agenda

Title of Meeting	132nd Meeting of the Public Health Agency Board
Date	15 April 2021 at 1.30pm
Venue	Via Zoom

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 18 March 2021		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 1.55	Finance Report	**PHA/01/04/21**	Director of Finance
8 2.05	Update on COVID-19 To include: • Presentation by Dr Liz Mitchell		Chief Executive

committee updates

9 2.45	Establishment of a Resources and General Purposes Committee	**PHA/02/04/21**	Chair

for approval

10 2.55	Annual Quality Report	**PHA/03/04/21**	Mr Morton

for noting

11 3.15	Implementation of a Daily AMT/SMT Huddle during the First Wave of the COVID-19 Pandemic using a QI Approach	**PHA/04/04/21**	Dr Keaney
12 3.35	Specialist Training Programme in Public Health	**PHA/05/05/21**	Dr Bergin

closing items

13 Any Other Business
3.40

14 Details of next meeting:

Thursday 20 May 2021 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

HSC Public Health Agency

minutes

Title of Meeting	131st Meeting of the Public Health Agency Board
Date	18 March 2021 at 1.30pm
Venue	12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair (*via video link*)
Mrs Olive MacLeod	-	Interim Chief Executive (*via video link*)
Dr Stephen Bergin	-	Interim Director of Public Health (*via video link*)
Mr Stephen Wilson	-	(*via video link*) Interim Director of Operations (*via video link*)
Alderman William Ashe	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director (*via video link*)
Alderman Paul Porter	-	Non-Executive Director (*via video link*)
Professor Nichola Rooney	-	Non-Executive Director (*via video link*)
Mr Joseph Stewart	-	Non-Executive Director (*via video link*)

In Attendance

Ms Tracey McCaig	-	Interim Director of Finance, HSCB *(via video link)*
Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Mr John Patrick Clayton	-	Non-Executive Director
Dr Aideen Keaney	-	Director of Quality Improvement

25/21	**Item 1 – Welcome and Apologies**
25/21.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Rodney Morton, Mr John Patrick Clayton and Dr Aideen Keaney.
26/21	**Item 2 – Declaration of Interests**
26/21.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No declarations were made.
27/21	**Item 3 – Minutes of previous meeting held on 18 February 2021**
27/21.1	The minutes of the Board meeting held on 18 February 2021 were

APPROVED as an accurate record of that meeting.

28/21 **Item 4 – Matters Arising**

18/21.1 Level of Funding for Health Research in Northern Ireland

28/21.1 The Chair advised that he had had a further conversation with Dr Bailie about this matter and it was agreed to hold off on sending any correspondence at this time because there are currently ongoing discussions about funding for COVID-19 research.

20/21.4 FIT Tests

28/21.2 The Chair noted that FIT tests are going ahead in all 5 Trust areas, but at a slower pace.

29/21 **Item 5 – Chair's Business**

29/21.1 The Chair apologised for the delay in issuing his Report saying that he had been participating this week in the recruitment exercise for the post of PHA Chief Executive.

29/21.2 The Chair said that it would be beneficial for PHA, and other HSC organisations, to move to 3-year funding cycles, similar to some Whitehall departments, and advised that, along with other HSC Chairs, an approach is going to be made to the Department regarding this. He felt that this would lead to a more effective use of time and resources.

29/21.3 The Chair informed members that he had listened to a recent Radio 4 programme on which there was a discussion on mental health. He reported that published research indicated that during the pandemic 25% of the population reported that they have experienced increased levels of anxiety and depression.

29/21.4 The Chair noted that last week, there was a Public Accounts Committee hearing about the amount of money being spent on testing and tracing in England. He said that £22bn is being spent annually on testing and tracing and if Northern Ireland was receiving its share of this amount it would receive £693m. Of the £22bn, he advised that £8bn is being spent on contact tracing UK-wide, the Northern Ireland share of which would be £229m. He added that a recent figure showed that PHA was spending £4.8m per annum on contact tracing and support. The Interim Chief Executive clarified that PHA is now following up on individuals who are self-isolating and is carrying out some research in this area, a report on this will be brought to the April Board meeting. He recalled that research has shown that less than 30% of individuals were isolating for the full period. He added that in that instance a 95% success rate in contacting would mean than less than 29% were in fact isolating for the full period of 10 days. He emphasised that in no way was he critical of the excellent service being provided by contact tracing staff. However, if

considerable extra resources are available, he felt that we should not be reluctant to garner additional funding in order to support in every way possible those advised to self-isolate.

30/21 **Item 6 – Chief Executive's Report**

30/21.1 The Interim Chief Executive noted that the Report continues to evolve and contains a lot of information. She advised that in terms of the COVID-19 vaccination programme, this will be transferring to PHA so in preparation for this, PHA has established a small working group to look at what this is. She said that PHA will require additional staff to co-ordinate this programme and that it will be likely be transferring to PHA within the next year. Dr Bergin reiterated that PHA will need to be ready so planning has commenced early. He said this programme will add to the list of vaccination programmes in which PHA is already involved, He added that it may be possible to run it alongside the flu programme.

30/21.2 Going through the Report, Professor Rooney asked for more information about CMR recommendations. Ms Roulston explained that this is a Case Management Review whereby in the event of the death of a child, the case is reported to the Safeguarding Board for Northern Ireland (SBNI) and a review carried out. In response to Professor Rooney's query about PHA's role, Ms Roulston explained that PHA acts as the host for SBNI and one of the PHA's nursing staff, Ms Emily Roberts, is a Safeguarding Nurse who along with Mr Morton, sits on the Board of SBNI.

30/21.3 Professor Rooney noted that the number of daily positive cases of COVID-19 is around 250 per day, but there is a large number of full time and part time staff. She asked if these full time are existing PHA staff. The Interim Chief Executive explained that PHA has a flexible model in place to cope with the number of cases and that there is a core group of staff who are working full time on a 1-year contract with an option for a second year. She added that there is also a number of part time staff and a substantial bank of Trust stuff. She said that this model represents the best value for money and is the most flexible. Professor Rooney asked if PHA will have to reduce the staff number if the number of cases reduces. The Interim Chief Executive explained that although the number of cases is lower staff are now increasing the number of attempted calls to each from 5 to 7 within the first 48 hours and are also carrying out more follow up calls. She noted that while PHA has contact details for people, these are mainly mobile numbers so it is difficult to determine if people are staying at home and PHA does not have the enforcement power to make people stay at home. She added that the staff on the bank list are brought in approximately once a month so as to maintain their skills and staff who come from a medical or nursing background are also being asked if they can help with the vaccination programme. She explained that the Department has written to all ALBs asking that staff be released to help with the new vaccination centre that will be opened at the SSE Arena next month. On the issue of vaccines,

	Professor Rooney asked if PHA is collecting data on whether PHA who have had a vaccination subsequently get COVID-19. The Interim Chief Executive advised that when a positive case is contacted, one of the first questions they are asked is whether they have had a COVID-19 vaccine.
30/21.4	Mr Stewart returned to the matter of PHA assuming responsibility for the management of the COVID-19 vaccination programme and noting that originally PHA was to have no involvement in this programme, but now it is to be managing it on an ongoing basis. He sought assurance that PHA can take this on and that it will not assume this responsibility without seeking additional funding. He added that it is important that the Executive Directors stay on top of this and keep the Board informed. The Interim Chief Executive said that the PHA is responsible for all vaccination programmes, but in this instance the Department of Health took on the management of this programme as it was felt to be too big for PHA. However, she said that the programme will come to PHA and she acknowledged that it will be a huge undertaking, therefore PHA has already begun to give consideration as to the implications and that when the time comes PHA will be clear on what it has to deliver. Dr Bergin clarified that although, there is no formal correspondence advising that PHA is taking on this programme, it is to be expected, hence PHA is beginning its planning now. He pointed out that PHA also manages the flu vaccination programme and this year over 1 million doses were administered so PHA is well rehearsed and well drilled in terms of carrying out such programmes but it will be working on a business case to get additional staff. The Chair asked if, going forward, the flu and COVID-19 vaccines can be administered at the same time, but Dr Bergin said that he did not know it this was the case.
30/21.5	Ms Mann-Kler asked about the Child Death Overview Panel. She noted that there have been increased concerns about safeguarding during COVID-19 and she asked about how this work will be taken forward, particularly now that the functions of the social care and children's directorate will not be transferring to PHA. Ms Roulston advised that last week she had spoken to Ms Eileen McEneaney, the Director of Nursing in the Northern Trust, and that Ms McEneaney has been asked to take forward a piece of work by the Department on the Child Death Overview Panel and will be seeking a nominee from HSCB and PHA to sit on a group. She added that the Department would like to see this piece of work completed as soon as possible. She advised that going forward, she thought that this function would remain within SBNI.
30/21.6	Ms Mann-Kler commented that while she welcomes the detail within the Chief Executive's Report, she would like to know how it fits with PHA's strategic objectives and if there was a way of restructuring the Report. The Interim Chief Executive said that PHA has its Corporate Plan and Business Plan and the purpose of this Report is to try to bring all of that together and to ensure the Board is given the full picture of everything that is happening across the organisation. She added that the Executive

	Directors also find it useful to reflect on what has been achieved over the last month, but she agreed that it could be looked at further. Ms Mann-Kler said that she did not wish to add to the workload of staff, but suggested that a biannual update would be beneficial which showed evidence of outcomes against objectives.
30/21.7	Alderman Ashe sought further clarity on individuals contracting COVID-19 after being vaccinated and how data is captured. Dr Bergin explained that PHA is developing a vaccination information management system where this data will be embedded. He noted that no vaccine is 100% effective so there will always be a small percentage of people who will get COVID-19 despite being vaccinated. He added that by this stage, all care home residents will have received their second dose and PHA is currently carrying out a study of the effectiveness of the vaccine. He noted that if the vaccine is 90% effective, then PHA would need to be able to study the characteristics of the 10% of people for whom it is not effective in terms of age, ethnicity, other morbidities etc. Furthermore, he said that PHA will need to look at variants and track these and the effectiveness of the vaccine in dealing with these. He commented that although PHA may not be carrying out the vaccinations, it will have the oversight and the intelligence to monitor the effectiveness.
30/21.8	Returning to the format of the Chief Executive's Report, Mr Wilson pointed out that PHA does not have an approved business plan in place for 2020/21 because of COVID and normally PHA would report against its business plan so this can be looked at going forward. Ms Mann-Kler said that it would be helpful to change the focus from activity to impact.
30/21.9	The Chair noted that Dr Diane Anderson has been appointed as Senior Health Intelligence Manager and he asked if her role will be different to that of her predecessor. Mr Wilson confirmed that Dr Anderson has taken up the role and although the job description has been slightly revised, her role will largely be similar. He added that she will be looking at the outworking of the Hussey Review in terms of how the different sources of data across the organisation are pulled together. The Chair said that it would be useful to see the revised job description (Action – Mr Wilson).
30/21.10	Alderman Porter asked how PHA is dealing with the amount of misinformation that is going out on social media about the vaccine and how quick PHA is in debunking any rumours that are circulating. The Interim Chief Executive explained that although the vaccination programme is led by the Department, the communications element is directed by the Minister and Mr Wilson and his team are delivering on it. Mr Wilson said that this is an issue that PHA is very alive to and advised that there is a health intelligence subgroup looking at misinformation and that Queen's University is also carrying out a piece of work. He explained that based on any of their findings PHA can tailor its messages appropriately. He acknowledged that there is a lot of information on social media but the Trusts and the Department are

working hard to get the key messages out. He added that today is the closing date for a survey that Trusts are conducting on staff attitudes towards the vaccine. He said that there is anecdotal evidence that there is a number of key groups who are not taking up the vaccine, so again tailored messages are being put and PHA is working with counterparts across the UK to ensure that there is a consistent approach. The Chair noted that there is a difference between anti-vaxxers and those who are vaccine hesitant. Mr Wilson said that there is an ongoing campaign which shows that there is a steady increase in the number of people who have said that they will get the vaccine, and a smaller number of those who are refusing to get it. The Chair asked about targeting socially deprived areas and Mr Wilson commented that this is where the benefit of a vaccine management system will come in.

31/21 **Item 7 – Finance Report (PHA/01/03/21)**

31/21.1 Ms McCaig presented the Finance Report for the period up to 31 January 2021 and advised that PHA is reporting an underspend to date of £1.3m but she is confident that this will be retracted by the Department, therefore the year-end position will be a break even one.

31/21.2 Ms McCaig explained that the slippage is made up of £500k from the programme budget and approximately £800k from the management and administration budget. She noted the Chair's concern about slippage and said that PHA is not alone in this situation in terms of not being able to spend funding due to COVID-19.

31/21.3 Ms McCaig gave an overview of the Trust programme expenditure and PHA's direct programme expenditure. Moving onto ring fenced allocations she said that PHA has received some funding in relation to COVID-19 and she expected that there will be further funding to come ensuring that a break even position will be achieved.

31/21.4 Ms McCaig advised that in terms of the management and administration budget, PHA has commenced an exercise to review the management and administration budget for 2021/22. With regard to capital funding, Ms McCaig said that PHA is expected to break even. Finally, looking at the prompt payment performance, Ms McCaig noted that it is unlikely at this stage that PHA will be able to reach the 95% target with regard to invoices being paid within 30 days but there has been a strong performance with regard to the 10-day target. She said that her team is working on a paper on how it can assist PHA in this regard.

31/21.5 Mr Stewart asked Ms McCaig for her assessment in terms of how confident she is that PHA will receive additional funding for COVID-19, and whether the projected surplus will increase further before the year end. Ms McCaig responded saying that in terms of the surplus she is expecting that this will grow slightly, but said that PHA is working with Trust and community and voluntary sector organisations although given the pandemic the ability to come up with alternative means of allocating

this funding is hampered. She added that PHA is working with the Department in terms of the amount of slippage which may be retracted as the Department is working to resolve the position for the HSC as a whole. In terms of COVID-19 funding she said she was confident that PHA will receive the money that it requires. Mr Stewart surmised that the underspend in 2020/21 could end up in the region of £2-£2.5 million.

31/21.6 The Chair asked if this underspend is solely due to COVID-19. Ms McCaig reiterated that all HSC organisations are in a similar position and this year it is especially difficult to reallocate funding. The Chair felt that at the start of each year PHA should prepare a priority list of potential areas that it could fund in the event of there being slippage. Alderman Porter agreed with this suggestion pointing out that PHA has a track record of always handing back money which then makes it more difficult to make the argument that it requires more funding to do its work.

31/21.7 The Board noted the Finance Report.

32/21 Item 8 – Update on COVID-19

32/21.1 The Interim Chief Executive advised that the number of positive cases has reduced slightly over the last week. She said that on 11 March there were 236 cases with 660 contacts and that yesterday the number of cases was 143 with 423 contacts. She added that today's opening figure is 140.

32/21.2 The Interim Chief Executive said that with the small number of cases it is becoming difficult to detect clusters and that clusters are appearing in different areas. She advised that PHA is focusing on looking for trends as they emerge so that a mobile testing unit can be deployed to an area if required and the health improvement team can work with organisations to get messages out to help reduce the spread of the disease.

32/21.3 The Interim Chief Executive advised that in terms of the restart programme, the Rebuild Management Board (RMB) is wanting to see outpatient services commence over Easter. However, she noted that PHA will be continuing to focus on testing, tracing and messaging as there has been a 3% increase in cases during the last week. She advised that the number of people getting tested is used as a crude measure of trying to predict the number of cases.

32/21.4 Dr Bergin said that this current period could last a few more months and certainly until people have had their second vaccination. Therefore he said it is important that people do not drop their guard. He said a further six months of effort is required. He noted that if the vaccine is 90% effective, but only 70% of the population have it then around a third of the population are potentially still vulnerable. He said that in time the population will have to live with this virus and that the key messages

around hands, face and space will be relevant for all of next winter. The Interim Chief Executive added that there is already a group looking at the planning for next winter.

32/21.5 Alderman Porter said that while he has supported the work that PHA has carried out over the last year, he said that needs to be a determination made as to whether the current public health approach is doing more harm than good. He asked what modelling is being used to determine what restrictions are being put in place as he felt that a tipping point is being reached. He explained that to base the approach on factors such as hospital admissions, numbers of cases and numbers of people vaccinated takes away from the fact that lockdown is impacting on people's mental health and there are people waiting for cancer screenings and other treatments. He said that this situation cannot continue for another six months. He asked if PHA is part of the conversation on these issues. Dr Bergin clarified that when he said six months, he was referring to the need to reinforce the public health messages for the next months. He advised that the measures and restrictions are policy decisions which are outwith the remit of PHA, but he pointed out that this year there was a much lower number of flu cases.

32/21.6 Ms Mann-Kler asked about the impact of the potential vaccine shortage. She also asked about the work that was done on a "lessons learnt" report that was discussed at the last Governance and Audit Committee and which should be brought to the Board. She raised the issue of the societal cost of the pandemic in terms of missed cancer diagnoses and the cost in terms of mental health. The Interim Chief Executive advised that there is a meeting taking place later today of the Vaccination Programme Board at which there will be a discussion about the potential delay in receiving vaccines. She added that Northern Ireland is slightly ahead in terms of its rollout and the impact of the delay will only be for about 2 weeks, but she assured members that anyone who has an appointment for a second vaccination will receive their second dose. With regard to the lessons learnt report, Mr Wilson said this refers to a report that Dr Keaney had prepared on the daily "huddle" and this is on the agenda for the next Board meeting.

32/21.7 Professor Rooney also raised the issue of screening and asked if PHA is measuring the impact of the cessation of screening. The Interim Chief Executive said that only some screening programmes were slowed down. Professor Rooney asked if there are data available in terms of numbers of people impacted. Dr Bergin outlined that each screening programme has a Quality Assurance Manager and that previously an annual report on each programme would have come to the PHA Board. He said he is aware that programmes are running behind. He advised that Dr Anna Gavin in the Northern Ireland Cancer Registry has estimated that there are up to 1,500 cases of cancer which would have been picked up in a non-COVID year. He said that it may take up to a year for cancer screening programmes to fully recover. He explained

that even those programmes that are up and running are functioning at a slower pace because of infection prevention control measures that need to be taken.

32/21.8 Professor Rooney asked if it was PHA's decision to stop screening, but Dr Bergin advised that it was a Ministerial decision. Professor Rooney asked if PHA had given advice on this matter. Dr Bergin said that the advice to the Minister would have come from the Chief Medical Officer's office based upon briefings provided by the PHA. He said that these issues will be picked up at the next meeting of the Screening Programme Board which is due to take place on Monday. The Interim Chief Executive added that screening is also discussed at the RMB meetings, but pointed out that there is little point in carrying out screening if the required follow up services cannot be offered. She reported that two Trusts had stopped screening, but only for a short period. She said that screening is discussed at the RMB meetings and any papers for decision go to the Minister. Professor Rooney said that she is seeking to clarify PHA's role in the decision to stop screening in the event of any look back exercise, and if PHA was providing data or advice. The Interim Chief Executive reiterated that only three programmes were stopped and the Trusts advised that they were stopping them. She added that funding was sought to run extra clinics. She said that PHA's role was to gather facts and report to the Department, and that Dr Adrian Mairs is currently working with the Trusts on a recovery plan.

32/21.9 Alderman Porter said that this goes back to the concern he raised as to whether PHA is aware of the harm that is being caused and where the tipping point is, and if PHA contributes to the conversation or merely provides data. He said he believed that PHA has a role in this. The Interim Chief Executive explained that she is a member of RMB and that when screening reports are presented the issue is capacity within Trusts because the current policy direction is to look after those who are in intensive care with COVID-19. She added that representatives from the Minister's office also attend these meetings. She said that Trusts are aware of their role and all of the issues are debated, but the Trusts are doing all that they can in the current circumstances. She accepted that it is a moral dilemma.

32/21.10 Professor Rooney asked whether this shows that there is a stronger focus on health rather than wellbeing and she pointed out that PHA's full title is the Regional Agency for Public Health and Social Wellbeing and going forward, does PHA needs to review its name.

32/21.11 Dr Bergin said that all of the public health advice is coalesced at the national SAGE groups.

33/21 Item 9 - Update from Chair of Governance and Audit Committee (PHA/02/03/21)

33/21.1 Mr Stewart informed members that the minutes of the Governance and Audit Committee held in December were available for noting, but that there were issues discussed at that meeting that were also discussed at the most recent meeting of the Committee on 8 March. He advised that while the Committee had asked for an audit of the contact tracing service to be carried out, it did not formally approve the terms of reference for the audit and he raised this with Internal Audit. However, he said that following a discussion with Internal Audit he was satisfied that the terms of reference would cover the issues at which the Committee wished to look. He noted that External Audit will be looking at the impact of the changes at senior management level over the last year.

33/21.2 Mr Stewart advised that he and Mr Clayton had attended a training event for Governance and Audit Committee members run by the Chief Executives' Forum. He said that following this training, he had had a discussion with Miss Rosemary Taylor as there is a need for the whole Board to take ownership of the Corporate Risk Register even though the Governance and Audit Committee carries out an in-depth review of the Register each time it is updated.

33/21.3 Mr Stewart noted that following an audit of risk management, Internal Audit had raised a concern about the timeliness of the Register being presented to the Committee and he was not happy with that as he was cognisant that the Interim Chief Executive had asked for an extensive review of the Corporate Risk Register at that time. He advised that the latest Register was brought to the Committee and contained 3 new risks, the first of these related to the recruitment of vaccinators. He said that the second new risk concerned the IT systems that support screening programmes as these need to be replaced, and the third risk related to the impact on PHA of the closure of HSCB.

33/21.4 Mr Stewart said that there were discussions at both meetings about finance and what support PHA will receive following the closure of HSCB. He advised that a list of options has been reduced to two and these are with the Department for consideration, but he hoped that there will be further consultation with PHA on this.

33/21.5 Mr Stewart said that there was an update on information governance and advised that Mr Clayton has taken on his role as being the NED representative on the Information Governance Steering Group. He noted that there were some concerns about the volume of data that PHA now holds and the need to ensure that all staff are properly trained.

33/21.6 Mr Stewart returned to the issue of the recruitment of vaccinators and said that he had asked Internal Audit to review this matter and although the terms of reference have yet to be agreed, it is likely that this will take place in April.

33/21.7 Mr Stewart advised that in addition to looking at the turnover of senior

staff, External Audit will be looking at governance and management overrides.

33/21.8 Mr Stewart said that he was deeply indebted to Ms Mann-Kler and Mr Clayton for their work in supporting him. The Chair endorsed this and thanked the members for being conscientious in their duties, acknowledging the volume of work that the Committee undertakes. He said that he continues to remain concerned about the finance function and he hoped that there will be extensive consultation on this matter and that the PHA Board will have an input.

33/21.9 The Board noted the update from the Chair of the Governance and Audit Committee.

34/21 Item 10 - Update from Chair of Remuneration and Terms of Service Committee

34/21.1 The Chair advised that the Remuneration and Terms of Service Committee had held a meeting last week and he would share the draft minutes with members when they were available.

34/21.2 Alderman Porter noted that the Committee had discussed the issue of senior executive pay. The Chair thanked Alderman Porter for reminding him of this and outlined that this has been an issue that has been ongoing for several years with senior executives not receiving a cost of living increase since 2016/17. He advised that there is legal action pending. He added that given the amount of work senior executives had carried out in the last year in supporting the HSC COVID-19 response, it is demotivating that they are being treated in this way and that as a collective, the PHA Board would like to see this money paid. He noted that the amount involved would be a small percentage of the overall HSC budget. Alderman Porter added that there is now a situation where junior staff, who are a different payscale, are earning more than their managers. He felt that it was appropriate that the Committee should do what it can to rectify this matter and he wished to put on record his support for the work of the Executive Directors during this time.

34/21.3 The Chair **AGREED** that he would link with other HSC Chairs, through the Chairs' Forum, and write to the Department to seek urgent resolution of this issue (Action – Chair).

34/21.4 The Board noted the update from the Chair of the Remuneration and Terms of Service Committee.

35/21 Item 11 - Establishment of a Resources and General Purposes Committee

35/21.1 The Chair advised that he had issued a short paper on the proposed establishment of a Resources and General Purposes Committee to members earlier today, and given that members would not have had the time to consider this fully, he asked that any comments on the paper be sent to him within the next week and that this would be brought back to the Board in April.

36/21 Item 12 - Review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority (PHA/03/03/21)

36/21.1 Mr Wilson advised that the annual review of PHA's Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority had taken place and had resulted in some minor amendments. He added that these had been brought to the Governance and Audit Committee at its meeting on 8 March and had been approved.

36/21.2 The Chair noted that there were sections in the Scheme of Delegation where it referred to "Appropriate Director" rather than naming a specific Director as in other instances. Mr Wilson said that this may depend on the subject matter of the topic.

36/21.3 The Board **APPROVED** the review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority.

37/21 Item 13 – Register of Interests (PHA/04/03/21)

37/21.1 The Chair asked that members ensure that their entries in the Register of Interests are correct and up to date and to advise Mr Graham of any changes at the earliest opportunity.

37/21.2 The Board noted the Register of Interests.

38/21 Item 14 – Any Other Business

38/21.1 The Chair asked that members are kept up to date on the issue of accommodation. The Interim Chief Executive advised that a survey was recently carried out but the results have not yet been made available.

38/21.2 The Chair asked if PHA has an option to look at other accommodation options. The Interim Chief Executive said that a lot has changed following the pandemic and it would be beneficial to see the report in the first instance. She advised that a new flexible working model is being developed and that the impact of this will need to be looked at. She said that this will be an opportunity for PHA to organise the space that it currently has in a better way.

38/21.3 The Chair advised that today is Ms Roulston's last PHA Board meeting before her retirement. He paid tribute to Ms Roulston's professionalism and dedication over many years which saw her recognised in the Queen's Honours List. He thanked her for her support to PHA and for

her work in both HSCB and the Northern Trust.

38/21.4 The Chair thanked members for their participation in today's meeting and drew the meeting to a close.

