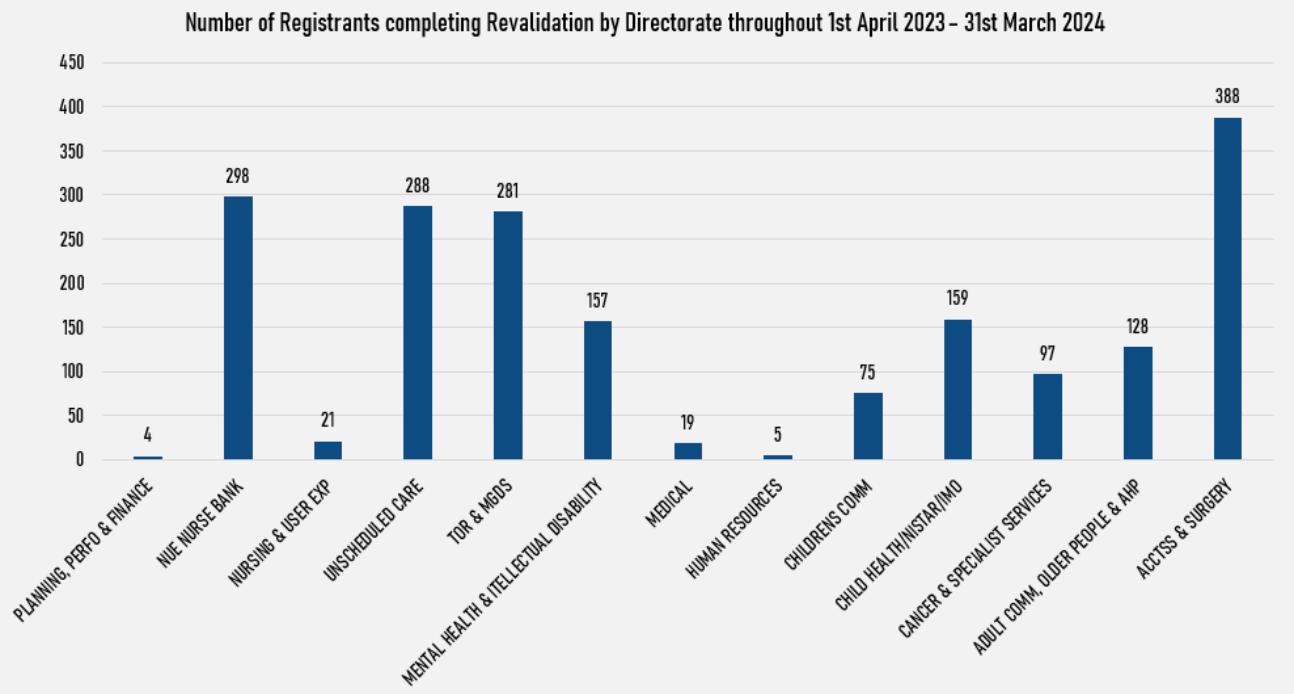
The purpose of Nursing Revalidation is to improve public protection by ensuring nurses and midwives continue to remain fit to practice throughout their career. The process requires all Nurses and Midwifes to demonstrate every three years a continued ability to practise safely and effectively to remain on the NMC register.

Revalidation will require registrants to demonstrate how they meet the standards of the updated NMC Code “Professional Standards of practice and behaviour for nurses, midwives and nursing associates” (NMC 2018).

Central to the Revalidation process is the NMC Code (2018) reinforcing that all registrants reference the Code to underpin all the Revalidation requirements including their written reflective accounts and reflective discussion.

Results

Throughout April 2023 - March 2024, 1917 Registrants across the BHSCT Directorate's successfully completed Revalidation as outlined in the table below.



Number of Registrants completing Revalidation by Directorate throughout 1st April 2023 – 31st March 2024

Staff Absenteeism (Sickness and Vacancy Rates)

The Trust is committed to providing an effective and high-quality service to patients and service users and recognises its duty to support our staff delivering that service by providing a working environment that is conducive to good health and well-being.

The Trust works to ensure that attendance is managed consistently, effectively and with compassion in line with HSC Values, the Trust Attendance Management Protocol, best practice and employment legislation.

From 1 April 2023 to 31 March 2024 the Trust sickness absence rate was 9.38% (hours lost). This figures includes ongoing long-term COVID-19 related absences.

During this period, the predominant reason for absence was mental health related, accounting for 32.02% hours lost of sick absence. Following this, the next 4 top reasons for sickness absence in this period were;

Musculoskeletal = 14.17% hours lost
Influenza = 7.96% hours lost
Asthma, Chest, Respiratory = 4.64% hours lost

There are many reasons why someone may experience a decline / deterioration in their physical, mental, or emotional health and so the Trust is also committed to providing a range of health & wellbeing initiatives, resources, and services to support all staff to be well at work, and when a period of absence has been required, to return to work as soon as feasible.

The Trust is continuing to work in partnership with staff, managers, Occupational Health and Trade Union colleagues to support those staff who have had time off as a result of ill health. The Trust continues its commitment to supporting employees to manage their mental, emotional and physical well-being through a wide range of initiatives such as:

- Staff Care, Belfast Recovery College, Lifeline, Clinical Psychology Services, Condition Management Programme, Stress Focus Groups, Here 4U, the Mind Ur Mind Toolkit, Menopause Toolkit, Long Covid Clinic, Bereavement Counselling, Chaplaincy Services, a range of interactive psychological wellbeing resources and the provision of a range of other support information and literature.

- Practical resources including support re finances, housing and relationships are included in our interactive wellbeing resource for staff.

●The delivery of free physical and mental health support information and advice to staff and the wider public through the bWell app and website and regional PHA Healthier Workplace wellbeing resources.

During the period the Attendance Management Team in HR delivered the following activities:

● Supported **55** staff through the process of ill health retirement.

● Supported **99** staff through the process of ill health terminations.

● Facilitated and supported **26** staff in the completion of the medical redeployment process.

● Delivered Attendance Management training virtually and in person to **174** managers

● Supported managers in relation to the management of attendance through toolkits and bespoke advice.

HR Officers in our Attendance Management Team also attended **10** Case Management Meetings together with Occupational Health Professionals and relevant Line Managers ensuring our staff were treated with compassion as well as appropriate management of their absence in line with our Trust's Attendance Management protocol and our Trust values.

Recruitment and Retention in the Social Work & Social Care Workforce

Key to the delivery of safe and effective services is a sufficient and sustainable social work and social care workforce. Similar to other professional groups within Health and Social Care there is a shortage in supply of qualified social workers in NI.

The Covid-19 pandemic created unprecedented challenges in the delivery of social care services across the region and it has become increasingly challenging to attract people into social care roles.

A survey and focus groups have been undertaken with social care staff to help inform the Trust strategy to become the employer of choice for social work and social care to enable a sustainable workforce for now and for the future.

Current work force planning and retention activity focuses on the following priorities:

Social Work Recruitment and Retention Strategic Group

- Organisation and Workforce Capacity:
- Enhancing Leadership
- Being Just and Open Culture
- Staff Experience and Wellbeing

Social Care Workforce Steering Group

- Leadership management
- Learning and career development
- Healthy Teams

Key achievements

- The cessation of using Recruitment Agencies in June 2023 which was in line with the DOH Ministerial directive.
- Establishing a bank of social work staff has brought some new supply to some services
- Reduction in staff turnover in some service areas.
- Introduction of skills mix to support social workers in some services reducing waiting times.

Challenges in filling all vacancies persist and will require regional collaboration with key partners and will be aligned to the recommendations of the DOH Workforce review recommendations. The Trust continue collaboration with the DOH on workforce plans for safe staffing and are represented on the DOH Social Workforce Implementation Board chaired by the Chief Social Work Officer.

Enhancing Approved Social Work Provision in the Belfast Trust Approved Social Work Daytime Service

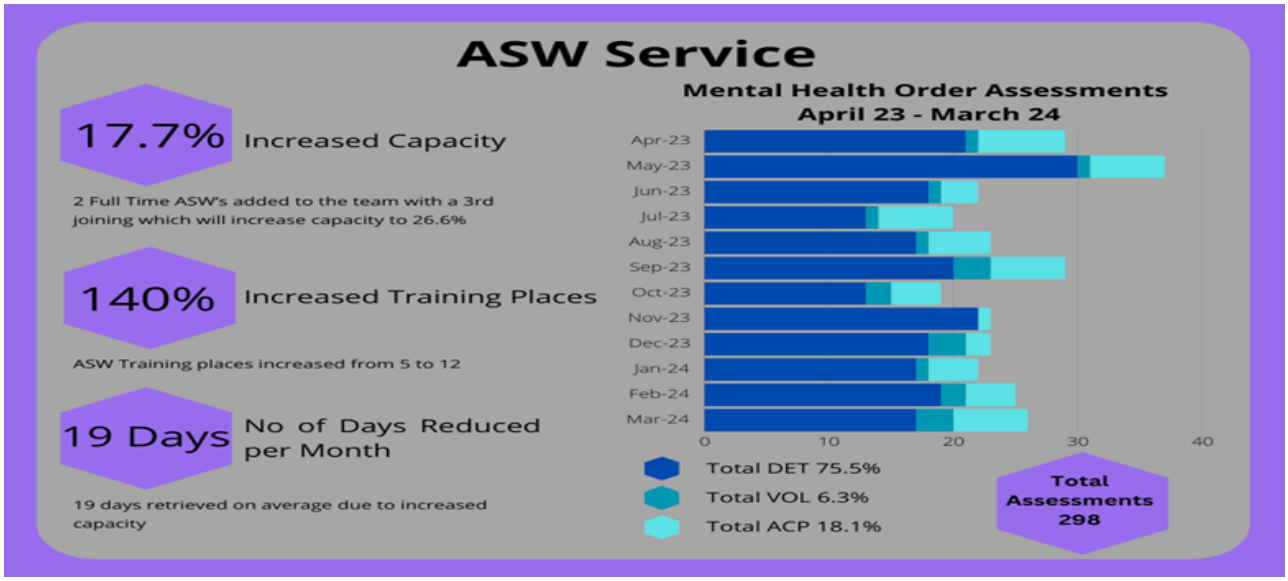
Approved Social Workers (ASWs) play a crucial role under the Mental Health (Northern Ireland) Order 1986. They are specially trained and authorised social workers who have the legal authority to make decisions about the compulsory admission and treatment of individuals with mental health issues. ASWs are responsible for assessing whether a person meets the criteria for involuntary admission to a hospital or treatment facility based on their mental health condition and the risk they may pose to themselves or others.

Understanding Approved Social Work under the Mental Health (Northern Ireland) Order 1986

ASWs carry out comprehensive mental health assessments to determine the need for compulsory measures. This process involves:

Recognising the critical need for timely and effective mental health assessments, we have significantly increased our provision of ASWs in the Belfast Trust Approved Social Work Daytime Service. We have hired full-time Approved Social Workers and this strategic hiring initiative has led to a remarkable **17.7% increase in ASW provision**, ensuring more robust coverage and reduced waiting times for assessments.

We have also increased our intake for the Approved Social Work Programme. Previously, we could accommodate 5 trainees, but we have now expanded this number to 12. This represents a **140% increase in training capacity,** ensuring a steady pipeline of qualified ASWs to support our growing service needs. **19 days per month retrieved** on average due to increased capacity and assessment totalling **298.**



Graphic showing Approved Social Work Provision Service statistics.

Impact of Increased Provision

The increased provision of ASWs is vital for ensuring that necessary assessments under the Mental Health (Northern Ireland) Order 1986 are conducted promptly and efficiently. By hiring more full-time staff and expanding our training program, we are better positioned to handle the demand for mental health assessments, thereby reducing the burden on our existing rota ASWs and ensuring timely access to assessment for patients and carers. This increase in staffing saves 19 days per month that would otherwise be covered by the current team, allowing for a more balanced workload and improved service delivery.

By expanding our ASW team and training program, we not only enhance our capacity to provide essential mental health services but also demonstrate our commitment to supporting the mental health needs of our community. This strategic growth ensures that we can continue to deliver high-quality, timely assessments and interventions, ultimately improving outcomes for those in need of our services.

See also:

Lifeline - Cheers for Peers

Cheers for Peers runs within our Lifeline service where staff can nominate a colleague for displaying behaviours associated with HSC values. This is run every quarter and winners receive a small prize, lifting morale and collegiality within the team.

Staff Wellbeing at times of heightened need and crisis

A Consultant Clinical psychologist was appointed to lead on the development and delivery of a coordinated response to staff wellbeing at times of heightened need and crisis e.g.: staff responding to crisis situations, serious adverse events, public inquiries, court proceedings and internal and external investigations.

This involves working closely with the BWell Health and Wellbeing steering group, and Occupational Health and HR to develop and evaluate interventions aimed at the prevention and self-management of mental health difficulties in staff across the organisation.

Examples of work includes:

- Support and advice in relation to psychological impact and potential needs of staff involved adverse incidents and high profile investigations.
- Introduction of ‘Manager Support Clinics’.
- Introduction of Staff Wellbeing workshops for teams
- Introduction of the Post Event Team Refection model to support teams following critical incidents.
- Development and support of ‘reflective practice’ including Schwartz rounds
- Individual psychological assessment and treatment

Post Team Event Reflection

The Post Team Event Reflection (PETR) psychological debrief model has been developed to recognise the potential impact of critical events at work on staff wellbeing. The model is based on best practice guidelines developed by the Association for Clinical Psychologists that seek to support individuals who work together and have collectively been involved in distressing and/or potentially traumatic events at work. The aim of PETR is to promote and support staff wellbeing, as well as create sense of cohesion, connection, collective efficacy and meaning making following a distressing event.

Supporting Neurodiversity in BHSCT

A Consultant Clinical Psychologist appointed to lead on supporting neurodiversity in work. Neurodiversity is the term used for the diversity of all brains; being neurodivergent means having a brain that works differently from the neurotypical person. Neurodivergence is commonly associated with ASD, ADHD, dyslexia, dyspraxia, dyscalculia, dysgraphia and Tourette's syndrome.

15-20% of the population are neurodivergent which translates to approx. 3,300 staff and 55,000 service users in Belfast Trust.

<u>Screening and Accessible Services</u>

Trust Governance and Assurance Framework: Policy Standards & Guidelines

In terms of policy development, Belfast Trust has developed a range of assurances to ensure that leaders, policy makers and decision makers are aware of our Section 75 and wider equality duties. These assurances include:

- Policies considered and approved by Belfast Trust Policy Committee and Policy and External Guidance Assurance Committee (formally known as the Standards and Guidelines Committee) provided they have been subject to an equality screening.

- All equality screening templates require a tripartite signature by the policy lead, an equality manager and an employment equality manager as appropriate.
- All of our completed and approved equality screenings are uploaded quarterly and are available on the Trust website.
- Our Policy template and ‘How to Write’ a policy guidance are all available on the staff intranet ‘The LOOP’ contains explicit reference to the need for an equality screening.

There were **75 equality screenings including 1 EQIA** were undertaken in this reporting period. Details of each screening is available on the Trust website in the quarterly outcome report as noted below:

- Outcome Report April - June 2023.docx
- Outcome Report July - Sept 2023.docx
- Outcome Report Oct - Dec 2023.docx
- Outcome Report Jan - Mar 2024.docx

Online Accessible and Inclusive Communication Toolkit for Staff Launched

Personal and Public Involvement (PPI) - Explaining Key Work

Belfast Trust also took part in the **PRIDE** parade and had a stand in the Pride village. For anyone who has not previously attended, the day has

a real carnival atmosphere with people from every age, different cultural backgrounds, different religious backgrounds and different genders and sexual orientations.

Belfast Trust were delighted to organise various initiatives throughout the week. The theme this year was **Love Your Mind.** As an inclusive employer and service provider, it is important that the Trust observes and celebrates diverse events for our staff and the people we serve.

Stride for Pride

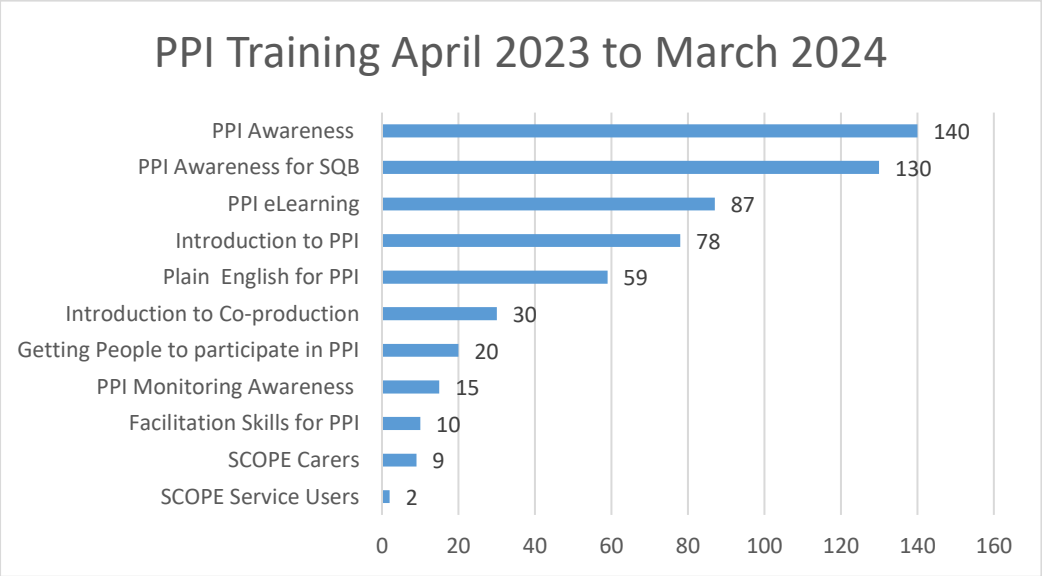
In the spirit of promoting both physical and mental health and wellbeing, two lunchtime walks for staff were organised on a number of Trust sites.

The Trust also shared a recording of QUIRE on the intranet as some of our talented staff are choir members. Quire are a choir with its roots firmly set in the LGBT community, and their mission is to excite, empower, educate, encourage, entertain and enrich the wider community through the celebration of music making, diversity and friendship. It was great news to learn that they have just been awarded Belfast Pride Entertainer of 2024.

Click here to watch the video of Quire

Involvement and Partnership training

The Involvement and Partnership Team deliver a range of training to support the development of staff knowledge and skills to undertake PPI. The SCOPE training is also delivered to service users and carers who would like to get involved with the Trust and this provides an induction to the Trust and the programme of work which they may get involved in. During 2023/24, 493 people participated in PPI training which included members of staff and service users and carers.



Graph showing PPI Training April 2023 to March 2024.

PPI Training is always very positively evaluated and comments received include:

- *Great session and I look forward to completing more PPI modules*
- *Engaging and motivating training session. Good quality content*
- *Great session, coming away more informed. Excellent resources*
- *Well done to the PPI team - a very informative, beneficial session*
- *Really great informative session. I am going to recommend it to all other service users.*

There is continued commitment to ensuring that involvement of service users and carers is central to all Quality Improvement work and the Team deliver training and support clinics as part of the Safety Quality Belfast training programme.

Information regarding PPI is shared across the Trust via the dedicated LOOP section on the Trust internet platform. This provides access to PPI training and resources including a range of tools. The Trust external website, 'Involving You' section was up-dated to ensure a range of information is available to service users, carers and the public who wish to get involved. A total of four newsletters were developed by the team to showcase the range of involvement work being undertaken:

Involvement and you – 2 editions

Learning Disability – 1 edition

Reader Panel – 1 edition

Our 'Every Customer Counts' Campaign extends

Belfast Trust is a signatory of the NI Equality Commission's 'Every Customer Counts' campaign. Using this framework, the Trust has undertaken a number of projects aimed at improving the accessibility of services, buildings and facilities for anyone who is disabled whether a visitor, carer, patient or service user.

Initially, working to improve access at the **Eye Outpatient Diagnostic Unit** (EODU) in the RVH, the **Regional Fertility Clinic** came on board and use the framework to consider the accessibility of its communication and the issue of consent**.** Going forward it is hoped that the campaign will bring about small changes to the **Bridgewater suite (cancer centre),** the **GUM clinic** and our **Complaints Service.**

One of the greatest achievement of this campaign is the creation of the Sighted Guide Service at the RVH and a video for service users showing

how to get to EODU. Read the feedback from service users about the video:

Quotes below to go into two speech bubbles

*“*Great idea. I came across an excellent and really helpful video on-line showing how to get from the RVH main entrance up to the EODU reception.”

“It is a good distance and requires using 2 different elevators (if you are able to, stairs are available) and of course long corridors with lots of signposts to the various departments. So… having this video will help get you to the correct area quickly and allows you to proceed straight to the reception without having to keep checking all the various signs etc. along those long corridors.”

Introducing literacy support software Read & Write for Staff:

Belfast Trust is committed to fully supporting all staff to be the best they can be, whatever their abilities or challenges, roles or responsibilities. We recognise that effective communication - between colleagues, clients, customers and stakeholders - is the lifeblood of this organisation, and written communication lies at the heart of this.

For this reason, this year, we have invested in the literacy support software, Read & Write across the Trust to support staff with literacy differences such as dyslexia, print challenges, and visual impairments for those who need English language assistance.

It is important to us that all staff feel valued at work and are fully supported to carry out their jobs to the best of their abilities. That’s why we have made Read & Write available to anyone who wants extra support with everyday tasks like writing emails and documents, or reading online material.

Even if you aren’t affected by dyslexia or print challenges, Read & Write can help us all to work smarter, reduce inaccuracies and improve outputs. As such, it is available for everyone to use, on every PC, laptop and tablet across the organisation.

Open this Page Tiger Resource:

Read & Write Support for Trust Staff: Toolkit & Guidance to find out what the software can do, How to access it and Help to use it.

3. MEASURING THE IMPROVEMENT

Reducing Healthcare Associated Infections (HCAIs)

Reducing harm from Healthcare Associated Infections (HCAI) remains a key priority for the Belfast Health and Social Care Trust (BHSCT). Strategies used to reduce HCAI include ongoing Risk Assessment in relation to patient placement, Hand Hygiene (HH), appropriate use of Personal Protective Equipment (PPE), Aseptic Non-Touch Technique (ANTT), Antimicrobial Stewardship, environmental cleanliness and effective decontamination of equipment. Wards and departments, with oversight from the Health Care Associated Infection and Antimicrobial

Stewardship Improvement Team, have continued to drive improvement and influence change in relation to these strategies.

