Public Health Agency

AGENDA

Confidential Session of the Public Health Agency board to be held on Thursday 21 August 2014, at 12:30pm, Public Health Agency, Conference Rooms, 12-22 Linenhall Street, Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	12:30	Welcome and Apologies		Chair
2.	12:35	Minutes of previous confidential meeting		Chair
3.	12:35	Matters Arising		
4.	12:40	Update on Lifeline Contract		Dr Harper / Mr McClean
5.	13.00	Remuneration Committee Update		Chair
6.	13.10	Any Other Business		Chief Executive

7. **Date, Time and Venue of Next Meeting**
To be confirmed

Public Health Agency

MINUTES

Minutes of the Confidential Session of the Public Health Agency held on Thursday 19 June 2014 at 12:15pm, in Public Health Agency, Conference Rooms, 2nd Floor, 12-22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Ms Mary McMahon	-	Chair
Dr Eddie Rooney	-	Chief Executive
Mrs Pat Cullen	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Alderman William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Dr Jeremy Harbison	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director

IN ATTENDANCE:

Mr Paul Cummings	-	Director of Finance, HSCB
Mr Robert Graham	-	Secretariat

APOLOGIES:

Mrs Julie Erskine	-	Non-Executive Director
Mrs Miriam Karp	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Mr Tony Rodgers	-	Assistant Director of Social Services, HSCB

		Action
CC/15/14	**Item 1 – Apologies**	
CC/15/14.1	The Chair welcomed everyone to the meeting and noted apologies from Mrs Julie Erskine, Mrs Miriam Karp, Alderman Paul Porter and Mr Tony Rodgers.	
CC/16/14	**Item 2 – Minutes of previous confidential meeting**	
CC/16/14.1	Members approved the minutes of the previous confidential meeting, held on 20 February 2014 as an accurate record of the meeting. The minutes were duly signed by the Chair.	

CC/17/14	**Item 3 – Overview of the Management of Serious Adverse Incidents**
CC/17/14.1	Mrs Cullen said that members had wished to use this opportunity to hear more about how learning from SAIs is disseminated and to recap on the SAI procedure. She invited Oriel Brown to deliver her presentation to members.
CC/17/14.2	Ms Brown advised that a new SAI process had been introduced in October 2013 with full implementation by April 2014. She explained the changes to the criteria of an SAI and the timescales for notification before detailing each of the different levels of investigation. Ms Brown gave an overview of patient and family involvement and advised that this area is being reviewed with regional guidance being developed and an information leaflet for service users.
CC/17/14.3	Ms Brown highlighted the role of the DRO and said that there are now fortnightly meetings of all DROs.
CC/17/14.4	In terms of learning, Ms Brown gave an overview of the roles of the SAI Review Group, the QSE (Quality, Safety and Experience) Group and the SQAT (Safety Quality Alerts Team). She gave a breakdown of the numbers of each type of alerts that had been issued during 2013/14 before explaining to members the different mechanisms for dissemination of learning e.g. learning letters, bi-annual reports and the Learning Matters newsletter.
CC/17/14.5	Ms Brown shared with members details of the number of SAIs by HSC Trust and by programme of care. She explained that the increased numbers were due to a number of factors, including the requirement to report child deaths, and an increased awareness of the need to report.
CC/17/14.6	Ms Brown finished by reiterating that it is important that to make a difference by learning from SAIs and making a commitment to act on that learning.
CC/17/14.7	The Chair asked whether the learning from SAIs is passed onto trainees. Ms Brown said that all information is sent to the main universities, as well as to Trusts and RQIA. She added that it would be included as part of the induction process.

CC/17/14.8	Dr Harbison asked if Trusts were operating with different thresholds for reporting SAIs given the varying levels of reporting across the HSC. Ms Brown noted that this may be due to the changes in criteria or because a specific service may be regional and only based in one Trust. She added that PHA has held meetings with Trusts to increase their awareness of SAIs. Mrs Cullen said that the change in the Chief Executive arrangements in the Northern Trust also impacted on the reporting culture of SAIs. Dr Harbison said that confirmed his issue that there are differences in the culture of reporting across Trusts. Mrs Cullen said that PHA has met with Trusts and after each meeting, there is a period where there is increased reporting, but this may not be sustained.
CC/17/14.9	Dr Harbison queried if baseline data was available across the UK. Ms Brown said that she was not aware of any as Northern Ireland uses a different system.
CC/17/14.10	Mr Coulter said that the system for collecting data was comprehensive, and he asked whether PHA had developed any formalised links with, for example, the Clinical Human Fractures Group. Ms Brown said that PHA does undertake human fractures training.
CC/17/14.11	Mr Cummings said that the culture of the organisation goes to the core and that there are different views as to how these SAIs should be dealt with. He said that this is the start of a journey of learning for the HSC. Dr Harper agreed that culture is at the heart of this and highlighted a tension between the roles of clinical staff, doctors and social work staff and their view of “things that happen”.
CC/17/14.12	Mr Cummings said that the name Serious Adverse Incidents is unhelpful. Dr Harper said that there had been discussions on the terminology, but there was a feeling that there could be a perception of hiding something if the name changed.
CC/17/14.13	Mr Mahaffy asked about Adverse Incidents and how confident PHA is that these are reported. Dr Harper said that there are currently 80,000 reported each year, and these are dealt with by the governance departments in each Trust. She added that with the forthcoming Donaldson Review, there could be a change in terms of reporting. Furthermore, she said that