39/21 Item 15 – Details of Next Meeting

Thursday 15 April 2021 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7ES

Signed by Chair:

Date:

Public Health Agency

Finance Report

2020-21

Month 11 - February 2021

PHA Financial Report - Executive Summary

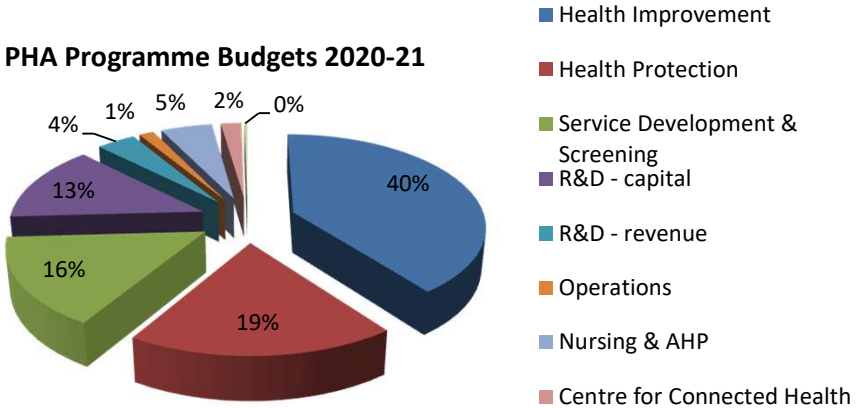
Year to Date Financial Position (page 2)

At the end of month 11 PHA is reporting an underspend of £0.8m against its profiled budget. This underspend is primarily the result of underspends on Administration budgets (page 6), and the limited potential to absorb this surplus on Programme priorities in the current year due to the pandemic.

Budget managers continue to be encouraged to closely review their profiles and financial positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.

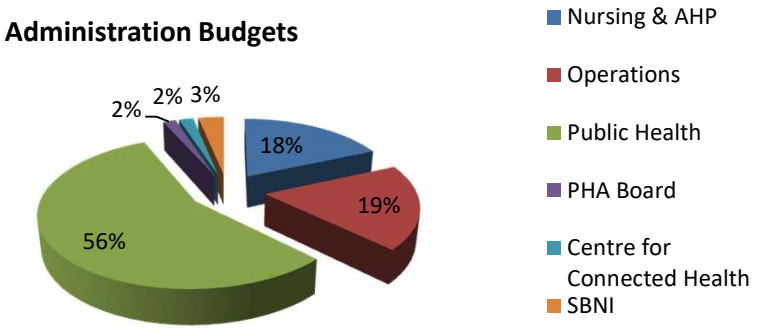


Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year. Slippage is expected to arise from Administration budgets in particular. In previous years this has been used to fund a range of in-year pressures and initiatives, however the impact of COVID-19 has reduced the potential to absorb this slippage in 2020-21. Discussions are on-going with the Department in the respect of the overall HSC financial position, and the forecast position reported above reflects these discussions.

Public Health Agency
2020 -21 Summary Position - February 2021

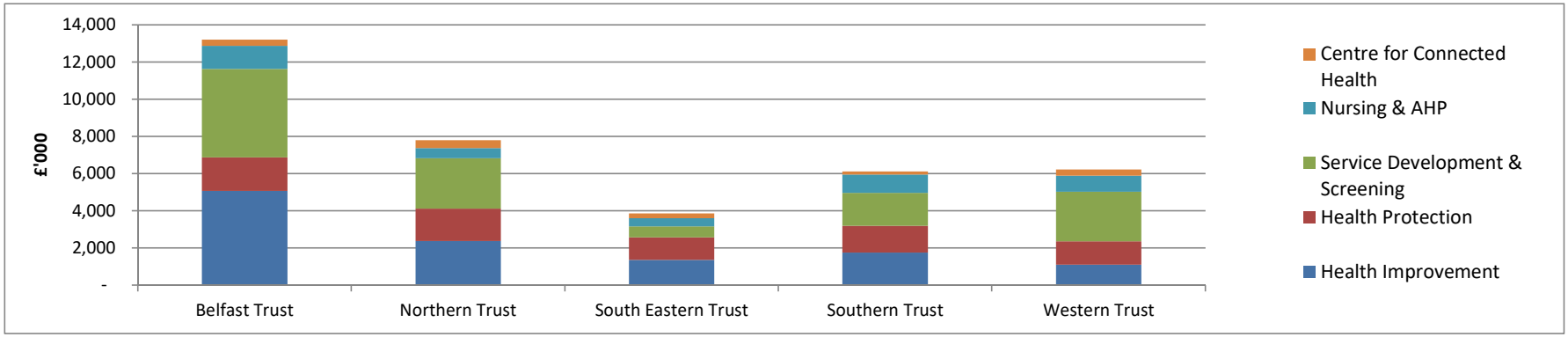
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	37,734	45,495	14,328	22,240	**119,797**	34,589	38,044	10,494	20,229	**103,357**
Assumed Retraction	-	(733)	-	(982)	**(1,715)**	-	-	-	-	**-**
Revenue Income from Other Sources	-	24	-	814	**838**	-	24	-	705	**728**
Total Available Resources	37,734	44,786	14,328	22,072	**118,920**	34,589	38,068	10,494	20,935	**104,085**
Expenditure										
Trusts	37,734	-	3,573	-	**41,307**	34,589	-	3,230	-	**37,819**
PHA Direct Programme *	-	44,786	10,755	-	**55,540**	-	38,003	7,265	-	**45,268**
PHA Administration	-	-	-	22,072	**22,072**	-	-		20,156	**20,156**
Total Proposed Budgets	37,734	44,786	14,328	22,072	**118,920**	34,589	38,003	10,494	20,156	**103,242**
Surplus/(Deficit) - Revenue	-	-	-	-	-	-	65	-	779	**844**
Cumulative variance (%)						***0.00%***	***0.17%***	***0.00%***	***3.72%***	***0.81%***

The year to date financial position for the PHA shows an underspend of £0.8m, which consists primarily of year-to-date underspends on Administration budgets.

A year-end breakeven position is currently forecast, allowing for an expected £1.7m retraction by DoH. This is in addition to a £0.7m retraction processed in February. These retractions are the result of underspends on the Administration and Programme budgets, with the impact of COVID-19 restricting the potential to recycle this funding by utilising it on Programme priorities as in previous years. Discussions will continue with the DoH in the respect of the overall HSC financial position, and the forecast position reported above reflects these discussions.

** PHA Direct Programme includes amounts which may transfer to Trusts later in the year*

Programme Expenditure with Trusts

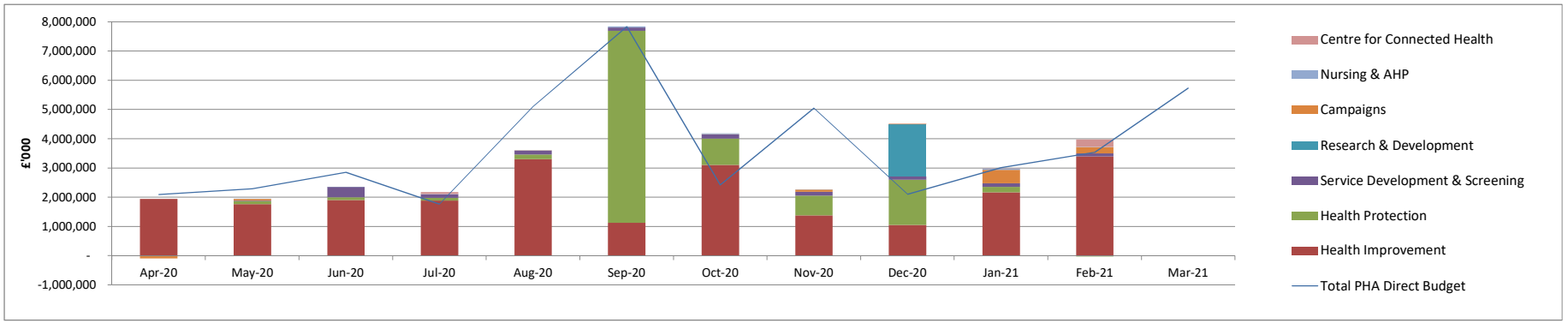


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,079	2,374	1,366	1,751	1,110	**11,681**	10,708	10,708	-
Health Protection	1,792	1,737	1,212	1,440	1,244	**7,425**	6,807	6,807	-
Service Development & Screening	4,764	2,720	581	1,769	2,672	**12,506**	11,464	11,464	-
Nursing & AHP	1,241	544	446	990	868	**4,089**	3,748	3,748	-
Centre for Connected Health	329	431	247	172	338	**1,516**	1,390	1,390	-
Other	152	122	56	91	95	**516**	473	473	-
Total current RRLs	**13,358**	**7,929**	**3,908**	**6,212**	**6,326**	**37,734**	**34,589**	**34,589**	-
Cumulative variance (%)									***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

The Other line relates to general allocations to Trusts for items such as the Apprenticeship Levy and Inflation.

PHA Direct Programme Expenditure



	Apr-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	2,096	2,096	2,096	1,239	4,555	972	1,209	1,856	1,157	2,465	3,247	2,926	**25,914**	22,988	23,048	(60)	*-0.3%*
Health Protection	-	100	160	192	186	6,577	917	916	958	410	70	64	**10,549**	10,485	10,311	174	*1.7%*
Service Development & Screening	-	95	562	215	364	215	215	31	50	2	44	352	**2,144**	1,793	1,792	0	*0.0%*
Research & Development	-	-	-	-	-	-	-	-	1,780	-	-	1,812	**3,592**	1,780	1,780	-	*0.0%*
Campaigns	-	-	-	10	20	45	60	- 15	250	80	144	778	**1,372**	594	733	(139)	*-23.4%*
Nursing & AHP	-	-	39	39	- 21	27	19	61	98	46	5	335	**650**	315	127	188	*59.6%*
Centre for Connected Health	-	-	-	70	-	-	-	-	8	8	28	255	**369**	114	330	(217)	*-190.7%*
Other	-	-	-	-	-	-	-	-	-	-	-	(788)	**(788)**	-	(118)	118	*100.0%*
Total PHA Direct Budget	**2,096**	**2,291**	**2,857**	**1,765**	**5,105**	**7,836**	**2,420**	**2,849**	**4,301**	**3,010**	**3,538**	**5,734**	**43,802**	**38,068**	**38,003**	**65**	
Cumulative variance (%)																***0.17%***	
Actual Expenditure	**1,854**	**2,030**	**2,394**	**2,219**	**3,594**	**7,874**	**4,577**	**2,215**	**4,439**	**2,843**	**3,963**	**-**	**38,003**				
Variance	**242**	**261**	**463**	**(454)**	**1,510**	**(38)**	**(2,157)**	**633**	**(138)**	**167**	**(425)**		**65**				

The year-to-date position shows an underspend of approximately £0.1m, mainly caused by surpluses the Nursing & Health Protection budgets, offset by expenditure ahead of profile in Campaigns and the Centre for Connected Health.

The budgets and profiles are shown after adjusting for retractions and new allocations from DoH.

An approximate breakeven position is expected on PHA Direct budgets for the full year.

Public Health Agency
2020-21 Ringfenced Position

	Annual Budget				Year to Date			
	Covid £'000	Transformation £'000	DAERA & EITP £'000	£'000	Covid £'000	Transformation £'000	DAERA & EITP £'000	£'000
Available Resources								
DoH Allocation	4,694	4,545	317	**9,556**	2,121	3,893	271	**6,284**
Assumed Allocation	4,772	-	-	**4,772**	4,210	-	-	**4,210**
Total	9,466	4,545	317	**14,328**	6,330	3,893	271	**10,494**
Expenditure								
Trusts	750	2,773	50	**3,573**	687	2,542	-	**3,230**
PHA Direct	8,715	1,772	267	**10,755**	5,642	1,351	271	**7,265**
Total	9,466	4,545	317	**14,328**	6,330	3,893	271	**10,494**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

PHA has received a COVID allocation of £4.7m to date, which is primarily for Flu Vaccinations. The additional £4.8m assumed funding is subject to continual review and may reduce slightly as projections are refined. PHA is working with DoH to ensure that the COVID funding secured reflects the anticipated expenditure before final allocations are made. As at February £6.3m has been incurred against these allocations, with the remaining expenditure expected during March. The costs incurred at present are in relation to Track & Trace, Enhanced Health Protection, Community PPE, COVID Infection, Protection & Control, Covid Annual Leave and Flu Vaccinations costs.

A number of Transformation projects are also on-going, and separate ringfenced funding has been received for these totalling £4.5m. These projects are being monitored and reported on separately to DoH, and it is assumed that any underspends identified will be retracted by DoH and a breakeven position will be achieved for the year.

The Other category includes EITP and DAERA ringfenced funds, which are also expected to breakeven at this stage.

PHA Administration

2020-21 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	4,030	326	2,957	12,367	314	348	466	**20,809**
Goods & Services	149	18	1,322	376	54	58	269	**2,246**
Total Budget	**4,179**	**344**	**4,279**	**12,744**	**369**	**406**	**735**	**23,055**
Budget profiled to date								
Salaries	3,576	299	2,709	11,308	287	319	427	**18,925**
Goods & Services	137	16	1,212	333	50	53	208	**2,009**
Total	**3,713**	**315**	**3,921**	**11,641**	**337**	**372**	**635**	**20,934**
Actual expenditure to date								
Salaries	3,535	315	2,533	11,351	228	341	372	**18,676**
Goods & Services	102	3	994	96	13	(16)	287	**1,479**
Total	**3,637**	**319**	**3,527**	**11,446**	**242**	**325**	**660**	**20,156**
Surplus/(Deficit) to date								
Salaries	41	(17)	176	(43)	59	(22)	55	**248**
Goods & Services	35	13	218	237	37	69	(80)	**529**
Surplus/(Deficit)	**76**	**(3)**	**394**	**195**	**95**	**47**	**(25)**	**778**
Cumulative variance (%)	*2.04%*	*-1.08%*	*10.05%*	*1.67%*	*28.24%*	*12.55%*	*-3.92%*	***3.72%***

PHA's administration budget is showing a year-to-date surplus of £0.8m, which is being generated by a number of long standing vacancies along with the impact of many staff continuing to work primarily from home, which is driving reduced expenditure in areas such as travel and courses. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £0.9m. In previous years this would normally have been absorbed through PHA Direct budgets to address programme priorities, but this is not an option in 2020-21 and agreement has been reached with DoH to have this funding retracted.

DoH has required PHA to meet the cost of the first 1% of the pay award in each of the last 2 years (2019-20 and 2020-21). The impact of this is currently being masked by high levels of vacancies and is under review as part of the budget setting process.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

Public Health Agency
2020-21 Capital Position

	Annual Budget			Year to Date		
	Trust £'000	PHA Direct £'000	£'000	Trust £'000	PHA Direct £'000	£'000
Available Resources						
Capital Grant - R&D	8,412	4,251	**12,663**	7,319	1,504	**8,823**
Other Capital funding	-	1,056	**1,056**	-	152	**152**
Capital Grant Allocation	**8,412**	**5,307**	**13,719**	**7,319**	**1,656**	**8,975**
Expenditure						
Capital Grant - R&D	8,412	4,251	**12,663**	7,319	1,504	**8,823**
Other Capital funding	-	846	**846**	-	152	**152**
Capital Expenditure	**8,412**	**5,097**	**13,509**	**7,319**	**1,656**	**8,975**
Surplus/(Deficit) - Capital	**-**	**210**	**210**	**-**	**-**	**-**

PHA has received a Capital budget of £13.7m in 2020-21, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £8.8m on R&D projects is shown for the year to date, and a breakeven position is anticipated for the full year.

Other Capital funding primarily consists of the Digital Test, Trace, Protect (DTTP) project (£830k) and other COVID capital funding (£119k). Slippage of £210k is forecast on the DTTP project due to lower than anticipated costs, predominantly for software licences. The deliverables of the project were achieved - the lower costs have not impacted on the required outputs of the project.

PHA Prompt Payment

Prompt Payment Statistics

	February 2021 Value	February 2021 Volume	Cumulative position as at February 2021 Value	Cumulative position as at February 2021 Volume
Total bills paid (relating to Prompt Payment target)	£6,022,386	668	£53,273,946	4,972
Total bills paid on time (within 30 days or under other agreed terms)	£5,956,344	655	£52,405,036	4,670
Percentage of bills paid on time	**98.9%**	**98.1%**	**98.4%**	**93.9%**

Prompt Payment performance for January and the year to date shows that on value the PHA is achieving its 30 day target of 95.0%. Cumulatively to date, PHA is not achieving the 95% target on volume and, whilst prompt payment performance has recovered in recent months, the final position is unlikely to reach the 95% target for the whole of the 2020-21 financial year.

The 10 day prompt payment performance remained strong at 83.8% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2020-21 of 70%.

PHA COVID-funded Expenditure to month 11

	Budget £'000	Spend to month 11 £'000	Balance to Spend at 28 Feb £'000	*Notes*
Contact Tracing Centre	3,653	2,892	761	*1*
Enhanced Health Protection team	1,350	1,316	34	*2*
Additional Flu Vaccinations	3,041	1,883	1,158	*3*
PPE for the Community & Voluntary Sector	230	200	30	
Infection Prevention Control Nursing	519	37	482	*4*
Vaccination Project (PHA element)	233	-	233	*5*
Regional Health Resource Model - PPE	120	-	120	
Additional Annual Leave carry forward	320	-	320	*6*
	9,466	**6,329**	**3,137**	

Notes

1 An average month's expenditure on Contact Tracing is approximately £0.6m so there may be some underspend on this project.

2 Some overspend is expected on this project, but this is being considered in the context of slippage on other budgets and factored in to the overall PHA financial position for year-end.

3 A further £552k has been allocated to Trusts during March 2021, and the balance of expenditure is expected to be recharged from HSCB.

4 A further £468k has been allocated to Trusts during March 2021, and this project is expected to breakeven.

5 This expenditure is entirely profiled for March 2021.

6 The annual leave cost will become clear once requests to carry forward leave are processed at year end.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	15 April 2021
Title of paper	Establishment of a Resources and General Purposes Committee
Reference	PHA/02/04/21
Prepared by	Andrew Dougal
Lead Director	Andrew Dougal
Recommendation	For **Approval** ☒ For **Noting** ☐

About two years ago the Board decided it would be appropriate to have an additional Committee in order to drill down on certain issues which did not come under the remit of the other two statutory committees of the Board.

It was agreed that this Committee would look at resources and general purposes but the establishment of such a Committee should wait until after there was a final decision as to whether or not social care and children services would be additional functions within the remit of the PHA.

I wish to propose that we proceed with the formation of that Committee which may in the first instance be termed the Resources and General Purposes Committee.

The proposed remit should be as follows:

- The Resources and General Purposes Committee (RGPC) will oversee the implementation of the PHA strategy through annual business plans and to ensure that resources both human and physical are optimally deployed in pursuing the objectives of the PHA;
- The RGPC will ensure that the PHA fulfils its responsibilities with respect to all aspects of human resources for the staff of the Agency;

Functions will include:

- Overseeing the development of the annual business plan and monitoring it implementation throughout the financial year; ensure that any potential underspends are redirected to another appropriate function in order to utilise optimally the budget allocation within each financial year;
- Overseeing the initiation of programs of research in public health specific to Northern Ireland and wider;

- Monitoring the outcomes from PHA-funded programmes both in-house, in health and social care trusts and in voluntary and community groups;
- Ensuring that recruitment and development policies of the PHA succeed in appointing and retaining staff of sufficient calibre and performance to meet effectively the objectives in the strategic plan as well as in each of the annual Business plans;
- Examining proposals for the establishment of new posts, re-grading of existing posts and the reorganisation of units or directorates within the PHA;
- Ensuring that contractors and subcontractors provide acceptable levels of terms and conditions for employees;
- Ensuring that there are policies and processes for effective participation, consultation and interaction with staff at all levels within the PHA;
- Ensuring that the PHA is compliant with occupational and environmental health and safety legislation, standards and codes of practice and that the PHA is working towards a target of carbon neutrality well before 2050;
- Overseeing the development and implementation of the PHA's equality strategies, policies and procedures;
- Ensuring that the PHA optimises relationships with all its diverse stakeholders;
- Ensuring highly effective collaboration with all 11 Local Councils particularly in the area of community planning;
- Drilling down and examining issues and present reports to the full Board of the PHA;
- Undertaking other work as delegated by the PHA Board.

The Committee will not have responsibility for the expenditure of funds unless such authority is specifically delegated by the PHA Board.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	15 April 2021
Title of paper	Annual Quality Report
Reference	PHA/03/04/21
Prepared by	Denise Boulter
Lead Director	Rodney Morton
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the 2019/20 Annual Quality Report.

2 Background Information

Under PHA's Corporate Objective 4, "All health and wellbeing services should be safe and high quality", there is a target that produce an Annual Quality Report as part of its work in overseeing the implementation of the Quality 2020 Strategy.

There is a requirement from the DoH that the PHA in conjunction with the HSCB produce an Annual Quality Report outlining our commitment to improving quality.

3 Key Issues

This is the PHA and HSCB's seventh Annual Quality Report. It is a requirement from DoH that each organisation produce this report. It has grown from strength to strength each year. It contains a range of topics included from all Directorates which have been identified by relevant Directors which demonstrates from both a corporate and directorate point of view the length and breadth of our commitment to improving quality.

The report has been written under the following 5 strategic goals:

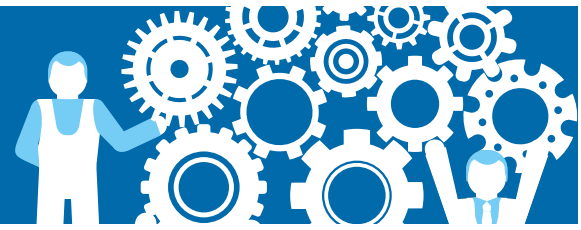
- Transforming the Culture
- Strengthening the workforce
- Measuring improvement

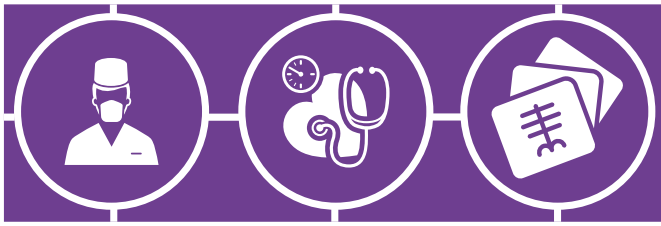
- Raising the standards
- Integrating the care

4 Next Steps

Following approval by the respective boards, the Annual Quality Report will be published on the HSCB and PHA websites.

Health and Social Care Board and Public Health Agency





Annual Quality Report
April 2019- September 2020

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

Foreword

Welcome to the seventh Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA). As Chief Executives we are pleased to share this report which outlines how we have improved the quality of health and social care services in line with our commitments set out in the Q2020 Strategy. Given the pressures created by Covid-19 completion of the annual report was deferred. This report covers the extended period April 2019 to September 2020.

The timeframe covered has been difficult for all of us but particularly for those impacted by COVID-19 and the report helpfully draws out how we have developed innovative solutions at pace to meet the significant challenges faced.

It is within this very challenging operating context the work undertaken to improve the quality, safety and experience of those who use Health and Social Care services is all the more remarkable.

We believe the report demonstrates not only how far we have come, but also our continued collective drive to achieving the vision of Quality 2020 against a background of increasing demands and unprecedented challenges. Looking to the future we are committed to delivering the highest standard of services, designed and implemented in partnership with those who use and work in our services.

In closing we would like to thank all Health and Social Care Staff for their commitment and dedication throughout the pandemic, we owe you a debt of gratitude.

Olive MacLeod
Chief Executive, PHA

Sharon Gallagher
Chief Executive, HSCB

Contents

Theme one

Transforming the culture

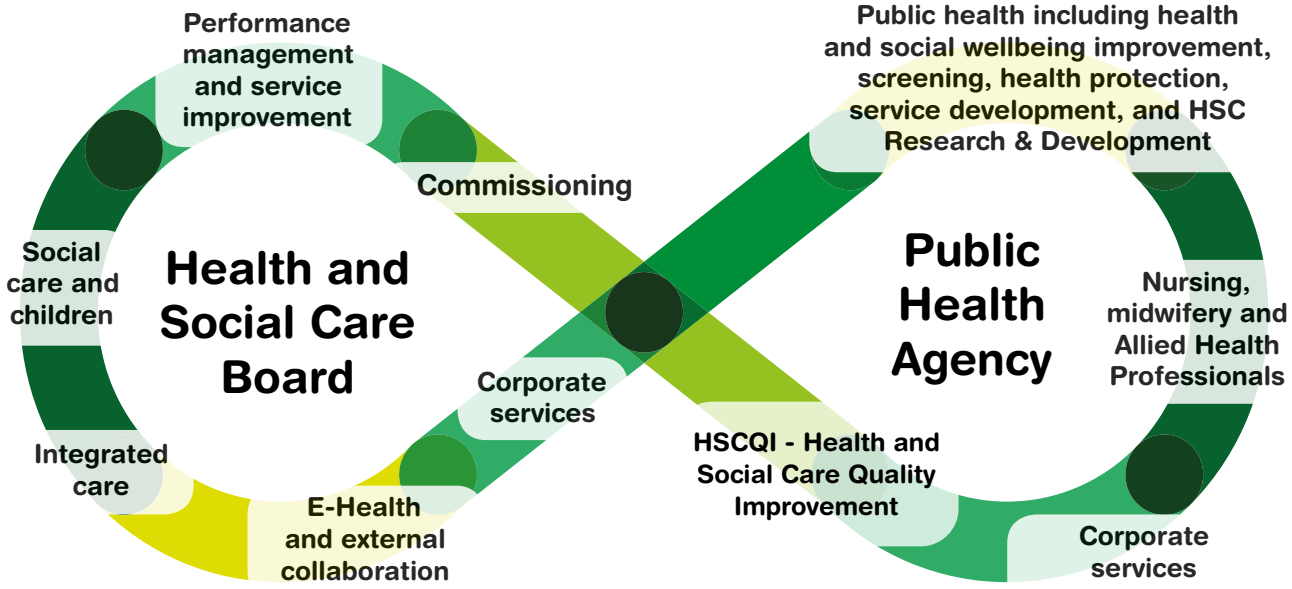
Transforming the culture

1.1 Introduction

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

1.2 Overview of HSCB & PHA

The HSCB and PHA are considered arm's-length bodies within HSC. Ensuring that services are safe, high quality, effective and meet people's needs is a core function of both the organisations, an objective which is outlined within each organisations corporate governance assurance framework. They continue to work collaboratively and focus on improving the quality of services delivered.