Measuring the Improvement

Within the HSC Service Delivery Plan 2023/24, the Public Health Agency set a Target Trajectory for maximum episodes of *Clostridium difficile* infections (CDI) and MRSA bacteraemia for the BHSCT. Given the challenges associated with reducing Gram-Negative Bacteraemia (GNB) infections to date, no maximum target was suggested for 2023/24, but rather each Trust were encouraged to minimise risk factors for GNB infections where possible.

The 2023/24 maximum target for CDIs was 107 with an outturn of 137. For MRSA bacteraemia the target was 10 and the outturn 21, these are based on 22/23 targets as none were set for 23/24.

Below is the BHSCT's five-year datasets for CDI and MRSA bacteraemia.

Clostridium difficile

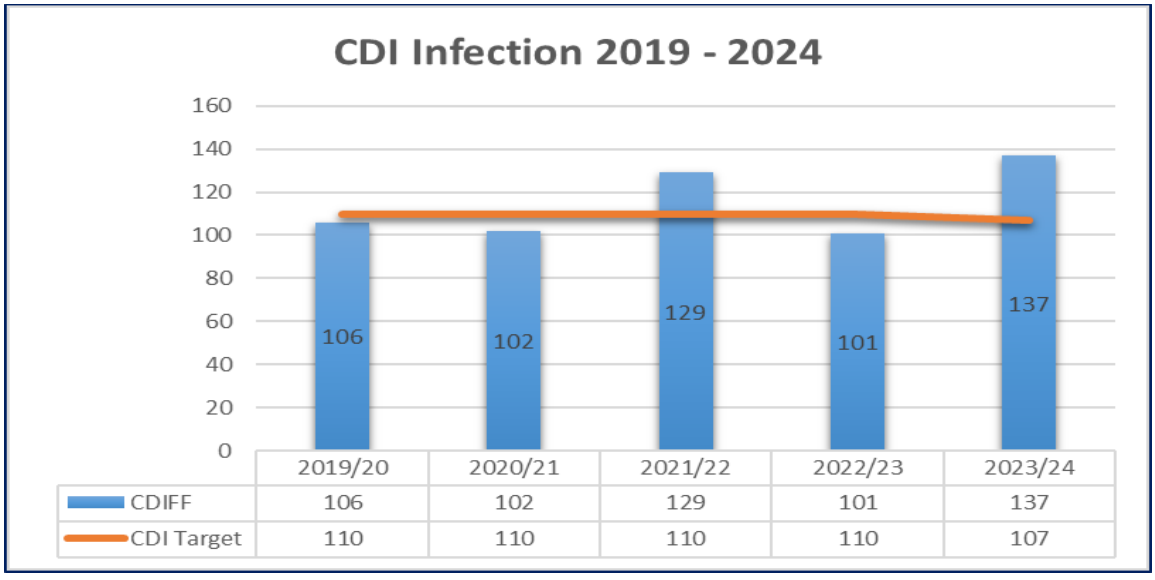


Chart showing Total Number of *Clostridium difficile* Infections. Target = 107, Result = 137 (01.03.2019 – 31.03.2024).

Post Infection Review Learning: *C.difficile* infection recorded on Part I of the death certificate

MRSA Bacteraemia

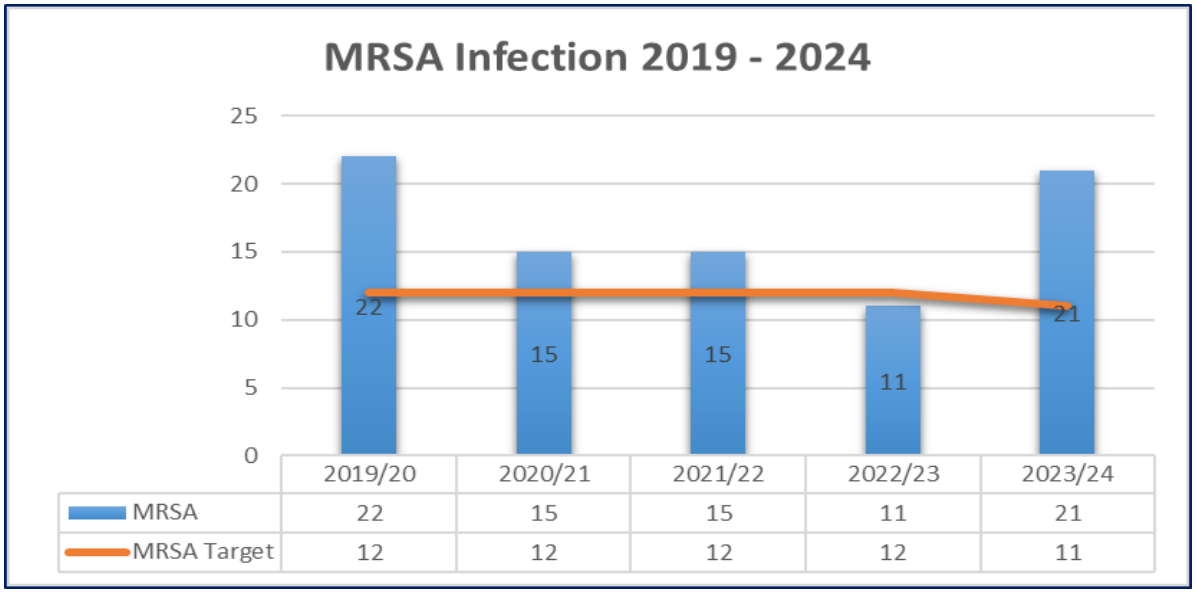


Chart showing Total Number of MRSA bacteraemia episodes. Target = 11, Results = 21 (01.03.2019 – 31.03.2024).

Post Infection Review Learning: MRSA bacteraemia

Investigation of the MRSA bacteraemia cases with the information available to the BHSCT identified the majority of cases were identified less than 48 hours after admission to the acute hospitals. The majority of cases have ongoing healthcare provided in the community due to long-term invasive devices.

Gram-Negative bacteraemia

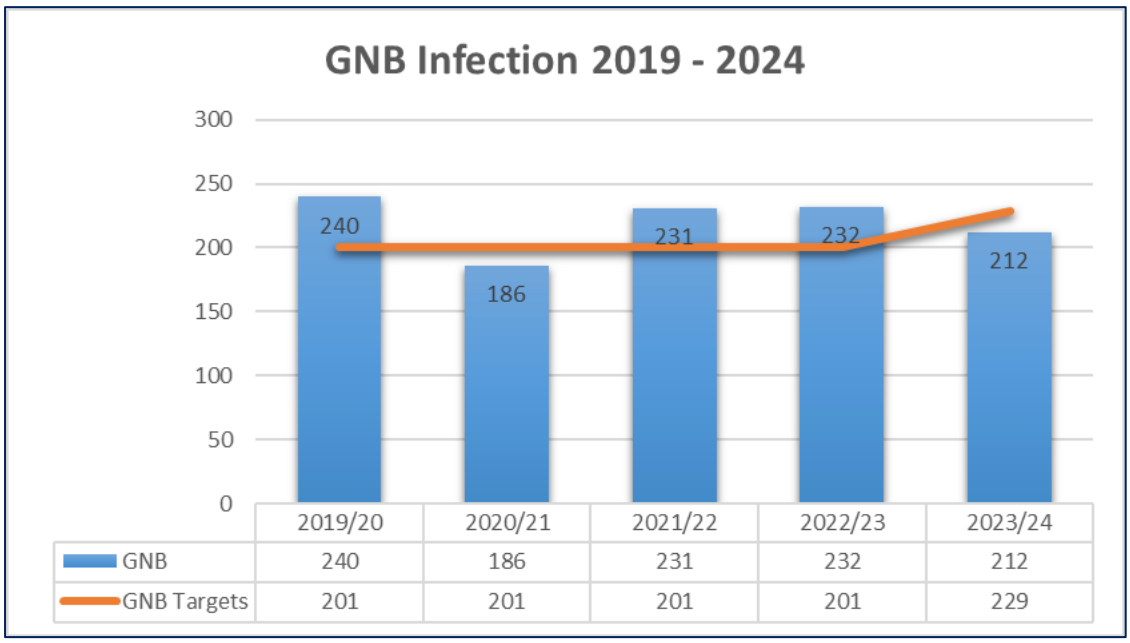
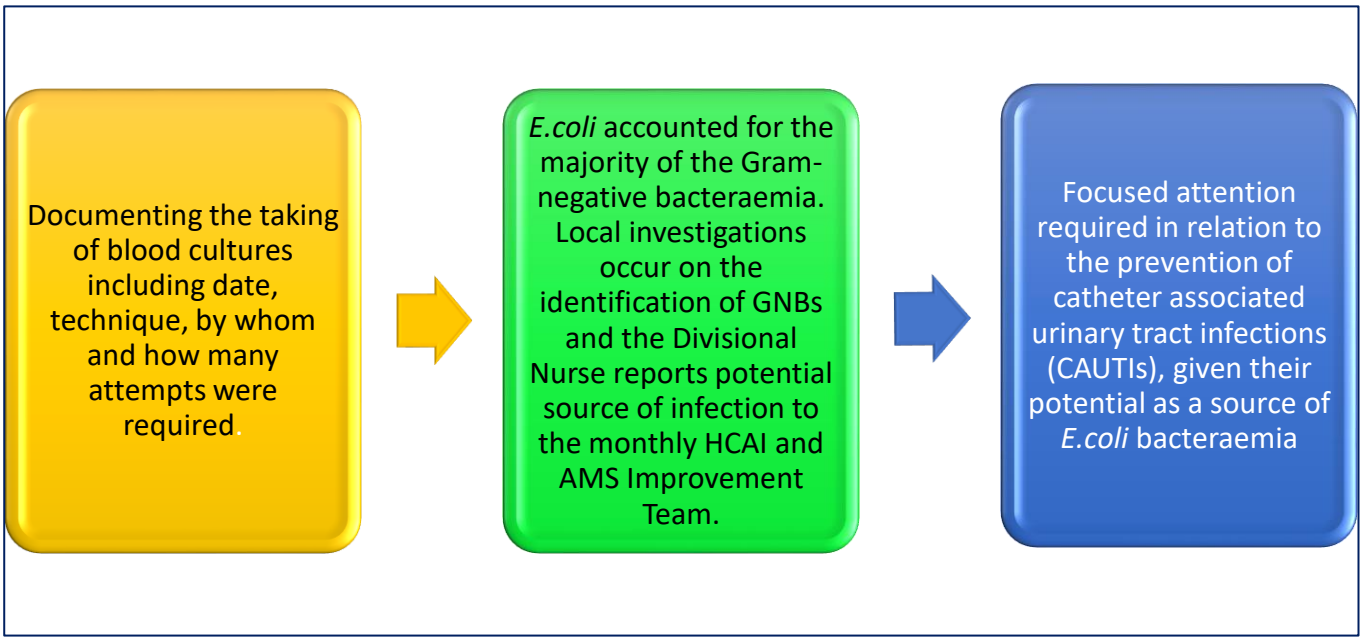


Chart showing Total Number of Gram-Negative bacteraemia episodes. Target = 229, Result = 212 (01.03.2019 – 31.03.2024)

Learning: Gram-Negative Bacteraemia



Post Infection Review learning

Post-COVID-19 there has been a significant increase in C.difficile infection rates both regionally and nationally, potentially the contributory factor is increased use of antimicrobials in both primary and secondary care. The patients presenting to BHSCT ED are often sicker than those that historically presented. In addition, this increased presentation to EDs frequently equates to inpatient wards running at over-capacity with longer patient stays, which in turn has a direct and commensurate increase in antibiotic use. Furthermore, although use of both

carbapenems and piperacillin-tazobactam has also increased this is also a direct consequence of increased occupancy of both ICU and haematology/oncology beds, which, due to the nature of their patient profiles, use these agents by necessity. There is regular microbiology input, in both ICU and haematology/oncology, areas have significant input from the Antimicrobial Stewardship pharmacy team and audit findings indicate antibiotic prescribing is appropriate.

COVID-19

In 2023/24, the IPC Team managed 157 COVID-19 outbreaks and supported 28 independent care homes in COVID-19 outbreak. The continued change of National and Regional guidance meant the management of the COVID-19 pandemic continued to evolve for the IPC Team and the Trust during 2023/2024. Whilst the need to ensure robust IPC practices remained a focus for the BHSCT, 2023/2024 saw a continued move towards ensuring re-mobilisation of services, as there was further relaxation of the COVID-19 restrictions. The IPC Team continued to be central to the Trust response and needed to deploy considerable resources into the following areas:

- Provision of specialist advice to adapt/ interpret guidance to their local settings and patient population
- Updating a range of resources in line with guidance, which included presentations on the general management of COVID-19, contact tracing and the donning/doffing procedures of PPE.
- Ongoing availability of the IPC team for specific queries/ management of individual cases.
- Support and advice in relation to the management of COVID-19 outbreaks.
- Participation in Trust safety and governance groups and the Nosocomial Assurance group for COVID-19 to review COVID-19 deaths.
- Participation in SAIs to identify and share learning.
- Participation in the COVID-19 Public Inquiry.
- Participation in the jointly commissioned review by the Chief Nursing Officer (Department of Health) and Director of Nursing, Midwifery and Allied Health Professionals (Public Health Agency) of the current IPC nursing position across the six Health and Social Care

Trust's in Northern Ireland, which included identifying key learning from the COVID-19 pandemic including pandemic preparedness.

Key learning themes identified in relation to COVID-19

- Early action/response is vital to ensure adequate preparedness and effective management.
- Collaborative team working is essential, both locally within the BHSCT and at a regional level.
- Effective communication is key to effect change, empower staff and can reduce anxiety.
- Ongoing need for daily review of patient placement to ensure effective use of single room facilities.
- Ongoing need to ensure general IPC principles embedded in practice to reduce the risk of transmission of infection.

Next Steps

During 2023/24 COVID-19 cases continued to present additional challenges to healthcare requiring reconfiguration of services/ service delivery and additional support from the IPC Team internally and regionally. Directed by the DoH, the IPCN Team have continued to support independent care homes experiencing outbreaks of COVID-19 in addition to their responsibilities to the BHSCT. As a relatively small team, this was particularly challenging; during 2023/24, in addition to COVID-19 outbreaks, the IPC Team managed numerous complex incidents and outbreaks, some of which continued over a prolonged period and placed significant strain on IPC Team capacity. To meet these demands, the IPC Team prioritised their resource, remaining responsive, innovative, supportive and adaptable.

Rebuilding and developing the IPC Team is a primary focus for 2024/25 in order to increase our ability to restart proactive work within the BHSCT. A planned independent review of the IPC Team will take place in 2024/25 and the IPC Team will prioritise the re-establishment of the IPC Audit Plan.

Hand Hygiene

Hand Hygiene is a key Infection Prevention and Control (IPC) measure to protect patients, visitors and staff and to reduce HCAIs. All staff, regardless of banding, profession or working must adhere to the Trust Hand Hygiene Policy. Audits are crucial to monitor compliance. Regular peer audits of each ward and department are undertaken by Service areas with the *minimum* compliance score set at ≥80%. The audit process is supported by a formal escalation process, which is outlined within the hand hygiene policy.

Proactive auditing by the IPC Team is another area that remains paused. Throughout 2023/24, audits were reactive, in response to outbreaks and increased incidents. There were 61 Hand Hygiene (HH) audits undertaken across the BHSCT during 2023/24 with an overall average score of 88%.

Below shows the quarterly percentage compliance from Hand Hygiene audits completed by the Infection Prevention Control Team from March 2021 to March 2024. Average scores ranged from 87% to 98%.

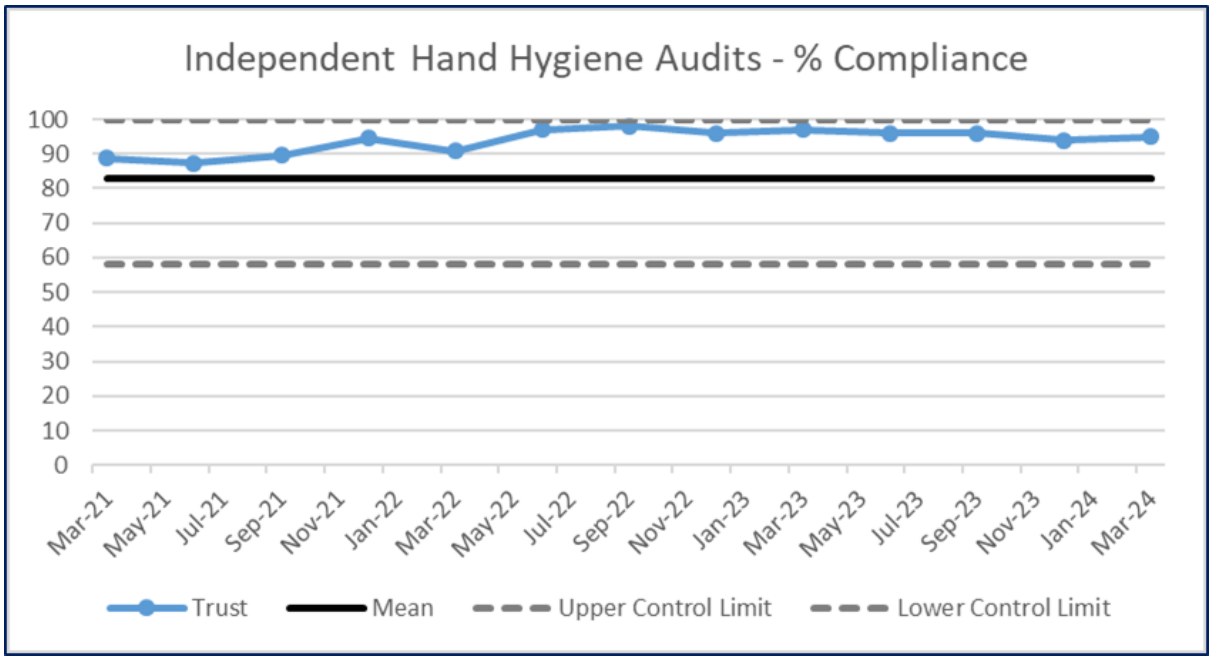


Chart showing Independent Hand Hygiene Audit Compliance (31.03.2021 – 31.03.2024).

The IPC Team continue to support areas obtaining non-compliant audit results through education (on both Hand Hygiene and peer auditor training) for all members of the multi-disciplinary team, consideration of practical solutions (such as location of hand sanitiser dispensers) and monitoring of practice until compliant scores are obtained.

Safer Surgery

WHO Checklist

The WHO Surgical safety checklist has been in place across all theatre departments within the Belfast Trust since 2010. It is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying and checking essential care interventions.

The checklist ensures that each surgical team has taken all the right steps before and after surgery to ensure patient safety for example by making the surgical team aware of any patient allergies; minimising the risk of surgery on the wrong site or the wrong patient or minimising the risk of the wrong procedure being performed.

Compliance with the checklist is measured through monthly audits which are reported on at Specialty, Divisional and Trust level.

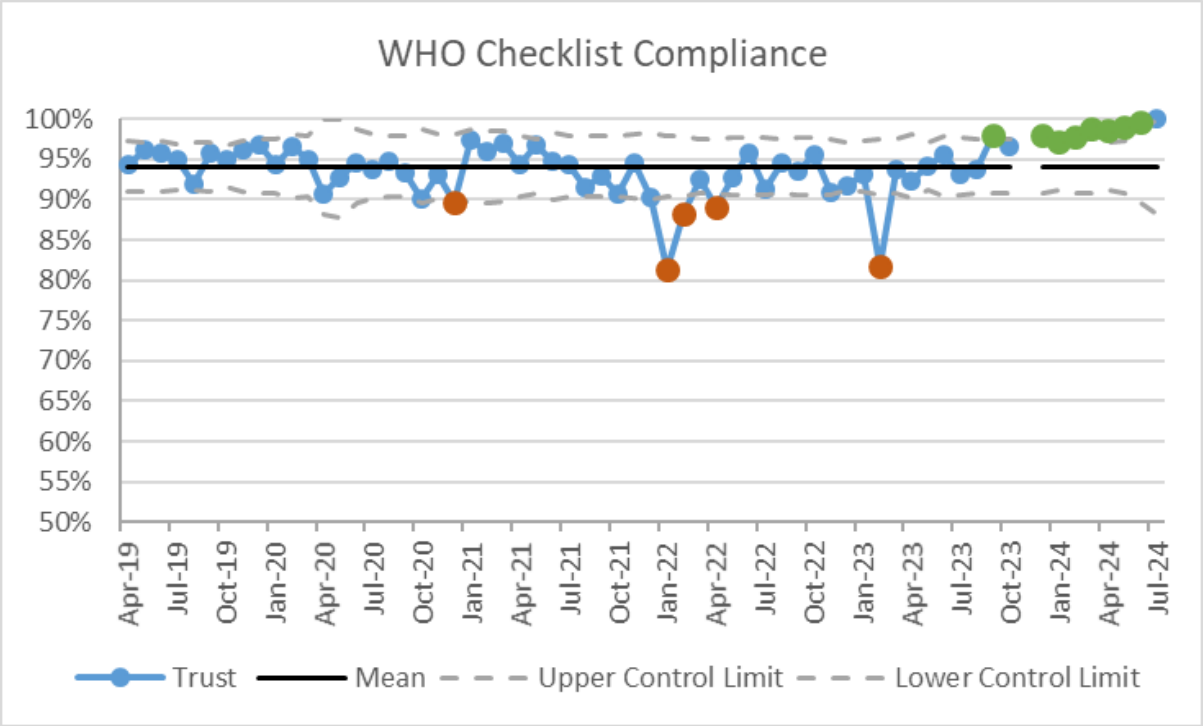


Chart showing WHO Checklist Compliance (Mean = 94%).

Falls Data

In 2023/24, there was 2,304 falls recorded within the acute adult inpatient area, an average of 192 falls per month. This is a 0.78% decrease in comparison to the previous year.