	medical revalidation has shown that doctors are reviewing their practice.
CC/17/14.14	Mr Mahaffy asked if there were any concerns about non-reporting in Trusts. Mrs Cullen said that there is currently a process underway, in conjunction with DHSSPS, looking at RAIL. She said that Trusts are reporting AIs, but there is variation. Furthermore, there needs to be a cleansing of the data as well as examination and analysis.
CC/17/14.15	Mr Cummings said that one of the biggest issues that needed to be addressed was the mechanism to support staff who have been involved in an SAI. Mrs Cullen said that this would have to be taken forward in conversation with the Trusts. Ms Brown said that there is support through RCN and Dr Harper added that, through work with NIMDTA, support mechanism for trainee doctors are being looked at. The Chair said that, as part of the employer's duty of care, it is important that staff do not feel isolated.
CC/17/14.16	The Chair noted that primary care does not report SAIs. Mrs Cullen advised that the majority of SAIs do not apply to primary care. However, practices are responsible for compiling an analysis of significant events bi-annually. The HSCB would then determine if any incidents were required to be dealt with as SAIs.
CC/17/14.17	The Chair asked whether the PHA Board could do more in regard to SAIs. Ms Brown reiterated that the learning is key, and it is important to get information out to frontline staff. Mrs Cullen said that capacity is an issue and the increasing number of SAIs is putting increased pressure on DROs who must ensure that the Trusts meet their 12-week deadline. Dr Harper added that it is difficult to get staff to reprioritise, but PHA needs to see what support can be put in place. Mrs Cullen added that the role of the DRO is increasingly being put in the spotlight given potential legal challenges.
CC/17/14.18	Members noted the update on Serious Adverse Incidents.

CC/18/14 **Item 4 – Update on Lifeline Contract**

CC/18/14.1 Dr Harper welcomed Brendan Bonner to the meeting. She said that there had been a number of concerns regarding the Lifeline contract which had been raised at previous Board meetings, both clinical and financial, and it would be useful for members to have an update on this.

CC/18/14.2 Mr Bonner gave the background to the contract with Contact and said that the current contract runs up until 31 March 2015, with the possibility of a 18-month extension.

CC/18/14.3 Mr Bonner gave members an overview of the key issues which emanated from a recent clinical audit which had been carried out into the service. These were around demand management and working within the budget allocation; data quality and reconciliation; data information in terms of the source of demand, service management and clinical outcomes; and financial issues.

CC/18/14.4 Mr Bonner advised that a report of the clinical audit had been brought to AMT and would be brought to the PHA Board in August. He said that the report highlighted 10 areas of good practice and 11 areas which required further clarification. Furthermore, there were 29 concerns which were broken down into 19 Priority One recommendations and 10 Priority Two recommendations. An action plan has been shared with Contact with 10 working days given to respond.

CC/18/14.5 Dr Harper said that the engagement with Contact had been complex and had involved input from staff in health intelligence, operations, finance and clinical staff.

CC/18/14.6 Mr Cummings asked whether the organisation delivering the Lifeline contract had existed prior to this contract. Mr Bonner said that Contact was a separate entity but that PHA owned the intellectual property rights to the Lifeline service.

CC/18/14.7 Dr Harbison sought clarity that a decision is to be made regarding whether to extend the existing contract or re-tender. Mr Bonner said that if the service were to cease, a decision would be required as to when this would happen, but if the service were to be re-commissioned it could be a different

	model.
CC/18/14.8	Mr Coulter asked if there were any clinical issues or concerns for users of the service. Mr Bonner assured members that there were no patient safety issues, but there were issues about the appropriate use of the service. Mr Cummings said that PHA needed to be able to control the service, or else this would compromise its governance systems. He added that if individuals are being referred to a service they don't require and the service is charging PHA for this, this could be construed as fraud.
CC/18/14.9	The Chief Executive said that this issue could surface in the public domain and that PHA needed to be undertaking this level of scrutiny of the data it was being presented with in order to have the best evidence available.
	The Chair thanked all of the staff involved in this work.
CC/18/14.10	Members noted the update on the Lifeline contract.
CC/18/14.11	
CC/19/14	**Item 5 - Any Other Business**
CC/19/14.1	There was no other business and the Chair brought the confidential session to a close.
	Signed by Chair: ________________
	Date: ________________