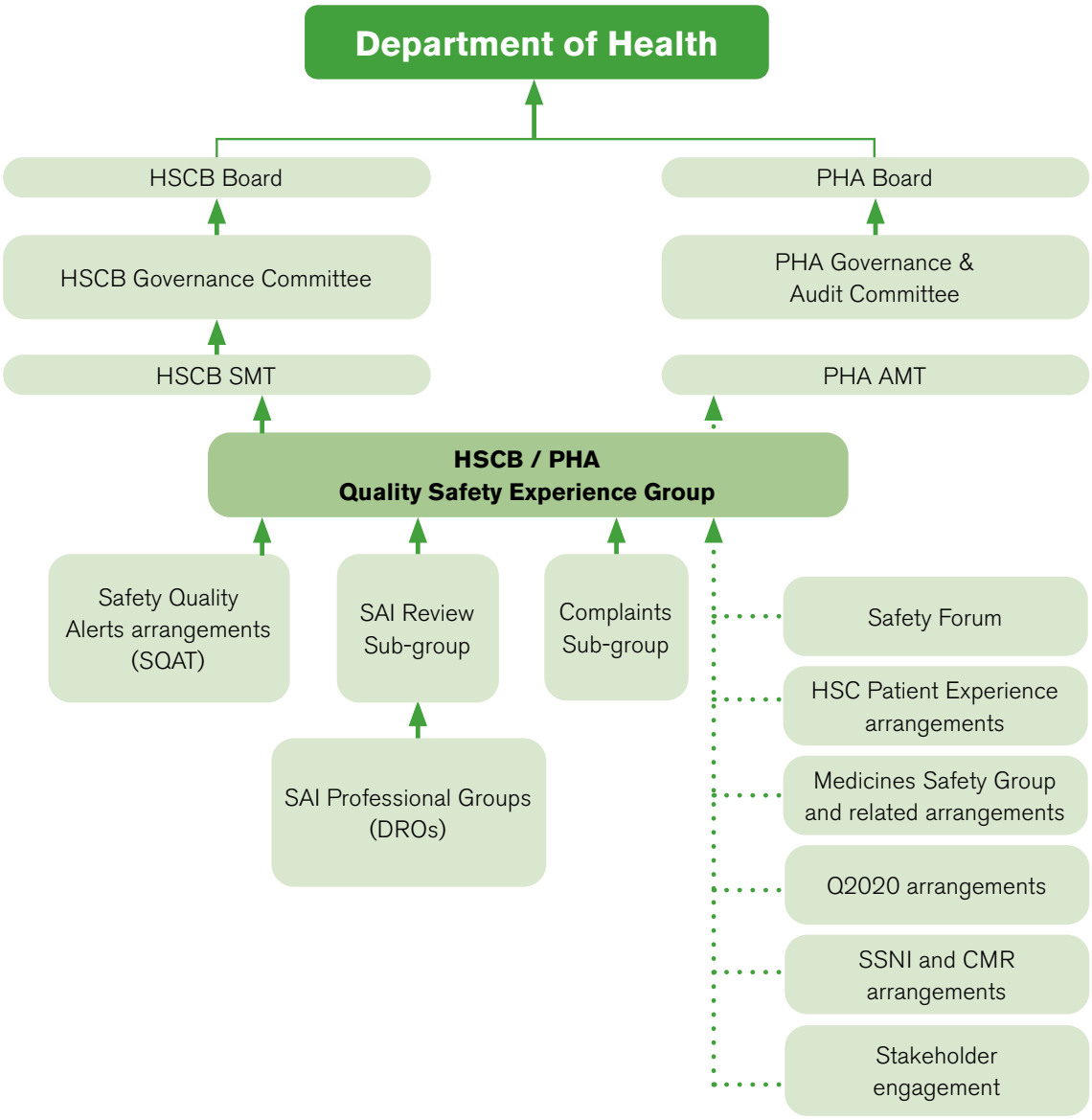


For further information relating to the HSCB and PHA's role, governance structure and the work that we do is available at:
http://www.hscboard.hscni.net/
http://www.publichealth.hscni.net/

1.3 Leadership and quality governance

Safety & quality governance

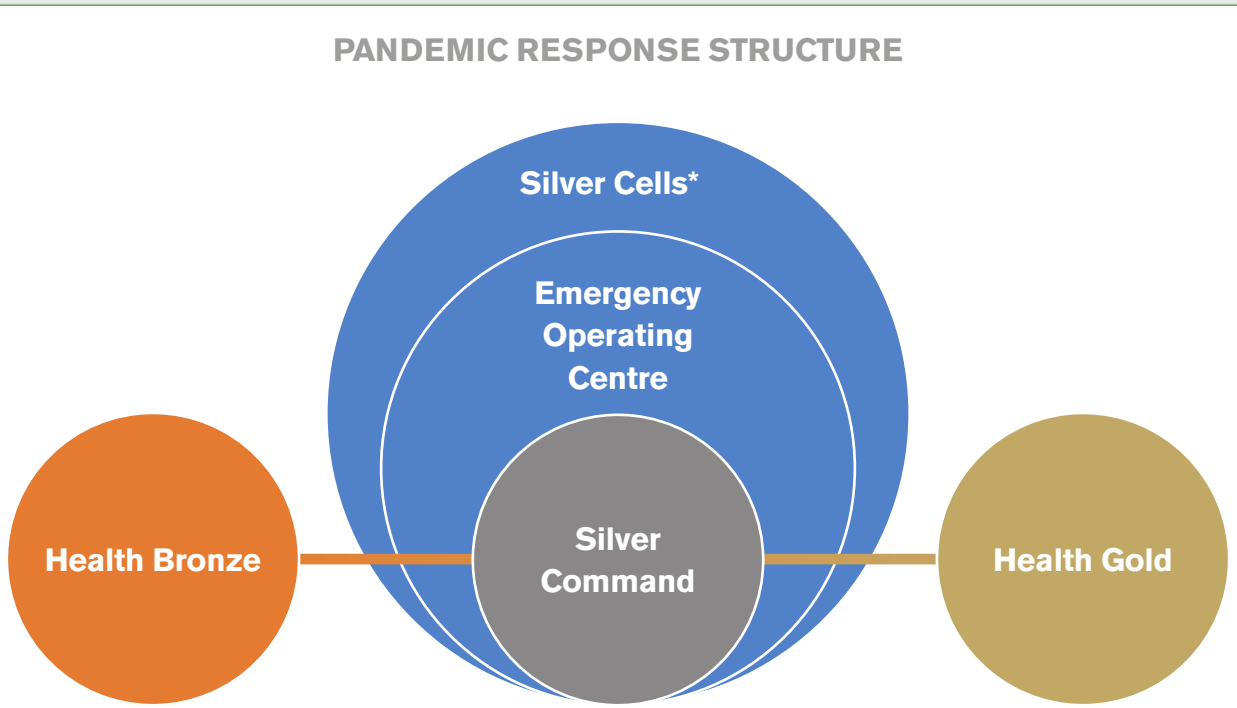
There are a number of core groups which oversee and provide governance on the quality of services commissioned or delivered by HSCB and PHA, outlined within the diagram. The **Quality, Safety and Experience (QSE) Group** provides an overarching structure whereby the HSCB and PHA can monitor and report on safety, effectiveness and the patient client experience to the respective Boards and committees. A range of groups; such as the Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident (SAI) Group, Designated Review Officer (DRO) professional groups and patient experience team, report to and support the work of QSE.



Transforming the culture

Leadership & governance in response to COVID-19

In February 2020 the HSCB and PHA put in place a structure to support the COVID-19 pandemic response based on the bronze, silver and gold approach



***Silver Cells include:**

- Health Protection Cell
- Logistics & Supplies Cell
- General Business
- Surge Services Capacity Cell
- Infection Control Cell
- Knowledge Management Cell
- Communication & Media Cell
- IT & Data Management Cell
- Technical Scientific Cell
- Incident Management Resource Cell

Transforming the culture

Further information:
Dr Aideen Keaney
Director HSCQI
Aideen.keaney@hscni.net

Joint PHA/HSCB Senior Management Team "Huddle"

During the Covid-19 emergency response the HSCQI Improvement Hub supported the PHA and HSCB joint emergency response to the COVID 19 pandemic by leading on the implementation of a joint PHA/HSCB Senior Management Team morning "Huddle". Using a QI approach, a "huddle" occurred on 18 mornings over the 10 week period (18th March 2020 – 18 May 2020). QI methodologies used included the Model for Improvement, Plan-Do-Study-Act cycles, Appreciative Inquiry and elements of Lean.

What is a "Huddle"?

Team Huddles are short meetings where each team member shares their key priorities for the day and important updates. These meetings keep team members informed of important information, help hold people accountable, and allow for sharing of collective information. Huddles are a key activity within Lean (Toyota Production System).

The approach

This "Huddle" approach was applied to the implementation of a joint PHA/HSCB Senior Management Team meeting in order to improve communication and action planning during the COVID-19 emergency pandemic response. Results demonstrated good participation from each of 15 PHA/HSCB silver supporting cells*. The "Huddle" allowed a structured approach to the communication of large volumes of activity contained in the action plans for each cell during a 40-50 minute morning meeting. Teamwork and communication between cells was demonstrated by the sharing of actions.

Feedback from appreciative inquiry to date has shown the usefulness of cell structures and the opportunities offered through a "Huddle" to see the "big picture", to work collaboratively within and across teams, directorates and organisations, thereby breaking down traditional organisational and professional boundaries.

This initiative demonstrates how, by using a Quality Improvement (QI) methodology, it was possible to implement a new meeting structure, one that many of the participants had never heard of nor participated in before. Applying a QI approach to this change enabled senior leaders from across both organisations to implement and adopt a new meeting format. This demonstrates the effectiveness of QI as an approach to leading and implementing change. During this 10 week period staff roles within both organisations continually evolved and the traditional stand up huddle approach had to be modified in order to take into account of social distancing and remote working.

The use of a QI approach to the implementation of a Huddle meeting during the emergency response of the COVID 19 pandemic is an approach which could be used to re-instate similar Huddle meetings as required in the future.

*Cells that support Silver Response within the Gold Silver Bronze emergency response.

A number of cells were established each with their own area of focus to support a response to the rapid moving environment relating to the emergence of the pandemic. An example of some of the work arising from the cell includes:

Transforming the culture

Infection Prevention Control (IPC) Cell

One of the main roles of the PHA / HSCB was a focus on infection prevention and control as COVID-19 began to spread in Northern Ireland. The work of the IPC cell involves overseeing the coordination of infection prevention and control across the HSC systems, Primary Care, including services provided by community, voluntary and independent sectors care providers. The Regional IPC Cell also has a link in the National IPC Cell. This cell is made up of representatives from across the Four Nations and it provides an opportunity to help shape and influence national guidance.

Personal protection equipment (PPE) helps protect those working in health and social care sectors. PPE covers a number of products which includes masks, visors and eye protectors, aprons and gowns. The UK government and devolved administrations have published clear guidance on appropriate PPE for health and social care workers. This has been written and reviewed by all four UK public health bodies and informed by NHS infection prevention control experts.

- Since the beginning of the COVID-19 pandemic in March 2020, over 261m PPE items have been procured to support HSC, including care homes. A Product Review Protocol has been developed between Infection Prevention and Control Leads (PHA and HSCTs), BSO and MOIC to assess all new PPE items to ensure they are suitable for use in healthcare settings.

During 2020, communication has been vital and regular meetings have taken place to discuss any IPC issues. These have included weekly Lead IPC Nurse Forum and Regional IPC cell meetings in which a wide range of IPC issues from across the region are discussed and resolved. An Outreach IPC Programme for Care Homes was also established and facilitated through HSCTs including the distribution of PPE.

In an effort to ensure regional consistency regarding the use and decontamination of reusable Respiratory Protection Equipment (RPE), a task and finish group has been established. The task and finish group is currently working on the development of a regional data specification with BSO.
An Expert Working Group has also been established to develop an implementation plan

Transforming the culture

for the PHE's COVID-19: "Guidance for the remobilisation of services within health and care settings which could potentially be linked to surge plans." This work continues and part of Northern Ireland's implementation plan may be informed by work being carried out in other regions.

The IPC Cell commissioned a 10,000 more Voices Survey of staff experience of PPE which closed at the end of September 2020. The report will be used to inform the approach to IPC policy and practice across Northern Ireland. A number of engagement meetings have also been undertaken with Trade Union colleagues to discuss important issues such as the IPC Product Review Group, fit testing, decontamination of PPE and FFP3 masks.

The impact of the IPC cell has been to improve early intervention in relation to the procurement and use of appropriate PPE which ensures safer systems of IPC throughout the pandemic.

261 million items
of PPE procured

250 items
reviewed through product review protocol

780 responses
to 10,000 Voices survey

"From the beginning of the pandemic, Integrated Care have found the advice and support coming from the IPC Cell invaluable. Without it there would be no formal link to any Infection Prevention Control team for Primary Care, Optometry, Dental and Pharmacy colleagues. The advice insured consistency across the region allowing colleagues on the frontline to feel safe and supported in appropriate PPE and ensuring their working environment was COVID secure."

Dr Gillian Clarke, GP Advisor, HSCB

Transforming the culture

Development of HSCQI Network March 2019 – September 2020

In early April 2019, the Department of Health formally launched the Health and Social Care Quality Improvement (HSCQI) body for Northern Ireland, expanding in scope and ambition on its predecessor organisation the HSC Safety Forum.

HSCQI is a network of improvers working across many areas of health and social care in Northern Ireland. HSCQI seeks to influence and be influenced by the HSCQI Leadership Alliance consisting of senior leaders in health and social care including the Chief Professional Officers, Chief Executives, Primary care leads and service user representation.

HSCQI aims to model the values and attributes the HSC aspires to, particularly enacting collective leadership, working together and openness in a patient and client-focused way. In particular, HSCQI has been tasked with developing and maturing an understanding of a learning system. The US based Institute of Medicine defines a learning system as a model where '*Science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience.*'

With a mandate from the HSCQI Leadership Alliance in the early part of summer 2020, a scoping exercise to identify 2-3 priorities to be applied to a learning system in the COVID-19 context were sought. Three areas were identified by members of the HSCQI network

Picture 1 – a blended approach to the scoping exercise for the learning system using ZOOM and in person approach to share, learn and develop together.

from across Northern Ireland: Virtual Visiting, Virtual Consultations and Staff Psychological Wellbeing and Safety. All three were regarded as important and providing purposeful value to the HSC both during the pandemic and as we sought to align to HSC rebuild and resilience efforts. Key examples of learning within these themes are being shared system wide through on-going project ECHO sessions.

In September 2020, the HSCQI Network were preparing to present their findings and examples in the three arenas to Minister Swann in early October with the intention to seek a mandate to work together as a network to mature a learning system that supports the HSC ambition to '*build back better*'.

The establishment of the HSCQI network has had the impact of improving collaboration across the HSC to promote safer systems throughout the COVID-19 pandemic. One outcome has been the virtual visiting platform which has improved the citizen experience when physical visiting is not available.

Transforming the culture

1.4 Learning

Learning from Serious Adverse Incidents (SAIs)

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

During the reporting period 329 SAIs were closed by the HSCB/PHA following review. The following methods of regional learning were approved to be taken forward in relation to the SAIs closed in 2019/20:

- **36** **Reminders of Best Practice Guidance Letters**
- **6** **Professional Letters**
- **5** **Learning Letters**
- **30** **Newsletter Articles were identified**
- **18** **Were referred to other specialist groups**
- **1** **Featured at the Regional SAI and Complaints Learning Event**

POC	Level 1	Level 2	Level 3	Total
Acute Services	117	24	1	142
Maternity and Child Health	12	3	0	15
Family and Childcare (inc CAMHS)	12	4	0	16
Elderly	11	1	0	12
Mental Health	88	20	2	110
Learning Disability	3	0	0	3
Physical Disability and Sensory Impairment	2	0	0	2
Primary Health and Adult Community (includes GP's)	23	2	0	25
Corporate Business / Other	4	0	0	4
Total	**272**	**54**	**3**	**329**

Transforming the culture

Listed below are two examples of regional learning issued in 2020:

- **WHO Surgical Checklist**

This first case relates to two incidents involving wrong site surgery. The first resulted in the amputation of the wrong toe. This happened following an ill patient causing disruption to the theatre list and another surgeon, who arrived after the initial checks were completed, carrying out the procedure rather than the planned surgeon. In the second incident, surgery was commenced on the wrong ear before this was recognised and the correct surgery undertaken. The report identified that the patient was boarded for surgery without stating the side for surgery. The patient was pre-assessed but not consented at the pre-assessment clinic and side for surgery was not clarified. The patient was then added to the theatre list without a side being identified, the wrong side was marked on the ward and the consent form was not completed. It should be noted that neither of these cases followed the entirety of the WHO Surgical Safety Checklist. As a result, a Reminder of Best Practice Guidance letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

- The letter was brought to the attention of relevant staff and shared at all safety briefings/huddles.
- Trusts reviewed and, as necessary, amended their systems to ensure that they reflect the Requirements Under Current Guidance section of the letter.

- **Correct administration of medicines**

In this case oral medication was administered intravenously to a patient in error. This medication was a controlled drug.

As a result a Reminder of Best Practice Guidance letter was issued to the wider HSC. Trusts were asked to:

- Disseminate the letter to all relevant staff.
- Ensure all clinical areas have the correct equipment available to ensure safe administration of medication.

The letter was also disseminated to all relevant independent sector providers and all relevant doctors in training.

For further information on learning from SAIs please see following link **http://www.hscboard.hscni.net/publications/sai-learning-reports/**

Transforming the culture

Learning from complaints

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

Setting the context during 2019/20:

- **HSCTs received 6105 complaints.**
- **HSCB received 140 complaints regarding Family Practitioner Services.**
- **HSCB acted as 'honest broker' in 70 complaints regarding Family Practitioner Services*.**

The top three categories of complaints are:

1. Treatment and care (1399 complaints)

2. Staff attitude and behaviour (1021 complaints)

3. Communication (948 complaints)

*Of note this year is a significant increase in the number of complaints where the HSCB has acted in the role of 'honest broker', which is in an intermediary capacity between the patient and the FPS practice, in an effort to resolve the complaint, or at least reach an understanding or agreed position on the issues.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety including thematic reviews and strategy and policy development.

Transforming the culture

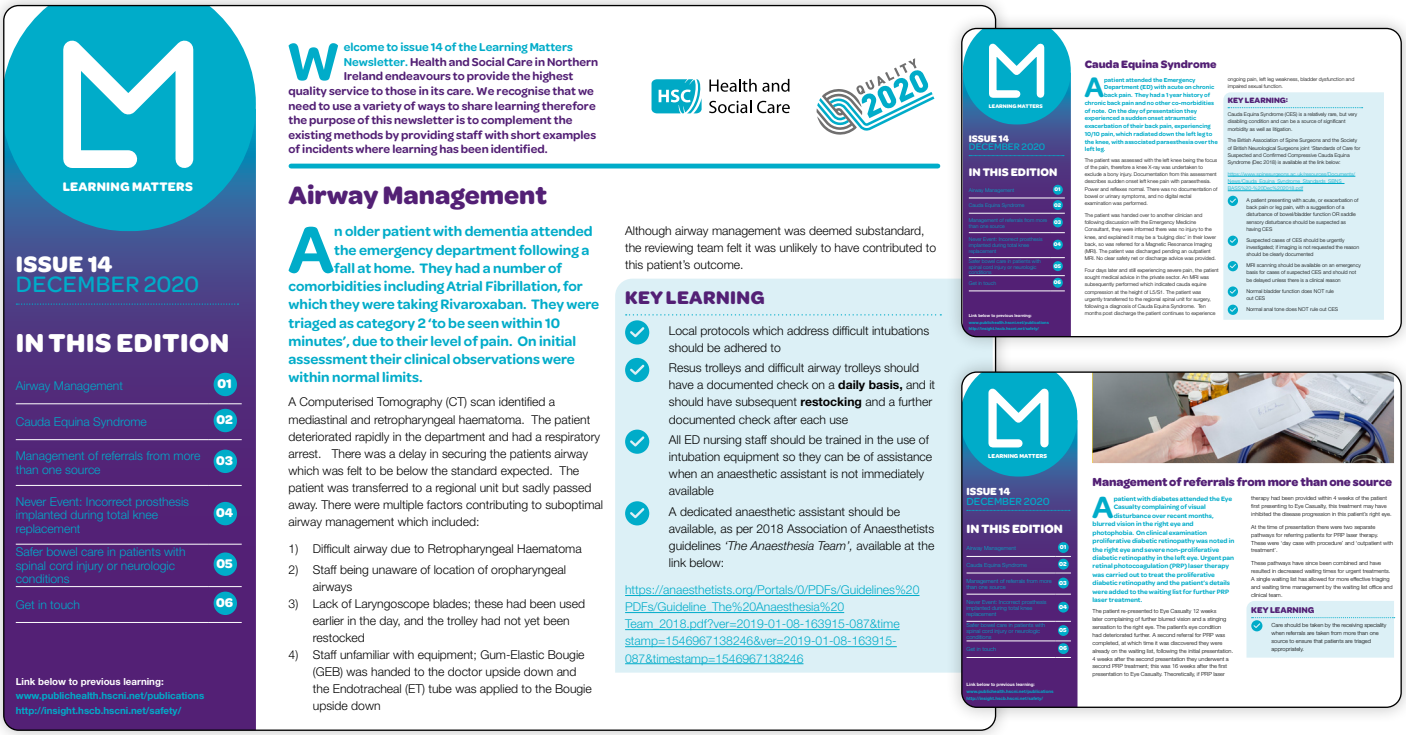
An example of learning from complaints: Cauda Equina Syndrome

A patient attended the ED with acute chronic back pain. She had a one year history of chronic back pain and no other co-morbidities of note. On the day of presentation she experienced a sudden onset atraumatic exacerbation of her back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

The patient was assessed with the left knee being the focus of the pain, therefore a knee X-ray was undertaken to exclude a bony injury. Documentation from this assessment describes sudden onset left knee pain with paraesthesia. The patient's power and reflexes were normal. There was no documentation of bowel or urinary symptoms, and no PR was performed.

The patient was handed over to another clinician and following discussion with the Emergency Medicine Consultant, she was informed that there was no injury to her knee, and explained to her that it may be a 'bulging disc' in her lower back. She was referred for an MRI scan. The patient was discharged pending an outpatient MRI. No clear safety net or discharge advice was provided.

Four days later and still experiencing severe pain, the patient sought medical advice in the private sector. An MRI was subsequently performed which indicated spinal cord compression at the height of L5/S1. The patient was urgently transferred to the RVH for spinal surgery following a diagnosis of Cauda Equina Syndrome. Ten months post discharge the patient continues to experience ongoing pain, left leg weakness, bladder dysfunction and impaired sexual function.


LEARNING MATTERS

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DECEMBER 2020

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Cauda Equina Syndrome 02
Management of referrals from more than one source 03
Never Event: Incorrect prosthesis implanted during total knee replacement 04
Safer bowel care in patients with spinal cord injury or neurologic conditions 05
Get in touch 06

Link below to previous learning:
www.publichealth.hscni.net/publications
http://insight.hscb.hscni.net/safety/

Welcome to issue 14 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Airway Management

An older patient with dementia attended the emergency department following a fall at home. They had a number of comorbidities including Atrial Fibrillation, for which they were taking Rivaroxaban. They were triaged as category 2 'to be seen within 10 minutes', due to their level of pain. On initial assessment their clinical observations were within normal limits.

A Computerised Tomography (CT) scan identified a mediastinal and retropharyngeal haematoma. The patient deteriorated rapidly in the department and had a respiratory arrest. There was a delay in securing the patients airway which was felt to be below the standard expected. The patient was transferred to a regional unit but sadly passed away. There were multiple factors contributing to suboptimal airway management which included:

1) Difficult airway due to Retropharyngeal Haematoma
2) Staff being unaware of location of oropharyngeal airways
3) Lack of Laryngoscope blades; these had been used earlier in the day, and the trolley had not yet been restocked
4) Staff unfamiliar with equipment; Gum-Elastic Bougie (GEB) was handed to the doctor upside down and the Endotracheal (ET) tube was applied to the Bougie upside down

Although airway management was deemed substandard, the reviewing team felt it was unlikely to have contributed to this patient's outcome.

KEY LEARNING

- Local protocols which address difficult intubations should be adhered to
- Resus trolleys and difficult airway trolleys should have a documented check on a **daily basis,** and it should have subsequent **restocking** and a further documented check after each use
- All ED nursing staff should be trained in the use of intubation equipment so they can be of assistance when an anaesthetic assistant is not immediately available
- A dedicated anaesthetic assistant should be available, as per 2018 Association of Anaesthetists guidelines *'The Anaesthesia Team'*, available at the link below:

https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_The%20Anaesthesia%20Team_2018.pdf?ver=2019-01-08-163915-087&timestamp=1546967138246&ver=2019-01-08-163915-087&timestamp=1546967138246

LEARNING MATTERS

ISSUE 14
DECEMBER 2020

IN THIS EDITION

Cauda Equina Syndrome

A patient attended the Emergency Department (ED) with acute on chronic back pain. They had a 1 year history of chronic back pain and no other co-morbidities of note. On the day of presentation they experienced a sudden onset atraumatic exacerbation of their back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

KEY LEARNING:

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES
- Suspected cases of CES should be urgently investigated; if imaging is not requested the reason should be clearly documented
- MRI scanning should be available on an emergency basis for cases of suspected CES and should not be delayed unless there is a clinical reason
- Normal bladder function does NOT rule out CES
- Normal anal tone does NOT rule out CES

LEARNING MATTERS

ISSUE 14
DECEMBER 2020

IN THIS EDITION

Management of referrals from more than one source

A patient with diabetes attended the Eye Casualty complaining of visual disturbance over recent months, blurred vision in the right eye and photophobia. On clinical examination proliferative diabetic retinopathy was noted in the right eye and severe non-proliferative diabetic retinopathy in the left eye. Urgent pan retinal photocoagulation (PRP) laser therapy was carried out to treat the proliferative diabetic retinopathy and the patient's details were added to the waiting list for further PRP laser treatment.