There was 80 injurious falls recorded, five of which, were catastrophic. This is an increase of 9.6% in serious falls in comparison to the previous year. A Minimum Data Set for post fall Incident review was completed for all injurious falls and the learning from each shared locally and regionally.

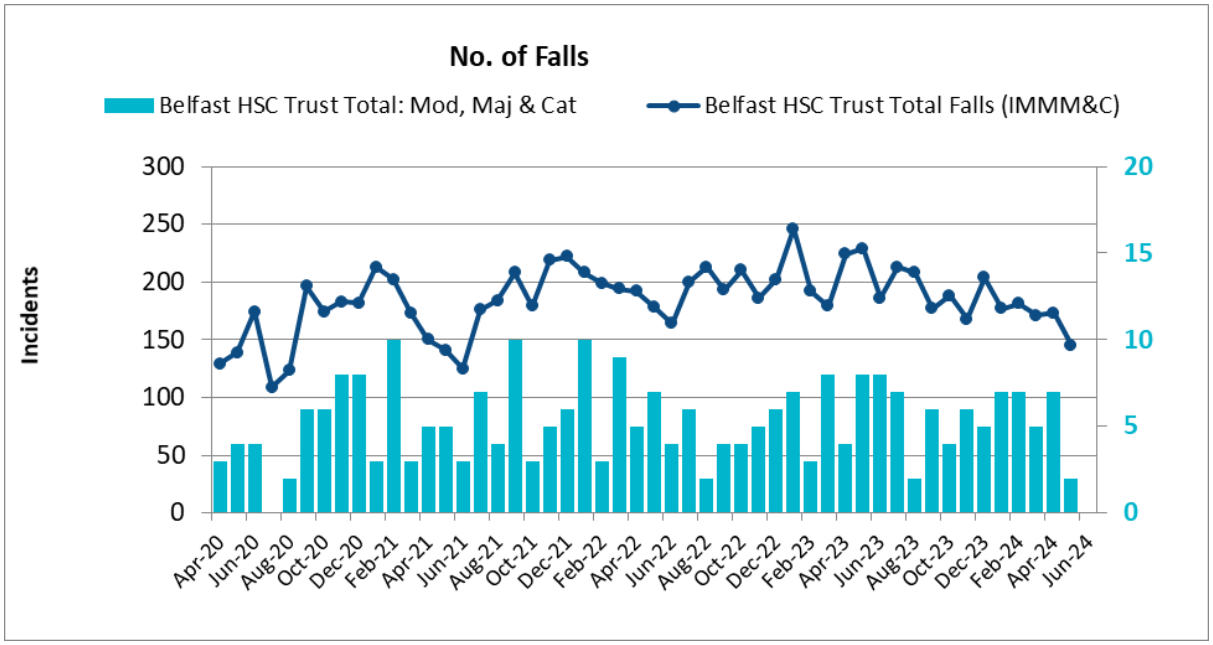


Chart showing Number of Falls Data. Average Number of Falls range from 110 to 250 per month from April 2020 to June 2024.

KEY: Mod, Maj and Cat = Moderate, Major and Catastrophic

IMMM & C = Insignificant, Minor, Moderate, Major and Catastrophic

Actions taken to reduce harm from falls within the BHSCT

In 2023, Ward E, MIH completed a falls Quality Improvement Project '#DontFallForE'. Staff have been committed to the scale and spread of this project, which in the past year, has been successfully implemented into Wards A, B, C and D, MIH

Falls assistive technology has also been introduced to these areas and low-rise beds are frequently used. 'Activity trollies' for patients with a diagnosed cognitive impairment/confusion have been introduced and staff have been supported with patient care by the Dementia Lead Nurse.

Falls Prevention

Inpatient falls are a frequent complication of hospital care that results in significant morbidity and mortality, including serious injuries, prolonged hospitalization, and decreased quality of life. A large proportion of our

patients are elderly and are at an increased risk of falling which makes falls prevention within the BHSCT a critical objective to enhance patient safety.
Within the Belfast Trust, our aim is to reduce the patient's risk of falling while in hospital. We do this by identifying those at risk of falling on admission and implement our evidence-based care, by completing a multifactorial fall risk assessment called 'FallSafe'

Key Learning Themes identified from post fall reviews:
· Incomplete fall risk assessment on admission.
· Fall Risk assessments not updated following a change in the patient's condition.
· Delirium Care pathway not being implemented
· Enhance Patient Care assessment tool not being completed
· Patients requiring constant supervision, left unattended
· Patients identified at risk of falling; falls prevention interventions implemented post the patient falling.

Emergency Department and Falls Prevention
"Falls are the number one single reason why older people are taking to the emergency department, and around 30% of people 65 and over will fall at least once a year" NHS England Plan for Recovering Urgent and Emergency Care January 2023

Boarding and overcrowding in our Emergency Departments has impacted on the patient's risk of falling within this environment. The RVH ED created a '2 minute update for falls in ED' this highlights the learning from injurious falls that have occurred within the department.

Fall risk assessments and falls prevention education is a priority for staff. However, the unique environment of ED with the overarching issue unresolved creates huge challenges for staff caring for patients in this environment.

Safe Use of Bed Rails
A National Patient Safety Alert by the MHRA in August 2023 highlighted the increase in deaths and serious injury related to medical beds, bed rails, trolleys, bariatric beds, lateral-turning devices and bed grab handles. The majority of these incidents were due to entrapment or falls.

The BHSCT has experienced fall incidents relating to bed rails, which have resulted in patient harm or death.
The MHRA published guidance on Bed rails: management and safe use on managing and using bed rails safely. This document sets out best practice in the provision, prescription, use, maintenance and fitting of bed rails and has been embedded into the updated version of the BHSCT 'Safe Use of Bed Rail' policy.
A 'Task and Finish group' formed within the Trust, to provide a collaborative response to the actions outlined within the alert.
The Regional Falls Prevention Group are currently developing a bed rail information leaflet; '**About Bedrails:** Information for Adult Service Users, Relatives and Carers' and a 'Regional Safe Use Of Bedrail' policy

FallSafe and Delirium
In September 2023, the Delirium Leads hosted their inaugural NI Regional Delirium Conference; 'Awareness to Action' Guest speakers included the FallSafe Co-ordinator from the Belfast Trust who shared the experience of patient falls related to delirium within the Trust.
Working collaboratively with the delirium leads continues and delirium related falls are referred to the delirium team by the FallSafe Coordinator

FallSafe Audit
The Trust continues to monitor and provide reports on the compliance of FallSafe Bundle A&B, the number of incidents of falls, those that cause moderate, major or catastrophic harm and the rate per 1,000 bed days. A monthly report of the audit is provided to each ward. This enables managers to identify areas of concern and address these by developing actions.

Falls Forum
The purpose of this MDT group is to identify and oversee key priorities to reduce both the number of falls and the harm from falls. It reviews incidents resulting in serious harm to ensure that they are assigned the correct severity grading, for statistical analysis and departmental returns.

The Forum is currently reviewing

- the Safe Use of Bed Rail policy and the Management and Prevention of Adult Inpatient Falls in a Hospital Setting policy

- a business case for the procurement of ‘Flat Lifting Equipment’ for the Royal Victoria Hospital to assist staff, retrieving a patient off the floor, to avoid causing pain and/or further injury.

- Regional Inpatient Falls Prevention Group

Learning from Falls Newsletter
The PHA produce an annual Learning from falls newsletter. It shares information and key learning derived from incidents of inpatient falls across HSC Trusts, which have been identified from post fall reviews, Serious Adverse Incident and Patient Experience, as shared with Care Opinion. The 3rd edition is due September 2024.

Falls Prevention in Hospital, Information for Patients and Visitors leaflet: The Public Health Agency Regional Inpatient Falls Prevention Group, which incorporates multidisciplinary staff from all Trusts and sets direction and informs strategy on falls prevention for adult inpatient wards. The Group provide advice, support and share regional learning as well as lead on the development of regional tools / pathways when deemed appropriate, regarding falls prevention and management across Northern Ireland.

As part of their programme of work, the Group has developed a new regionally agreed ***Falls Prevention in Hospital; Information for Patients and Visitors leaflet***. The purpose of this leaflet is to inform patients and their visitors of the steps they can take to reduce the incidence of falls. This leaflet should be used in tandem with the previously produced **Falls Poster**, which promoted the use of the Call Button by patients, to reduce the incidence of patients inappropriately attempting to mobilise, without the required assistance of hospital staff.

The Regional Falls Co-Ordinators have developed ‘Falls Grading’ definitions in partnership with The Regional In-patient Falls Prevention Group, which have been agreed for use within all HSC inpatient settings. The purpose of these definitions is to provide additional guidance for staff when using the HSC regional risk matrix to grade the severity of harm following a fall. The examples provided are not exhaustive nor should be substituted for clinical decisions and *each case should be dealt with on an individual basis*.

Learn HCSNI

The Clinical Education Centre have developed 4 e-learning Regional Falls Awareness modules:

1. Falls – Universal Module
2. Falls Care Home Setting
3. ***Falls Clinical Setting***
4. Falls Community Setting

The ***Falls Clinical Setting*** e learning augments the FallSafe Awareness sessions provided by the FallSafe Coordinator to the MDT throughout the acute adult inpatient setting.

Community Falls Pharmacist Role

The impact of a community falls pharmacist working as part of the pharmacy Medicines Optimisation in Older People team and along with the community falls MDT team has been assessed. De-prescribing FRID's (fall-risk increasing drugs) is a common strategy to help prevent falls. The anticholinergic burden (ACB) of medicines is the cumulative effect of taking multiple medicines that have anticholinergic effects and an ACB score of 3 or higher may increase risk of cognitive impairment and falls. The falls pharmacist reviews patients via home visits or by phone, identifying and managing FRID's, the patient's ACB and overall the appropriateness of medicines prescribed (via Medicines Appropriateness Index). BP is also measured and a bone health review undertaken with appropriate referral for DEXA scanning using a new direct pharmacist referral system. Some results from research review of the service to 92 patients include:

- ACB burden decreased by 33% following case management by the falls pharmacist
- An average of one FRID was stopped per patient
- MAI improved following case management by 56% and an average of 3.4 interventions per patient were made
- 22% of patients had an identified postural drop in BP with subsequent pharmacist actions including de-prescribing of medicines, referral on to cardiology and in one case to ED (AAA)

- 89 patients had FRAX bone health assessment completed with new pharmacist prescribing of bisphosphonate/vitamin D/calcium and a number of patients direct referral for DEXA scan
- User feedback on the pharmacists role has been positive and GP's have expressed that it is helpful that changes have already been discussed with the patient enabling quick action

Investment in the community falls pharmacist role leads to statistically significant improvement in polypharmacy & appropriateness of prescribing, ACB, clinically significant interventions, identification of osteopenia and osteoporosis and ultimately optimises medicines in older people who have fallen.

*Crawford, P., Plumb, R., Burns, P., Flanagan, S. and Parsons, C. A quantitative study on the impact of a community falls pharmacist role, on medicines optimisation in older people at risk of falls. BMC Geriatr **24**, 604 (2024).*

Pressure Sores / Pressure Ulcers

Pressure ulcers range in severity, from patches of discoloured skin to extensive wounds filled with necrotic tissue and involving fascia, muscle, and bone (CKS 2024). They usually occur over a bony prominence but may also be related to a medical device or other objects. Complications of pressure ulcers include pain, infection, and increased mortality.

They are recognised as one of the top three burdensome harms (Slawomirski et al, 2017), and result in the highest number of healthy life years lost (Hauck et al, 2017). In addition, Guest et al (2017) demonstrated that they detract from scarce NHS resources, resulting in the highest number of bed day losses, and high treatment costs (thought to be in excess of £1.4 million every day) (Guest et al 2017).

Number of Pressure Ulcers Reported

In order to prepare this report all pressure damage (n=2902) reported as a Clinical Incident was interrogated from April 2022 to March 2024**. 877** incidents were excluded from this report as they developed outside the Belfast Trust. This does not mean that the incident was ignored, rather the appropriate care authority was asked to review.

Incidents removed from the Belfast Trust Figures.

Reason	Number
Admitted to the Caseload with Pressure Damage	187
Acquired in Nursing Homes	291
Admitted to Case Load	261
Acquired outside of Belfast Trust	139
Total	877

A further **169 reports** of Cat 1 pressure ulcers were removed from this analysis as non blanch-able redness is not considered a clinical incident.

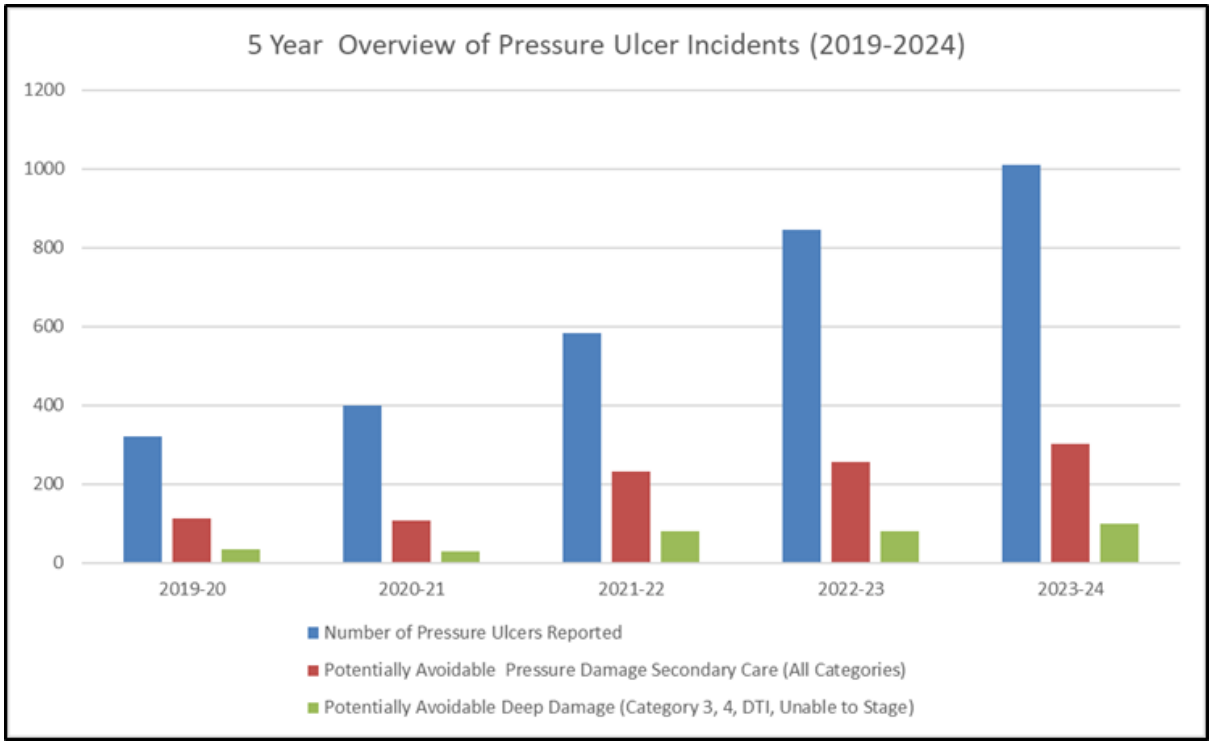


Chart showing a 5 Year Overview of pressure ulcer reports from 2019 to 2024.

From 1/4/23- 31/3/24, 1010 people developed a pressure ulcer whilst cared for by the Belfast Trust (Primary and Secondary Care). This represents an increase of 164 people in comparison to 2022-23. In 68% of cases (682 people), pressure damage was deemed unavoidable. This meant that there was no shortfall in nursing care, rather, the patient was medically unstable and could not be turned, or care was declined/could not be provided as per the patient's expressed wish.

Key Learning: Themes identified from post pressure ulcer Incident reviews:

In order to understand what we need to do better, a thematic analysis of pressure ulcer incidents was undertaken. Figure 4 shows that 80% of avoidable pressure damage related to the following:

1. A gap in the SSKIN Bundle care plan – this means that the care plan was incomplete
2. Pressure Ulcer not investigated – Superficial pressure ulcers are investigated by the Ward/Department Sister/Charge Nurse, or their

deputy. If they do not complete this analysis the incident is deemed avoidable.

3. Repositioning regime inadequate –patient was not moved in accordance with the plan of care (normally 4-6 hourly when in bed, and 2 hourly when up to sit).
4. Caused by equipment which was not repositioned as often as needed
5. SKIN Bundle care plan not instigated
6. Skin check under device not recorded at least once per shift
7. Gaps in record of pressure point check (expected at least once per shift)
8. Therapy cushion needs not assessed – patient up to sit without a pressure relieving cushion.

Collaborations

Regional: The Trust actively participates with the PHA and other HSC Trusts through The Regional Pressure Ulcer Group. Our figures and work in pressure ulcer prevention is shared and discussed in order to determine share best practice and learn from others. This group is currently updating the Regional Pressure Ulcer Prevention Leaflet for Patients and Carers.

The Trust is also working the PHA, the CEC to create and deliver a pressure ulcer prevention package for midwives. This includes the development of a validated risk assessment and SSKIN Bundle Care Plan on Encompass, an eLearning package (available through LearnHSCNI), and on line training through the Clinical Education Centre.

Learn HCSNI – The Trust has worked closely with the Leadership Centre to update eLearning modules on Pressure Ulcer Prevention for Registered Practitioners and Health Care Assistants. We also co-produced a module on PURPOSE-T Pressure Ulcer Risk Assessment Risk Assessment

Queens University – The Trust works with School of Nursing, Queens University Belfast, to deliver a 12 week module on pressure ulcer prevention and management.

National: The Belfast Trust plays an active role in the #4Nations Stop the Pressure Campaign. Last year the theme was 'Every Contact Counts' and Our Emergency Department Nursing Staff produced a video outlining the importance and challenges of pressure ulcer prevention in ED. This can be viewed here:

https://societyoftissueviability.org/community/stop-the-pressure-2024/every-contact-counts-to-stop-the-pressure/every-contact-counts-to-stop-the-pressure-n/

In addition, the Neonatal Intensive Care Unit produced a video which outlined why neonates are at risk of pressure damage. You can view the video here:

https://societyoftissueviability.org/community/stop-the-pressure-2024/every-contact-counts-to-stop-the-pressure/every-contact-counts-to-stop-the-pressure-c/

Sr. Brenda McCann also provided expert advice during a live webinar for the Society of Tissue Viability during Stop the Pressure Week (13th November 2023). This was well received.

This year we are working to make our pressure ulcer message more inclusive and with the help of colleagues from across Northern Ireland and Belfast Trust Learning Disability Nurses, we have created a video for service users who use Makaton. The video will be launched in November 2024.

Next Steps:

Over the next financial year, the Trust will work to address the 8 key areas detailed in the thematic review. They will also work with the areas which had the highest number of pressure ulcers in order to put a strategy in place to reduce harm.

Example of Good Practice

The Tissue Viability Nurse (TVN) Team review pressure ulcer incidents on a daily basis. If the patient has sustained superficial damage, the

TVN will alert the Ward Sister or District Nursing Sister to complete a post pressure ulcer incident review. This is a regionally agreed tool which outlines best practice. By completing this review, the team caring for the patient can compare care delivered against national and international standards of care. This enables them to see what was done and what could be done better. Learning is then shared.

If the TVN notes a significant pressure ulcer they will immediately contact the ward to gather more information, ensure a management plan is in place, and make arrangements to see and assess the person as needed. Following this, they will undertake a review of care alongside the nurse-in-charge patient. This means that care is peer reviewed. If there appears to be an omission in care, the Tissue Viability Nurse will assist the Ward Sister and an Assistant Service Manager to investigate further. The Team also monitor the number of pressure ulcers by department and alert them to emerging patterns and trends.

Venous Thromboembolism (VTE)

The term Venous Thromboembolism (VTE) encompasses both diagnoses of deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE can affect anyone regardless of age, gender, race or ethnicity and is the number one cause of **PREVENTABLE** death in hospital.

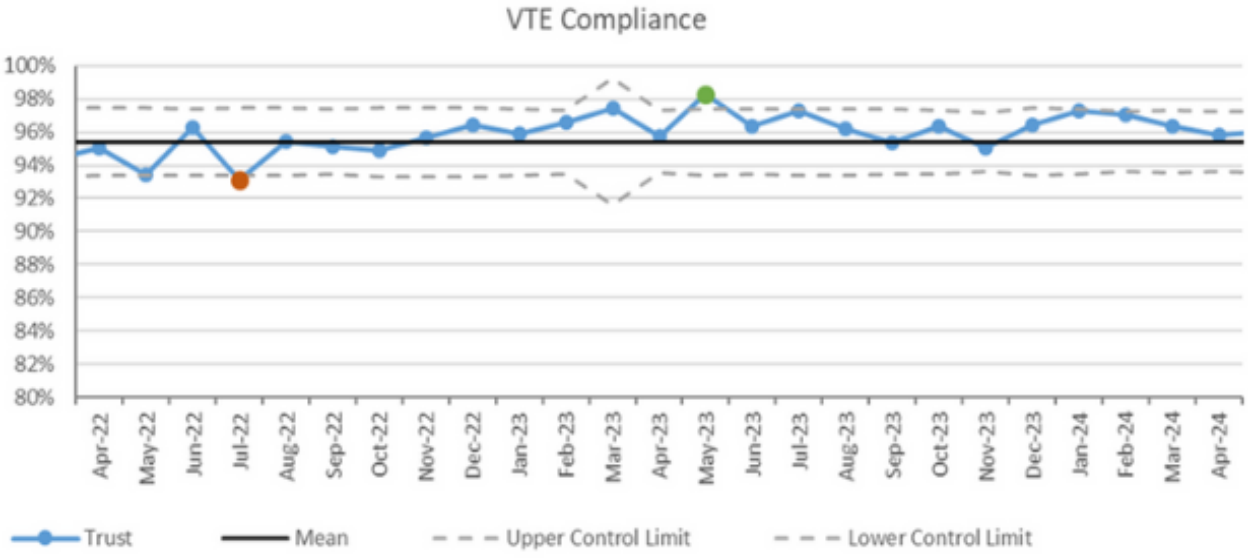
VTE diseases cover a broad spectrum ranging from asymptomatic calf vein thrombosis to symptomatic DVT. They can be **fatal** if they lead to PE, where blood supply to the lungs is occluded by thrombus. Non-fatal VTE can cause serious long-term conditions such as post-thrombotic syndrome and/or chronic thromboembolic pulmonary hypertension, requiring long-term treatment and review, causing much inconvenience and distress to the patient. Management of these chronic conditions are at huge cost to heath service.

Many researchers have identified VTE as a poorly managed risk, which if managed appropriately could save thousands of lives every year. It is

difficult to predict which patients will develop VTE and therefore it is vitally important to risk assess all hospital inpatients for their risk of VTE in order to determine which patients need additional thromboprophylaxis.

Almost all inpatients are identified as having one risk factor for VTE, with 40% of inpatients having three or more risk factors when the mandatory VTE Risk Assessment is undertaken within 24 hours of admission. Up to 60% of all VTE are associated with having had a hospital admission within a 90-day period, referred to as a Hospital Acquired Thrombosis (HAT).

The BHSCT strives to achieve zero patient harm, and trust wide, staff endeavour to maintain high level of compliance with regard to VTE risk assessment, achieving, maintaining and often exceeding the Trust target.



Graph showing BHSCT VTE Risk Assessment Compliance Jan 2012 to Aug 2024. (Mean = 95.6%)

Future plans;

- Maintaining current high standard compliance rate, through education, audit and working with Epic team

- Establish a robust root cause analysis pathway for hospital acquired thrombosis
- Extend our VTE mission to include Obstetric care.

Medication Management

Medication related episodes accounts for one of the highest reported incidents within the Belfast Trust. Medication errors are defined as an error in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines (MHRA, 2014; BHSCT, 2017).

A medication error can pose a threat to the patient as well as the organisation. The member of staff who made the error can also be affected. Ensuring that medicines are used safely is challenging. The medicines use process is highly complex, with multiple steps involved: from the decision to initiate treatment to ordering, prescribing, dispensing, administration and monitoring.

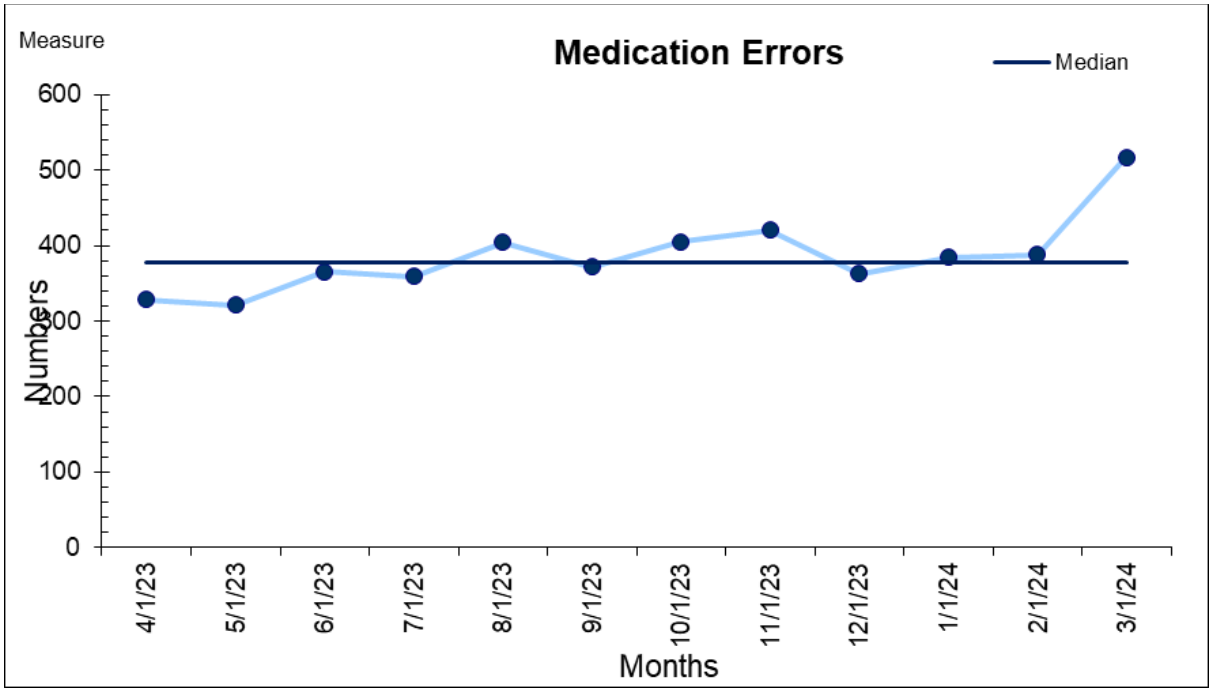
The Department of Health want medication safety to be a priority for everyone receiving and providing care within our health and social care system. Transforming Medication Safety in Northern Ireland (TSMNI) is **a 5 year strategy** in response to the World Health Organisation's Third Global Patient Safety Challenge 'Medication without Harm'. The goal is to reduce severe, avoidable medication-related harm globally by 50% over the next 5 years and to improve safe practices with medicines and support a medication safety culture.

All staff need to be aware of their own responsibilities and that ensuring medication safety is part of their role. These responsibilities also include reporting and learning from incidents where harm has occurred or potential risks are identified, as well as learning from excellence and celebrating when things go right. A culture of medication safety across health and social care is essential to ensuring patient safety.

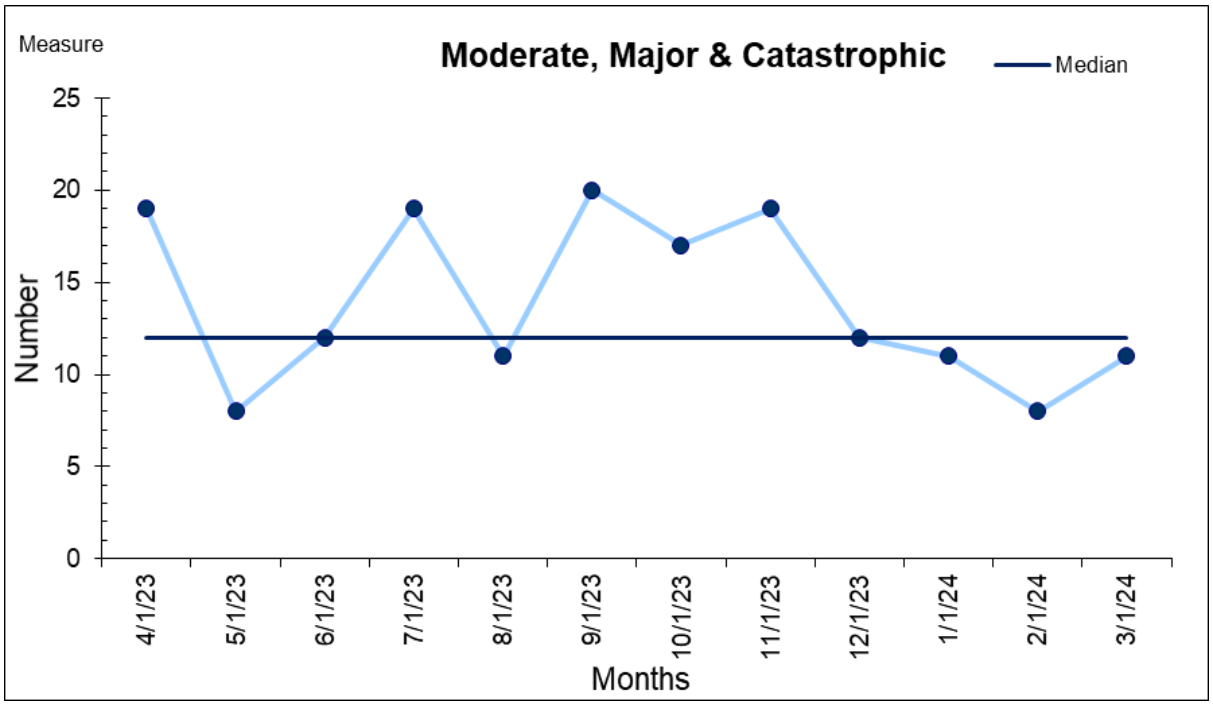
Medication data

In 2023/2024, there was 4626 medication errors recorded with the Belfast Trust with an average of 385 incidents per month. There was 137

incidents categorised as Moderate, Major and Catastrophic with 14 categorised as catastrophic.



Graph showing Medication errors data. (Median = 380)



Graph showing Medication errors data, moderate, major and catastrophic. (Median = 12)

Medication Safety Group

The Trust Medication Safety Group regular meet to discuss these incidents. They have a role in supporting directorates in their provision of first line assurance in relation to the management of medication within the Belfast Trust. They support directorates:

- by reviewing of all reported medication incidents,
- provision of a weekly medication incident report to directorate governance managers highlighting medication incidents reported within their directorate in the previous 7 days which are of particular concern.
- Weekly MDT review of all medication incidents approved in the previous week
- Assurance that medication incidents are being monitored

The Medication Safety team undertake a thematic analysis of medication related incidents reported within each directorate to identify areas of risk within that directorate related to the prescribing, administration or supply of medications and provide a report on these to each directorate in advance of the Medication Risk and Safety Assurance Group (MRSAG)

- Weekly review of medication incidents identified a number of Datix Reports related to omitted doses of critical medications and investigate these to identify shared learning across the Trust
- Medication Omissions and Delays podcast disseminated throughout ‘Safetember 22’ and ‘March to Safety’ to highlight Give on Time Medicines, Reducing Harm from Missed Doses, Critical Medicines, Back to Basics and Most Recent Errors
- A Nursing Medicine Management Framework, this was standardised for Nursing staff across the Trust to manage Medication Errors and Omissions in practice
- This Framework contains Nurses Medicine Framework, Medicines Management Competence Assessment, Guide for Professionals Performing Medicine Management, Medication Adverse Event Investigation Analysis and Reflection and Medicines Omission Error Database
- Quality Improvement project: De-labelling Allergies
- Quality Improvement project: Reducing Omitted Doses and Improvement work
- Next step is to continue to identify themes from Datix incidents and continue to provide shared learning.

Yellow Card Centre

Northern Ireland has historically had the **lowest** Yellow Card Reporting of any UK region. The TSMNI programme included the establishment of a Yellow Card Centre in Northern Ireland to promote Yellow Card reporting and to raise awareness of adverse reactions as a patient safety issue.

Since its launch in September 2023, the Northern Ireland Yellow Card Centre has focused in promoting Yellow Card through virtual and face to face training events and promotional stands.

Yellow Card awareness training has been provided to 354 members of the multi-disciplinary health team across Northern Ireland

Throughout 2023/24 Yellow Card reports from Northern Ireland have shown an upward trend.

Key Learning Themes

Top 10 categories themes reported:

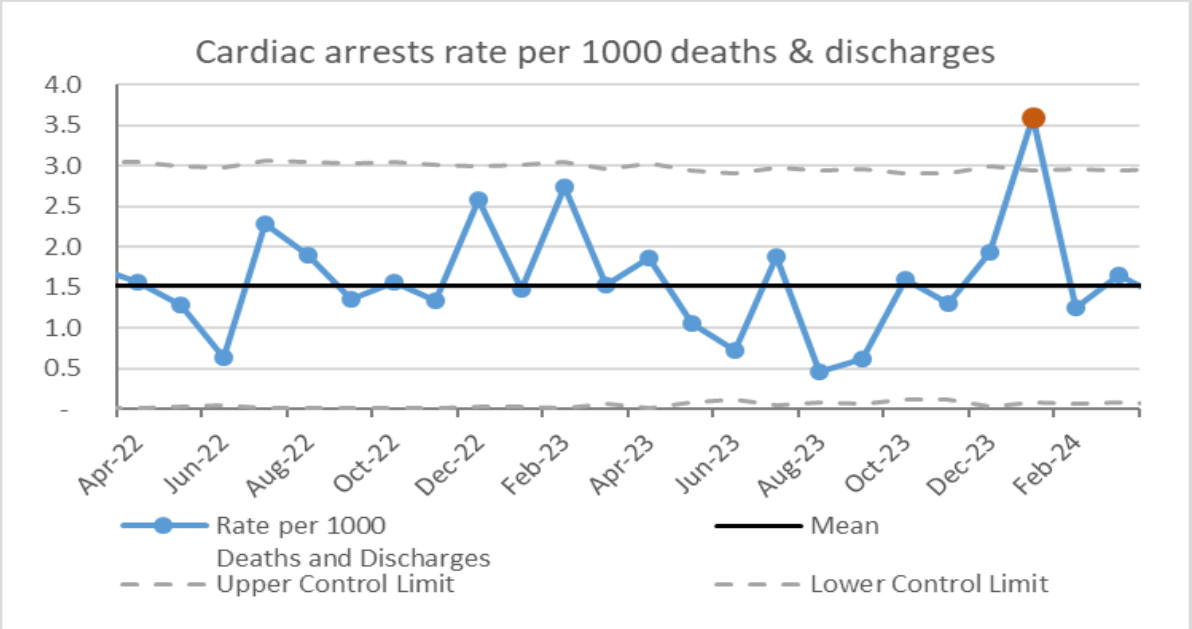
· 1. Wrong dose of a critical medication
· 2. Omission/delay of critical medication
· 3. Identified incident at least of Potential Moderate harm
· 4. Identified as potential medication SAI/SEA
· 5. Medication Storage security
· 6. PSNI involvement reported
· 7. Issue with DKA protocol
· 8. Issue with Perioperative Diabetic Protocol
· 9. Issue with Blister pack at Discharge
· 10. Issue with supply of discharge medication or authority to administer paperwork

Reasons for Increase

• We are seeing more incidents compared to previous years – better reporting system
• More wards have moved and amalgamated within the past 2 years and continue to do so
• Issues with SALTO keys with staff not having access to keys and thus sharing of keys and in some cases doors left open for these staff nurses to access
• Increased number of patients with Dependencies (Alcohol and Drugs) helping themselves and trying to break into trollies and cupboards to gain access to drugs

Cardiac Arrest Rates

This data shows the decrease in cardiac arrest calls between 22/23 & 23/24 of 13%. These are areas within the BHSCT that consistently use 6666 to call for emergency medical assistance. Excludes ED, ICU and CCU as agreed regionally by all trusts in NI as these areas do not always activate the team.



Graph showing Cardiac arrest rates per 1000 deaths and discharges. (Mean = 1.5 per 1000 deaths and discharges).

Improvement Work

Children's Hospital: B-HIVE

The B-HIVE (Belfast Highly Immersive Virtual Environment) is a multi-purpose space located in RBHSC Education suite. It is one of the first immersive learning

Children's Hospital: Garden

Being able to be outdoors and enjoy fresh air no matter what the weather is like is very important. At times we have children who spend time in our care who don't have access to the outdoors for long periods of time. The hospital can be a very boring place, despite our best efforts, and it is really difficult for children and young people to be confined indoors for long periods of time with little to no opportunity to get outside except to the front door of the building.

The garden previously was somewhere that people could look at with a myriad of favourite animal characters on show, but it wasn't as user friendly as we would have liked it to be. Therefore we undertook a project to give it a makeover

Children's Hospital: Programme Treatment Unit (PTU)

The Royal Belfast Hospital for Sick Children (RBHSC) is the only specialist children's hospital within Northern Ireland and it includes the only stand-alone Children's Emergency Department

The implement a Programme Treatment Unit (PTU) with an aim to deliver medical ambulatory care to children and young people attending RBHSC

Personal and Public Involvement (PPI)

Belfast Plan 2024+

Belfast Trust produced a single year plan for 2020/21 to facilitate a DoH commitment to align the corporate planning schedule with Programme for Government.

The Corporate Plan was then extended and amended for a further three years (21/22- 23/24) with the agreement of DoH, focusing on our 6 key priorities. A new way to care for older people, Urgent and emergency care, Time-critical surgery, Outpatient modernisation, Vulnerable groups in our communities and Real-time feedback from patients and staff.

The Belfast Plan 2024+ has been developed to replace the current corporate plan. It has retained key service priorities and expanded these to provide more detail on what we will do.

The Plan reiterates our commitment to being a listening and learning organisation, which seeks to deliver excellence in safety and quality and reaffirms our commitment to our service users, carers and families and to our staff. The Belfast Plan will remain flexible in its timeframe in order to respond to DoH arrangements for the next Programme for Government.

The Plan has been developed following discussions with service users and carers, community and voluntary sector reps, across teams internally and with partners in primary care, the disability committee and trades union colleagues.

Compliance with Equality Legislation

In accordance with the Trust's statutory duties under Section 75 of the Northern Ireland Act 1998, an annual progress report to the Equality Commission for Northern Ireland has been prepared for submission. This report provides assurance to not only the ECNI but also internally to our Trust Board and Executive Team on our legislative compliance.

The Trust takes the opportunity to report on equality screening and equality impact assessment activity and how the difference this has made on practice or policy by considering potential impact on people across the 9 protected Section 75 categories. (Age, Men and Women Generally, Marital Status, Sexual Orientation, Those with and without a Disability, Those with and without Caring Responsibilities, Race, Religious Belief, Political Opinion)

It also covers the training we provide to our staff, how we communicate and how we provide information and services to the people we serve. The Trust is proactive in this area and goes way beyond compliance to promote and share best practice. Some of the work is featured in our biannual publications: Equality Bites and the Good Relations bulletin.

Quality Improvement Case Studies

[Quality Improvement - Home (sharepoint.com)]

	May to October 2023	November 2023 to April 2024
Total infants ≤34 weeks	95	73
Hypothermia on admission	11%	5.5%
Hyperthermia on admission	8.5%	15%
Overall normothermia	81%	83%

Heading Home together

B. Rao, C. Black, C. Glover, B. McCann,
S. Hollywood, G. Hanna.
Regional Neonatal Unit, Royal Maternity Hospital

Regional Neonatal Intensive Care Unit Belfast

Belfast Health and Social Care Trust
caring supporting improving together

Safety & quality

A family integrated care Project

Background

Family integrated care is an evidence based model of care that improves outcomes for infants and their families

It is recommended by the British Association of Perinatal Medicine

The benefits:
- Reduced mortality
- Reduced infection rates
- Increased breastmilk feeding
- Earlier discharge
- Improved parent wellbeing

The goal of FICare is to facilitate partnership between parents and NICU staff, to promote parent-infant interactions, and to build parent confidence

It involves:
- Empowering parents
- Focusing on parent wellbeing
- Parent involvement in cares
- A welcoming and supportive environment
- Unit culture change

Parent Voices

"We live 90 miles from the hospital, so we have a lot of travelling. We also have other children at home"

"Thanks for the fantastic parents' program that brings us all together"

"We have been so thankful for the staff and facilities provided"

"The required milestones to my baby being able to come home have not been clear"

Aim Statement

To improve parent experience scores of family integrated care (Ficare) in Regional NICU for high risk infants, born less than 32 weeks by 10% by the end of June 2024

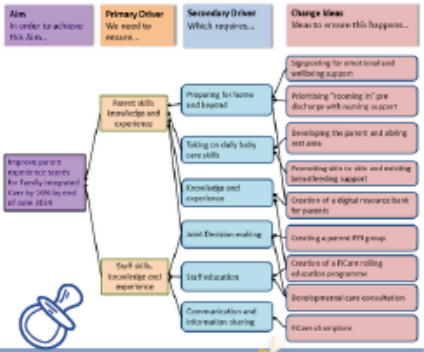
Parent PPI Group

We created a Parent Advisory Group to inform our changes and give a parent perspective on:

- Creating our questionnaire
- Understanding what parents want from the NICU team in supporting FICare
- Developing parent education sessions
- Creating parent friendly resources

What changes?

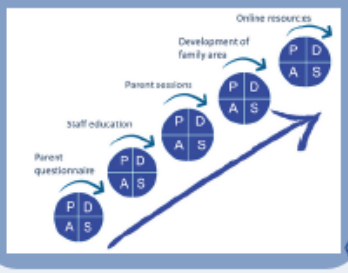
Our driver diagram demonstrates the changes we decided to make to achieve this aim



PDSA cycles and changes

We created a parent experience questionnaire to capture data
This is a measure of how well we are implementing Ficare and how this impacts parents' experiences taking care of their baby

We implemented PDSA cycles based on change ideas and continually collected data when babies reached 28 days old and at the point of discharge



Challenges and Learning

What's next?

- Starting a Developmental Care Ward round
- Rolling out the FICare model through the Neonatal Network
- Ongoing liaison with the Parent Advisory Group
- Linking into our Buttercup Discharges Project
- Moving into a New Maternity Hospital with single rooms
- Creating a monthly parent feedback dashboard to create legacy and keep up motivation for change

Project Progress in Data

We obtained baseline data demonstrating a median questionnaire score of 104

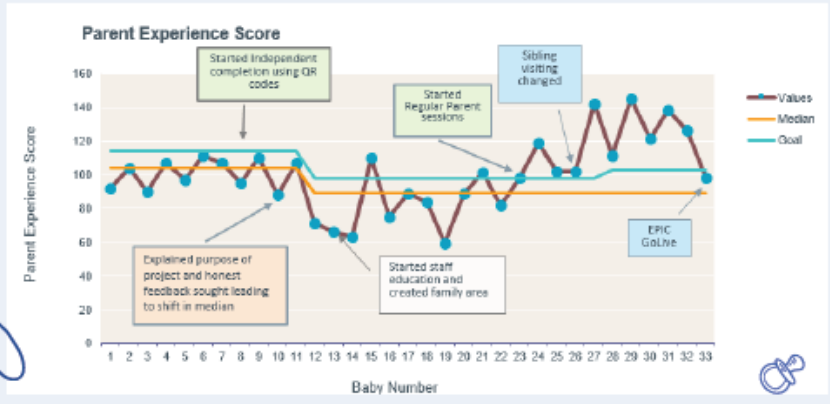
On reviewing the responses, we recognised parents were being overly generous in their feedback and we explained the purpose of the project more clearly

Subsequent questionnaires reflected more realistic feedback, which shifted the median baseline and therefore the 10% "goal" line

Over time, PDSA cycles had an impact on the parent experience scores

Our Run chart demonstrates that an initial *trend* upwards in parent experience scores eventually turned into a *shift* over the goal line, in keeping with a sustained change

Since the EPIC go-Live we have noted a dip below the goal line again and this has given us a new motivation to keep up our changes and refocus from computers at the bedside, back to parents and babies!