KEY LEARNING

- Care should be taken by the receiving specialty when referrals are taken from more than one source to ensure that patients are triaged appropriately.

Transforming the culture

Key Learning:
Cauda Equina Syndrome (CES) is a relatively rare, but very disabling condition and can be a source of significant morbidity as well as litigation.

The British Association of Spine Surgeons and the Society of British Neurological Surgeons joint 'Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome' (Dec 2018) available at link below:
https://www.spinesurgeons.ac.uk/resources/Documents/News/Cauda_Equina_Syndrome_Standards_SBNS_BASS%20-%20Dec%202018.pdf

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES.
- Suspected cases of CES should be urgently investigated, if imaging is not requested it should be clearly documented why.
- MRI scanning should be available on an emergency basis for cases of suspected CES, it should not be delayed unless there is a clinical reason for doing.
- Normal bladder function does NOT rule out CES.
- Normal anal tone does NOT rule out CES.

Learning from SAI's and complaints is key to ensuring safer systems throughout the HSC to improve clinical and care outcomes through learning when things within the system go wrong.

Learning from experience

10,000 More Voices. Care Homes & Covid-19- The Lived Experience of Care Home Residents, their Relatives and Staff during Covid-19 Pandemic.

Background

"We are a hidden treasure … and unfortunately no one is looking for us."

Words of a Care Home Resident

In May 2020 the 10,000 More Voices Team commenced a study to capture the experiences of residents, relatives and staff in Care Homes during Covid-19 pandemic. The findings of this project were central to *the Rapid Learning Initiative into the Transmission of Covid-19 in Care Homes (1)* as part of the second surge planning through the Department of Health. The 10,000 More Voices Initiative is part of Patient Client Experience (PCE) work, led within the Public Health Agency (PHA) and seeks to provide a person centred approach to improving and influencing the health and social care system, through the voices of Experience.

Approach

The study sought to collect experiences through three bespoke surveys exploring the following core concepts of the experience in Care Homes

- Communication
- Safety
- Care delivery
- Changes
- Good practice
- Challenges

Respondents were requested to share their story through an open question and to share deeper reflections by responding to self-indexing statements known as triads (three related elements of a concept) and dyads (extreme aspects of a concept). Surveys were available through an online link, printed copy or telephone/video conferencing consultation. Easy read versions were also developed to widely engage with the defined groups. Each core concept was analysed through Sensemaker® Analyst Software. This software captures the experiences from real people and supports the visualisation of patterns through triads and dyads, determining key messages from residents, relatives and staff.

Findings

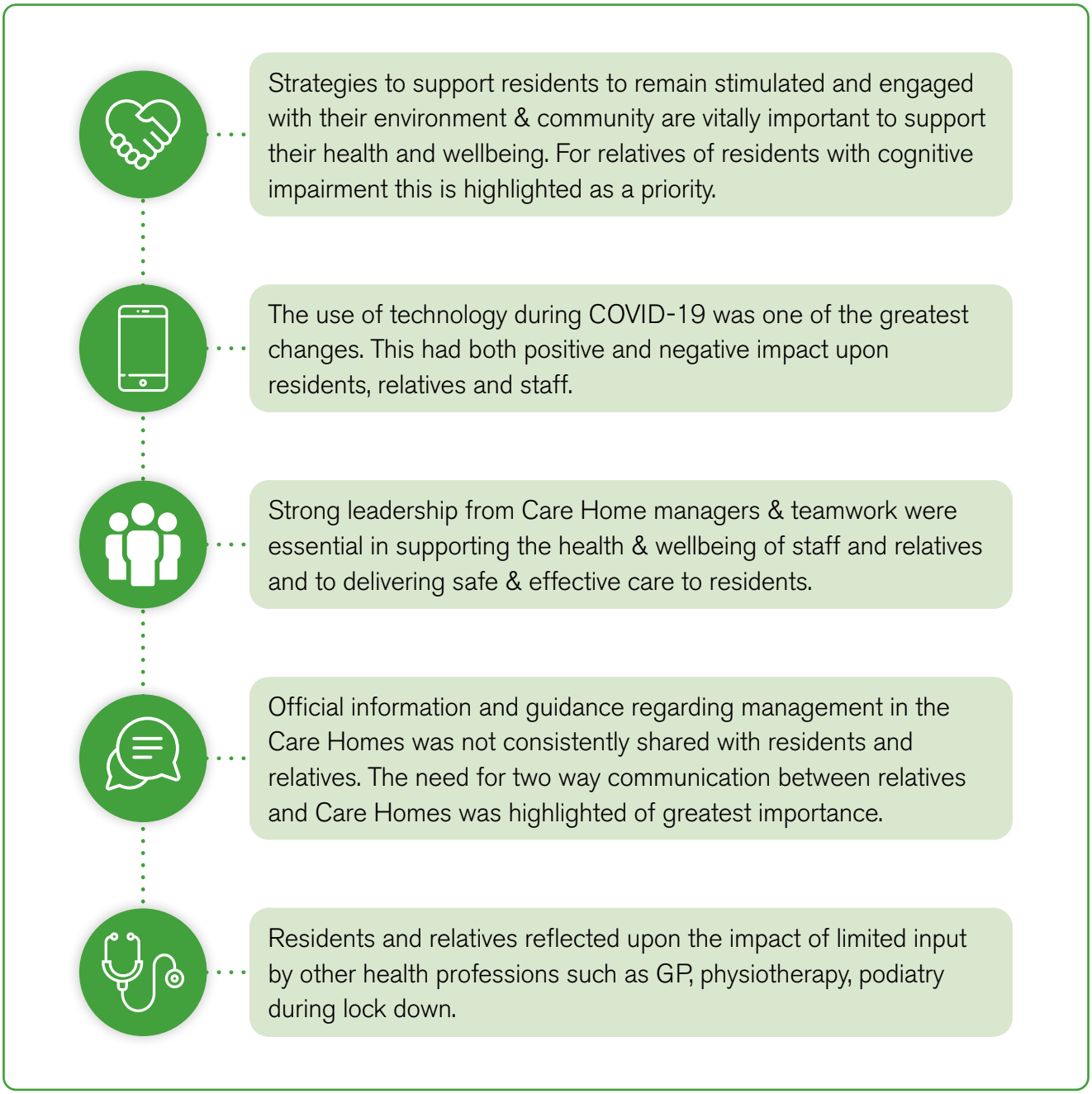
Table 1 outlines the number of returns according to each respondent group received between 24th June 2020 and 31st August 2020.

TABLE 1 NUMBER OF SURVEYS RETURNED PER RESPONDENT GROUP

Respondent Group	Number of returns
Residents	519
Relatives	109
Staff	116

Transforming the culture

THE FOLLOWING DIAGRAM OUTLINES THE KEY MESSAGES OF THE COLLECTIVE ANALYSIS OF ALL RETURNS.



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Conclusion

> *"Hear the patient voice at every level- even when that voice is a whisper."*
>
> **Don Berwick-**[2]

The purpose of a 10,000 More Voices study is to ensure the voice of the respondents, in this case residents, relatives and staff, will make a difference at both a local and strategic level. The key findings outlined and the direct words of the respondents have informed actions to support residents, relatives and staff during a second surge of Covid-19. This study has also reinforced the need for a culture shift in engaging openly with the residents and relatives of Care Homes, affirming that at all levels of the health and social care system their voice are heard.

References

1. Department of Health, *The Rapid Learning Initiative into the Transmission of Covid-19 in Care Homes* Available from **https://www.health-ni.gov.uk/news/minister-welcomes-rapid-learning-initiative-report-care-home-pandemic-experiences**. [accessed on 3rd September 2020].

2. Berwick, D. *A promise to learn – a commitment to act. Improving the safety of patients in England.* Available from **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf** [accessed 5th October 2020]

Further information

Linda Craig (Regional Lead for Patient, Client Experience)
Email: **linda.craig3@hscni.net**
Contact: 028 9536 2869

Full report available through **www.10000morevoices.hscni.net.**

Transforming the culture

Online User Feedback – Care Opinion

In August 2020 a new online user feedback service was launched in Northern Ireland, called Care Opinion. This service offers the people of Northern Ireland and their families to give feedback on their experiences when engaging with the Health and Social Care system. Care Opinion supports the collation of the spectrum of experiences – from positive engagement which should be celebrated and shared to experiences where improvement can be made. Care Opinion is a moderated service offering a safe opportunity for people to share their experiences. The service promotes an open and transparent culture with the information posted on the Care Opinion website (**www.careopinion.org**).

Care Opinion also supports meaningful engagement between the person who has shared their experiences and the services involved, with responses provided by trained responders in each Trust. This service provides an opportunity to affect change at a local level and also collectively influence strategy and regional developments. In 2020 it has never been more important to engagement in a meaningful manner with the people who attend our services and to also provide a platform through which they can share their story.

From August 2020 to January 2021 there have been 523 stories shared on the website which have been viewed over 42,000 times. 74% of the stories have been positive and reach out to say thank you to the staff of Health and Social Care. As a result of the stories shared, there have been 31 local changes planned or made, demonstrating how the feedback informs and influences the services we deliver. Collectively the stories on Care Opinion are informing the regional work in relation to the COVID-19 pandemic. This is the start of our journey to embed an online user feedback system into Health and Social Care in Northern Ireland. If you would like to learn more about Care Opinion check out the website **www.careopinion.org** or contact Michelle Tennyson or Linda Craig in the Public Health Agency.

WORD CLOUD:

WHAT WAS POSITIVE ABOUT YOUR EXPERIENCE?

1.5 Signs of Safety

Whilst responding to COVID-19 has impacted on the implementation of Signs of Safety, the implementation process itself has continued within the Trusts.

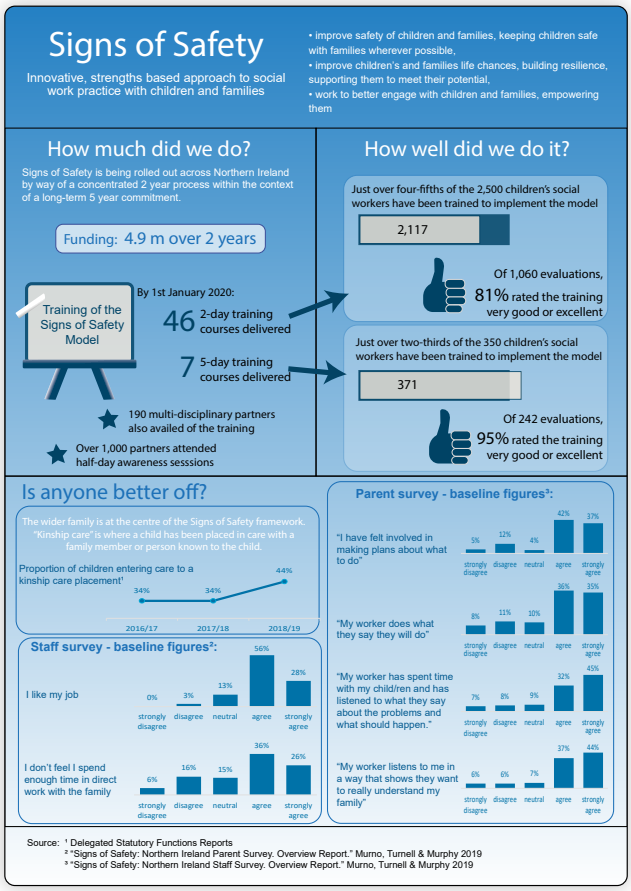
As part of the restart of services the Regional Steering Group for Signs of Safety has begun to meet again on a monthly basis. A fortnightly implementation group meeting has been set up with the 5 Trusts.

By 2020, 46, 2 day training courses had been delivered to 2117 of the 2,500 children's social workers to enable implementation of the model. 7 five day training courses had been delivered to 371 social workers. In addition 190 partners availed of the training.

A regional training plan for Signs of safety 2020/21 has been developed and is being implemented.

As part of monitoring the effectiveness of implementation, an annual staff and parent survey was undertaken initially in 2019 and then in 2020. In terms of the staff survey several areas of improvement can be noted from the first survey (2019). Most significantly there has been a substantial increase in workers who have used the practice from 49.3% to 77.1%. The dominant impression is of a workforce that is generally positive about using Signs of Safety. Areas for improvement have been noted for 2020/21.

The dominant message from parents continues to be positive. Most positive comments related



to-feeling listened to (79.8%), their worker doing what they say they will do (72.7%) and the worker being clear about their concerns about the family situation (85.4%).

A Northern Ireland Leaders day was held in June 2020 to review implementation progress and set goals for 2020/21.

Meaningful measures - work measuring the impact of implementation of Signs of safety continued. Dashboards were developed in Trusts, the parent and staff surveys were repeated and work was completed on an OBA Report card.

For 2020/21 Re-establishing dashboard Testing and developing further work on case outcome measures.

Theme two

Strengthening the workforce

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 1000 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution.

Health and wellbeing 2026: delivering together asks HSC to become exemplars of good practice in supporting staff health and wellbeing. The HSC Workforce Strategy 2026: delivering for our people also sets out ambitious goals for a workforce that will match the requirements of a transformed health and social care system. The World Health Organization (WHO) defines what is meant by workplace health:

"A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace..."

The HSCB and PHA are committed to supporting staff health and well-being and particularly over the last 18 months during the COVID-19 pandemic have introduced a number of initiatives to listen to and engage with staff; and promote best practice through investing in training and education.

2.2 Supporting staff within HSCB & PHA during COVID

Staff health and well-being

The response to COVID-19 brought unprecedented pressures for staff across HSC. In March 2020 a joint PHA, HSCB and BSO COVID-19 Staff Health and Wellbeing Group to support staff was established.

The group was led by PHA Assistant Director and has representation from across Health Improvement, Nursing and Allied Health Professionals, Human Resources, Operations and Personal and Public Involvement. This membership brings significant expertise and operates within three defined sub-groups:

1. Feedback and monitoring.
2. Resources.
3. Comfort measures.

Feedback and monitoring

Effective workplace health action begins with employee engagement. Staff were invited to provide feedback through workplace health champions and a confidential email address. Concerns raised included home working, caring responsibilities, social distancing in a work environment and action was subsequently taken to address these and other issues raised.

A SharePoint resource was built by the resources subgroup and used the Take 5 messages as a template. This useful resource hosts a wide range of information and signposts staff to available help. **https://regional.sharepoint.hscni.net/sites/shw/SitePages/Home.aspx**

Strengthening the workforce

Comfort measures

Comfort rooms were established by the group – these rooms were a safe space for those staff who were working in the offices to avail of refreshments and to take time away from their desk to reflect and recharge. Staff were also invited to record their reflections and to contribute artwork in work buildings.

Support from Communications and IT Services proved to be essential to help ensure staff were made aware of available support and able to feed into suggestions. Personal stories were added to internal newsletters and using Take 5 themes, staff were invited to share how they were managing to maintain their wellbeing during COVID-19 lockdown.

Support for staff health and wellbeing is of course needed beyond COVID-19 and PHA, HSCB and BSO Staff Health and Wellbeing Group is developing proposals to build on this work. These proposals involve establishing a coordinated and consistent approach to workplace health and wellbeing, with employee engagement underpinning this work. A HSC publication 'Supporting the wellbeing needs of our Health and Social Care staff during COVID-19: a framework for leaders and managers offers an approach' will be integrated into future action plans.

The impact of these resources has been staff feeling supported through the pandemic by providing improved access to support mechanisms. The essential learning from this is to ensure we continue with these support mechanisms moving forward.

Strengthening the workforce

Knowledge Management

Knowledge Management Cell (KMC) article for Annual Quality Report

The Knowledge Management Cell (KMC) was established in March 2020 to support the Public Health Response to COVID-19. It provided support to the Emergency Operations Centre and the other Silver Cells to ensure the swift flow of accurate Public Health guidance and information and timely provision of responses to COVID-19 queries in a rapidly changing situation.

Chaired by Assistant Director of Nursing, the membership was drawn from across the PHA/HSCB to include staff from the Public Health Directorate, PHA Health Improvement Division, PHA & HSCB Communications, PHA Nursing, Midwifery & AHP Directorate, PHA Health Intelligence, HSC Research & Development Directorate, Social Care and HSC Quality Improvement and Innovation.

KMC continues to respond to queries received through a newly established bespoke KMC sharepoint system using a specific email address for this purpose. The KMC has direct access to a range of knowledge experts, including those already involved in other Cells, and expert colleagues who provide a critical friend role to ensure information is quality assured and up to date, in a rapidly changing environment.

A Service Handbook was developed to clearly outline the steps in the process for how the cell manages queries, this handbook was independently quality assured.

The Triage and Logging team function is operational between 9am-5pm Monday to Friday for non-urgent, non-clinical COVID-19 related queries.

KMC developed reporting systems against a number of Key Performance Indicators, which are then used to produce weekly monitoring reports for the Cell members and reported through to the Silver Huddle during the first wave and now via the Covid 19 huddle.

KPI Data

Since KMC was established in March 2020 the dedicated email address **CovKMT@hscni.net** has received 990 queries and 519 resources for inclusion in KMC Resources.

Strengthening the workforce

Knowledge Management

The reporting system was finalised on 22 April 2020, from which point 591 issues have been logged, details of which are summarised below.

Knowledge Management Cell – Report
For emails logged from 22/04/2020 – 18/02/2021
Item Range 316-990 inclusive
Data downloaded on 18/02/2021

Emails logged: 591
Status: 0 Open; 591 Closed
Priority: 586 Normal; 5 Urgent

Source of Email

PHA	310
KMC Member	187
Another Cell	30
HSCB	27
Silver	11
Duty Room	11
Non-HSC – Statutory	3
HSCT	3
Contact Us Page	3
Other HC provider eg care worker, nursing home etc	2
Individual member of public	2
DOH	1
Gold	1

Primary Source of Email

PHA	208
No additional Source	87
KMC Member	66
Other	62
HSCB	44
Non-HSC – Gov Dept.	40
DoH	31
Non-HSC – C&V sector	12
HSCT	10
Non-HSC – Statutory	7
Individual member of public	6
Contact Us Page	5
Another Cell	5
Other HC provider eg care worker, nursing home etc	4
Silver	3
Primary Care	1

Issue category

Information Provision	469
Information Request	50
Query	60
Other	12

Thematic Area
Note this field is multiple entry and so the totals are greater than the number of items.

Health Improvement	129
Health Protection	181
Health Services	97
Non-Health Services	70
Other	343

Strengthening the workforce

Traffic to other cells

Infection Control	10
Infection Control	10
Technical Scientific	5
Emergency Operations Centre	4
Social & Community	3
Health Protection	1
Communications & Media	1
Multiple/Other	10

Thematic area of 'Query' Issue Category

Health Improvement	19
Health Protection	22
Health Services	14
Non-Health Services	9
Other	26

Gaps in Advice / Guidance
8 Gaps identified
Issues 364, 370, 423, 498, 580, 623, 714, 801

Response time (*considers working hours only - 9-5 Mon-Fri)*

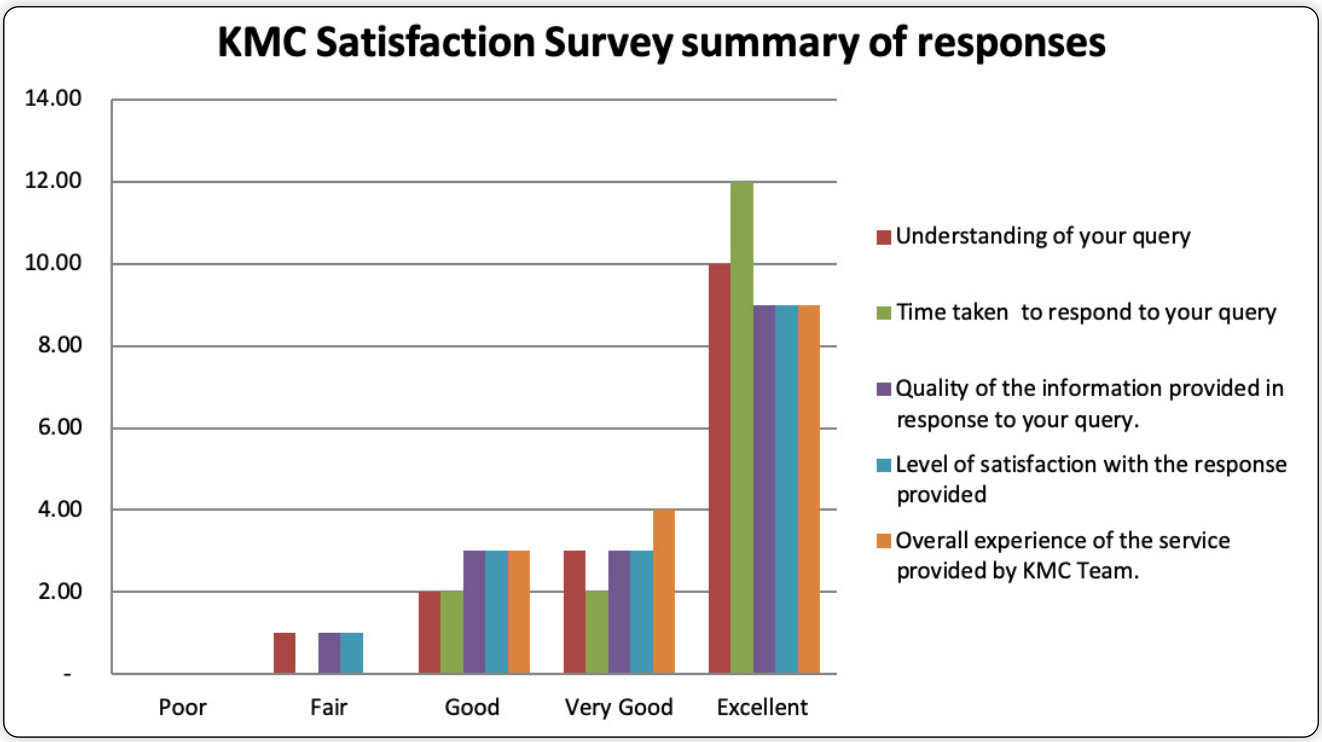
	Average TIme	Target Time
Time between mail received and logged	29 mins	1 hr
Time between mail logged and triaged	38 mins	1hr
Time between triage and issue resolved	2h 09 mins	2/6hr
Average time between mail received and issue resolved	3h 12 mins	4/8hr

KPI Areas

KPI Area	Average time between received and resolved (hh:mm)	No. of Issues
For information / guidance review / learning community	1:22	400
Forwarded to another cell for following up	14:48	21
Forwarded to knowledge experts for response	23:42	29
Response provided using existing guidance	2:32	25
Forwarded to another cell for info	6:44	7
Query unclear, requested further information	10:11	6
Unable to respond – query deemed inappropriate	2:49	9
N/A/Other/Misc/Multiple	3:19	76

***18 entries with date entry errors excluded**

Strengthening the workforce



Some direct quotes received from users:

> *It is a wonderful source for information especially during COVID when it is so difficult to keep up with so many email communications – a single source works better.*

> *This is the first time putting a direct query through and I was very pleased with the result – links to relevant information from which I could extract what was particularly relevant.*

> *I found the service really useful in terms of directing me to the right documents, however, I still had to read through docs and interpret the information provided but appreciate this is the nature of COVID with continual changes being introduced as lockdown eases.*

Strengthening the workforce

Emotional well-being support

There is significant research and evidence outlining the psychological impact of a pandemic, including the measures of social distancing and social isolation, on both the general population and healthcare staff.

Learning from the experiences of colleagues in other countries during the coronavirus pandemic – and our own experiences here in NI in terms of adjustment to societal trauma – that there is value in structured, planned and considered physical and psychological supports that support good mental health and wellbeing and that such frameworks should operate during the immediate crisis and extend into the longer term aftermath.

The pandemic called for a collective response that was caring and humane to help people affected by the pandemic. The Mental Health and Emotional Wellbeing Surge Cell (MHEWB) was formed in April 2020 as part of the wider Executive Cell response to COVID 19. The cell included representatives from DoH, PHA, HSCB, HSC Trusts and Community and Voluntary partners. The aim of the Cell was to ensure that the response to the psychological impact of the pandemic drew on and contributed to national and international clinical expertise and evidence-based practice and was consistent with guidance emerging from the UK four nations and Republic of Ireland.

A number of key resources and actions were delivered which also contributed to the DoH launching their COVID 19 Mental Health Response Plan. The plan focussed on seven strategic themes that had been identified to

respond to the impact of the pandemic on the population in Northern Ireland.

The overarching outcome of the plan is to increase the psychological wellbeing and good mental health for the population as a whole. The MHEWB Surge Cell ensured the delivery of an accountable, efficient, and effective network of services to implement the Response Plan. An important function of the cell was to carry out a rapid and rolling review of emerging evidence nationally and internationally and identify research priorities.

For further information see **https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic**

All the resources and information developed by the MHEWB Cell are available on the **Minding your Head** website. **http://www.mindingyourhead.info**

Strengthening the workforce

Resources developed included:
Children and Young People's Strategic Partnership (CYPSP) (hscni.net)

AHP Education Webinar Series

The arrival of the Covid-19 global pandemic has resulted in an extraordinary challenge across the health and social care system. Allied Health Professionals (AHPs) have played a vital role across the acute/hospital, community and care home settings. The pandemic has resulted in clinicians' upskilling in particular specialisms. AHPs, alongside the wider Multidisciplinary Team (MDT) have adapted their service provision and embraced new ways of working to reduce the risk of transmission of the virus. This has included the use of virtual technologies and innovative practice to continue to provide high quality care.

To reflect on the events of pandemic and consolidate learning a series of AHP education webinars were developed to provide an accessible interactive learning opportunity for AHP and health care professionals. These webinars were commissioned by the Chief AHP Officer in the DoH and developed and hosted by the PHA and CEC in collaboration.

The aims of the AHP education webinar series were:

- To provide an accessible learning opportunity for AHPs and other health professionals across Northern Ireland to share and reflect on the learning from the first Covid-19 pandemic surge.
- To showcase the AHP role in the rehabilitation and recovery challenge during the pandemic.
- To help AHP and other health professionals to plan for a second surge.
- To provide a local and national perspective of the challenges faced in the pandemic.
- To explore the use of webinars as an appropriate tool for future sharing/learning.