4. RAISING THE STANDARDS

Emergency Department (ED) Information

Overall new and unplanned attendances at the BHSCT Adult Urgent and Emergency Care services have increased from 141,541 in 2022/23 to 146,914 in 2023/24 and increase of approximately 4%.

Data trends

Published statistics on the time spent in emergency care departments (ED) throughout Northern Ireland to the end of March 2024; demonstrate the follow key points:

- During the quarter ending 31 March 2024, less than half (42.7%) of patients spent less than 4 hours at an ED, less than in the same quarter in 2023 (47.2%).
- Between March 2023 and March 2024, the number waiting over 12 hours increased from 8,730 to 9,443, accounting for 17.8% of attendances in March 2024.
- The median time patients who were discharged home (not admitted) spent in a Type 1 ED was 4 hours 29 minutes in March 2024, 13 minutes more than the time taken during the same month last year (4 hours 16 minutes).
- The median time patients who were admitted to hospital spent in a Type 1 ED was 15 hours 11 minutes in March 2024, 59 minutes more than the same month last year (14 hours 12 minutes)

New and unplanned attendances at BHSCT Adult Urgent and Emergency Care increased by approximately 4% from 141,541 in 22/23 to 146,914 in 23/24.

URGENT & EMERGENCY CARE	MARCH 24	OCT - DEC 23 (Monthly Avg)	MARCH 23	MARCH 20
ED ATTENDANCES	14,334	13,821	14,859	10,887
4 HR ED PERFORMANCE	35%	39%	38%	63%
12 HR ED PERFORMANCE	3,086	2,531	2,565	437

PATIENTS WITH DECISION TO ADMIT	24%	25%	23%	20%
AVG DTA TO ED EXIT TIME (MINS)	834	794	778	275
% PATIENTS ADMITTED	16%	17%	16%	18%
% PATIENTS DID NOT WAIT	15%	12%	11%	6%
UCC ATTENDANCES	2,228	2,388	1,989	1,923
GP OUT OF HOURS CALLS	6,013	7,364	13,998	11,187

* Readmissions 2023/24 Belfast Trust 7.0%, Peer 8.5%

Improvement Work

Endoscopy Service

• The Trust continues to have a good position on the backlog of Endoscopy Service Planned patients (those waiting past 13 weeks of date) March 2024 at 63 (approx. 1% of regional backlog).

Trust	No. of patients	% of total
BHSCT	• 63	• 0.84

SEHSCT	• 2,716	• 36.02
NHSCT	• 1,426	• 18.91
SHSCT	• 2,380	• 31.56
WHSCT	• 955	• 12.67
Total	• 7,540	• 100

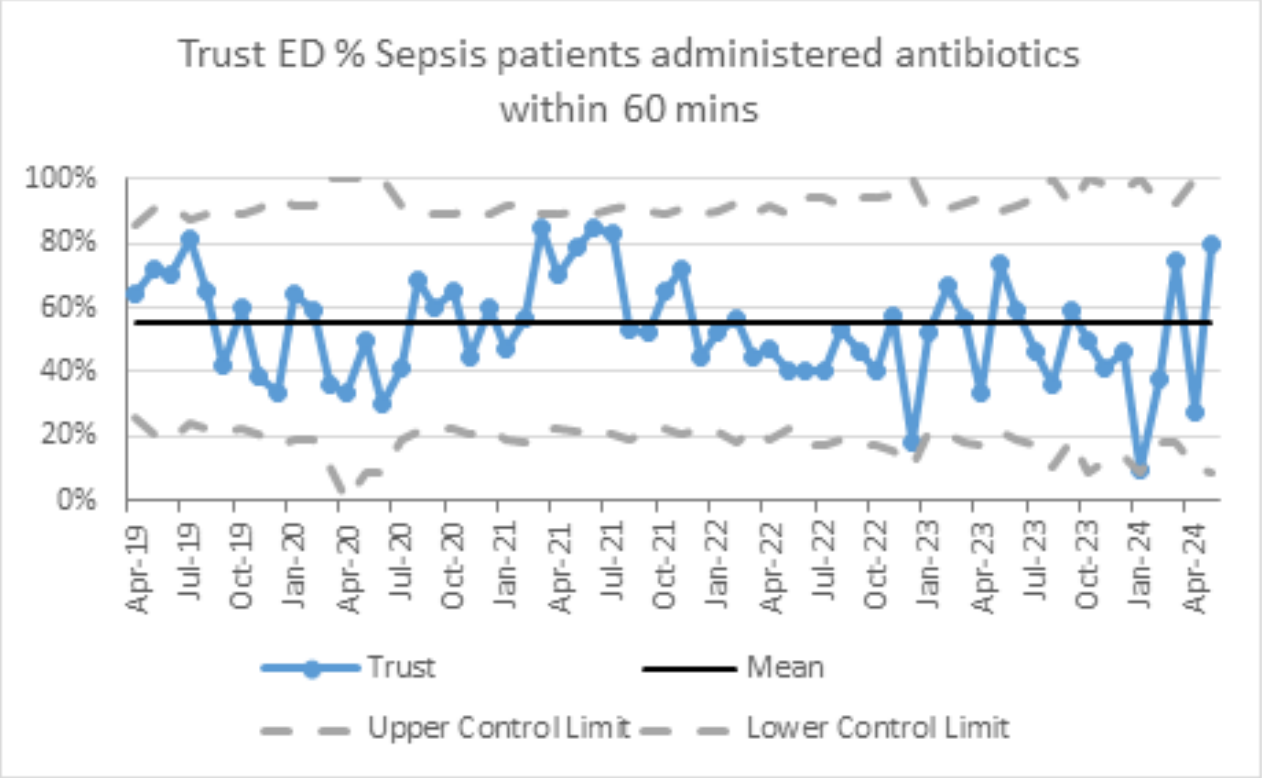
In addition, over the last year, there has been steady progress with long waiting urgent and routine patients.

Timeframe	**Mar-24**	**Mar-23**	**Difference**
> 9 weeks	1,740	3,474	-1,734
> 13 weeks	1,639	3,300	-1,661
> 52 weeks	1,089	2,094	-1,005

Sepsis in Emergency Departments

Sepsis is a condition where the body has a severe response to infection injuring its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognized early and treated promptly. Sepsis 6 is the name given to a bundle of interventions designed to reduce the mortality of patients with sepsis through timely intervention.

The graph below shows the percentage of patients who were administered antibiotics within 60 minutes of arrival to the emergency department. Mean is approximately 56%.

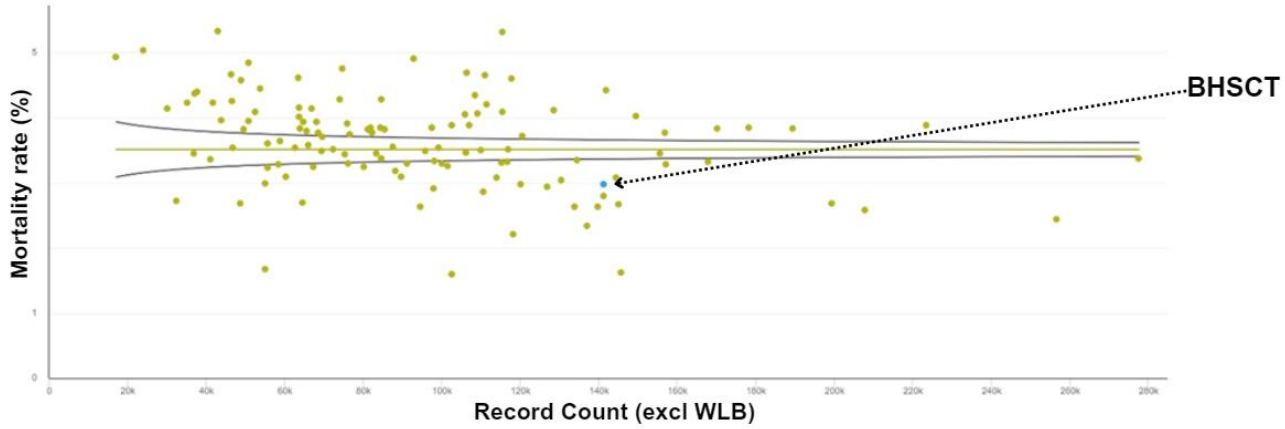


Mortality Information

The Trust robustly reviews the deaths of patients in our hospitals and compares this information with other peer hospitals for the same period. One way in which this information (known as the crude mortality rate) is shared is via a graph called a Funnel Plot Chart. Funnel Plots add an element of statistical reliability to basic figures; they do this by applying statistical control limits above and below the average performance of a

group. These limits are represented by the top and bottom lines on the graph with an average line in the middle.

In essence a hospital is within normal ranges of variance in mortality if they stay within the top and bottom lines (each hospital within a peer group is represented by a dot).



In this case BHSCT is outside the funnel but on the low side rather than high side. These graphs are not a guarantee of performance within themselves and have limitations but used in conjunction with other measures provide an additional view of this important measure.

Embedding Services

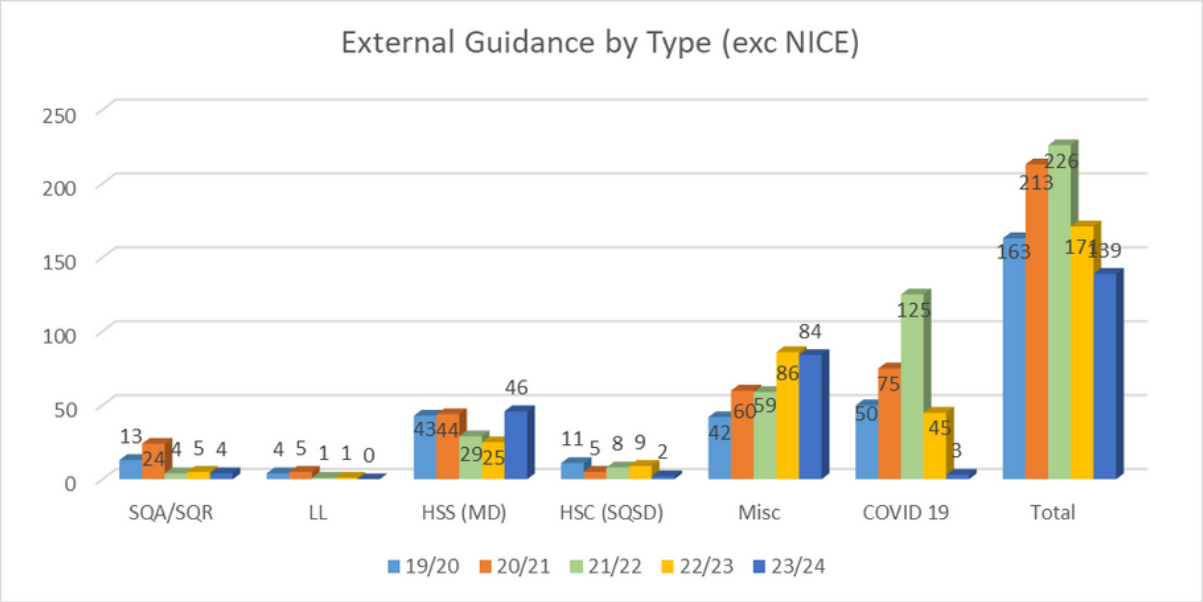
The Lifeline service has successfully embedded call recording into its service providing increased protection and safeguards for service users and staff. The system, designed to raise standards of care, promotes continuous improvement of service delivery and has been warmly welcomed by the team.

Since implementation and the introduction of a recorded message welcoming people to Lifeline, there has been a reduction in inactive calls by 9%. These are calls where the caller hangs up or is silent.

External Guidelines

The Trust receives external guidance from many sources, i.e., the Department of Health (DoH), SPPG and the Public Health Agency (PHA). External guidance is issued in many different forms as set out in the table below:

The chart below provides a breakdown of External Guidance (excluding NICE) received each year since 2019-2020. It shows a decrease overall in the number received in 2023-2024 (139) compared to the previous four years (171 in 2022-2023, 226 in 2021-2022, 213 in 2020-2021 and 163 in 2019-2020)



There was a decrease in the number of Safety & Quality Alerts / Reminders, and HSC (SQSD) circulars and a slight decrease in miscellaneous correspondence received during 2023-2024. COVID-related correspondence reduced considerably for the second consecutive year. There was also a noted increase in the number of HSS (MD) correspondence received.

Most correspondence received does not require a response in terms of the implementation of actions, and for the purposes of reporting these

are categorised as ‘For Information’. For the year 2023-2024, 37% (96) of all correspondence received required a response.

Next Steps

- To further review the composition of the PEG Assurance Committee and review the role of the committee with regard to the identification and escalation of risk and provision of assurance in relation to policies and external guidance. The frequency of PEG Assurance Committee meetings has been increased to monthly with alternating agendas of review of new policies, Interventional procedures etc. and seeking assurance on progress to review overdue policies with Directorates/Divisions.
- The Trust “Policy Development and Approval” policy, has been reviewed and returned to the policy reviewers post-revision. It is envisaged that this will be tabled at PEG Assurance Committee during Q1 2024/2025 The “Developing and Implementing a Care Pathway” draft document is under review to ascertain the optimal format of this guidance to ensure that the processes are kept ‘live’ and aligned to the changing demands of the organisation, particularly with reference to digital development. The “Policy for the Introduction of a New Interventional Procedure” has been approved and uploaded to the Loop.
- Standard Operating Procedures (SOPs) and Frequently Asked Questions (FAQs) will be developed and shared via the Loop to assist policy authors/reviewers in developing and maintaining policies to underpin the Policy Development and Approval” policy. This will include specific requirements for monitoring of policies in light of shared learning and auditing of policies to ensure effectiveness. The PEG Assurance Committee will advise policy authors and responsible Directors of the requirement that all new policies must be audited 12 months after the operational date to provide assurance to the committee that the auditing and monitoring of the policy has been complied with post-implementation. All policy monitoring audits must be registered with the Quality Improvement & Audit Team, the outcomes reported and an action plan prepared, where applicable.

- Learning from the Muckamore Abbey Hospital Inquiry (MAHI) is expected to highlight the importance of seeking assurance that policies are disseminated, implemented and monitored. The PEG Assurance Committee will ensure that these recommendations are reviewed in line with the terms of reference of the committee recognising however that Directors are accountable for the policies within their specific area of professional corporate or functional responsibility.
- To liaise with other Trusts and undertake a benchmarking exercise with regard to Integrated Care Pathway processes and report back to the PEG Assurance Committee.
- To review the format of the External Guidance and the Out-of-Date Policies reports tabled at the PEG Assurance Committee.
- To present the finalised Internal / External Guidance Standard Operating Procedures (SOP) at the PEG Assurance Committee.
- IT Management System Approach: To establish progress of a proposed regional IT system for the dissemination of external guidance and evaluate the current process for managing policies with a potential new IT system approach.
- To maintain the Quality Management System (QMS) data set for policies and external guidance.
    - To extend the pilot of Standards & Guidelines Team staff supporting a Service with regard to the completion of a NICE Baseline Assessment Tool (BAT) which commenced in August 2023
    - To undertake a comprehensive review with Services of NICE Guidelines/ BATs relating to the 2014-2019 period.
    - To finalise the process and supporting documentation for Management of External Guidance including NICE Guidelines in conjunction with the NICE Implementation Facilitator for Northern Ireland in relation to Trust processes aligned to NICE.
- To ensure the timely and effective dissemination and collate Directorate/Divisional assurance of implementation of agreed NICE guidance where reasonably practical. There is a regional backlog of assurance of dissemination/implementation for NICE guidance which SPPG have disseminated in March 2024. A phased approach has been agreed regionally to respond to this

backlog of assurance as follows: Phase 1 – Assurance outstanding from 2022/23 to be provided by end September 2024 and Phase 2 – Assurance outstanding from 2023/24 to be provided by March.

NICE guidance is issued in a number of formats as detailed below and this can also be found on the NICE website (www.NICE.org.uk):

- NICE Guidelines (NGs) – treatment and care of patients with specific diseases and conditions.
- Technology Appraisals (TAs) – use of new and existing medicines and other treatments
- Interventional Procedures – cover the safety and efficacy of surgical procedures.

Following the publication by NICE, the DoH will initiate a review process of published Clinical Guidelines, Technology Appraisals and Public Health guidelines. It is proofed by the DoH to check for legal, policy and financial consequences related to the implementation in Northern Ireland. Following this, the DoH issue the endorsed document to the Trust.

In line with NICE Circular HSC (SQSD) 12/22 which sets out the requirements for the monitoring and implementation of NICE Guidance, the DoH seeks positive assurance on all NICE Guidance issued. The DoH issues an assurance report to all Trusts on a bi-monthly basis.

The Trust is required to provide assurance that initial actions of targeted dissemination, identification of a clinical/management lead and implementation planning have taken place. This is in addition to the positive assurance that will be sought on implementation. The PEG Assurance Committee has responsibility for the monitoring of implementation of NICE Guidelines.

NICE Guidance received 2019-2024 by Type (including TA and IPG)

- There were 9 NICE Guidelines endorsed and issued in NI in 2023-2024; 27 in 2022-2023, 26 in 2021-2022; 26 in 2020-2021 and 25 in 2019-2020.
- There were 80 Technology Appraisals endorsed during the reporting period, a decrease of 47 on the previous year.
- There were 30 Interventional Procedure Guidelines received into the Trust during 2023-2024, a small decrease of 6 on the previous year.
- Overall, there was a decrease of 37% in the number of NICE-related guidance issued and endorsed in NI during 2023-2024 compared to the previous year.

During the period 2023-2024, the following amendments to the management of external guidance process were agreed:

- Review of External Guidance Processes
- Liaise with the NICE Implementation Consultant for Northern Ireland and devise an action plan in relation to addressing the backlog of omitted baseline assessment tools.

Clinical Audit

· National and regional audits supported by the clinical audit team
· Local clinical audits are also supported (resource dependent) as a means of measuring practice against defined standards to:
· Provide reassurance that compliance with standards is good
· Highlight poor compliance to reduce risk and inefficiencies
· Lead to improved patient care and outcomes

Clinical Audits Registered 2023/2024	
Local Clinical Audits	131
National Clinical Audits	34
Regional Clinical Audits	27
Total	**192**

JACIE Accreditation:

In October 2023, the haematology transplant service gained JACIE (Joint accreditation committee ISCT-EBMT) accreditation. JACIE is Europe's only official accreditation body in the field of hematopoietic stem cell transplant and cellular therapy. It promotes high-quality patient care and medical and laboratory practice through a profession-led, voluntary accreditation scheme. To achieve accreditation, the stem cell transplant team worked towards and successfully met the 7th edition standards outlined by JACIE. Following this, the centre also underwent an in person inspection in October 2022. The team have worked immensely hard to gain accreditation and look forward to the opportunities that will now arise from receiving JACIE accreditation.

CHKS ISO Accreditation:

CHKS is a leading global provider of healthcare intelligence and quality improvement services. The CHKS standards are mapped to the International Quality Management Systems Standard - ISO 9001, and CHKS, having gained external accreditation from UKAS (United Kingdom Accreditation Service), can award health and care organisations with certification to ISO 9001 alongside their accreditation award.

In achieving CHKS/ISO 9001:2015 accreditation, in 2023, the Radiotherapy department embarked on a journey of quality to enhance and improve productivity, performance, patient experience and patient outcomes. This process involves an external evaluation to assure that CHKS standards and the process for standards development, meet international best practice requirements, demonstrating to patients and stakeholders the robustness of the radiotherapy department.

Throughout the CHKS audit there were numerous positive comments from the auditors, highlighting “evident person centred care” and the excellent team of staff in NICC. It is considered to be an outstanding achievement to have fully met 484 out of the 484 CHKS criteria.

National Comparative Audit of Blood Transfusion NICE Quality Standard QS138 (NHS Blood and Transplant, 2023 – report published 29/02/2024)

Background

Patient Blood Management (PBM) is a multidisciplinary, evidence-based approach to optimising the care of patients who might need a blood transfusion. The deployment of PBM initiatives reduces inappropriate transfusion, which improves patient safety, reduces hospital costs and helps to ensure the availability of blood components when there is no alternative. Audit of PBM practice is vital to help an understanding the quality of care and to indicate where corrective measures are needed. The Transfusion 2024 plan outlines four key areas for clinical and laboratory transfusion practice for safe patient care across the NHS. The strategy for PBM includes the development of a self-assessment tool for use by hospitals to allow assessment of compliance with the NICE Quality Standard, progress with the implementation of PBM and benchmarking between hospitals.

Aims

- Provide the opportunity to evaluate local evidence of progress towards compliance with the four quality statements in the NICE Quality Standard for Blood Transfusion since the 2021 audit.
- Provide data to hospital teams to allow their understanding of what steps they can take to implement PBM and to measure their effectiveness in improving patient care.
- Allow the transfusion community, including the National Blood Transfusion Committee, to benchmark the progress of PBM and its effect on improving patient outcomes.

Methodology

All NHS Trusts in the UK were invited to take part in the audit. Trusts were allowed to enrol as whole Trusts or as hospitals within a Trust, so we use the term “sites” to describe those who contributed data. Each participating site was issued with a stationery pack that contains guidance for selecting a sample for audit and four data collection forms, with ten copies of each, allowing them to audit up to 40 patients. The audit standards were derived from the statements in the NICE Quality Standard QS138. The audit was divided into four sections, A, B, C & D. An individual patient’s record could be used for more than one section. Data were collected on cases seen during January, February and March 2023. 126 sites contributed data on 3730 patients. 100/139 (72%) of NHS England Trusts participated. For Quality Statement 1 there were data on 1030 patients, 1335 for Quality Statement 2, 1205 for Quality Statement 3 and 1356 for Quality Statement 4. See Appendix D for a list of participating sites.

Summary

The re-audit found little evidence of progress towards compliance with the four NICE Quality Statements for Blood Transfusion. Key findings:

- 617/908 (68%) of the patients who were known to have iron deficiency anaemia prior to being admitted for surgery were treated with iron before surgery (compared to 59% in the 2021 audit).