A series of three AHP education webinars based on the Covid-19 pandemic and recovery were undertaken in August and September 2020. A range of AHP and MDT experts from across organisations within Northern Ireland and mainland UK were selected as panellists. Expert patients were also recruited through direct communication with HSC Trusts. This ensured that each webinar included up to date academic literature, as well as staff and patient experiences to accurately inform learning.

The three AHP education webinars covered the following areas:

- Critical Care
- Community Services
- Care Homes

Each AHP education webinar was delivered as a live stream via Zoom and recorded for watch back via an unlisted YouTube video with the link shared across the system to maximise the audience reach.

As the Covid-19 pandemic continues to create a complex challenge across the system, it is imperative that education continues on a safe and accessible platform to enhance the provision of services. Future events are being developed and will focus not only on the delivery of care, but the whole spectrum of service planning, commissioning, delivery and evaluation. In addition key stakeholders will be involved in future events where appropriate and this will include partners across organisations, staff, patients, carers and the public to ensure the correct content is being delivered.

2.3 Education, training and capacity building opportunities

Scottish Improvement Leader Programme

On Friday 18th Oct 2019 26 members of HSC staff graduated from the regional Scottish Improvement Leader (ScIL) programme, commissioned through the HSCQI transformation funding. This programme, which is run over 10 months, awards graduates a level 3 QI qualification linked to the NI attributes framework. The objective of the ScIL programme is for participants to develop an in-depth understanding of core Improvement Science concepts. Graduates will have the ability to apply Improvement Science tools, techniques and methods to improvement projects (including system thinking, building knowledge, understanding variation and measurement for improvement, the people side of improvement and how these factors interact). These ScIL graduates will be using their new skills to lead and manage change for improvement, generating and facilitating learning and coaching individuals and teams in Improvement Science.

Throughout the duration of the programme participants undertook their own improvement project to consolidate their learning and apply skills from learning workshops and events into practice.

Strengthening the workforce

The graduation ceremony was held in the long gallery in parliament buildings with invited guests from across the HSC system.

A second cohort of participants commenced the programme in October 2019.

This will lead to the improvement methodology being progressed through the HSC as the way to manage change by a testing and improvement message.

SciL data

Organisation (clinical)		Organisation (non clinical)	
Belfast Trust	6	PHA/ HSCB	6
Northern Trust	7	Arm's Length Bodies (ALB)	10
Western Trust	7	Department of Health	3
Southern Trust	6	Professional body	2
South Eastern Trust	7		
NIAS	3		
Primary Care	2		
Total	**38**		**21**

Primary Care Multi-disciplinary Teams (MDTs)

Multi-Disciplinary Teams (MDTs) involved the recruitment of practice-based physiotherapists, mental health workers and social workers to GP practices; these MDT members will work alongside GPs and practice staff with the aim of better meeting the needs social, physical and mental health wellbeing of the local population. This model also includes significant investment in additional nursing specialist roles such as health visiting and district nursing.

July 2018 saw the initial rollout of pilot areas, with GP Federations in Down and Derry/Londonderry to be the first to benefit from MDTs in their practices. 2019/20 and 2020/21 brought further expansion of the model into West Belfast, Causeway and Newry & District providing patient focused accessible care to population of c 640,000 with significant investment to date totalling £30m. The project has recruited significant numbers of additional staff to work within GP practices; over 260 staff are already in post across 95 practices to improve mental health and social wellbeing of patients.

The MDTs remain a key priority within the health and social care transformation programme, helping provide more care closer to people's homes and improving access for practice populations. Evidence suggests that this approach will see patient issues resolved more quickly, for instance by reducing the need for referrals and appointments elsewhere, easing demand and pressure on hospitals.

Plans are being developed to roll out MDTs across all 17 Federation areas.

£30m
of investments

260 staff across
95 GP practices

2.4 Supporting HSC Staff during COVID

Introduction of rainbow rooms resource boxes.

Rainbow Rooms were introduced across Care Homes in Northern Ireland to help and support staff that have done so much for our loved ones during the pandemic. The Rainbow Rooms idea was adopted from the rainbow symbol of solidarity used by the NHS/HSC during the current pandemic.

The rooms provided some much needed space and quiet time for staff during difficult periods resulting from the pandemic. Rainbow Room resource boxes were delivered to each of the 483 care homes across Northern Ireland and were filled with information and advice on health and wellbeing issues to support staff as well as activity packs, toiletries, water bottles, tea, coffee and snacks.

Each box was unique and acted as a gesture of support to help strengthen the relationships between the care homes and the local voluntary and community sector.

The initiative was delivered through a collaboration led by the HSCB, Integrated Care Partnerships (ICPs), PHA, HSC Trusts and the Healthy Living Centre Alliance. Healthy Living Centres across NI received donations for the Rainbow Rooms from the Red Cross and the Food Standards Agency as well as from a wide range of local organisations and businesses.

Strengthening the workforce

Project ECHO

Using videoconferencing technology, Project ECHO® NI provides a safe virtual space for education, training, sharing best practice and supporting staff working in highly pressured and challenging situations. Project ECHO NI uses Zoom technology to connect communities of practice.

This really came in to its own during the pandemic when social distancing measures were required. Participants come together in real time to receive updates, new guidance, build relationships and learn from each other. These sessions are interactive so all participants have the opportunity to seek answers to questions and concerns they have.

Participants also have the opportunity to learn through anonymised case discussions. As many networks were already established pre-COVID, having the foundation already there along with the infrastructure including the dedicated ECHO team and technology enabled ECHO NI to hit the ground with a change in focus where required.

Throughout the coronavirus pandemic, Project ECHO® NI has supported and continues to support various networks involving Secondary Care HCP's, GP's, Optometrists, Community Pharmacists, Nursing Homes, Residential Homes, Care at Home Staff and Community & Voluntary organisations to name a few.

An example of such support is the use of this established method by the PHA to get messages out quickly to the Care Home sector. Some of these sessions have had almost 300 people participate. Recent examples of this have been sessions on 'Swabbing of residents' and 'Environmental Cleanliness in Care Homes'.

ECHO has provided instant access to much needed support – demonstrated by the high numbers involved – over 10,000 people from mid-march until the end of November.

The ECHO model prides itself in moving knowledge, not people, in regular real-time collaborative education sessions where ***'everyone a teacher, everyone a learner'.***

For more info on Project ECHO:
www.echonorthernireland.co.uk

2.5 PPI Leadership programme

The PHA has continued to support cultural change within the HSC, to one whereby partnership working with people with lived and living experience, both service users and carers is the norm. Through the Leaders in Partnership programme and others, such as the bespoke training we have commissioned and delivered, including the webinars on Consultation, Involvement and Co-Production where more than 500 attended the sessions and a further 470 has since viewed them. The PHA are leading on the work of building a critical mass of people within and outside the HSC who have the requisite knowledge, skills, expertise and experience to effect real change, with associated consequent improvements in quality, safety and efficiency.

Leading in Partnership – Leadership Programme for Involvement and Co-Production

In 2019/20 the PHA commissioned two further cohorts of the successful 'Leading in Partnership' leadership programme. Over 130 participants have now undertaken the programme, including HSC staff, service users, carers and members of the community and voluntary sector. The programme continues to be in demand, with Cohort 5 (which finished on 12th January 2021) having three times as many applicants compared to the number of available places, with more than 60 applicants for 18 spaces. Cohort 6 which is due to start on 29th January 2021 and has had received 57 applications and a waiting list has been developed for any future programmes.

With the continued success of the programme, we developed a one off information session that will give applicants a 'taster' of the programme, as well as being able to reach a wider audience than the current programme can facilitate.

Through the growth of The Leaders in Partnership Programme and the continued development of other training, we are aiming to build a cohort of people in the region with knowledge, expertise and experience in involvement and co-production. This "critical mass" of people both within HSC and external to it, with these attributes, will be key in our collective endeavours to deliver systemic cultural change the HSC, in our drive to become a truly person centred service. One where partnership working is valued, respected and seen as standard practice and where we strive to co-design and co-produce services that are targeted to need, that are of the highest quality, that are efficient and owned and respected by the community.

Over 130 participants have now undertaken the programme

60 applicants for 18 spaces in COHORT 5

57 applications for COHORT 6

Strengthening the workforce

Ministerial support

The team were delighted that Minister for Health Robin Swann MLA took time out from his hectic schedule in October to join a cohort of the Leading in Partnership Programme, to discuss their learning experiences on Leadership in Involvement, Co-Production and Partnership Working. The Minister was welcomed to the virtual session by Director Rodney Morton. He was given an outline of the programme from our Assistant Director Michelle Tennyson, before hearing directly from the course participants themselves, who included HSC staff, service users and carers.

The Minister was unambiguous in his endorsement of this overall approach and saluted the PHA, and our partners in the HSC Leadership Centre, for our determination and creativity in rising to the challenge to deliver this programme in the circumstances. As Minister, he restated his commitment to the statutory duty of Involvement and re-iterated his and the Department's belief that we need to harness this collaborative approach to effectively tackle the challenges that we face in terms of health and social well-being.

60+ **applicants for 18 spaces at Cohort 5**

57 **applications received for Cohort 6**

Over 130 **participants have now undertaken the leadership programme**

Theme three

Measuring improvement

Measuring improvement

3.1 Introduction

The HSCB and PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. We promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

3.2 Quality Improvement Plan; measuring improvements

The HSCB and PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. We promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

Quality improvement plans

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

Last year the QIP target areas were:

- Pressure ulcer prevention
- Falls prevention
- National Early Warning Scores (NEWS)
- Mixed gender accommodation

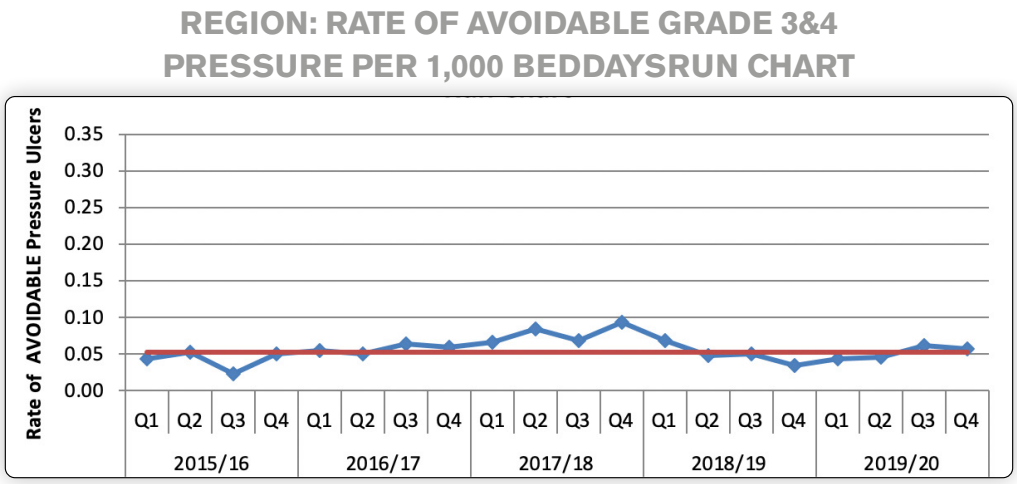
Pressure ulcer prevention

The PHA along with the HSCB supports HSC Trusts through the Regional Pressure Ulcer Prevention Group to implement the SSKIN bundle; an evidenced based collection of interventions proven to prevent pressure ulcers. This group provides advice and support and shares regional learning related to pressure ulcer prevention and management.

A basic principle of quality measurement is: if it can't be measured, it can't be improved. Therefore we recognise that pressure ulcer performance must be counted and tracked as a core component of our quality improvement programme. At the Regional Pressure Ulcer Prevention Group, HSCTs agreed to focus on reduction of avoidable grade 3 and 4 pressure ulcers, as these create deeper cavity wounds which can result in more pain and suffering to patients.

Measuring improvement

The graph below shows the total regional rates of pressure ulcers grade 3 and 4 from April 2015 – March 2020.



The data indicates that there has been a decrease regionally since 2017/18 in the number of grade 3 and 4 avoidable pressure ulcers, with the 2019/20 data indicating rates remaining around the median. This demonstrates the impact of collective leadership and commitment shown by HSC Trusts in driving down the rate of hospital acquired pressure damage, thus improving the clinical care outcomes, as well as improved patient experience for those citizens who use health and social care services.

Falls prevention

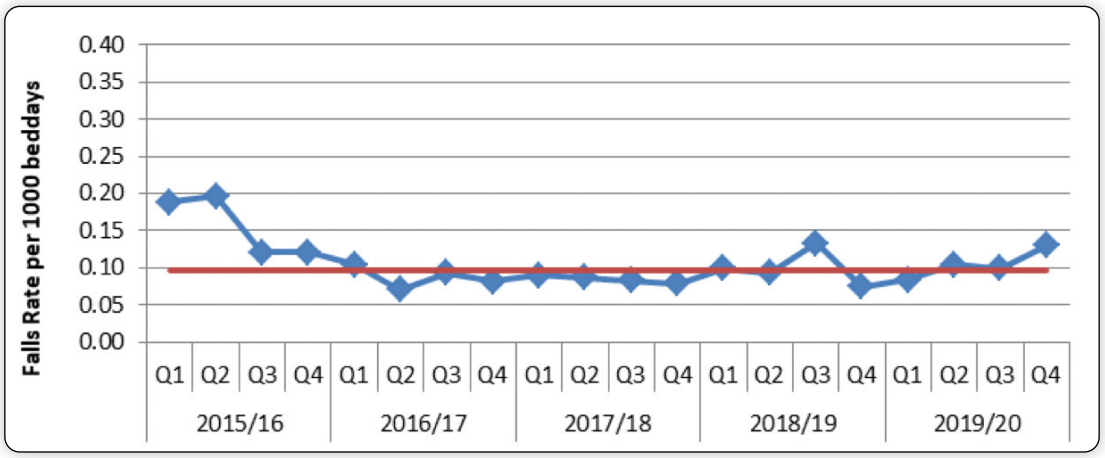
During 2019/20 the PHA and HSCB, through the Regional Falls Prevention Group, have continued to support HSCTs to implement and spread the Royal College of Physicians 'Fallsafe' bundle; an evidence-based collection of interventions proven to reduce falls in inpatient settings. HSCTs measure compliance against the 'fallsafe' bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the HSCTs.

The 'Falls Bundle' as detailed here contains a number of regionally agreed elements, outlined below which are evidenced to reduce falls, against which Trusts measure compliance and report to the PHA and HSCB.

Part A Elements	Part B Elements
• Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed • Call bell in sight and reach • Safe footwear • Personal items within reach • No slips or trips hazards	• Cognitive Screening • Lying and Standing BP recorded • Full medication review requested • Bedrails risk assessment

Measuring improvement

REGION: RATE OF MODERATE TO MAJOR/CATASTROPHIC FALLS PER 1000 BED DAYS RUN CHART



During 2019/20 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major or catastrophic harm. The run chart here shows the regional picture on the rate of moderate to major/catastrophic falls per 1000 bed days since 2015 to quarter 4 2020.

Regionally there has been no significant trend in the rate of moderate to major/catastrophic falls over the past year across HSC Trusts, however it is important to note that rates of in-patient falls remain at their lowest since monitoring commenced in 2015. This low rate of falls clearly demonstrates the impact of the ongoing improvement initiatives and focus on prevention of falls across HSC Trusts, including use of a wide range of falls technologies and prevention strategies.

In quarter 4 of 19/20 it is evident there is a slight increase in the rate of moderate to major/ catastrophic falls per 1000 bed days. From a patient safety perspective this will be kept under review to pinpoint areas which may be experiencing a rise in falls and ensure Trusts are supported to put the necessary improvements plans in place to address this.

National Early Warning Scores (NEWS)

Since its initial launch in 2012 by the Royal College of Physicians, the National Early Warning Scores (NEWS) chart has seen widespread uptake across the NHS. Currently all HSC Trusts in Northern Ireland are using NEWS. Through standardisation of NEWS we can reduce the number of patients whose conditions deteriorate whilst in hospital, and potentially save lives.

The HSC Safety Forum, now HSCQI, led the regional implementation of NEWS across HSCTs, including appropriate escalation arrangements to improve care of the deteriorating patient. The NEWS tool supports healthcare staff in the early identification of deterioration in a patient's condition as it advocates a system to standardise the assessment and response to acute illness. Abnormal scores prompt specific actions and/ or referral to senior expertise. Part of the roll out of NEWS involved facilitating HSCTs to define their expectations regarding intervention when scores are abnormal.

Measuring improvement

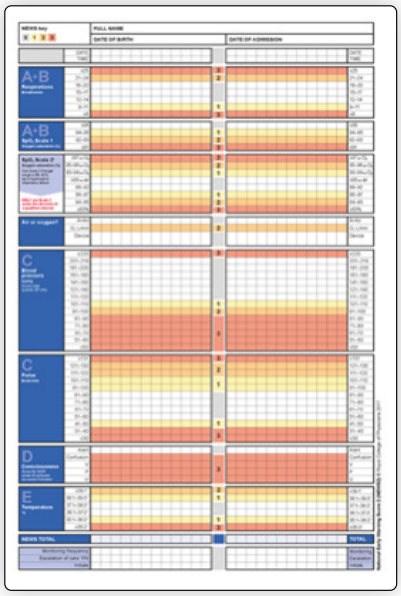
NEWS2 is the latest version of the National Early Warning Score, updated in December 2017. Since April 2018 the Safety Forum/ HSCQI has worked with Trusts to:

- Develop a plan to implement and measure NEWS to identify early deterioration and prompt specific action.
- Develop arrangements to implement NEWS2.

The HSCQI hub led the Regional NEWS2 group to support Trust colleagues in the effective implementation and roll out of NEWS2 right across all HSC Trusts. The Chief Medical Officer requested that implementation of NEWS2 be completed by March 2020; however this may have been delayed in some areas due to the impact of the COVID-19 pandemic. It is of vital importance in terms of patient safety that such a tool is used across all appropriate healthcare facilities, as it has the impact of ensuring early recognition, response and appropriate escalation in patients who may deteriorate which undoubtedly saves lives.

Mixed Gender Accommodation

HSC is committed to the delivery of person-centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity while in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area. In line with the DoH Guiding Principles for Mixed Gender Accommodation, each HSCT has developed a policy for the management of mixed gender accommodation in hospital. During 2019/20 the PHA and HSCB supported HSCTs to:



- Put in place effective arrangements to adhere to their policy for the provision of safe and effective care and treatment in mixed gender accommodation
- Put in place the findings of a thematic review of mixed gender accommodation in inpatient adult wards, which will help to inform the progression of further improvement in mixed gender accommodation for 2020/21
- Measure and report compliance with their policy for mixed gender accommodation in 100% of inpatient areas

Due to the nature of some estate in certain Trusts, it can be challenging to ensure mixed gender accommodation is always avoided; however it is evident that there is an ongoing commitment from Trust colleagues to ensure that the policy is adhered to. The HSC Trusts are committed to providing high quality, safe, person-centred care and by embedding these guiding principles they will ultimately have a positive impact and importantly enhance the patient experience for those who use our health and social care services.

NICE
National Institute for Health and Care Excellence

3.3 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non-departmental public body responsible for providing national guidance and advice to improve health and social care. NICE produces different types of guidance, including:

- Technology appraisals (new drugs, medical treatments and therapies).
- Clinical guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions).
- Public health guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB and PHA have put in place processes to implement technology appraisals, clinical guidelines and public health guidance published by NICE and endorsed by the DoH.

Between 1st April 2019 and 30th September 2020, the HSCB/PHA issued 51 Technology Appraisals to the HSC and continues to monitor the implementation of 22 Clinical Guidelines which have been issued to the service.

More information about the technology appraisals and clinical guidelines that are being implemented can be found at **www.hscboard.hscni.net/nice**

3.4 Measuring Improvement during COVID-19 Pandemic

The importance of monitoring and measuring the performance of HSC services and improvements in the delivery of those services is a long-established function of the HSCB. This is done using information reporting and analyses against a suite of objectives, standards and associated quality and improvement indicators. This information is then used to inform a series of performance accountability and service improvement processes across the HSC.

Examples of specific services which were monitored and measured across these 3 key areas are as follows:

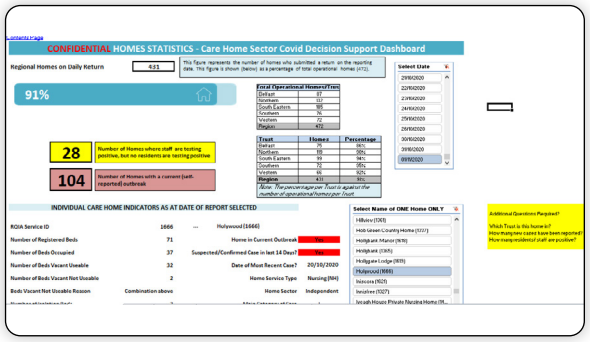
- Daily monitoring of acute hospital bed occupancy pressures – including the volume of Covid-19 patients
- Trends in ICU bed utilisation and patients needing respiratory support
- Bed modelling to project the potential future impact of the Pandemic
- The impact of Covid-19 on the delivery of elective services
- Decision Support monitoring for Care Homes
- The rebuilding of Cancer services
- Understanding the impact of Covid-19 on Delayed Hospital Discharges

Measuring improvement

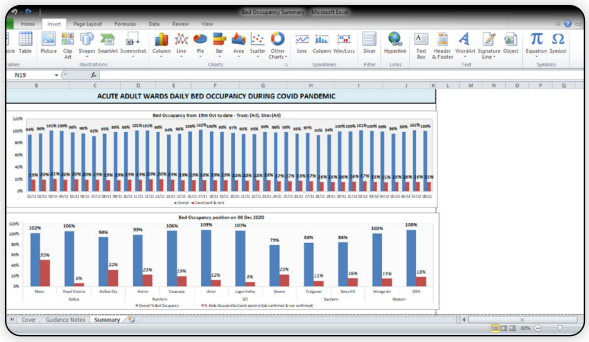
Obviously the Covid-19 Pandemic has posed significant challenges across the HSC and this has also been the case when trying to monitor and measure performance and service delivery. Consequently, monitoring of HSC performance has had to focus on 3 key areas:

- The scale of the Covid-19 Pandemic challenge facing the HSC
- The impact of the Pandemic on the delivery of services
- The rebuilding of those services

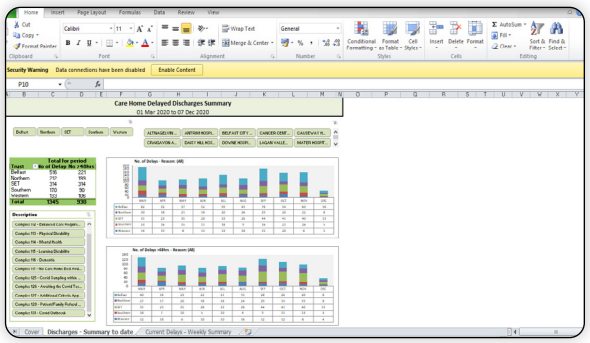
In providing this level of monitoring, there is a continual challenge to ensure the information is provided in an easily consumable format for decision-makers. This leads to the use of a variety of tools being used such as Dashboards, Trend Charts, Sitreps etc. of which some examples are illustrated below.



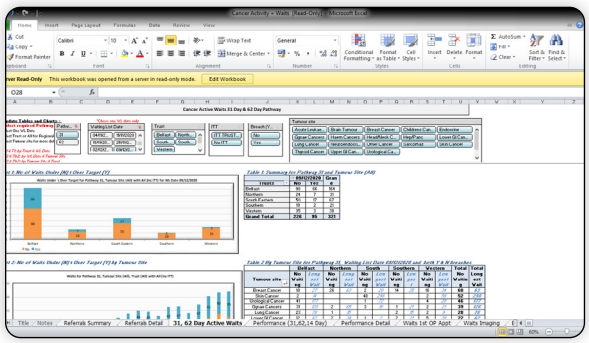
i) Care Homes Decision Support



ii) Acute Bed Occupancy and Covid-19 Inpatients



iii) Delayed Hospital Discharges due to Care Home and Covid-19 related Reasons



iv) Cancer Services Waits

The impact of measuring these areas allows the rebuild agenda to have the necessary data to know which areas require priority moving forward to ensure safer systems for the future.

3.5 Impact of COVID-19 on Screening Services

Population screening programmes have a key role to play in early detection of disease. The PHA has responsibility for commissioning, coordinating and quality assuring eight screening programmes.

Approximately 400,000 invitations for screening are issued per annum across these programmes.

Pause in screening during the first wave of COVID-19

The following five screening programmes were temporarily paused in the second week of March 2020, at the advice of the DoH:

- Routine breast screening
- Bowel cancer screening
- Cervical screening
- Abdominal aortic aneurysm (AAA) screening and surveillance monitoring
- Routine diabetic eye screening (DESP) and surveillance monitoring

This was in response to COVID-19; both to reduce the risk of exposure to the virus for the public and Health and Social Care (HSC) staff, and so that HSC staff and laboratory resources could be redirected towards the pandemic response.

While some the above programmes were paused due to COVID-19, screening continued to be offered to people who required:

- Higher risk breast screening - all eligible women continued to be screened at the higher risk screening unit in Antrim Area Hospital
- Diabetic eye screening for pregnant women (sight saving laser treatments and urgent intravitreal injections continued to be provided)
- Infectious diseases in pregnancy screening
- Newborn blood spot screening
- Newborn hearing screening

Restoration and recovery of paused screening programmes

The Strategic Framework for Rebuilding HSC Services, published by the DoH in June 2020, called for the phased restoration of these five programmes.

In early June 2020, the PHA established a Screening Restoration Group to coordinate the process of restoring these screening programmes. Individual programme-specific plans were developed and progress made across all areas.

Teamwork and collaborative working is a vital element of the recovery process – the Screening Restoration Group is working in close partnership with HSCB and all HSC Trusts and charity partnerships, in addition to liaising with colleagues in the UK Four Nations' groups and in the Republic of Ireland.

It is important to remember that screening services are provided to a 'healthy population' who have no symptoms. Between screening

appointments, or as people wait for a rescheduled screening appointment to take place, anyone who experiences any new signs or symptoms is encouraged to seek medical advice through their GP.

The PHA continues to promote regular public health messaging through a number of channels, advising people to be aware of the symptoms of cancer. The importance of partaking in screening programmes when invited also continues to be promoted and the PHA collaborates closely with all organisations involved in screening programmes to promote informed choice and uptake in screening.

Restoration of screening services and the on-going innovative work in screening is therefore vital over the coming years.

Screening programmes are adapting to the changes required due to new infection control measure and a variety of innovative solutions are being proposed to manage the restoration of screening programmes during the pandemic. Ultimately, the PHA continues to work towards improved screening services for the Northern Ireland population, and some examples of this innovation are highlighted below.

Breast Cancer Screening Programme

Before COVID-19, HSC Trusts utilised a system called SMART clinics – this maximises the number of participants that can be invited to attend a screening clinic based on probability of attendance. These were not in use when screening was initially re-started as it could result in more than one participant arriving at the same time, therefore compromising social distancing and infection control measures. The re-introduction of SMART clinics was piloted at the static unit in Linenhall Street. This was successful and was rolled out to other static units. A pilot has also been conducted in two mobile units where a Portakabin has been successfully used to manage multiple attendances.

SMART clinics have now been rolled out across all units from the beginning of October. As the reintroduction of SMART clinics allowed for better utilisation of appointment slots, self-referral for breast screening for women over the age of 70 could be reinstated at the same time.

Measuring improvement

Bowel Cancer Screening Programme

During the restoration period, extensive planning work has been continuing for the introduction of quantitative Faecal Immunochemical Testing (qFIT), which is on track for implementation from the end of December 2020.

This new type of test will replace the previous screening kit. As before, the test detects the presence of hidden blood in the stool which may be a sign of colorectal cancer and therefore warrants further investigation. The result from qFIT is more accurate than the current test and is expected to allow the programme to pick up more cancers. The other important difference is that qFIT is an easier-to-use kit for individuals to collect their sample of bowel motion.

Data from Scotland and England have shown that the uptake of bowel screening has increased following the change to qFIT.2

The PHA / HSCB are working collaboratively with all Trusts to assess and monitor the expected impact of qFIT on screening colonoscopy services.

We implemented the test in January 2021; however this was then followed by a challenging period for the screening programme. Due to service pressures related to the COVID-19 pandemic, some Trusts temporarily stood down their assessment services. This led to us taking an operational decision to reduce the frequency of invites issued.

It is anticipated that qFIT will result in increased uptake. It is also a more sensitive test and brings NI into line with the rest of the UK.

3.6 Measuring new ways of working

Reforming Rapid Angina Assessment Clinic (RAAC) Services

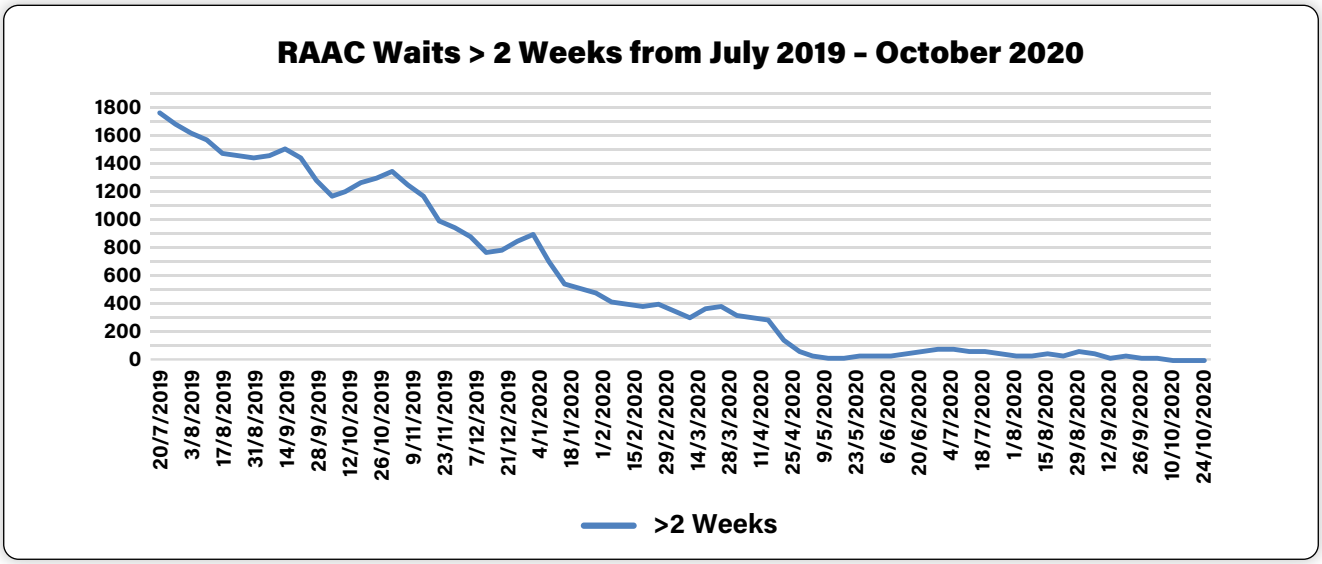
The recommended standard for the assessment of patients who develop new symptoms that might be due to angina is within two weeks of receipt of referral into the RAAC service. NICE guidelines updated in November 2016, reiterated the criteria to be used for assessment of suspected angina. However, a regional audit carried out in September 2018 demonstrated that 42% of RAAC referrals did not meet the updated guidance (*CG95: Chest pain of recent onset: assessment and diagnosis)*.

Following an SAI into the death of a patient whilst waiting on a RAAC appointment and the subsequent inquest into the death in early 2019, it was agreed that the HSCB / PHA would undertake a regional review of RAAC services and work with Trusts to address the long waiting times. At July 2019, approximately 1,800 patients were waiting over 2 weeks to be seen at RAACs.

A regional multi-professional Task and Finish Group was established who worked collectively to address the key issues facing the service. Actions included:

- developing regionally agreed referral protocols for ED staff, GPs and RAAC teams;
- developing standardised regional clinical template letters;
- establishing education and awareness sessions;
- applying NICE CG95 criteria to both new referrals and to the backlog;
- facilitating cross Trust patient transfers to support the equalisation of waiting lists;
- establishing robust performance monitoring arrangements so that individual patients could be tracked.

This collaborative approach resulted in no patients waiting over 2 weeks to be seen at the end of October 2020 as demonstrated in table.



Measuring improvement

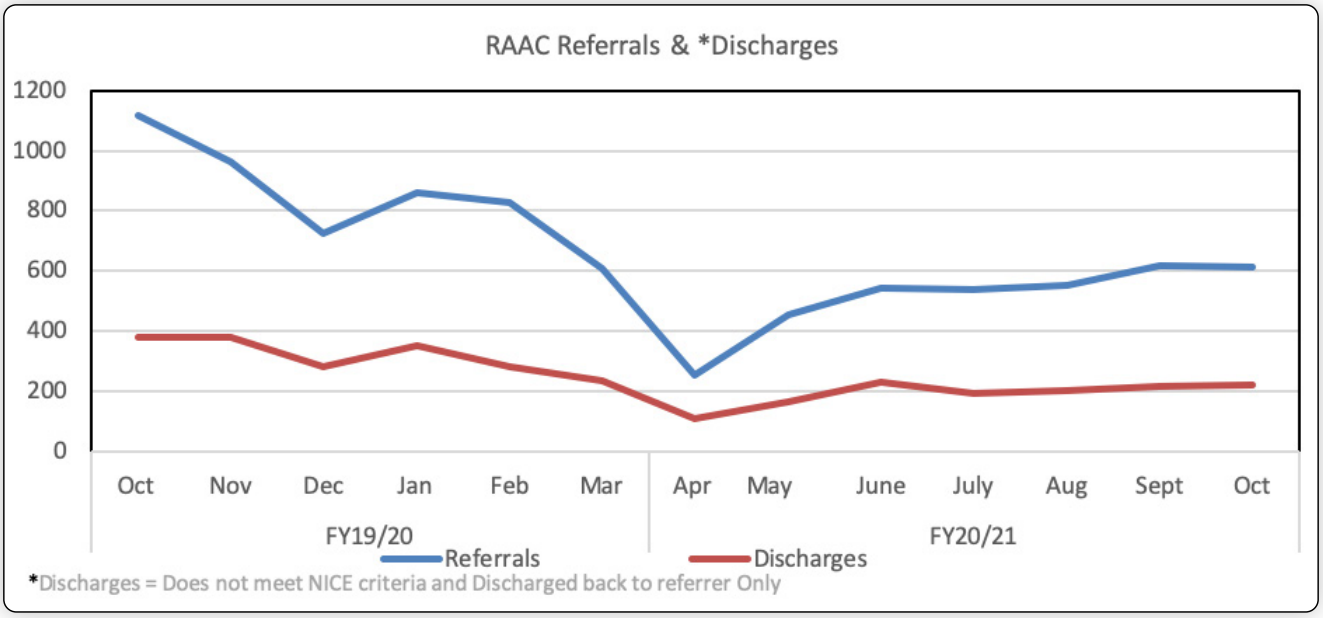
There has also been a 46% reduction in monthly referrals to RAACs due to improved adherence to NICE criteria for stable angina. RAAC referrals received not meeting NICE criteria has also reduced by 51% and are now either referred directly to cardiology (if another cardiac condition is suspected) or a letter sent to the referrer and patient outlining the reason why stable angina is not suspected and why the patient does not need to be seen. See table below.

A feedback loop to primary care, EDs, the Task and Finish Group and the Cardiac Network has helped reduce the variation in RAAC referrals and ensured patients are now seen within 2 weeks. The additional capacity created has also enabled RAAC nurses to co-work in cardiac ambulatory areas.

Although referral practice has changed, continued education and training for referrers and RAAC staff is required. The plan to address this is to use Project Echo to ensure service change is embedded and sustained moving forward.

The impact of this project is clear by the outputs in reducing waiting times for this service therefore improving both clinical outcomes and citizen experience for patients within this service.

RAAC REFERRALS & DISCHARGES (DISCHARGES INDICATES REFERRALS DISCHARGED FOLLOWING TRIAGE THAT DO NOT MEET NICE CRITERIA)



Theme four

Raising the standards

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered.

4.2 Collaborative working

HSCQI maternity collaborative

The HSCQI maternity collaborative is a sub group of the Maternity Strategy Implementation Group (MSIG) that has cross-trust and multi-professional input. The HSCQI maternity collaborative aims to improve the safety and outcomes of maternal and neonatal care by reducing regional variation in practice to provide a high quality healthcare experience for all women, babies and families across maternity services. As part of the work of the Maternity Collaborative all HSC Trusts plan to introduce a physiological approach for interpretation of cardiotocographs (CTG) for intrapartum fetal monitoring to improve maternal and neonatal outcomes. By using a physiological approach to CTG interpretation and having greater understanding and incorporation of physiology, we expect to see a reduction in unnecessary intervention for women as well as a reduction in fetal hypoxic neurological injury, intrapartum stillbirth and early neonatal death. To achieve this transition a Regional Intrapartum Fetal Monitoring Guideline and intrapartum physiological based evaluation tool and checklist have been developed, along with the provision of regional masterclass training for maternity staff.

400 staff across NI trained in new assessment

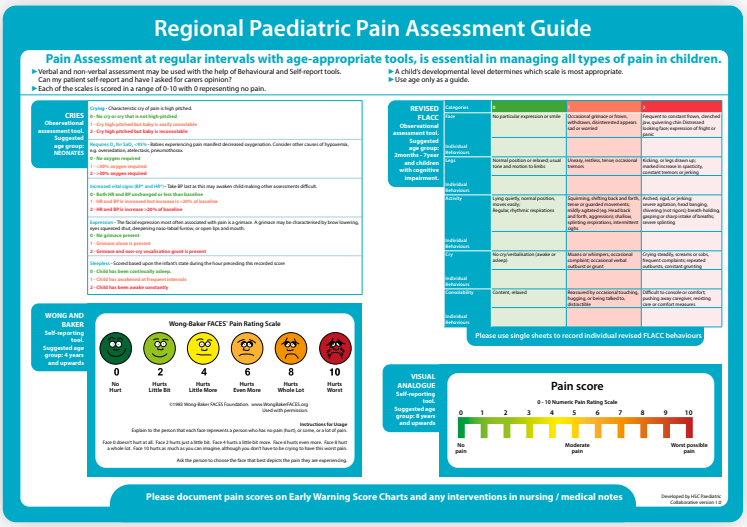
200 first cohort

100 second cohort

100 virtual session due to COVID

There are approximately 1500 maternity staff in NI so almost 1/3 complete.

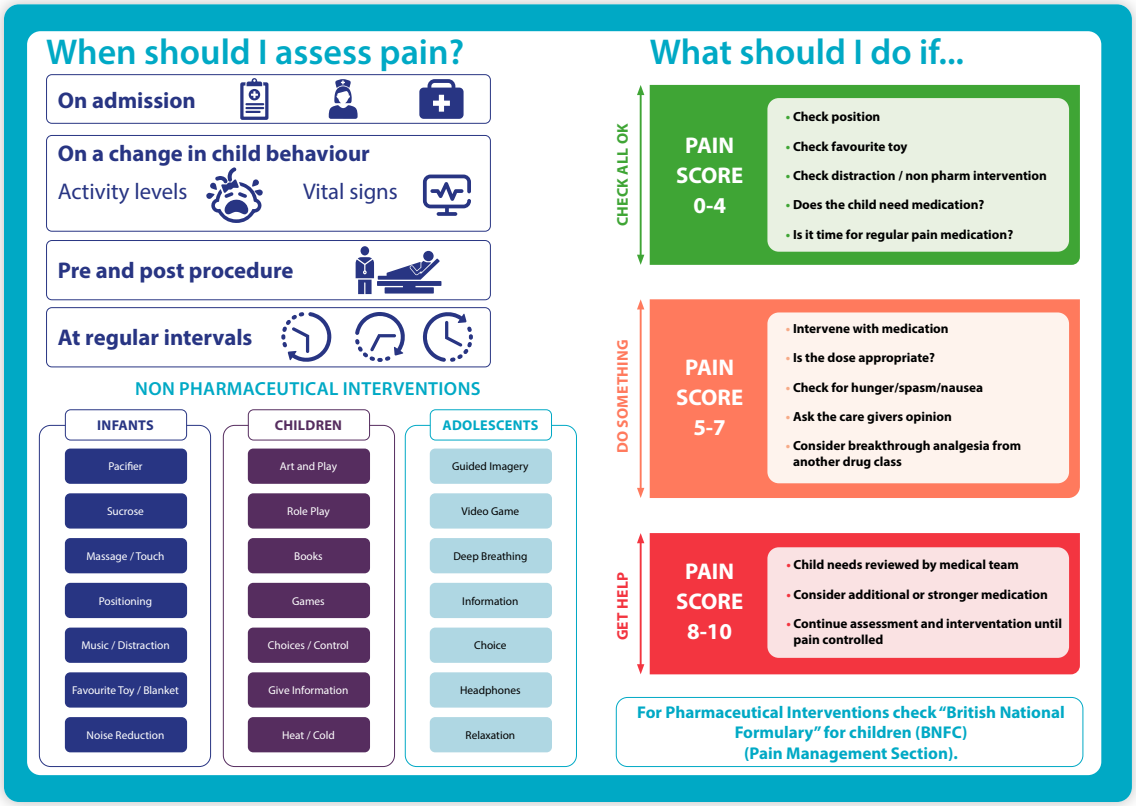
Regional Paediatric Pain Assessment Guide



In August 2019 a new Regional Paediatric Pain Assessment Guide was launched. This was developed by the HSCQI Paediatric Collaborative in consultation with RBHSC pain nurse specialist Louise Mac Donald.

Speaking at the launch Louise Mac Donald said *"Pain Assessment at regular intervals with age-appropriate tools, is essential in managing all types of pain in children. It is important to document pain assessment scores and reassess to ensure any intervention required is effective. Verbal and non-verbal assessment may be used by Healthcare professionals, with the help of behavioural and self-report tools. The NI HSCQI Paediatric Collaborative has developed this regional guide to aid the pain assessment process and facilitate timely and appropriate interventions."*

This chart will complement the updated paediatric early warning score charts.



Raising the standards

Mental and emotional wellbeing and suicide prevention

Improving mental health and emotional wellbeing and reducing suicide is a key priority for Public Health. Suicide is a preventable problem within our society and one that requires a collaborative approach across government departments and in partnership with a wide range of community & voluntary and statutory organisations.

Regardless of which sector persons within our community receive help, support or information from, it is essential that they receive a high quality service with a focus on improvement.

The PHA & HSCB have worked with partners within the community, voluntary and statutory sector to develop **Quality Standards for Services Promoting Mental and Emotional Wellbeing and Suicide Prevention (Quality Standards).** These set the minimum standards which organisations should work to, including:

- Management and governance
- Training
- Self-Harm
- Counselling
- Complementary Therapies
- Bereavement support, with a supplementary guidance for bereavement support groups

The Quality Standards are designed to encourage and support improved services and provide a legislative and best practice framework against which performance can be measured.

The standards are accessible to any organisation as a self-assessment tool allowing organisations to evaluate how they apply to their organisation. Additionally, each year a number of organisations are chosen at random for independent assessment. To date 21 organisations have participated in an independent assessment which provides a benchmark of organisational policies and practices against the standards and provides assistance to make changes where appropriate.

As best practice, organisations should revisit and review their standards assessment on an annual basis to account for legislative, best practice or individual changes within their organisation.

For further information:

- www.publichealth.hscni.net/publications/quality-standards-services-promoting-mental-and-emotional-wellbeing-and-suicide-prevent
- www.pharesourcehub.co.uk/

Think Family Social Work Assessment

A family focused initiative, based on Falkov's Family Model (2012), was piloted across mental health teams in NI. The initiative was called the Think Family Social Work Assessment and consisted of three elements: a family conversation, assessment and review. This study aimed to investigate the benefits of this initiative for family recovery from the perspective of family members, social workers and other professionals.

A self-report questionnaire was constructed by the HSCB and was used to collate feedback at pre and post engagement stages in the initiative from social workers in adult mental health services in five HSC Trusts in NI. Questionnaires were also completed by parents, adult siblings, carers, children and other involved professionals at the post stage.

Findings suggest a positive shift in perceptions by social workers, family members and involved professionals. Key insights included: improved communication between family members and professionals; better understanding of the impact of mental health on the family; and the use of a strengths-based approach to identify professional and family perspectives on resources, needs and concerns. Professionals reported an improvement in collaboration between services.

This evaluation of the Think Family Social Work Assessment demonstrated preliminary positive outcomes. The assessment component contributed to needs identification and fuller understanding of each family's strengths and vulnerabilities.

Raising the standards

Children and Young People Strategic Partnership

CYPSP, led by HSCB and PHA continues in its commitment to improving the quality of early intervention services to children and young people through:

- The coordination of multi-agency, and multi-disciplinary collaborative children's services planning, and locality based service delivery
- Involvement and coproduction with children and families, and
- The use of data to continually drive our learning, shape our services and measure outcomes and achievements

Our Journey through Disability

A key priority identified for the CYPSP Newry Locality Planning Group (LPG) was to improve outcomes for children and young people with a disability. A Disability Sub-Group was established to plan for an event which would bring together services and organisations working in the locality area for children and young people with a disability and/or additional needs.

A consultation event took place on 27th March 2019, and a paper was co-produced with parents identifying 18 recommendations for action. The report was launched by the Children and Young People's Strategic Partnership (CYPSP) with the view that the recommendations would be taken forward as one of the CYPSP's main priorities in delivering better outcomes for Children and Young people with a Disability and their families.

Building a research community

> *Our vision is that people in Northern Ireland who use our services will have confidence that social work and social care policy, practice and service outcomes are underpinned by a strong research evidence base committed to continual improvement.*

Since 2017 through an initiative taken by the HSCB, the application process of a Post qualifying *Research Methods* Programme, run as a partnership with Ulster University, was opened up to service users and carers. This has been facilitated through funding by the HSCB and responsibility for module design and accreditation being undertaken by the university.

The initiative was based on the belief that co-production would be better realized through having service users trained in rigorous research methods. Service users and carers undertake, on a part time basis three academic modules over the course of three years. Completion of all three modules leads to service users and carers gaining an MSc in Development and Co-Production in Social Care Research.

The uniqueness of the programme is that the academic entry requirements are the same as that required of social workers and likewise the classroom teaching is undertaken entirely with social workers and service users and carers together. Three service users and carers have gained accreditation at MSc Level and six others are on that learning journey.

Providing teaching on research methods for service users jointly with experienced social workers is an exciting development and shows potential for developing co-production of social care research and translating evidence into practice.

This initiative has been noted as good practice and has resulted in a publication in a peer reviewed journal and presentations at national and international conferences.

4.3 Supporting patients and clients through Networks

Diabetes clinical helpline

The Diabetes Network is led by HSCB / PHA. It brings together people living with **diabetes**, carers, and health and social care professionals working in partnership with **Diabetes UK** on the design and delivery of better diabetes services. Last year it set up a Clinical Helpline, in partnership with HSC Trusts to provide additional clinical support and advice to people living with diabetes and their carers. This service supported 430 people over the initial 12 week COVID first surge period 8 April – 28 June 2020 running 7 days a week, alongside existing Trust services Monday to Friday and as a stand-alone service, Saturday and Sunday, 9am until 3pm.

The service provided much needed resilience across secondary, primary and community care services and secured significant patient outcomes including much needed clinical advice and information for the diabetic population, clinical consultation in the absence of face to face appointments and consequent admission avoidance.

The Network hosted a Regional Helpline discussion 21 July 2020 to capture feedback and lessons across the service period. This information has been used to support thinking in this area with a view to considering how this service model could be best utilised/ mainstreamed in the future.

No More Silos Network

The No More Silos Network led by HSCB / PHA aims to ensure that urgent & emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and staff. This is both in terms of the pressures anticipated this winter, the pressures faced in the light of increase in COVID-19 cases; and the systemic issues faced by emergency care generally.

The initial work of the Interim Network was to establish a strategic network with 5 local implementation groups. The local implementation groups are made up of HSC local leaders and user representatives. Initially, these groups ensured that high level plans were presented to the Minister, have been agreed and developed on the basis of local knowledge and have secured buy-in from front line colleagues.

Make sure you PHONE FIRST before going to an Emergency Department

Raising the standards

Further to formal notification from the Department of Health on 22nd September 2020, the No More Silos Network has been given approval to oversee the implementation of the 10 Key Actions in the No More Silos Action Plan.

With the Ministers formal approval, the No More Silos Network has now moved to the implementation phase of the key actions. This approach will continue to build on the positive partnerships established during the COVID response, but also from our existing collaboration working across a number of specialities and pathways over the years which will translate into the implementation of our actions.

The NMS Network and Local Implementation Groups have engaged with all key HSC Stakeholders to progress a number of key actions that will have an impact in the short term on current ED pressures, winter pressures and the current pandemic response. All local implementation groups are progressing all key actions. Progress to date includes the implementation of Urgent Care Centres and the 24/7 Telephone Clinical Assessment Service - Phone First. The impact of this is to improve the citizen's journey and experience through urgent and emergency care and as a result improve clinical outcomes.

Stroke Network

Stroke is a devastating disease for the patient and family and is estimated to cost the NHS around £3bn per year, with additional cost to the economy of a further £4bn in lost productivity, disability and informal care (National Audit Office, 2005). Over 50% of survivors are left with long-term disability. 85% of strokes are ischaemic, resulting from a blood vessel becoming blocked. Brain tissue is then damaged from a lack of oxygen and nutrients. Up to 20% of people with ischaemic strokes are suitable for, and respond to intravenous thrombolysis (IVT). The benefit of which is time dependent.

The **door-to-needle time** (DNT) is the time from presentation of patient with symptoms at the hospital to the start of IVT. Stroke guidelines say this should be less than 60 minutes. Therefore, lowering the median DNT is an essential goal for quality improvement.

The SEHSCT Quality Improvement Lead, taking forward the quality improvement agenda of the NI Stroke Network, led by HSCB and PHA, sought to improve the Ulster Hospital thrombolysis grade as recorded in the Sentinel Stroke National Audit Programme (SSNAP).

In the monitoring period April-September 2019 the Ulster Hospital was graded 'D' and it was recognised that doing nothing was not an option! Retrospective data analysis highlighted the 'D-grade' was not synonymous with global underperformance but rather reflected a disparity in median DTN times in the in-hours and out-of-hours (OOH) setting – 31mins and 78.5mins respectively.

The 'Stroke-QI-Room' was developed as a platform to engage multi-professional cross-departmental thrombolysis team members. Interactive meetings were facilitated fortnightly in a dedicated room with representation from the Emergency Department, Radiology, Stroke Nurses/Doctors, Medical Registrars, Pharmacy, AHPs and Patient Flow. Mutual understanding of barriers and waste in process provided a basis for solution development. Team outputs included a role and responsibilities document and a streamlined thrombolysis algorithm co-produced through a value stream mapping exercise. Change ideas iteratively tested via PDSA cycling with out-of-hours DTN times recorded on run chart.

Implementation of 'Stroke QI Room' resulted in a signalled change on the run chart with an improvement 'shift' in DTN times. From 18/9/19 – 31/05/20, OOH DNT time reduced from 78.5 to 41minutes, aligning to the in-hours service and within the recommended timeframe. Consequently, the Ulster site achieved an 'A' grade in SSNAP thrombolysis domain (October-December 19). This ultimately improves patient outcomes.

The feedback and successful outcomes from this pilot has been shared with the regional Stroke Network with view to scale and spread the learning and approaches across other HSC Trusts.