- 900/1335 (67.5%) patients undergoing surgery with expected moderate blood loss received tranexamic acid (compared to 67% in the 2021 audit).
- 766/1205 (63.6%) patients receiving elective red blood cell transfusions had both their haemoglobin checked and a clinical re-assessment after a unit of red cells was transfused (compared to 58% in the 2021 audit).
- Only 475/1356 (35%) of transfused patients had evidence of receiving both written and verbal information about the risks, benefits and alternatives to transfusion (compared to 26% in the 2021 audit).

Comparison of audit results in 2021 and 2023

Quality Statement (The standards for this audit were adapted from those issued in NICE QS138)	2021 (Overall)	2023 (Overall)	2023 (BHSCT)
1: People with iron deficiency anaemia are treated with iron supplementation before surgery.	665/1131 (59%)	617/908 (68%)	8/11 (73%)
2: Adults who are having surgery and expected to have moderate blood loss receive tranexamic acid.	1079/1599 (67%)	900/1336 (67%)	26/29 (90%)
3: People are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a	893/1534 (58%)	766/1205 (64%)	3/4 (75%)

chronic transfusion programme.			
4: People who have had a transfusion are given verbal and written information about blood transfusion.	422/1622 (26%)	475/1356 (35%)	4/6 (67%)

Recommendations

· Hospitals should examine their procedures for implementing the NICE Quality Standard for Blood Transfusion. They should explore the barriers to their implementation and work to overcome them.

· Hospitals should undertake regular repeat audits of the NICE Quality Standard using the National Comparative Audit and the QS138 Quality Insights tool as a quality improvement initiative.

· See Appendix C (Page 26, full report) for a list of resources to support implementation of the NICE Quality Standard.

For more information please click the below link:

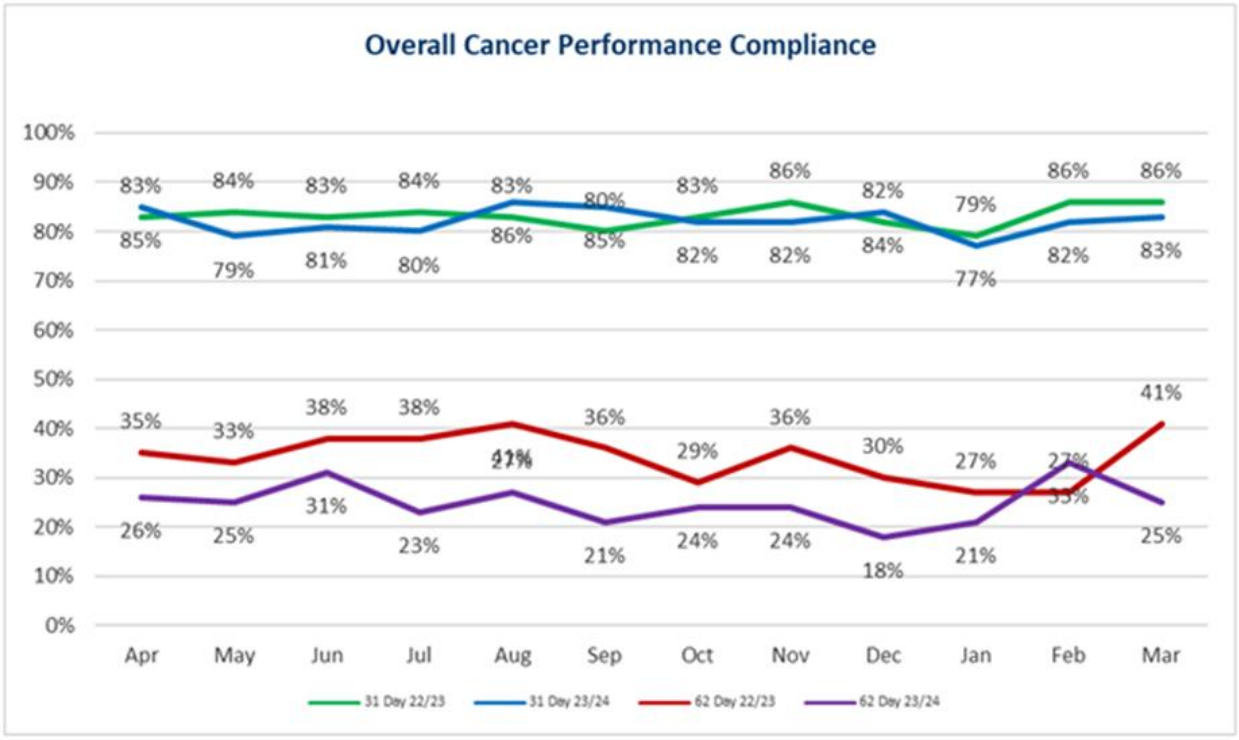
https://hospital.blood.co.uk/audits/national-comparative-audit/reports-grouped-by-year/2023-national-comparative-audit-of-nice-quality-standard-qs138/

Cancer Services Performance

During the year we have worked to improve performance against the 14, 31 and 62 day targets for cancer, however meeting these targets continues to be challenging due to the increased number of red flag referrals (11% increase), referrals, capacity issues and late transfers from other Trusts in the region.

This upcoming year will see ongoing challenges due to long regional waiting lists and challenges ensuring timely access to diagnostics and treatment.

The graph below shows performance against these targets from April 2023 – March 2024 compared to April 2022 – March 2023.



The Cancer Access Standards (targets) are:

● 100% of all urgent suspected breast cancer referrals should be seen within 14 days

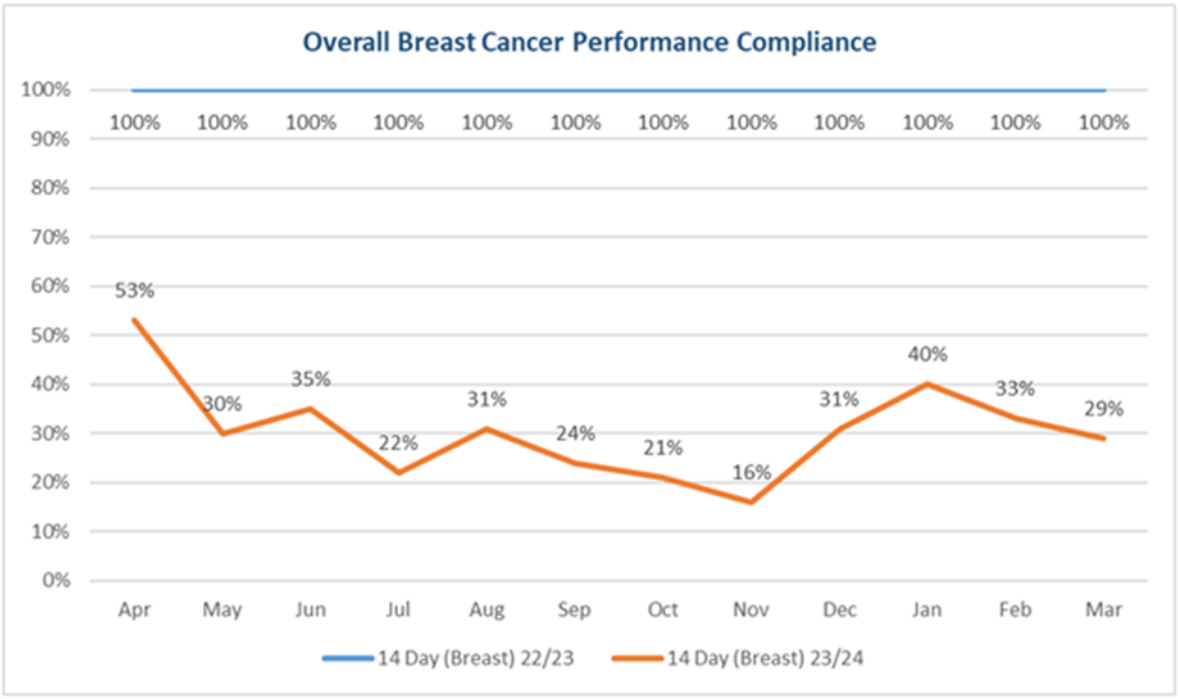
● 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat

● 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Comparisons across the 14, 31 and 62 day pathways show an overall reduction in performance against these targets. The breast service are

receiving referrals from across the region to equalise waiting times which has had an impact on meeting the 14 day target. It is important to note that there has been an 11%increase in red flag referrals across the pathways and a 5% increase in cancer diagnosis.

The graph below shows performance against these targets from April 2023 – March 2024 compared to April 2022 – March 2023. Mean Result 22/23 = 100% Compliance. Mean Result 23/24 = 30% Compliance.



Key Issues to achieve our targets in 2023/24:

First Appointment

- Outpatient Capacity - achieving and sustaining 14 day waiting times to first outpatient appointment across all specialities
- Diagnostic waiting time and the need for shorter waiting times in

- Endoscopy (OGD and Colonoscopy)

- Hysteroscopy

- CT Guided Biopsy

- Cystoscopy

- TP biopsy

- Pathology reporting

- Treatment

- Theatre capacity - issues across all specialities due to the impact of the pandemic

- Capacity for chemotherapy, radiotherapy and brachytherapy.

- Inter-trust transfers (ITTs)

- Late ITTs from other Trusts continue to impact on BHSCT overall 62-day performance.

- Complex diagnostic pathways

Actions and improvements undertaken in 2023/2024 include:

- The completion of a PDP Pathway Development Project (PDP), which is a collaborative working agreement between MSD and the NHS designed to support healthcare providers to optimise cancer pathways, enabling patients to be diagnosed and treated faster.
- We formed a project team to look at the renal pathway and produce an improvement plan to improve the pathway for patients diagnosed with renal cancer and resulted in the successful implantation of the adjuvant pathway which was shortlisted for the NI Healthcare Awards event in April 24.
- The Cancer Services Team worked in conjunction with NICaN and Primary Care to deliver monthly GP education events tailored to answer queries from GPs with updates on current pathways and guidance.

Quality Improvement Work

Calm

Reducing distressed behaviours in patients with confusion

Authors

Debbie Rainey- Dementia Service Improvement Lead - Acute
Rocio Munia Lopez - Service Improvement Facilitator for Palliative & End of life Care
Emma Sweeney and Amy O'Donnell, - Delirium Prevention Co-Ordinators

The Calm project team would like to thank : mentor Brona Shaw, Project Wards 7B and 7C and the Carers who co-produced the ward leaflet

Background

Incidents of distress, sometimes referred to by staff as aggression or challenging behaviour, can have a negative impact and affect patients, staff and visitors. Dementia and delirium are in the top three reasons for Datix incidents of distress in acute care wards in BHSCT.

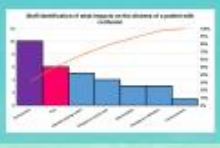
From October 2022 and July 2023 there were 45 Datix incidents of aggression by an inpatient in the BHSCT citing confusion, dementia or delirium as the cause. Two project wards were identified from this data.

Objective

To reduce the number of patients experiencing distress related to dementia, delirium and confusion in RVH Wards 7B and 7C by 20%, by May 2024.

Baseline Data

Results of a staff questionnaire in project wards, on September 2023 showed a confidence level of 2.9 out of 5 in managing distressed behaviours. Change ideas were identified by staff as Pain and Environment to reduce the distress of confused patients.



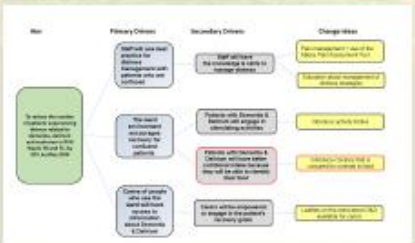
Measures

Outcome measures

Number of patients with distress per day

Process measures

Percentage increase of analgesia being administered regularly
Percentage increase in staff confidence
Number of carers leaflets provided



Interventions

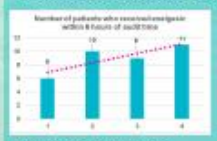
PDSA Cycle 1. Pain Assessment and Management:
Short training sessions on the use of the Abbey pain assessment tool with ward staff , due to limited impacted this was studied and a change of training was implemented. Modelling was used to completing this pain tool with ward staff and discussion of pain management strategies as the bedside.

PDSA Cycle 2. Environment:
King's Fund dementia-friendly environmental audit completed in October 2023 and its environmental recommendations we planned, budgeted and implemented.

PDSA Cycle 3. PPI:
Carer leaflet co-produced with an identified group of carers with an interest in hospital care for people with dementia and delirium.

Results

PDSA 1: had the greatest effect in both wards upon the management of distress in confused patients.



PDSA1: The pain audit showed a progressive increase in the use of analgesia during the project.

The staff confidence questionnaire: 20% increase in staff confidence at managing distressed behaviours at the end of PDSA cycle 1.

PDSA 2: Confusion friendly signs were placed in toilet and shower areas to improve orientation to the ward environment. An activity box was provided to improve cognitive engagement and reduce distress for patients with confusion. The improvement in the run charts was maintained during this intervention

PDSA 3: 11 carer's leaflets were provided. Formal feedback was provided by 2 carers:
"Good to know what is available on the ward for people with confusion"
"Helpful information"

Analysis

PDSA 1 was embraced by project wards, it was encouraging to the team to see that changes to the way an assessment is taught can have an impact of reducing distress, the project team plan to incorporate bedside modelling into other areas of work.

PDSA 2 resources were applied for, through charitable funds and e-procurement. This took longer to procure and then implement than anticipated. We discovered that it is hard to test an environmental change in the short term- this change will likely be more effective over a longer period.

PDSA 3: the carer's leaflet, took longer to co-produce than we expected. We found that we needed to balance the needs of the project against what the carer's wanted to include. The resulting leaflet was more detailed but likely to be more meaningful to carers.

Challenges

It is difficult to implement a change when the project team are not core staff members.

The wards regularly had patients boarding, presenting challenges to the ward environment.

Encompass was implemented during the the project, the resulting training of at least two days may have affected staffing numbers and skill mix.
This may explain the increase in distressed patients towards the end of the project. Despite an increase in distressed patients in 7B towards the end for the project, there was still a 28% reduction from baseline.

Conclusion

- Pain has the greatest impact on distressed behaviours
- The project team found the change idea for pain easiest to implement in a ward environment
- Environmental change is difficult to measure in the short term
- Carers leaflet feedback was positive

Next Steps

- Consider the wider use of the Abbey Pain Scale to manage pain and distress for confused patients
- Wider roll out of Dementia Environmental Audit
- Implementation of contrast coloured crockery

References

1. King's Fund Dementia Friendly Audit Tool for Hospitals: https://adsdementiablog.wordpress.com/wp-content/uploads/2023/07/is-your-hospital-dementia-friendly.pdf

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Safety & quality

HSC Values

Belfast Health and Social Care Trust
caring supporting improving together

We can't get no (20%) satisfaction!

Safety & quality

SQB 2023-2024. Project Team 10:

Rachel Hill, Emma Molloy, Orla Holmes, Ryan Leslie, Amanda Crossan, Damian O'Neill.

Background

- Cystic Fibrosis (CF) outpatient clinics run in a unique manner to avoid direct patient to patient contact in order to minimise the risk of cross infection.
- To effectively do this, patients with CF (pwCF) are allocated individual rooms at clinic and each discipline within the CF team then assesses the pwCF in turn. Thus, patient appointments can be between 1 and 2 hours long.
- We feel the patient experience and the flow of CF staff within these CF clinics could be improved to benefit all parties.
- We decided to engage with patients from the outset to formally examine their satisfaction with the current clinic format. We anticipated that by reviewing and changing in line with feedback, we would improve the patient experience.

Aim Statement

To improve the patient experience of attending CF outpatient clinic, through co-production and streamlining of current practice. This will be demonstrated by a 20% improvement in patient satisfaction.

Outcome measure:

Routine Clinic Patient Experience Survey & Patient stories

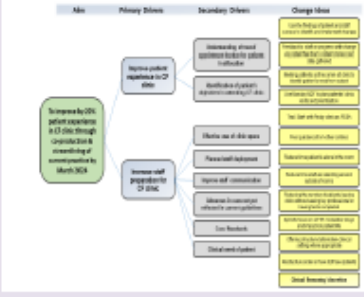
Process measures:

- Checklist for CF staff for CF clinic
- Patient questionnaire at end of CF clinic

Balancing measure:

Time and motion studies from Clinic (pre & post) by end of June 2024

Driver Diagram



Patient feedback

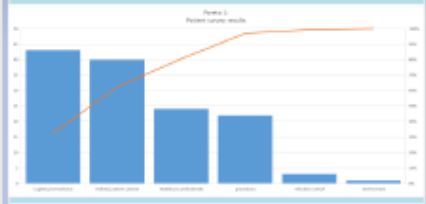
"At the end when I see the doctor on a few occasions I haven't been told I can leave and end up being forget about in the room"

"I may not often need to see every member of the team at every appointment if my condition is stable, so if I could chose who I would like to see this could speed up the process"

"The travel as I am from Newry, so can take a while out of my day."

Pareto Charts

The Patient survey identified many areas of potential improvement. Thematic analysis found that the majority of patient dissatisfaction stemmed from two areas; Convenience and Patient-centred care. The follow-up survey showed improvement in both these areas.

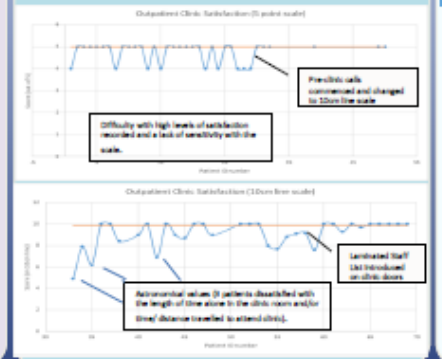


PDSA Cycles

- Questionnaire to all CF patients at clinic
- Introduction of pre-clinic telephone calls to provide choices

A series of five PDSA cycles were performed with minor changes to the format, timing and content of pre-clinic calls as well as the format of the clinic itself. These tests of change, showed an improvement in patient satisfaction, attendance at clinic and provided the opportunity to fill slots that were created by patients who confirmed their inability to attend.

Run Charts



Discussion – hurdles, barriers, enjoyment, what did you learn, benefits for service area, finances, other reflections

We realised that whilst we do have high levels of patient satisfaction in our service there are issues in relation to patient flow in clinics that need to be addressed such as patients not knowing when their appointment is completed so they can go home.

We gained better understanding of the parking issues, travel distance and pressures our patients face when they attend a CF clinic appointment.

We learned a lot about our team and how everyone views change differently and of the need to work together. The PPI input and patient surveys provided invaluable perspective on our service.

As part of our improvement plan, we also surveyed 9 other NHS CF centers across the UK and Scotland, to determine if anyone had solved the problems associated with CF clinics.

We learned QI methodology from our many challenges, mistakes and real life experiences.

Post-project, patient feedback.

"Choice between face to face or virtual is great for those travelling a fair distance or have busy lives. Especially if they attend regularly."

"They (clinics) seem more structured and efficient. The thing I like most is getting the chance to talk to the specialists I need to see most for that visit and getting the chance to see all the team."

Future plans

We have learnt that despite strong satisfaction from patients using the CF service, there were several areas for improvement.

These included:

- a need to provide more choice in the format of appointments, eg: Telemedicine of phone clinics.
- Improving communication within clinic.

The next stage in our QI journey will explore the potential of a hybrid model of virtual and F2F clinics for patients. Despite our high satisfaction rates, patient's clearly wish to have both choice and involvement in how their care is provided.

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Safety & quality

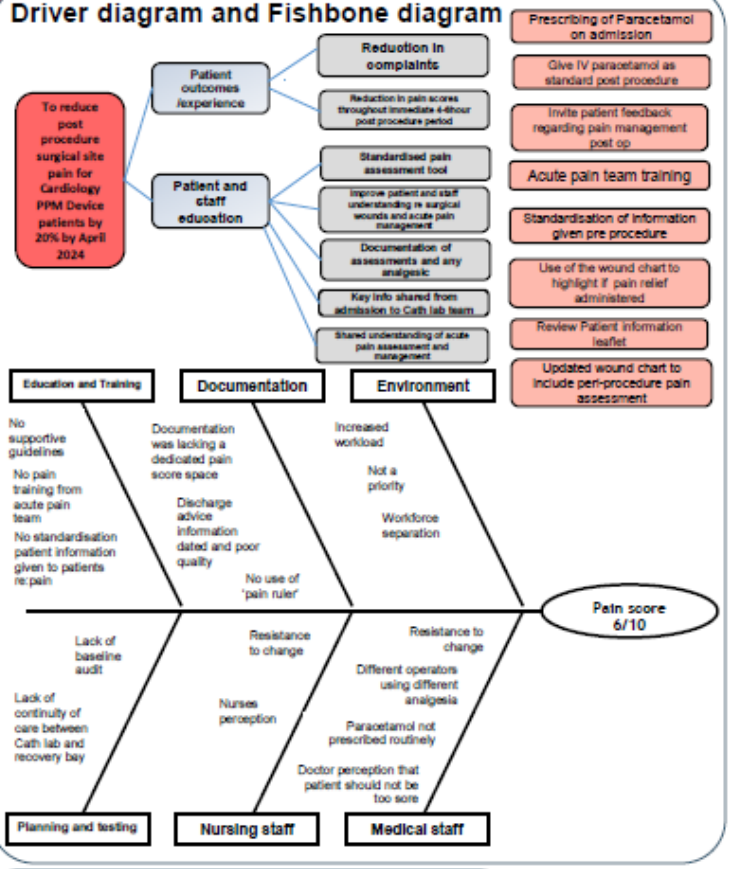
Project PAIN

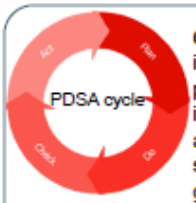
Deborah Baillie, Stephanie Nevin, Jess McMullan, Harriet Bradford, Michael Shahmohammadi, Nick McKeag

Introduction to the project:
The cardiology department received two complaints regarding pain post cardiac device implantation in early 2023. We therefore decided to act and audit patient's pain in the month of May 2023. The results indicated pain was higher than expected and averaged a score of 6/10 at 90 minutes post procedure. Although some surgical pain can be expected when having a cardiac device implanted, as a team we wanted to minimise and manage pain more effectively.

AIM STATEMENT : To reduce post procedure surgical site pain for Cardiology PPM Device patients by 20% by April 2024.