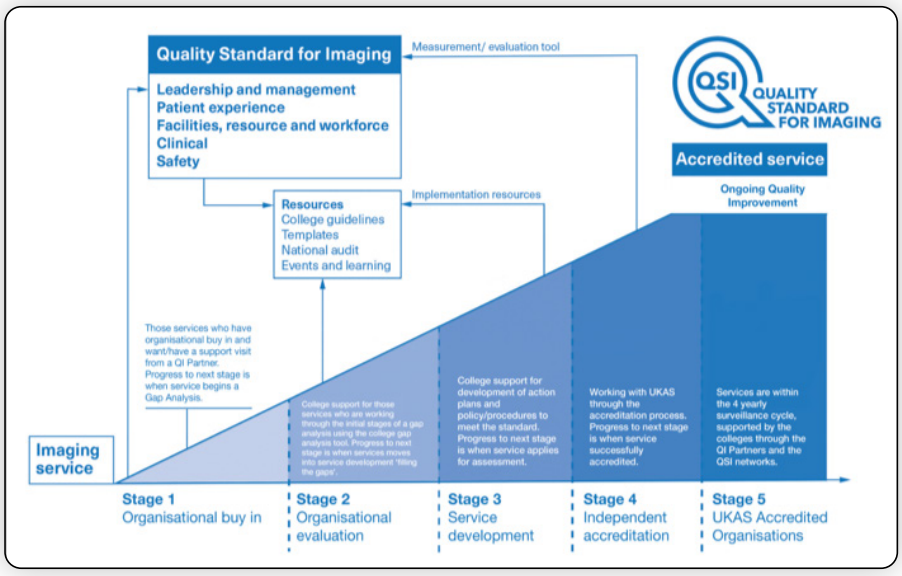
Raising the standards

Radiology Network

The Royal College of Radiologists (RCR) and College of Radiographers (CoR) developed the Quality Standard for Imaging (QSI) to support diagnostic imaging services to make continuous improvements to ensure that patients consistently receive high quality services delivered by competent staff working in safe environments. Services that meet the Standard can also opt to seek accreditation via an independent third party.

The Standard reflects wide consultation with professional colleagues, as well as relevant UK government agencies and regulatory bodies. It has been assessed for use in all four countries of the UK. In Northern Ireland, the regional programme commenced in 2017 to implement and embed the QSI Standard within imaging services and to support all five HSC Trusts to achieve accreditation. A Lead QSI Radiographer and Radiologist were appointed in each Trust and a Regional Lead from HSCB oversees the programme. After intensive preparation, and a formal assessment visit in February 2020, the Western HSC Trust received their award of accreditation in August 2020 (Stage 5). The Western Trust is the first Trust in NI and the first imaging service outside England to achieve this award. The Southern and South Eastern Trusts have successfully progressed through their pre-assessment stage with formal assessment visits planned for Spring 2021 (Stage 4). The Belfast and Northern Trusts are on track to submit applications to become accredited in early 2021 (Stage 3).

The regional QSI Programme has been commended as an exemplar model for collaborative working and a number of health economies in England have adopted the network approach based on the NI model. Fundamentally, this programme provides objective, external assurance that imaging services in NI are high quality, safe and effective and that continuous quality improvement is driving patient care.

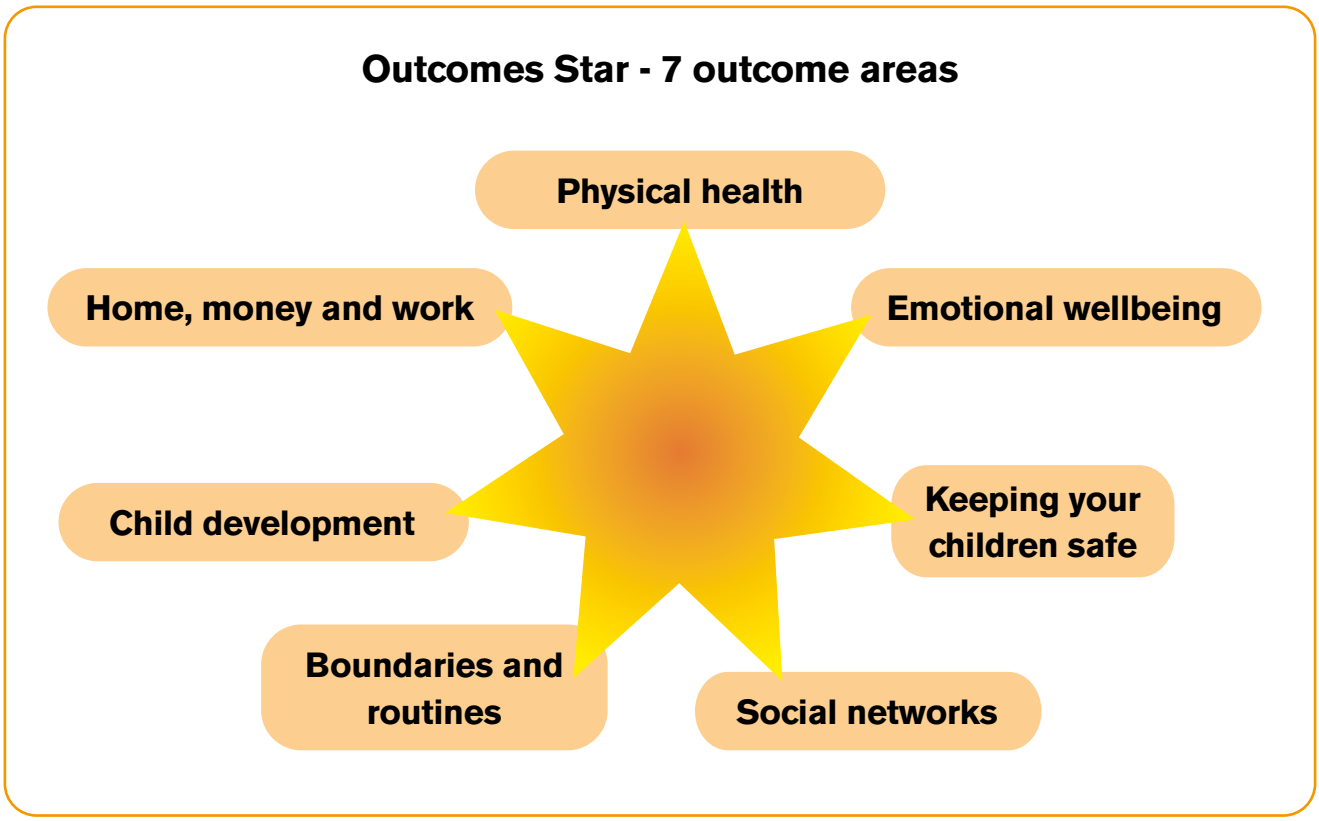


4.4 Children and Young People

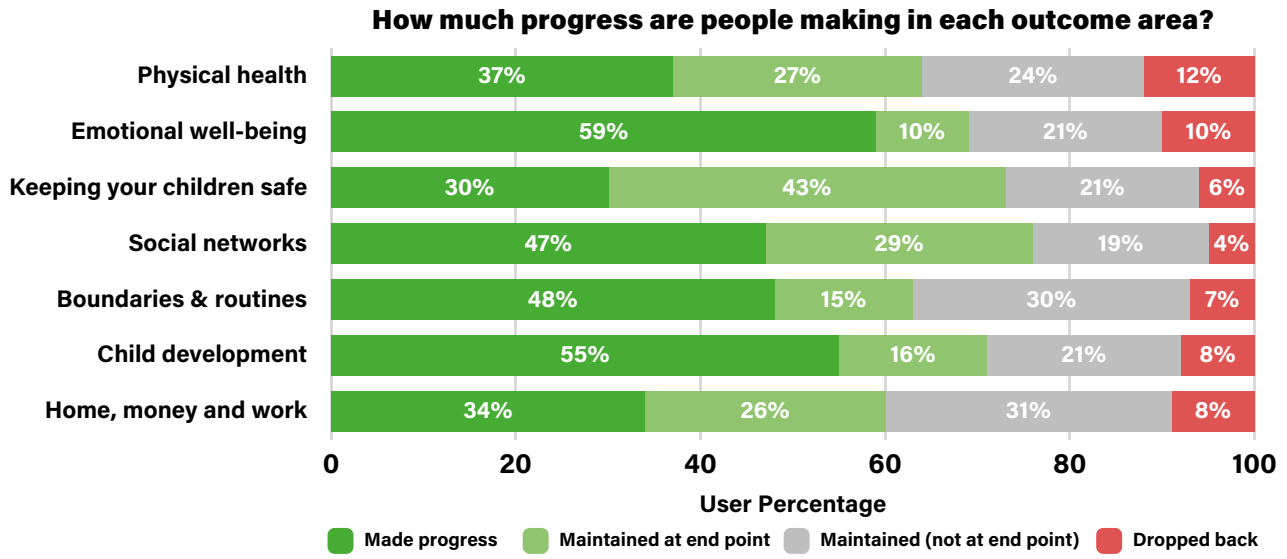
Sure Start - Lighting the Future for Young Children

Sure Start is a programme targeted at parents and children under the age of four living in the most disadvantaged areas. It brings together health, family support and early education services which are designed to support children's learning skills, health, well-being, social and emotional development. There are around 39,000 children registered in 38 Sure Start Projects offering services both in the home and in group based settings. Sure Start offers outreach and home visiting services, family support and parenting information, good quality play and learning, primary and community healthcare and advice, and speech language and communication. The HSCB provides systems leadership and manages and administers the Sure Start Programme which is funded by DE. Partnership working is the very foundation of the Sure Start Programme and HSCB / PHA works with a range of voluntary and community providers as well as all five HSC Trusts.

The Outcomes Star is an evidence-based tool for measuring and supporting change. In 2019/20 it began to be introduced to Sure Start registered families. At present the tool is primarily used by family support staff working with individual families while delivering services in a home and group based format supporting a family's journey of change.



Raising the standards



Source: Outcomes Star - Family Star Early Years

The family use the tool to chart their own journey of change and Sure Start offers each family a unique service pathway to meet their needs. An Outcome Star is completed at the start and end of the intervention to record the impact Sure Start had had on the family's progress in the key domains.

The figures provided below are based on 178 service users who completed both the first and second star readings after a Sure Start intervention before the beginning of the pandemic.

This sample of Outcome Star results clearly shows that Sure Start's holistic service offering of health, family support and early education services has a positive impact of improving outcomes across all 7 domain areas. 89% of families improve in at least one area, with 57% of families improving in 3 or more outcome areas. Many vulnerable families will require multiple areas of support and the results show that Sure Start as a multi-disciplinary team can provide a "one stop shop" for family support needs.

Are people making progress?

89%
of people are making progress in at least one outcome area

75%
of people are making progress in at least two outcome areas

57%
of people are making progress in at least three outcome areas

3.1
Average number of outcome areas someone is making progress

For further information visit Sure Start Webpage via CCP website to see how Sure Start supported families during COVID 19 #SureStartWorks http://childcarepartnerships.hscni.net/sure-start-during-covid-19/

Supporting children with Special Educational Needs

It is recorded that in 2019 - there are 19,200 children with a Statement of Special Educational Needs (SEN) in NI which equates to 5.5% of the school population and is a 36% increase in the past 9 years (NIAO, 2020).

HSC plays an essential role in providing health advice for children undergoing Statutory Assessment to assist in both the early identification of a children's needs and ensuring the appropriate the intervention and support is available to enable to access the curriculum.

Standardisation and improvements across the HSC system in identifying and supporting children with possible Special Educational Needs undergoing Statutory Assessment. Improved identification and more integrated and timely provision has improved outcomes for children and young children enabling them to learn, achieve and develop and has enhanced greater co-operation across the Health and Education sectors."

Health and Social Care staff play a critical role working with the Education Authority to identify children who may have Special Educational Needs (SEN). This input is in line with the Special Educational Needs and Disability Act (2016) and helps to determine whether they need a Statement of SEN that outlines the supports from across the health and education they need to enable them to access the NI educational curriculum to the best of their ability. A NI Audit Office (NIAO) report carried out in 2017 identified that only 21% of Statements of SEN were completed within the 26 week statutory time limit, and the Education Authority (EA) stated that the majority of delays were primarily related to advice reports from Health and Social Care staff. This highlighted the importance of addressing these delays, not only to ensure Health and Social Care Trusts met the legislative timeframe but most importantly to enable children and young people to receive the supports they require to achieve, learn and develop, giving them the very best start in life.

The PHA worked with Department of Education, EA and Trusts to review the pathways and compliance rates across each of the 5 Health and Social Care Trusts. Measures were taken to improve not only compliance and performance in this area but also outcomes and achievements amongst children and young people with SENs. Non-recurrent transformation funding was secured from DoH to support the appointment of a SEN Co-ordinator and Data Analyst in each Trust who work closely with the PHA putting processes in place to reform the Health and Social Care input to the statutory process.
Significant achievements from this work include:

- Development of a single point of entry to co-ordinate requests and set a monitoring function to determine demand and performance.
- Successful implementation of an electronic exchange of information system across Health and Education to ensure timely and seamless sharing of information.
- Implementation of a standardised and streamlined process for the provision of timely and consistent health advice for children undergoing Statutory Assessment.

- Increased knowledge in Health and Social Care on legislative frameworks associated with SEN and their requirements.
- Improved compliance with healthcare advice for children undergoing Statutory Assessment which was referenced in a 2020 NIAO report. From this initiative advice reports from Community Paediatricians, Occupational Therapy, Speech and Language Therapy and Physiotherapy across the 5 Trusts have improved in the 6 week complance 49% in December 2019 to 90% in October 2020.
- Early identification of children and young people's needs followed be timely supports and interventions to enable them to better meet their full potential.
- Enhanced working between Health and Social Care staff with EA and schools to ensure the requirements of the Children's Services Co-operation Act NI (2015) are met.
- More effective use of resources and greater standardisation and appropriate advice reports outlining the requirements to address the child's needs in the educational setting.

Work in this area to date has made significant positive impacts on the provision of health advice for children undergoing Statutory Assessment, which has been recognised by both DE and DoH and in a recently released NIAO report. An area for further development identified is to expand the services and professions in Trusts who could contribute to assessments. This provides a more integrated assessment of need and subsequent provision to ensure that the child's needs are met holistically.

There is evidence of greater partnership working from this initiative between EA, PHA and the Health and Social Care Trusts. This has led to more integrated, proactive models of care based on early intervention and developed regionally to ensure consistency of delivery at a local level.

Development of a regional Children and Young People (CYP) Emotional Health and Well-Being (EHWB) Services Framework to support the delivery of early intervention and integrated diagnostic approaches

The PHA and HSCB have worked closely with a range of stakeholders to support the development of a CYP EHWB Services Framework to deliver more integrated and early intervention models of support for CYP who are experiencing a range of difficulties in this area.

The development of this Framework was deemed necessary to ensure CYP and their parents/carers are able to access more streamlined and integrated support that focuses on early identification and proactively addresses presenting EHWB needs as soon as they arise and to provide necessary and consistent support for families.

Raising the standards

The Framework is supported by local, national and international studies with a key focus on early intervention at a population and specialist level to improve outcomes for CYP. The Framework is line with policy directions including 'New Decade New Approach' and aims to co-ordinate pathways to prevent CYP being managed by a range of professionals/ services through the development of a EHWB single point of entry. The Framework also aims to enhance integration across specialist diagnostic services particularly where ASD, ADHD or significant Mental Health diagnostic assessments are being considered.

This Framework has been developed to address negative experiences amongst CYP and families who have accessed EHWB services. Feedback received included the need for more joined-up and consistent EHWB models; greater access to timely and responsive support particularly at transition points; and the delivery of more holistic and personalised care that helps CYP realise and achieve their goals, hopes and ambitions.

A key driver of the Framework is partnership working to help meet the holistic needs of the CYP alongside the development of a needs-led model to meet any developing EHWB needs of the CYP and where necessary more specialist support to address diagnostic and/or co-morbid needs. This will ensure greater understanding and management of a continuum of needs in a co-ordinated and proactive way.

The EHWB Services Framework is designed to transform models of services and deliver the following key outcomes;

- The development of a co-produced model with active involvement of CYP and their families.
- Maintaining a prevention and early intervention focus.
- Re-aligning CYP EHWB services to meet identified needs through early intervention and integrated diagnostic pathways across CAMHs, ASD and ADHD.
- Enhanced co-working with other agencies and partnerships to ensure integrated, seamless and holistic models of support.
- Timely access for CYP and their families and the delivery of a wrap-around model of support.

In the development of this Framework there has been active engagement and joint working with the Department of Education in their development of the 'CYP EHWB in Education Framework', which is currently being finalised. This framework is focused on supporting the emotional and mental well-being needs of CYP in the school setting by strengthening their self-esteem and emotional resilience. The interagency working in the development of these Frameworks is critical to ensure the delivering of an integrated approach across the health and education sectors a more complex stage where more specialist supports are needed.

Theme five

Integrating the care

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to supporting an integrated HSC system in Northern Ireland which will enable the seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB and PHA last year which contributed to raising the quality of care and outcomes experienced by patients, clients and their families.

5.2 New Models of Service Delivery

Primary Care Elective Services

In October 2016, the Health Minister launched *Health and Welling Being 2026: Delivering Together*, an ambitious 10 year approach to transforming the health and social care system in Northern Ireland. One of the key actions within the document was the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis, and as a result, in February 2017, the *Elective Care Plan: Transformation and Reform of Elective Care Services* was published.

The actions in the plan were designed to improve access to services for patients, their families and carers and to place elective care on a sustainable footing, resulting in improved waiting times.

To facilitate the primary care elective transformation agenda, the HSCB/PHA, in conjunction with GP Federations, have designed and implemented a range of pathways to enable the appropriate management of patients in primary care, and minimise the need to refer to secondary care. Beyond primary care capacity, this supports an improved approach to demand management via peer support, peer review, peer education, self-management and self-directed care at a population level within GP federations.

Current priorities across Federations are the implementation and delivery of Primary Care services in the following specialties, thus reducing the requirement to refer to secondary care:

- Dermatology: to safely manage a range of routine dermatological conditions in a primary care setting.
- Gynaecology: to safely manage a range of routine gynaecological conditions (Coil fitting, LARC) in a primary care setting.
- Vasectomy: to safely deliver non-scalpel procedures in a primary care setting.
- MSK/Pain: to safely manage a range of routine MSK conditions in a primary care setting.
- Minor Surgery: to safely manage a range of routine minor surgical procedures (lipoma excisions, sebaceous cysts, dermatofibroma, excisions for diagnostic purposes) in a primary care setting.

Planning is currently underway to introduce new pathways in specialties such as Cardiology and Dementia in 21/22.

The impact of this has been to improve the citizen experience by improving access within these pathways.

Integrating the care

Community pain support programme

An estimated 1 in 5 people in Northern Ireland live with chronic pain. Medication relieves chronic pain by around 30% only, in most cases. The Pain Support Programmes (PSPs) aim to help people with chronic pain to learn new ways to manage their pain, reduce their reliance on medication and improve their quality of life.

Examples of outcomes and feedback from the programmes (Sept - Dec 2019)

- 78% of participants completed the programme.
- At the beginning of the programme, only 15% used self management strategies in addition to medication. This increased to 83% at week 12, and 91% 3 months after the end of the PSP.
- 68% of all participants attended 8+ sessions and this resulted in an increase in Pain Self Efficacy1 score to each individual of between 6-8 points (out of a total of 16).

The HSCB and PHA have a role in commissioning pain management services and improving the use of medicines. 32 twelve week PSPs were run in 16 Healthy Living Centres across NI between September 2019 and March 2020. These were attended by approximately 500 people with chronic pain. Each week is devoted to specific activities known to help chronic pain. For example, as keeping moving is important, every week involves some light physical activity. Other weeks cover looking after your mind, the role of medication (by a local pharmacist) and the importance of having a 'pain self-management toolkit'. Sessions are also devoted to peer learning and sharing.

Further information on the NI Healthy Living Centres can be found at: **http://www.hlcalliance.org/**

The Pain Support Programmes were recently recognised with two prestigious PrescQIPP awards:

Winner: Category: Developing or Working across Integrated Care/Sustainability and Transformation Partnerships

Silver Award: Voted second place overall of all 2020 award winners

Integrating the care

Primary Care Infrastructure Development Programme

The HSCB continues to support the roll out of the Primary Care Infrastructure Development Programme, aimed at delivering a Hub and Spoke approach to the delivery of primary and community care services. Primary and community care is considered to be the appropriate setting to meet the majority of the health and social service needs of the population. The services and resources available within this setting have the potential to prevent the development of conditions which might later require hospitalisation as well as facilitating earlier discharge from hospital. The hub facilities will essentially encompass those services which do not require a hospital bed but which are too complex or specialised to be provided in a local GP surgery (a spoke).

A milestone was reached with planning permission being granted for a Community Treatment and Care Centre in Newry. It is expected that the contract for the centre will be awarded in 2021 followed by a 2 year build programme. It will facilitate the co-location of primary and community care and complementary secondary care services, grouped within a single facility for the purposes of delivering integrated care services and patient care. Significant investment in bespoke premises has allowed for increased capacity within primary and community care making services more accessible to patients as well as facilitating the roll out of multi-disciplinary working within GP premises and an increase in the number of practices who can provide GP training.

£3.9m invested in transforming GP premises to support new ways of working and providing more services closer to people's homes.

Pharmacy and Medicines Management response to COVID-19 surge

A range of pharmacy and medicines management initiatives have contributed to improving the quality of services in response to the COVID-19 pandemic. These have been led by the HSCB working in partnership with Community Pharmacy contractors with support from PHA, BSO, HSC Trusts, DoH, and GP practices. Examples of those initiatives include:

- **Emergency Supply Service**

Given the demand on services during the initial COVID surge in March 2020, patients and/or their carers were encouraged to order their usual medicines in good time. Despite this patients reported running out of their medicines. Indeed, it was estimated that prior to COVID between 5-10% of GP OOH contacts were to access repeat medication that had not been supplied in-hours. The Emergency Supply service was commissioned from community pharmacies by HSCB, which has facilitated the provision of chronic medicines when patients have been unable to get a supply of their routine medicines obviating a contact with GP Out of Hours Services.

- **Serious shortage Protocol**

In order to maintain the continuity of medicines through the supply chain in preparation for EU exit, the DoH introduced a Serious Shortage protocol mechanism. This facilitated the lawful substitution of a specific dosage form of a medicine that was in short supply. HSCB commissioned a service from community pharmacy to implement this arrangement. This was not needed during EU exit in January 2020 but was implemented and used during the initial surge of COVID-19 pandemic. This service model will be reviewed to inform future use of this mechanism for the remainder of 20/21.

- **Access to medicines in out of hours and end of life care**

Access to medicines in out of hours and particularly for those requiring palliative care or end of life care was a particular issue which was addressed through enhanced community pharmacy rota opening over public holidays; increasing the coverage of dedicated palliative care community pharmacies; and, for a temporary period, putting in place an on-call arrangement for palliative care pharmacies linking to Trust pharmacies for access to palliative care medicines until end June 2020. Review of these services has led to extension of these service arrangements over the winter period.

- **Pharmacy Services to Care Homes**

The need to support medicines management arrangements for care homes was recognised and to that end, enhancements have been made to the current contractual arrangements that are in place to align a dedicated community pharmacy to a care home. Further development of the pharmacy care home service had been planned for 2020/21 but funding has not been secured. During the period April to June, medicines stock boxes containing essential stock medicines for palliative and urgent treatment have been offered to all nursing homes and a mechanism to replenish stock has been established. During this period a process was established for the reuse of patients own drugs in care homes. This provision was recently stood down and will be evaluated before September to inform further plans. Oxygen supply to care homes was also recognised as an important issue and refinements have been made to the provision of oxygen to care homes. These will be maintained and kept under review for the remainder of the year.

- **Community Volunteer Service**

HSCB has worked with Community Development Health Network to establish a volunteer delivery service in response to the need to transport medicines to shielded patients during the first wave of the COVID pandemic. This service delivered in excess of 80,000 prescriptions.

- **Use of Video-consultation within pharmacies**

HSCB secured access to a Zoom enterprise licence for community pharmacies in order to undertake video-consultations. This has facilitated remote smoking cessation counselling and consultations for minor ailments

- **Community Pharmacy – Living Well Service**

As the most accessible and accessed health care venue before COVID and during COVID, pharmacies are a natural locus for the provision of health and well-being information and signposting to other services. The Living Well service was commissioned and delivered successfully in 19/20 and provided a unique and valuable mechanism to reassure, support self-care and signpost the public to services as appropriate. With the rebuild of HSC service, this service is providing a helpful source of information for the public and a series of campaigns are being delivered.

All of the above show how pharmacy services are integral to community response to COVID integrating all areas of health and social care.

Community pan-disability support programme

Local government is responsible for a wide range of programmes and services that contribute to health and wellbeing of the communities in which they serve, including leisure and recreation, play parks, forest trails, green spaces, arts and cultural activities. These services empower people to utilise opportunities to improve their own health, and throughout this last year we have all looked towards council facilities in our local environments to provide a valuable alternative diversion from all things COVID.

Across Northern Ireland, 21% of the population are recorded as having a disability. This in itself creates health inequalities through economical, physical, communication and social barriers to accessing services and opportunities.

The PHA, HSCB, Departments for Communities (DfC), Department of Agriculture and Environment and Rural Affairs (DAERA) and the 11 local councils have developed an approach to support excellent and innovative practice in access inclusion for the pan-disability community through engaging this community, developing collaboration and creating the conditions for meaningful change. This has been achieved through:

- Piloting the local government access inclusion model within Fermanagh and Omagh District Council and Derry City and Strabane District Council. This model includes an Access Inclusion Officer working across council directorates to ensure all health events, activities and programmes are accessible and inclusive to the pan-disability community.

- Worked DfC, DAERA and the 11 councils, to implement a regional capital grants programme which has invested £800,000 in the 2020/2021 financial year (a total of £2.8 million over three years). This programme has assisted in making the physical changes for access inclusion practice within health improvement venues across Northern Ireland.
- Funded a training programme for council officers from all 11 councils to engage and train in excellent practice in access inclusion.
- Worked closely with Disability Sport Northern Ireland to create guidelines for local governments relating to excellent practice in the creation of inclusive outdoor spaces.
- Work is now underway to develop a funded Regional Access Inclusion Support Service to assist the 11 councils in Northern Ireland to continue their work on adapting fully inclusive, innovative, access and inclusion practice.

This valuable work is an excellent example of cross-departmental working which transforms culture and practice. This initiative will continue to break down the social, physical and communicational barriers to participation faced by the pan disability community, empowering people with disabilities to maximise local opportunities to improve their own health and encourage community-based rehabilitation.

5.3 Integrated Care Partnerships

Belfast Integrated Care Partnership – Together let's make it better

Palliative and End of life care is everyone's business. Current Palliative and End of Life Care services are not always reaching local people at a time and place they need them.