Driver diagram and Fishbone diagram





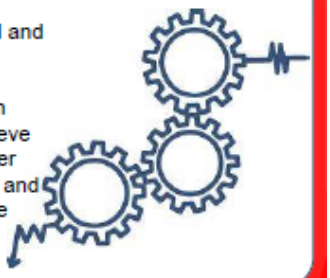
Cycle 1: Standardisation of information given to patients pre procedure. This helped to improve patient expectation and awareness and improve staff confidence in information given to patient.

Cycle 2: Staff training from acute pain training team, use of new wound chart and pain ruler. We linked with acute pain team and arranged 2 drop in training mornings with bespoke slides assessing surgical pain and use of a pain scale. Pain scale laminated and given to patient.

Cycle 3: IV paracetamol prescribed routinely on admission. We linked with medical staff consenting the patient for PPM implantation to ensure paracetamol is prescribed on admission.

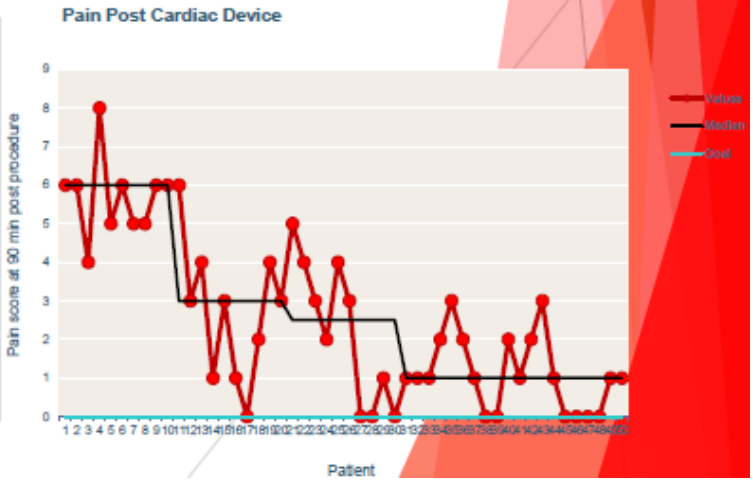
Cycle 4: Give IV paracetamol as standard on return to ward. Again we linked with medical staff consenting the patient to ensure paracetamol is prescribed on admission.

Cycle 5: Reviewed and improved patient information leaflet given to patients on discharge. We believe this provided greater patient satisfaction and improved discharge advice and expectation.



Discussion:
Overall we believe this project has been a resounding success and our aim has been reached. Our run chart clearly shows how the median score has dropped from 6/10 to 1/10 at 90 minutes post procedure. Staff satisfaction in the project is good and most staff believe the main success of the project is patients have an awareness of what to expect regarding pain. Staff confidence in assessing and treating pain has also improved. The greatest barrier faced was the prescription of IV Paracetamol from the medical staff however, with the Trust's move to Encompass this issue may be addressed.

What's next:
With the Trust's move to Encompass there with be a period of adjustment for all staff and patients however, what we have learnt throughout this project can still be implemented using the new system. Our next goal is to make our discharge information digitalised and create a QR code link for patients to access to allow us to keep our information keep to date and evidenced based.



Improving adherence to the Chronic Obstructive Pulmonary Disease Discharge Bundle

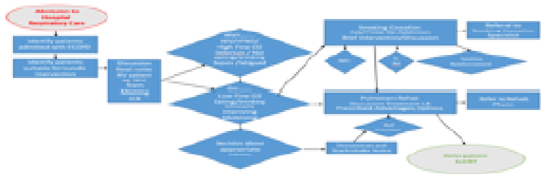
Introduction:

Shockingly 22% of patients will have died within a year of their first admission to hospital with an exacerbation of COPD and 50% will have died within 4 years[1]. However if the evidenced based interventions included in the BTS COPD Discharge Bundle[2] are implemented, the patient outcomes are known to significantly improve. These are complex interventions which require ongoing input from the specialist respiratory MDT. They include nicotine addiction support, attendance at pulmonary rehabilitation, correct choice of inhaled therapy and enhanced self-management skills.

Aim: To complete all 4 interventions of the COPD Bundle for an additional 10 patients per month admitted to respiratory wards A/B/7CC/5F, by March 2024.

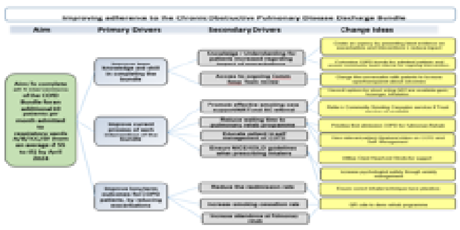
Method:

- The project team included the Respiratory MDT team from the Mater/Royal and the Community Respiratory Team.
- Model for Improvement[3] was the methodology used for this QI.
- The evidence was shared to create a sense of urgency for this quality improvement project at an integrated team study day.
- Process mapping was undertaken to ensure we knew our system.
- A project charter was agreed and a Driver Diagram was developed to guide the project.
- Monthly data collection and analysis was undertaken and shared.
- Human factors were considered and examined to understand the effects of teamwork, interventions, processes, culture and the workspace and organisation.
- The additional 10 patients/month will increase adherence to reach the 770 COPD patients admitted per year.



Process Change:

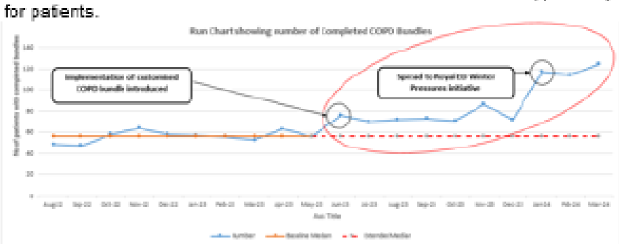
- The change ideas are focused on 3 key areas: the team, the processes and the patient outcomes.
- The bundle itself was adapted and customised for Belfast Trust.
- The discussion with patients was more open and transparent so they could understand the importance of the interventions on their future outcomes.
- Our smoking cessation support changed and NRT resources improved.
- First COPD patients were prioritised for pulmonary rehab access.
- Importance of inhaler technique/self-management were emphasised.



Refs:
[1][illegible] Thorax (2012); 67:957-963
[2]BTS COPD Discharge Bundle https://www.brit-thoracic.org
[3]The Improvement Guide, 2nd Edition. Provost & Murray (2011)
[4]Langley et al (2009) The Health Care Data Guide

Results:

The run chart shows the baseline data from August 2022 and when the QI project started in June 2023. We were able to demonstrate we met our aim quickly because we have a cohesive, committed and highly specialist team who all prioritised this quality improvement. There has been a shift in clinical practice above what was anticipated. We introduced a further change idea in January 2024 when a respiratory nurse specialist was seconded to RVH ED to ensure that the COPD bundle was commenced at the earliest opportunity for patients.



Conclusion:

We have achieved and sustained our initial aim through collaborative teamwork and have incorporated this COPD Bundle into Encompass so the improvement can be maintained.

Key Learning:

The importance of knowing your system and then ensuring an agreed vision. Display the plan through a driver diagram which everyone understands and owns. Collecting the right data from the beginning is essential.

Measuring interventions and their outcomes is a big driver for sustained change. The QI process and model for improvement helps build team morale and pride in the service.

Achievements:

- Increased my knowledge of QI.
- Understand data and QI Charts[4].
- Improve the knowledge, skill and appreciation of QI across the wider Respiratory MDT.

Next Steps:

Develop a live registry of COPD patients to ensure access to the right interventions to reduce/prevent exacerbations. Continue to liaise with other HSC Trusts across NI to scale up and spread the COPD Bundle. Develop admission profile data to determine the long term impact of the COPD bundle on readmissions and mortality to address population health issues for these patients. It would be beneficial to discuss funding for a Respiratory Nurse Specialist to implement the COPD Bundle in ED as this could result in an ongoing reduction in the number of admissions for COPD patients over time.

Contact:
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NHS Education for Scotland

ScIL Scottish Improvement Leader

For more information regarding SQB and ScIL posters, click the internal link below:

QI Posters (sharepoint.com)

Personal and Public Involvement (PPI) – Explaining Key Work

AccessAble

Funding secured through the Trust Charitable Funds income stream financed a significant AccessAble project on the RVH site. Almost £50k was allocated (across three years) to fund access auditors to visit public facing buildings and services on the RVH site. As a result approximately 150 digital access guides were produced in order to improve wayfinding across this busy, complex acute site.

The guides are available to members of the public via Belfast Trust website and AccessAble website Belfast Health and Social Care Trust | AccessAble and will support disabled people to access and navigate the site as a service user, patient or visitor to the RVH. The guides provide factual information and photographs of car parking arrangements, accessible toilet facilities, loop systems etc. and is available in alternative formats such as Easy Read.

In addition to the online access guides, best practice guides and a low cost improvement matrix and RAG status matrix were produced to assist our Estates and Capital Development Teams in terms of capital projects and minor works.

Involvement Network

The Trust continues to maintain the virtual Involvement Network and regularly promotes involvement opportunities. During this year, we have reviewed membership to ensure it is up to date. This provides a platform to share involvement opportunities and keep a range of stakeholders up-to-date with opportunities to get involved and training available.

The Trust Reader Panel continues to provide feedback on a range of Trust information which includes patient leaflets and Group Terms of Reference to ensure it is reader friendly.

There continues to be a wide range of service user and carer engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which facilitates people to become involved in the development, improvement and evaluation of Trust services. Staff strive to ensure that involvement opportunities are accessible to people and that people are supported to be involved in a way that suits their needs, experience and ability. Opportunities to get involved are shared via the Trust Involvement Network and also across services.

There are a number of Trust-wide User Forums and specific Service User groups facilitated by and linked to the Trust, which can provide opportunities for service user and other stakeholders to engage in decision-making, feedback processes and associated risk issues. Groups include the Carer Network, the Snowdrop Group and HIV Service User Forum.

In June 2023, the Trust hosted an Involvement Recognition event in Belfast City Hall. The Trust said thank you to all those who are involved in helping to design and delivery better services and 85 people attended from across 15 service areas.

The PPI team continued to target support towards the Trust's Key Priority areas of work, as detailed in our Corporate Plan 2021-2023:

- New model of care for older people
- Urgent and emergency care
- Time-critical surgery
- Outpatient modernisation
- Vulnerable groups in our population
- Seeking real-time feedback from patients and staff

Work has included:

- Establishing an Older People's Service 'Carer Involvement Hub'
- Hosting involvement sessions for Dementia Support Housing

- Engaging a range of stakeholders to input into the modernisation of GP Out of Hours Service for Belfast Trust
- Facilitating the Learning Disability Community Forum
- Co-Chair the Deaf Sign Language Group
- Engaging service users and carers to input into the development of the Trust plan for 2024 onwards.

The Trust participates in the Regional PPI Forum which is hosted by the Public Health Agency and its related subgroups including, PPI training and monitoring of PPI.

5. INTEGRATING THE CARE

Improvement Work in Community Care and Hospital Social Work

Adult Safeguarding - The development of materials to assist staff and the public including patients, service users and carers to recognise, respond and report adult abuse.

Background

Potential risks to the safety of patients/service users were identified due to:

- Lack of compliance with regionally agreed Adult Safeguarding Policy and Procedures. Not all staff were aware how to recognise and respond to adult safeguarding incidents, including domestic abuse.
- Adult safeguarding concerns being addressed inconsistently across the Trust.

Scoping was undertaken in 2021identiifed a limited information for staff or the public; on the Trust intranet, the BHSCT Website, or visible materials within service areas.

What did we do?

Information produced for staff included Information produced for the public includes:

- Extensive information being added to the Trust Intranet “the Loop”
- “Awareness raising” sessions; open and targeted towards specific service areas
- Human trafficking/ modern slavery, and domestic abuse/ sexual violence training
- Standardised manuals, flow charts, user guides, aide memoires, and video guides
- Adult Safeguarding link staff network established
- Adult Safeguarding infographic, and the social media videos
- A domestic violence conference in Dec 2023 and pocket size guide for staff
- Standardised noticeboards and pop up banners
- Specific information for the “seniors booklet” and “GP portal”

- BHSCT Website information has been significantly increased
- A leaflet explaining what happens after someone raises a concern
- A co-production project is ongoing to create public materials about domestic abuse.

What difference did it make?

- Greatly enhanced public facing information, enabling the public to know what adult safeguarding is, who to contact for help, and the process if a report is made.
- Independent staff review in 2023 found the information produced was practical, user friendly, and easily understood. They also reported greater understanding of their roles and responsibilities, and how to recognise, respond to, and report adult abuse.

Nutrition & Dietetics

Background

Allied Health Profession services fall under Ministerial Targets relating to Access Time to services, no service user should be waiting more than 13 weeks for an initial assessment. Timely access to the Community Nutrition Support Service is pivotal in promoting patient health and preventing complications. Increasing demands and challenging caseloads have resulted in extended waiting times for urgent appointments, posing significant challenges to patient outcomes and satisfaction. In recognition of this, my improvement project aims to reduce urgent waiting times. The project aims to streamline processes, optimise resources and enhance service delivery ensuring patients receive prompt, high quality care.

Improvements made

The introduction of clear triage criteria coupled with a dedicated resource to delivers virtual consultations. The team have been able to dedicate appointment slots on delivering timely access to urgent

referrals. This has resulted in a reduction of urgent referrals waiting over 13 weeks.

Occupational Therapy

The aim of our project was to reduce the waiting time for patients on the Occupational Therapy, elective hand therapy routine waiting list from 85 weeks to 52 weeks by end of June 2024

Introduction/Background

The OT Team receives referrals for adults and children with a range of hand conditions. Referrals received following elective hand surgery are prioritised as urgent due to the time critical nature of peri and post-operative work, all other referrals for conservative (non-surgical) treatment of hand conditions are prioritised as routine. In August 2023, the waiting time for patients on the routine waiting list was 85 weeks.

Improvements made

Role analysis identified that clinical staff were completing admin tasks e.g. making appointments, sending letters, answering phone. By moving to electronic diary management, reorganising the admin capacity, updating admin processes and enhanced triage, the time saved by clinical staff, created additional clinical capacity, which was dedicated to routine waiting list clients, resulting in reduced waiting times and better clinical outcomes. By May 2024 our longest wait was 35 weeks.

Planned Next steps

Dedicated time slots will continue to be ring-fenced for our routine waiters. This QI project was completed as part of TASC 2024 programme into which scale and spread is embedded. Results from 2024 TASC projects will be used to inform future QI projects across the region.

Physiotherapy

Regional Disablement Service / Amputee Physiotherapy Team

‘Improving Lower Limb Amputee’s Confidence Using a Prosthesis in their own Home’

The Amputee Physiotherapy Team's abstract 'Improving Lower Limb Amputee’s Confidence Using a Prosthesis in their home' was selected for an ePoster display at the International Forum on Quality and Safety in Healthcare in Copenhagen in 2023.

‘Developing Allied Health Profession (AHP) Services for People with Haemophilia’

Lou Sayers has been informed that her abstract tilted 'The DASH Project - Developing AHP Services for People with Haemophilia' has been accepted by the EAHAD* 2024 Organising and Scientific Committees and will be part of the oral presentations at the EAHAD 2024 Congress in Frankfurt, Germany in February 2024.

**European Association for Haemophilia and Allied Disorders*

Meadowlands Patient Games

A new trial of ward-based and gym-based games for patients in Meadowlands has be a great success. Benefits for both the patients, as well as the staff, from a fresh new approach to encouraging purposeful movement. A morale-lifting, fun and effective way to provide rehabilitation - well done to all the Meadowlands' Physiotherapy Team.

Mental Health - *Psychological Services*

‘Improving Timely Access to Adult Psychological Therapies’

BHSCT Psychological Services use quality improvement methodology in order to measure improvement.

This year, two QI projects focused on **‘improving timely access to adult psychological therapies’.**

- The first QI project focused on the provision of group therapy to successfully enhance service delivery and reduce waiting times.
- The second QI project focused on reducing the DNA rate. This project found that the introduction of text message reminders reduced DNA rate by 85%, yielding a full year saving of approximately £38,000. It is expected that the introduction of the ‘My Care’ app will further improve attendance and engagement with mental health services.

See poster below:

NHS Education for Scotland

Improving Timely Access to Adult Psychological Therapies for Clients with Mental Health Difficulties

Dr Sarah Meekin, Consultant Clinical Psychologist,
Head of Psychological Services BHSCT

Introduction

Northern Ireland has highest prevalence of MH problems in UK, with a demonstrated yearly increase since 2013-14, and additional pressures since Covid-19. A lack of investment has resulted in high waiting lists and workforce challenges for the delivery of specialist Psychological therapies. Despite changes made in providing virtual options, the capacity within Psychological Services does not suffice to manage the demand. Waiting lists at project start were 1351 days with 210 people waiting an initial appointment, against a target waiting time of 84 days. This position raises concerns regarding potential deterioration for clients whilst waiting, wasted opportunity for early intervention and reduced morbidity, staff morale and further workforce recruitment and retention problems.

AIM: Reduce length of time waiting for Psychological Services to 600 days (50%) by March 2023

Methods:

The project involved a multiprofessional approach, across Psychological Services & Adult Mental Health Services, including a Service User Consultant in AMH. A number of QI methods were used including a Driver Diagram to identify primary and secondary drivers and change ideas, and a Gantt Chart for Project Planning.

Process Mapping was used to understand the current process, potential bottlenecks and gaps in service delivery. The initial process map clearly demonstrated complex referral pathways with limited options for interventions (Figure 1). PDSA Cycles were used to review the impact of a number of initiatives on length of wait.

Figure 1:

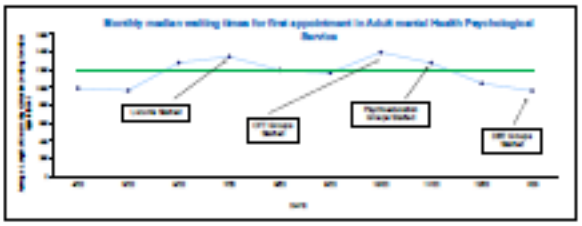
Process Changes: Figure 2

Following review of the Driver Diagram below, changes were made to simplify the referral process and to increase capacity via use of locums and increasing availability of group interventions

Figure 2:

Results

A run chart was used to display the changes in length of time waiting for an appointment over time. There are insufficient data points to note special cause changes. However there is an encouraging trajectory of reduction in days waiting over number of months. Ongoing work will hopefully demonstrate special cause change over time. As of the end of January 2023 average waiting times in days had been reduced to 966 (around 30% reduction) from initial longest wait of 1351 at start of changes.



Conclusions

Given the scale of problem and ongoing referrals received, additional staff providing 1-1 therapy would not be sufficient to solve challenge as seen by impact of additional locum staff- this supported the need for change in service delivery.

The availability of a range of group interventions is showing potential benefit in maintaining reduction in time waiting but more data needed to make definitive claims with regards to special cause changes.

Key Learning

There were significant challenges along the way – particularly highlighting poor data collection methods in existence within the system. Improvement in this area has become part of the need moving forward.

Next steps:

- Data will continue to be collected as to impact of group delivery and more attention will be paid to balancing measures of referrals and DNAs.
- Client feedback and outcome measures to be reviewed to ensure group interventions have same potential to effect change as 1-1 interventions

Key References: The Healthcare data Guide
Provost et al

Contact:
Sarah.Meekin@belfasttrust.hscni.net

ScIL Scottish Improvement Leader

New inter-agency and multidisciplinary Children Looked After Advisory Service for Primary Schools

- A partnership service between Belfast Health & Social Care Trust and Department of Education
- This new service, sited in Belfast Trust, has been established **regionally** across Northern Ireland following a successful pilot which aims to improve the social and emotional, and academic progress of children who are looked after
- Psychological Services within BHSCT receive recurrent annual funding for 1x8B & 3x8a Psychologists to support the programme regionally
- Underpinned by The Attach Programme (TAP), a programme of intervention developed for schools which aims to foster the holistic development of the child, both through facilitating whole school and key adult training on trauma, childhood adversity, and attachment friendly practice
- Future vision to extend the support to Early Years and Secondary Schools Post Primary Education.

Click **HERE** to find out further information on this service

See poster below:

NHS Education for Scotland

Reducing Active Caseload in a Community Mental Health Team

Aim: To Reduce Active caseload in the East Recovery Community Mental Health Team by 10% by April 2024

Introduction:
The East Recovery Community Mental Health team currently provide assessment and treatment for individuals with serious mental illness. Often the nature of such illness can cause chronic or relapsing symptoms. Historically patients remain on caseloads for many years even when symptoms are well managed. The result is that caseload size is increasing and outstripping capacity. The unfortunate consequence means that there is difficulty in offering timely appointments when patients require additional input to prevent deterioration.

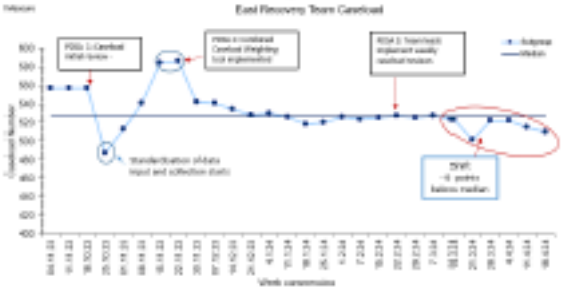
Method:
Establishing a project team was essential to the success of the project. This included administrative staff, personnel in key leadership roles and frontline staff.
To understand our system the project team;

- Undertook a cause and effect exercise shown below
- Carried out a process map of a patient journey
- Held focused discussions with interfacing teams

Utilising the model for improvement we developed a measurement plan detailed here and a driver diagram shown below to develop change ideas that were then tested using PDSA cycles.

Measurement Plan:
Outcome measure: Number of patients on team caseload including unallocated and active cases
Process measure: Number of patients transferred to PIFU pathway.
Balance Measure: Number of new referrals

Results:
Our baseline measures showed random variation in caseload size. From our first PDSA cycle we learnt that there was a need to have an overview of the caseload with a standard approach to data input and quality assurance of the data. PDSA cycle two tested a caseload weighting tool with the Team Leader having oversight of all practitioner caseloads in one spreadsheet reviewed weekly. This highlighted double counting of patients and records remaining open after discharge showing a greater capacity in the team than previously evident. The run chart below shows a shift following PDSA 3 which utilised a caseload validation tool by team leaders during supervision sessions. The team have achieved an 8% reduction in the caseload



Conclusion:
While initial plans were to test a "Patient initiated follow up pathway", the project highlighted that the service was previously operating in a data blind environment. Bringing the ability to oversee total team caseload in a meaningful way assisted team leaders to explore obstacles to discharge within the team.

Key Project Learning:
Performance data gathered from outside the service was not presented in a way that allowed interrogation of trends.
Improvement means doing differently not doing more of.

Personal Learning:
Ensure I understand the system before jumping to a solution or change idea
Understanding balancing measures
Power of celebrating small wins, 1% on top of 1% soon builds momentum

Achievements:
Involving CMHT in the QI project has brought an enthusiasm to understand the system in which we work and that introducing small changes can have an accumulative effect.
The service has identified resource to provide informatics support.

Next Steps:
Test protected time in MDT meeting for discharge planning.
Identify patients suitable for Patient initiated follow up pathway.

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ScIL Scottish Improvement Leader

Early Post Discharge Appointment project

This project aimed to reduce the length of time a patient waits to be offered a follow-up appointment after they are discharged from acute mental health inpatient care – the National Confidential Inquiry (NCISH) recommends that this appointment should occur within 3 days to reduce risk of suicide as evidence shows day 3 is the highest risk day

- So far in 2024 **94%** of ALL patients discharged from mental health inpatient care have attended their appointment
- So far in 2024, the monthly average of **ALL** patients, who have been offered an appointment within 3 days following discharge from mental health inpatient care, is 88%
- In February 2024 – **100% of ALL** patients discharged from mental health inpatient care attended their early post discharge appointment – there were no DNA/CNA's
- Of those who attended their follow-up appointment, **95%** were seen face to face.

Delirium Bundles

Project Aim - To reduce the number of patients experiencing distress related to dementia, delirium and confusion in RVH Wards 7B and 7C by 20%, by May 2024

Physical care of the mentally ill (Schizophrenia Report Nov 2012)

Patients with serious mental illness have much higher rates of physical illness than the general population and are susceptible to hypothyroidism, dermatitis, obesity and hypertension. Additionally those will mental illness do less to protect their health with stubbornly high rates of those who continue to smoke.

For this reason our community and day case team are trained in identifying and screening service users to identify those who smoke and make interventions alongside the Trust's Smoking Cessation Team.

Additional to this information is provided to ensure service users are aware of how to look after their physical health and access physical healthcare should they require it.

To monitor this our CMHT maintain regular contact with primary care colleagues to ensure a patients holistic care needs are met encourage a collaborative approach in caring for the patient.

Keeping well staying well

Community Mental Health teams developed psycho-education sessions in a group setting for mental health service-users to support recovery and develop a Personal Wellbeing Plan with a Peer Support Worker. Using QI methodology we increased uptake of the service by 10%.

Adult Social Care Services

Adult Social Work and Social Care is part of the Directorates of Mental Health, Intellectual Disabilities and Psychological Services and Adult Community and Older People's Services, & Allied Health Professionals.

Carer Support

The number of carers offered a carer's assessment in adult social care has remained stable across service. There has been a slight % increase within this reporting period of 3.6%. The uptake of carer's assessment has however increased by 6.62% from 1873 to 1997 carer's assessments completed.

The number of carers receiving a carer's grant has reduced by 5.4% in this reporting period. The Trust reports that 2,213 carers availed of a carers grant from 1st April 23- 31st March 24. The number carers

receiving Direct Payments has reduced by 9%. This correlates to a reduction of 1.

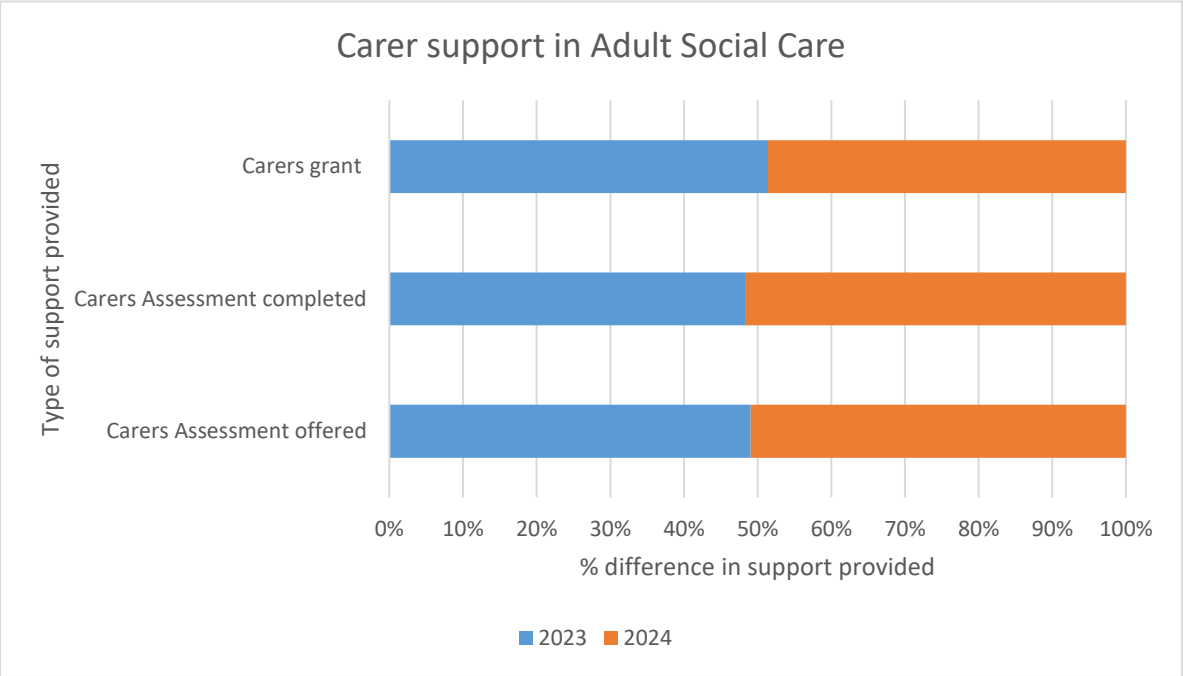


Table showing the % of carer Support in Adult Social Care 22/23 vs. 23/24.

Direct Payments

The number of adults in receipt of a direct payment has remained stable in the reporting period. There are currently 696 adults in receipt of a service who have chosen direct payments as the way to receive this service. This is an increase of 0.28%.

Applications for Assessment made by Approved Social Workers

The Trust continues to provide Approved Social Work services both with a day time rota and in the coordination and management of the Regional Emergency Social Work Service, which provides out of hours social work support across Northern Ireland.

The number of applications for assessment made by Approved Social Workers has reduced in both services in this reporting period. The % of applications for a period of assessment in hospital, made by Approved

Social Workers, is as follows. [This is the figure where people have been detained.]

Day service; -12.09% (from 339 in 22/23 to 298 in 23/24)

RESWS; - 13.5% (from 737 to 637)

Adult Safeguarding Referrals

In the financial year April 23 to March 24 – there were 4543 ASG referrals received, of which:

- 1850 were screened as “at risk of harm” and had an alternative safeguarding response in place.
- 639 were screened as a “in need of protection investigation” which would have a protection plan in place
- The rest were either screened as “no further action” or passed to another trust.

Learning Disability

Annual Health Check

It is estimated that 333 adults with a learning disability had an annual health check*.

*Further data and information on this is captured by the DOH

Readmittance to Hospital Following Community Placement Resettlement

0% of adults with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Connected Community Care
Empowering Local Wellbeing

Integrated Care Partnerships (ICPs)

The Connected Community Care service

The Connected Community Care service is an initiative developed by the Belfast Integrated Care Partnerships to connect people to local health and wellbeing support services to help them keep well. As a citywide social prescribing service, Connected Community Care work in partnership with statutory, voluntary and community organisations to help connect those at risk of chronic conditions, social isolation, dementia and a cancer diagnosis to support services within their local community.

For further information on this service please click **HERE**

Satisfaction Survey

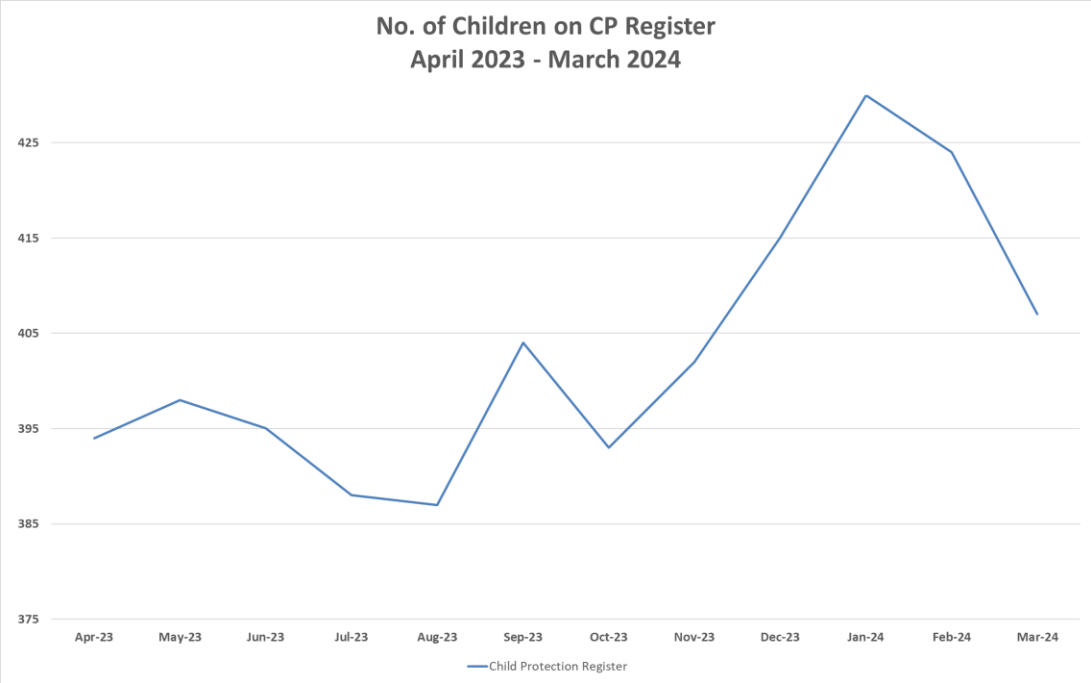
From the 23 – 24 satisfaction survey:
95% of service users said that they were treated with courtesy and professionalism
97% said that they felt listened to and their needs understood
73% said that their health and wellbeing improved as a result of the service
80% rated the service as excellent

The complete results of the satisfaction survey can be found **HERE**

Children's Social Care Services

Child Protection

As of **31/03/2024** there were **410 children** on the Child Protection register. This in an **increase of 15 children** when compared with last year's reporting period.



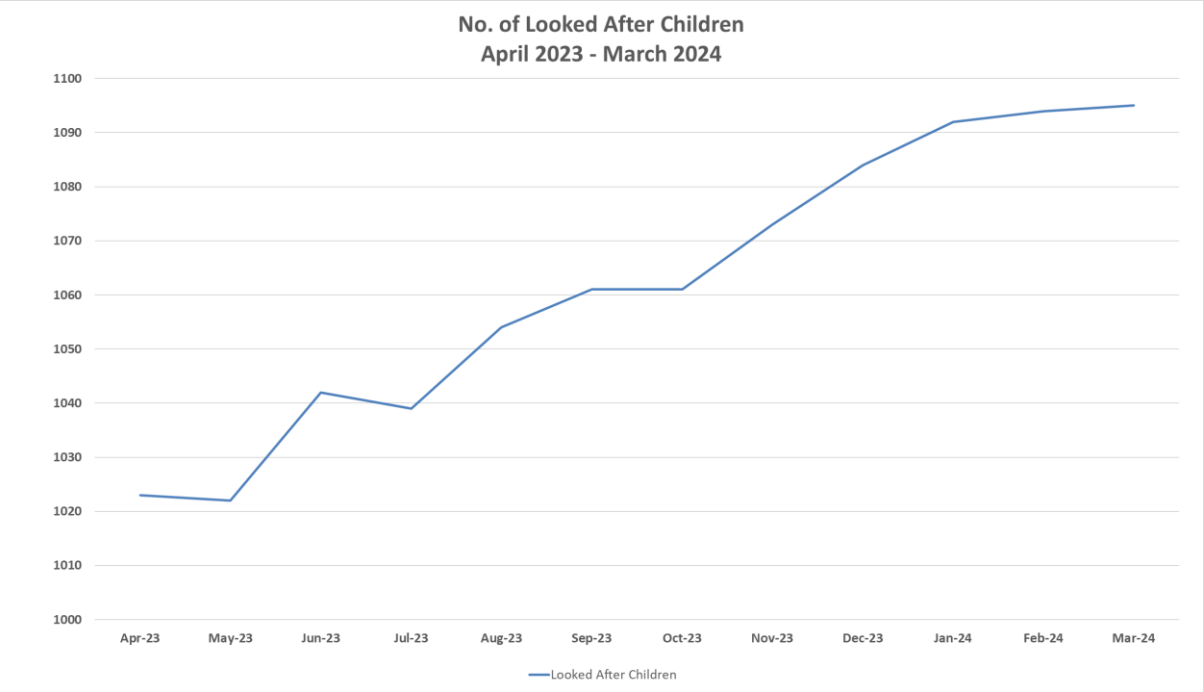
Graph showing Number of Children on CP Register 23/24.

Child Protection Referrals

In this reporting period **100%** of children or young persons were seen within 24 hours of a Child protection referral being made. (Source: HSCB-Priority 5 Return). This in an **increase of 0.3%** when compared with last year's reporting period.

Looked After Children

As of **31/03/2024** there were **1095** Looked After Children (LAC) within the Belfast Health and Social Care Trust. This in **an increase of 66 children** when compared with last year's reporting period.



Graph showing Number of Looked After Children 23/24.

Reviews for Looked After Children

There were a total of **283** LAC reviews held outside of the regionally agreed timescales for 2023-24 reporting period*. This is a **decrease of 92 LAC Reviews** held outside of the agreed timescales, resulting in a **24.5% decrease** when compared with last year's reporting period.

**Note this is a count of reviews during the period as per 10.1.16/17 DSF requirement, not a count of children so to give this as a percentage of the LAC*

Looked After Children in Care

In this reporting period **100%** of all looked after children in care for more than 9 months have a Permanency Panel Recommendation (CP 10.3.26). This remains consistent with last year's figures, resulting in **no change** with the previous reporting period.

Young People known to Leaving an Aftercare Service are Engaged in Education, Training, and Employment

76% of young people known to leaving an aftercare services in the Belfast Health and Social Care Trust are engaged in education, training, and employment*. This remains consistent with last year's figures, resulting in **no change** with the previous reporting period.

*DSF/Corporate Parenting Returns (10.4.10)

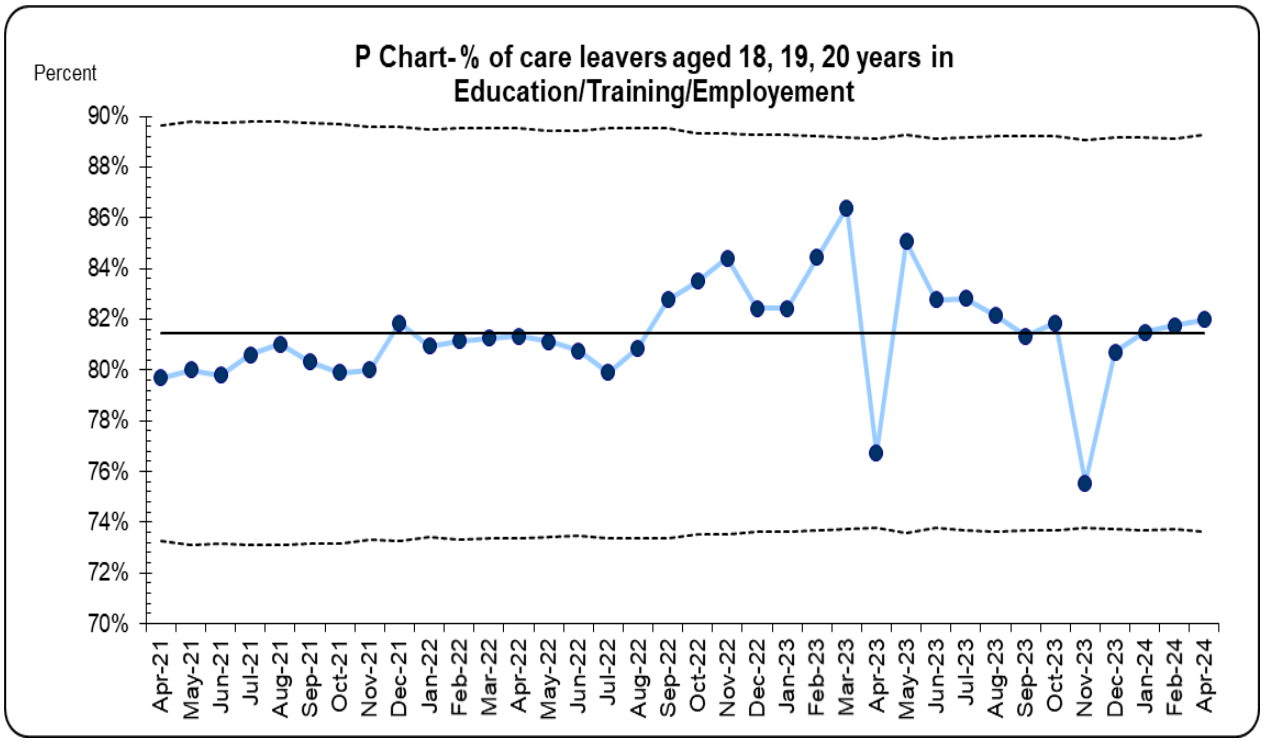


Table showing % of Care Leavers aged 18, 19, 20 years in Education/training/Employment 23/24.

Disabled Children

82% of disabled children has a transition plan in place when they leave school within the Belfast Health and Social Care Trust*. . This in **a decrease of 18%** when compared with last year's reporting period.

*Source: DSF/Corporate Parenting Returns (10.1.7)

Direct Payments

0% of children are currently in receipt of Direct Payments as set against the HSCB commissioning direction target DSF/Corporate Parenting Returns*. This remains consistent with last year's figures, resulting in **no change** with the previous reporting period. *As of 31/03/2024

Personal and Public Involvement (PPI) – Explaining key Work

Chaplaincy Service

A new Faith, Spiritual and Cultural Handbook – Caring for a person near or after death has been co-produced by Belfast Trust Chaplains, Faith Leaders, Trust Equality Leads and Bereavement Co-ordinators. The handbook was developed for the Bereaved NI website.
Faith, Spiritual and Cultural Handbook - Death - 2024 (pagetiger.com)

Refugee Week

Took park in Refugee week for the first time. The theme for Refugee Week 2024 was "Our Home". Belfast Trust had its first Cultural Competency Training session for staff. We presented at the Health Awareness – Holistic Wellbeing for all session and we had a stall for the first time at the Great Refugee Week Picnic.

Shopmobility & the Sighted Guide Services @RVH

Our Shopmobility and the Sighted Guide services are available to anyone who requires support to access buildings/services on the large

RVH site. Both services are now located within the main foyer of the RVH and continue to grow in demand.

In partnership with Shopmobility electric scooters and manual wheelchairs are provided free of charge to any service user, patient or visitor who requires it. This gives many disabled people independence when getting to an appointment, visiting a loved one or when being admitted or discharged. The contract is reviewed annually to ensure value for money and impact. A steering group exists to oversee and promote the project.

A Sighted Guide Service at the RVH is a tangible demonstration of Belfast Trust's continued commitment to deliver accessible services to disabled people. More than 30 Trust staff were trained by the sensory support team to 'meet and greet' anyone with a visual impairment to support them to get around the large complex RVH site.

Feedback from those that have used the services includes:

- Excellent service. Very friendly and helpful. I could not have attended my appointment without this service. It is too far for me to walk
- Excellent service. Very efficient & friendly service. Made it comfortable to attend appt.
- The help I received was great and friendly. I have mobility problems and without help wouldn't have been able to reach the department I had to get to.

Thank You Video from BHSCT Consultant Anaesthetist and QI Faculty: Dr Martin Duffy

Thank you for taking the time to read this year's Annual Quality Report.

Within the Belfast Trust we aim to ensure that quality improvement remains a Trust wide priority. QI is considered essential to providing sustainable, high quality person-centred care.

Our staff are encouraged to share responsibility for quality improvement at all levels and we continue to build the capacity & capability to enhance patient and service user experience and to deliver safe, compassionate care throughout the organisation.

We collectively acknowledge the ongoing challenges within the complex adaptive healthcare system. QI forms part of the journey towards a restorative, just and learning culture, based around a safety, well-being and quality focussed organisational ethos. This is enhanced by fostering relationships to break down silos and share best practice.

Effective leadership is important to promote shared standards and for staff to feel engaged, empowered and supported to deliver improvements. In Belfast Trust we continue to build the skills and capabilities by ensuring a consistent and coherent approach to quality improvement and patient safety. We give agency and support to frontline colleagues to engage in quality improvement by providing training, support and tools to deliver improvements at the point of care.

To deliver high quality care we engage in meaningful patient and service user involvement. These service developments are systematically incorporated into our growing culture of learning to enhance safety. We are committed to improve patient experience and health outcomes. We listen to patients, staff and the public and work collectively to enhance system performance and enhance wellbeing. We are driven to learn from when things do not go as planned and as well as from when things happen as planned to provide an expected high quality experience and good outcome. In Belfast Trust, Quality and safety is the collective responsibility for all our healthcare teams and we learn, deliver and improve together.

This quality improvement work is demonstrated throughout this year's Annual Quality Report. These improvement projects are only possible due to the amazing effort from our staff in Belfast Trust, who continue to

prioritise quality and safety even while working in some of the most under pressure departments.

The production of the Annual Quality Report would not be possible without the Quality Improvement Team, based in Musgrave Park Hospital. Special thanks also goes to Ms Caroline McMenamin from the Planning and Equality Team, our colleagues in the Corporate Communications team and each Directorate Representative who submitted their data, their stories and their time.

There is an interactive version of the Report HERE