The Integrated Care Partnerships in Belfast (ICPs), including BHSCT, recently organised a workshop entitled Together Lets Make it Better. The main aim of the workshop was to promote collaborative working and use the combined wisdom and experience in the system to determine how we can be even better. The workshop included health care professionals from across all sectors with the common goal of addressing present challenges facing palliative care services in Belfast.

Themes discussed at the workshop included:

- How could care have been improved?
- Who should provide care?
- How could planning and provision of care have been improved?

Key messages which emerged from the workshop included:

- Early Identification of a patient with Palliative and/or End of Life needs
- Allocation of a key worker
- Advanced care planning
- Co-ordination/Co-ordinator

The workshop clearly identified current gaps in the service and work is underway to address these to help ensure that we continue to treat people with dignity and ensure that we can, where practical, carry out their wishes and that we are compassionate and responsive to their needs.

> *"At birth and death, we are privileged to accompany people through moments of enormous meaning and power, moments to be remembered."*

Western Integrated Care Partnerships – End of life care during COVID-19

The Western ICPs met collectively and weekly in response to the COVID-19 restrictions, and the potential impact on the local population.

Supporting ICP partnership organisations, work included supporting Community Hubs through which WHSCT collaborated with Local Government and promoting flexible ways of delivering services, such as taking Healthy Living Centre programmes to streets and rural settlements.

As part of this, concern was raised on the impact wake and funeral restrictions may have on the ability to process bereavement and potential effect on people's mental health. Working with our Palliative Care in Partnership colleagues, a workshop was held examining what End of Life means and how this can begin to be normalised and supported within the local community.

The workshop was delivered virtually by the Project ECHO team and guest speakers included Dr Max Watson, Hospice UK, Palliative Care in Partnership and showcased existing good practice from Foyle Hospice Compassionate Communities programme, as well as ICPs Service User representatives.

There was a total of 73 participants in attendance at the event from a range of different backgrounds, such as community and voluntary sectors, Councils, Care Homes, health care staff such as nursing, social work and allied health professionals, GPs and Pharmacists. Feedback from the event was very positive, participants indicated that they found the event useful and would be able to take the learning into their respective areas of work, to improve their approach to conversations around death and dying.

An outcome of this work was the beginning of collaboration with the PHA Health Improvement Teams and linking some of the contracted work to promoting End of Life. This includes "Artscare NI" who are taking forward 'Life's Road Trip' within HSCT settings and Community organisations, and the development of a virtual 'Heart of Living and Dying' session for dissemination through Age Friendly Officers within Local Councils.

Northern Integrated Care Partnership - Diabetes Prevention Programme

Type 2 Diabetes Mellitus is one of the most common long term health conditions in Northern Ireland, associated with significant morbidity, mortality and healthcare costs. The prevalence continues to increase, and it is estimated that by 2027 there will be a further 45,000 cases of Type 2 patients across NI. The risk of developing Type 2 Diabetes Mellitus is strongly linked to modifiable health behaviours, in particular diet and weight.

In April 2019 the Northern Local Commissioning Group in partnership with NHSCT and the Northern Integrated Care Partnership commissioned a Diabetes Prevention Programme. The aim was to provide a 9 month intensive behaviour change intervention in individuals who are particularly high risk. Their risk was assessed using both a risk assessment score and blood tests. As of June 2020, 300 people had successfully completed the programme and reduced their risk of developing Type 2 Diabetes Mellitus.

300

people successfully completed the programme by June 2020

45,000

further cases of Type 2 patients across NI by 2027

5.4 Introduction of new ways of working as a result of COVID-19

SH: 24

SH:24 is a community interest company that has been providing an online sexually transmitted infections (STI) testing service in Northern Ireland on behalf of its HSC services since October 2019 as a pilot. This was due to end on 31 March 2020 and was highly successful with over 8,000 people ordering STI testing kits without the use of any paid advertising. Follow up of patients with diagnosed STIs was undertaken by NI HSCT's genitourinary medical (GUM) teams.

Uptake exceeded originally anticipated demand by more than 100%. Monthly monitoring reports have shown how over 40% of NI SH: 24 users had never been to a GUM clinic before and a further 15% had not been to one in over a year. This means that SH: 24 have been able to reach a different group of people than traditional GUM services.

Due to the success of the pilot and aware of the possibilities, GUM clinic service providers began to deliver much of their services to HIV patients and those at risk of HIV through SH:24 preferring telemedicine instead of face to face contacts. During lockdown the demand for on line STI testing increased significantly unlike in other parts of the UK, highlighting the level of ongoing unmet sexual health needs observed already during the pilot.

In light of the pandemic and due to the success of the pilot being able to deliver a virtual service which was cost effective, well received and efficient, the HSCB / PHA identified slippage to continue on line STI testing for the period April to December 2020.

Integrating the care

Urgent Dental Care during the COVID-19 Pandemic

COVID 19 had a catastrophic impact on the provision of dentistry in Northern Ireland. On the 18th March 2020 it was apparent that Aerosol Generating Procedures (AGPs) would be restricted under UK Government Guidance and this came into effect on the 23rd March 2020. The vast majority of urgent dental care entails an AGP. Consequently Hospital Dental Services, Community Dental Services (CDS) and General Dental Services (GDS) were equally impacted and unable to execute the critical function of providing urgent care.

Life threatening dental emergencies are not common however they can develop quickly; early advice and intervention is important.

A gap in access to dental services, due to the restrictions, created a high risk that patients requiring urgent treatment would seek help in a General Medical Practice or at Emergency Departments. A model to deliver the urgent care requirements of all of the dental service sectors became essential immediately.

The HSCB Dental Team focused its efforts to deliver five Urgent Dental Care Centres (UDCCs) without delay. In just over a fortnight, a new single regional model for the delivery of urgent dental care for all patients was coproduced and operational.

CDS and their staff hosted the service in each Trust. General Dental Practitioners and high street oral surgery specialists provided the dental treatment whilst secondary care specialist advice could be called upon if required. The role of the HSCB Dental Team was to be the key enabler to deliver on this ambitious project. It was a great example of collaborative working across all the dental service sectors, the HSCB and the DoH.

The collaborative efforts of dentists and their teams at UDCCs have treated more than **5,000** patients to date in a COVID safe environment and continue to operate this service as we move through the pandemic.

Integrating the care

Ophthalmic Service Improvements

The impacts of covid-19 will be deep and profound and the challenges of maintaining services whilst protecting HSC through rebuilding and surge phases require an integrated approach like never before.

Ophthalmic services across primary, secondary and community and voluntary care pre-covid were already well integrated, with the Northern Ireland Eyecare Network taking a strategic approach to how services can be better coordinated and delivered.

The modernisation of the acute eye pathway is an example that was planned and in train pre-pandemic, but which Covid has pushed on at pace.

Pre-Covid, NI benefited from a regional Primary Eyecare Assessment and Referral Service (NIPEARS) which aims to be the first point of contact for non-sight-threatening acute eye problems which would otherwise present in eye casualty or general practice.

BHSCT eye casualty sees and treats in excess of 15,000 patients annually, but analysis indicates that over half of these could be appropriately managed in the community. Shifting this point of care would improve outcomes and experience for patients whilst also freeing capacity in hospital eye departments.

In line with the wider strategic review of reform of urgent and emergency care through “No More Silos” BHSCT eye casualty has moved from a “walk in” to an appointment-only service, reducing footfall into the acute hospital, secure in the knowledge that patients have an alternative pathway in place through NIPEARS.

Throughout Covid since March, primary care optometry practices continued to offer urgent eyecare aligned with NIPEARS, and since April 2020 BHSCT has operated an appointment-only system but one which supports primary care referrers with clinical advice and fast-tracked pathways for those requiring an eye

casualty appointment. Although a regional integrated IT platform is not yet in place, the pathways have also benefitted from a "virtual-where-possible" approach, using video and telephony, and remote consultations where appropriate.

Primary care optometry has been supported in provision of acute eyecare through the introduction of a remote training platform enabling webinars to be provided with local ophthalmologists and Eye Casualty staff delivering effective training.

These developments have involved integrated work between everybody involved in provision of the Acute Eyecare pathway including BHSCT and WHSCT, primary care optometry and the HSCB. It has also included sharing of information and guidance with main Emergency Departments, GPs and community pharmacies and with the general public through press and social media.

An impact of the service development has already been seen in a significant reduction in footfall in BHSCT Eye Casualty since the introduction pf the "appointment only" attendance and a simultaneous increase in primary care optometry NIPEARS attendances.

This quality improvement initiative has not only integrated services, and helped with the Covid response, it also offers a platform for improved communication and metrics to ensure that patients are seen and managed - "right person, right time, and right place."

Improving Access to Services for the Deaf Community

The COVID-19 pandemic has changed our lives. We are all working and communicating in different ways. We're learning, adapting, and figuring out how to stay safe but also how to maintain our connections with one another. For Deaf people, society's response to the pandemic has created new obstacles not just in everyday life but also in terms of their equal access to Health and Social Care. At the start of the outbreak, many services switched to telephone contact only. While this was done to protect everyone through social distancing, there was a risk that it would severely limit both the Deaf community's access to services, and the ability of our staff to communicate effectively with Deaf people.

To overcome this barrier, the DoH and the Department for Communities funded a remote sign language interpreting service. This novel service has been commissioned as a temporary COVID-19 measure. It is managed by the HSCB as one element of the wider *Regional Communication Support Services Programme.* This Programme refers to a range of projects led by the Health and Social Care Board, where we work with a range of internal and external partners and stakeholders to redesign and improve existing communication support services for people who are Deaf, deafblind and hard of hearing.

The pandemic created a unique opportunity to explore and test new ways of working, such as the remote sign language interpreting through the *Regional Communication Support Services* Programme.

Integrating the care

Provided by Interpreter Now, the service enables British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and all non-emergency Health and Social Care services during the pandemic. It also allows health and social care staff to access a remote interpreter to support their clinical assessment and care of Deaf people. The service is free at point of use and available 24 hours a day, 7 days a week. All of the BSL and ISL interpreters are qualified, registered, and highly experienced.

The service includes two elements:
- Video Relay Service (VRS) and
- Video Remote Interpreting (VRI)

The **Video Relay Service (VRS)** was introduced first to ensure immediate access to telephone services. It allows Deaf people to connect with sign language interpreters online via video link. VRS can be used to:

- Organise a GP appointment,
- Make an outpatient booking,
- Translate medical advice received in the post, or
- Call a pharmacy.

With **Video Remote Interpreting (VRI)**, the Deaf person and health and social care practitioner are in the same location. They access an interpreter online via secure video link (e.g. a tablet, smart phone, or computer). It's like the interpreter is in the room.

The VRI service can be used for things like:

- Short HSC appointments such as a GP appointment,
- A pharmacy consultation, or
- Arrival at an Emergency Department until a face to face interpreter can be sourced.

Since the service went live in April 2020, almost 400 people have registered to use it. In the month of November alone, it enabled Deaf service users to make more than 1,000 independent, on-demand phone calls to a broad range of health and social care services, including:

The feedback so far is overwhelmingly positive: the service has the potential to transform Deaf service users' experiences and outcomes in relation to health and social care, supporting their independence and active participation in communication and decisions that affect them.

5.5 Northern Ireland Neighbourhood District Nursing (NDN) model of care

The Department of Health District Nursing Framework 2018-2026 (DoH 2018) provides the strategic direction for the District Nursing service in NI. One outcome in the Framework was to develop a regional community nurse-led model of care prototype and then scale and spread.

The Nursing and Midwifery Task Group (DoH 2020) highlights significant transformation of nursing and midwifery services is essential to the stability and sustainability of the NI HSC system and one theme is to deliver population health and wellbeing outcomes.

The aim of the NI NDN model is to improve safety, quality and experience by developing a 'one team' approach within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care. Teams work in partnership with patients, carers, families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team (MDT).

The objectives of the model are to:

- Test a new model of District Nursing linked to Primary Care MDT
- Promote a new public health model for District Nursing
- Improve patient care through proactive management of population health
- Develop self-organised teams under a collective leadership model
- Test a coaching model for District Nursing
- Reduce bureaucracy and maximise the use of technology in care
- Test Delivering Care staffing levels in District Nursing

Integrating the care

Five district nursing teams, one in each HSC Trust, started to test the model in stages in June-July 2019. A Quadruple Aim approach was used in the evaluation and interim results are outlined below.

The benefit of using a structured, proactive population health and public health based approach	Structured local population health needs assessment informed development of community health improvement plans and QI projects. E.g. Ballycastle undertook a Palliative Care IHI QI project. Outcomes 18% people died in hospital (NI average 48%)
Efficient use of DN resource (total 43 DN staff equating to 4% DN workforce aligned to 3% GP Population)	OBA scorecard monitoring return Q3 19/20- total working caseload 819 people, **average 17 patients per WTE** (regional figure is 13)
Effective education and supportive interventions enabling patient self-management	Q3 (19/20) **59 patients supported to self-manage** in areas of diabetes, continence, medicines and weight management
A highly rated service by patients, families and carers	10,000More Voices survey - **83%** of respondents rated experience as strongly positive
Coproduction and collaborative team approach supported by coaching	People Measurement survey - **overall engagement score 4.39** from 29 respondents (HSCNI 2019 engagement score was 3.78). One respondent said, "*Whilst the self-managing team aspect can be challenging at times, I feel well supported and the 'coach approach' encourages ownership and collaborative working.*"

An evaluation report has been completed and will be available on the PHA website. Further work will be undertaken to apply the principles of economic assessment and demonstrating value of the NDN model as part of scale and spread.

Conclusion

There is a requirement from the DoH that the PHA in conjunction with the HSCB produce an Annual Quality Report outlining our commitment to improving quality.

The report is split into 5 sections which are aligned to the Q2020 Strategy and each section uses a different theme & colour to represent its context.

1. **Transforming the culture**
   This section is green which symbolises organic and includes a tree / butterfly's to represent growth, transformation etc. This section includes information on:
   - Quality leadership & governance structure
   - How we learn from SAI's, complaints, patient experience
   - Our commitment to involvement and prioritising co-production and the difference this has made for patients and clients with reference to HSC Hospital passport, Always Events etc.

2. **Strengthening the workforce**
   This section is blue which traditionally represents industry and includes symbols of cogs working together. We have included a range of topics under this section to include how we support HSCB/PHA staff to grow. Opportunities we have afforded to wider HSC to upskill in terms of quality improvement and education/training opportunities we have commissioned to continue to improve. This has particularly focused this year on support through the Covid pandemic.

3. **Measuring Improvement**
   This section is red, representing blood – blood test being one measurement for health. The topics in this section include PHA/HSCBs lead in relation to quality improvement plans for pressure ulcer prevention, falls, NEWS and mixed gender accommodation. New examples are also included regarding the impact of the pandemic on certain services and new initiatives to reduce this.

4. **Raising the standards**
   We cannot print in gold – so this is the closest we got. This represents gold standard – which is what we are trying to achieve in order to become a 'leader for excellence in health and social care'.

   This section includes information relating to clinical networks established, improvements in maternity & children's services such as fetal monitoring in labour and improvements in primary care.

5. **Integrating the care**
   This section is represented using different healthcare symbols linking together to show how we integrate as one system between primary care, secondary care, embracing new technology & systems to improve the quality of services. Examples in this section include improvements to ophthalmology and dental services, access for deaf clients and neighbourhood nursing.

As stated in the introduction the HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, and transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

For further information
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HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	15 April 2021
Title of paper	Implementation of a Daily AMT/SMT Huddle during the First Wave of the COVID 19 Pandemic using a QI Approach - 17/03/2020 - 18/05/2020
Reference	PHA/04/04/21
Prepared by	HSCQI Hub Team
Lead Director	Dr Aideen Keaney
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this summary paper is for the PHA Board to note the report.

2 Background Information

At a workshop on the 18th of March 2020, PHA AMT and HSCB SMT Directors agreed to implement a morning Huddle to enhance communication between the COVID 19 emergency response Silver Support Cells. A Quality Improvement methodology (QI) was applied to the implementation of this joint organisation Huddle.

3 Key Issues

While a Huddle approach to a joint AMT/SMT meeting was a new concept to many in both organisations, it was possible to implement a joint organisation Huddle in a relatively short space of time. Attendance at the Huddle was good, indicating senior leadership commitment to the pandemic emergency response. The Huddle allowed team members from each of 15 cells to highlight key issues and updates, usually within a 40-50 minute duration, thereby facilitating the sharing of information and learning, while simultaneously gaining a real-time “big picture” overview. Challenges were posed by social distancing and IT issues. Areas for improvement were identified many of which were which were addressed during the lifetime of the Huddle. The summary report gives an overview of how a QI approach was applied to the implementation of the joint organisation Huddle and how data for improvement can be used to demonstrate progress and impact.

4 Next Steps

Learning identified during the implementation of this Huddle during the first wave of the COVID 19 pandemic can be used to inform the implementation of any future Huddles.

The application of a QI approach to the implementation of a Huddle in this joint organisational setting demonstrates that a QI approach can be used effectively across many areas of the HSC system both clinical and non-clinical.

Implementation of a Daily AMT/SMT "Huddle" during the first wave of the COVID 19 pandemic using a QI approach

17 / 03 / 2020 - 18 / 05 / 2020

Final version 21.12.20

Summary:

What is a "Huddle"?

"Team Huddles are short meetings where each team member shares their number one priority of the day and important updates. These meetings keep team members informed of important information, help hold people accountable, and allow for sharing of collective information" (ref The Power of Huddles –Team Builder Plus www.teambuilderplus.com)

The AMT/SMT executive team "Huddle"

At a workshop on 18th March 2020 AMT / SMT Directors agreed to implement a morning Huddle to enhance communication between the COVID 19 Emergency Response Silver Support Cells.

A Quality Improvement (QI) methodology was applied to the implementation of the Huddle and an aim statement was defined:

"By 1st April 2020 a SMT/AMT "Huddle" will take place *every day to improve communication and action planning between **Silver Support Cells during the response to the COVID-19 pandemic."

*It will take place every morning Mon-Fri at 08:30 hrs
*It will last no more than 30 minutes (To allow sufficient time for discussion from all cells this was changed to 40-50 minutes)
**It will involve representatives from all (15) Silver support cells

Why?

To support a whole system response to the emerging COVID-19 pandemic. In general the emergency response to any pandemic is focused on 3 key areas:

- Communication
- Logistics and supply
- Technical knowledge

Implementing a morning Huddle allowed a" big picture" overview of the joint emergency response at AMT /SMT level, a particular focus being on enhancing communication.

When?

- Daily from 19th March
- Twice weekly from 30 March
- Weekly from 27th April
- Stopped 18th May

How?
By applying a QI methodology called the "Model for Improvement".

So what? (Results): (Qualitative)

- What worked well during the implementation process?
    - "Action slides were a helpful record of actions"
    - "A useful forum to hear what others (cells) are doing"
    - "An opportunity for all present to learn and get a sense of 'bigger picture'"
    - "An opportunity to list actions not discussed elsewhere"
- Challenges identified during the implementation process.
    - "Huddle Format not experienced by many participants before"
    - "It was another meeting in an already busy schedule"
    - The Huddle duration was shorter than standard executive team meetings – it was felt by some that there was sometimes not enough time to ask questions.
- Further improvement identified during the implementation process.
    - The need to decrease the frequency of the Huddle – over 10 weeks the frequency of the Huddle reduced from daily to twice weekly to weekly.
    - The need to clarify a system for escalation of key issues identified during the Huddle – it was subsequently agreed that these issues would be addressed through the Exec Oversight Cell
    - The need to clarify a system for discussion of papers (out with the Huddle). These were subsequently listed as agenda items on the AMT / SMT meeting (which occurred immediately after each Huddle.)

So what? (Results): (Quantitative)

- 18 "Huddle" meetings held between 19 March and 18 May 2020 (10 weeks).
- 15 cells were represented
- In room participation decreased and virtual participation increased after social distancing measures were introduced
- "Huddle" meetings usually lasted 40-50 minutes
- SMT/AMT business usually completed in around 20 minutes after Huddle
- Evidence of sharing of actions between cells

Conclusion

The "Huddle" approach to a morning AMT /SMT meeting was a new concept to many in the organisation, yet it was possible to implement it in a short space of time. Attendance at the Huddle was good, indicating senior leadership commitment to the pandemic emergency response. The Huddle allowed team members from each of 15 cells to highlight key issues and updates, usually within a 40-50 minute duration, thereby facilitating sharing of information, learning and gaining "a big picture" overview. However challenges were posed by social distancing and IT issues, and areas for improvement were identified. During the 10 week period beginning on the 19th March, 18 joint AMT / SMT morning Huddles were held. During this time many of those who attended the morning Huddle also attended the daily HSC Silver meetings. While the initial aim was to hold a Huddle every morning, the frequency of Huddles gradually reduced to twice a week and then weekly with the last Huddle taking place on the 18th May. Using QI methodology to implement the Huddle ensured that in addition to leading a whole system response both organisations were also focused on continuous improvement. Areas for improvement identified can be used to inform the implementation of any future Huddles.

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	15 April 2021
Title of paper	Specialist Training Programme in Public Health
Reference	PHA/05/04/21
Prepared by	Denise O'Hagan
Lead Director	Stephen Bergin
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

This paper aims to update PHA Board members regarding the Specialist Training Programme in Public Health. An annual update will be provided to the Board going forward.

2 Background Information

The specialist training programme in Public Health is overseen by the Northern Ireland Medical and Dental Training Agency (NIMDTA). PHA is the lead employer and main training provider for specialty registrars in Public Health. The programme aims to equip trainees with the appropriate training to complete the curriculum set out by the FPH and subsequently register as a specialist /consultant with the General Medical Council or UK Public Health Register. They are then eligible to apply for Consultant or Specialist posts in Public Health in organisations such as the PHA, academic institutions etc.

A region such as Northern Ireland needs to have an adequate number of consultants/ specialists in place to deliver on the Public Health agenda, particularly in relation to being able to respond to issues such as COVID-19 and address health inequalities. Recent reports by Dr Ruth Hussey and also by the FPH have highlighted the need to enhance consultant capacity in NI.

3 Structure of the training programme

The five year training programme follows the curriculum set out by the UK Faculty of Public Health (FPH). During the first year trainees undertake a Masters in Public Health to provide the underpinning knowledge base to sit the professional examinations. During the remaining four years trainees undertake service work in approved training locations and must evidence progress against the defined national curriculum as set out by the FPH. The PHA is the main training location but placements are also offered in the Department of Health, the Centre for Public Health at Queen's University and other approved locations. There is annual review of each trainee's progress which is overseen by NIMDTA.

4 Recruitment to the Training Programme

Eligibility to apply to the training programme in NI has recently changed and it is now open to both medical and non-medical applicants. This brings NI into line with other parts of the UK which have been recruiting people from a range of backgrounds to the training programme for many years. During the period when Ministers were not in place in NI, a temporary agreement was reached with the Department of Health and NIMDTA to enable this to progress. The legislative changes are to be brought forward in due course.

The first non-medical trainee commences training with the PHA in April 2021. A UK wide recruitment process is currently underway and it is anticipated that PHA will recruit three candidates (who may be from either medical or non-medical backgrounds) to commence training in August 2021.

5 Oversight of the Training Programme

NIDMTA's Public Health Specialty Training Committee oversees recruitment, annual assessment and placement of trainees, and quality within the training programme. This involves reviewing feedback received from trainees and trainers as part of the national annual GMC surveys.

Findings have just become available for the most recent survey which was carried out in autumn 2020. Trainees in NI were broadly similar to other UK regions, however, differed from others on one particular question. Trainees in NI reported that that the work was emotionally exhausting. This probably reflects the pressures experienced during COVID-19 by our very small pool of trainees. Trainees were heavily involved in the early phase of the COVID response when demands were very intensive and the wider structures, that have since been developed, were not yet in place. This highlights the need to ensure adequate attention to wellbeing in the workplace, particular at critical times and adequate preparedness and capacitiy in the organisation for future similar scenarios.

6 Role of the PHA in the delivery of training

The PHA has a responsibility to engage at Director level or equivalent with NIMDTA on training related matters. The assistant Director for Screening and Professional Standards has responsibliity in this area and has line management responsibility for the group of trainees. The PHA has a responsibility to ensure that there are sufficient numbers of supervisors available to deliver training and that supervisors have time in their job plans to meet their commitments in relation to their training role.

Since July 2016, all Educational Supervisors and Attachments Supervisors must be approved by the GMC. It is important that the PHA ensures that all consultants / specialists undertake the appropriate training in order to meet NIMDTA and GMC requirements and maintain their skills as designated supervisors. This forms part of annual consultant appraisal and needs to be given enhanced focus going forward to ensure an adequate pool of supervisors if the training programme is to expand as proposed later in this paper.

7 Funding

The PHA receives funding from NIMDTA for 10 speciality registrar posts. NIMDTA provides the basic salary costs. Registrars in Public Health deliver the first tier of the out of hours rota in Health Protection. Note that the costs associated with employer's costs and the out of hours rota are not covered by NIMDTA and are borne by the PHA, this is circa 250k to 300k. The budget build process for 2021/22 will review the funding source for these costs.

Due to the age profile of the consultant workforce, anticipated retirements and the fact that there were several vacant consultant posts in the PHA, it was agreed with NIMDTA in 2019 that the PHA would re-direct funding from vacant consultant posts to temporarily increase the number of specialty registrars from 10 to 12 wte posts.

The COVID -19 pandemic has further highlighted the need to ensure that there is an adequate consultant/ specialist workforce. A business case is currently being prepared to seek approval from the Department to expand the training programme from the existing position of 10wte recurrent posts to perhaps 14wte posts.

8 Future direction

The PHA Board will be provided with an annual update going forward in relation to the specialist training programme.

A business case is being developed, for submission to the Department of Health, with regards to expansion of the training programme to ensure adequate numbers of eligible candidates to apply for future consultant posts.

While this paper focuses on training towards FPH ‘specialist ./ consultant’ status, it is likely that in coming years there will be demand from within the existing non-medical workforce in PHA for more defined career paths and the opportunity to work towards both practitioner and eventually specialist registration with the UKPHR and FPH. The PHA and other bodies in NI may wish to give consideration to the creation of structures which support this.