HSC Public Health Agency

AGENDA

66th Meeting of the Public Health Agency board to be held on Thursday 19 June 2014, at 1:30pm, Public Health Agency, Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1:30	Welcome and Apologies		Chair
2.	1:30	Declaration of Interests		Chair
3.	1:30	Minutes of the PHA board Meeting held on 15 May 2014		Chair
4.	1:35	Matters Arising		Chair
5.	1:40	Chair's Business		Chair
6.	1:45	Chief Executive's Business		Chief Executive
7.	1:50	Finance / Operations Update		
		• Investment Plan 2014/15 – Final Draft	**PHA/01/06/14 (for Approval)**	Mr McClean
		• PHA Budgets 2014/15	**PHA/02/06/14 (for Approval)**	Mr Cummings
8.	2:10	Governance and Audit Committee Update • Minutes of 10 April 2014 meeting • Verbal briefing from Chair	**PHA/03/06/14 (for Noting)**	Mr Coulter
9.	2:20	Corporate Risk Register	**PHA/04/06/14 (for Noting)**	Mr McClean

10.	2:30	Remuneration Committee Update • Minutes of 4 December 2013 meeting • Verbal briefing from Chair	**PHA/05/06/14 (for Noting)**	Chair
11.	2:40	Project Initiation Document: Development of PHA Strategic Priorities 2015/20	**PHA/06/06/14 (for Approval)**	Chief Executive
12.	3:00	Programme Report: Health Protection		Dr Harper
13.	3:25	Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2012/13	**PHA/07/06/14 (for Noting)**	Dr Harper
14.	3:45	DPH Annual Report 2013	**PHA/08/06/14 (for Noting)**	Dr Harper
15.	3:55	Personal and Public Involvement Report	**PHA/09/06/14 (for Noting)**	Mrs Cullen
16.	4:20	Annual Progress Report 2013/14 to the Equality Commission	**PHA/10/06/14 (for Approval)**	Mr McClean
17.	4:35	Any Other Business		

18. **Date, Time and Venue of Next Meeting**
Thursday 21 August 2014
1:30pm
Conference Rooms 3/4
Public Health Agency
12-22 Linenhall Street
Belfast
BT2 8BS

Public Health Agency

MINUTES

Minutes of the 65th Meeting of the Public Health Agency board held on Thursday 15 May 2014 at 1:30pm, in Public Health Agency, Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Ms Mary McMahon	-	Chair
Dr Eddie Rooney	-	Chief Executive
Mrs Pat Cullen	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Alderman William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Mrs Julie Erskine	-	Non-Executive Director
Dr Jeremy Harbison	-	Non-Executive Director
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

IN ATTENDANCE:

Mr Simon Christie	-	Assistant Director of Finance, HSCB
Mr Tony Rodgers	-	Assistant Director of Social Services, HSCB
Mr Robert Graham	-	Secretariat

APOLOGIES:

Mr Owen Harkin	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

		Action
63/14	**Item 1 – Welcome and Apologies**	
63/14.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Owen Harkin and Mrs Joanne McKissick.	
64/14	**Item 2 - Declaration of Interests**	
64/14.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. None were declared.	

65/14	**Item 3 – Minutes of the PHA Board Meeting held on 17 April 2014**	
65/14.1	The minutes of the previous meeting, held on 17 April 2014, were approved as an accurate record of the meeting, subject to one amendment. In paragraph 56/14.1, the minute should read, "…there was a year to date surplus of £1.3m". The minutes were duly signed by the Chair.	
66/14	**Item 4 – Matters Arising**	
	46/14 Update on Inter-sectoral Programme Boards	
66/14.1	The Chair advised that Mr McClean had circulated dates for a proposed first meeting of the Local Government group. Mrs Cullen advised that she would finalise a date for the first meeting of the Older People's group. Dr Harper requested that the membership and terms of reference of each group be circulated, and it was agreed that this would be done.	Mrs Cullen Secretariat
67/14	**Item 5 – Chair's Business**	
67/14.1	The Chair advised that she had attended a recent NICON event where the new Chief Executive of the NHS Confederation had given a talk and had highlighted the significant issues facing the NHS in England. At the same event, the Chair said that, as part of the round table discussions, she had heard positive feedback on the 10,000 voices project.	
68/14	**Item 6 – Chief Executive's Business**	
68/14.1	The Chief Executive advised that the PHA had appointed an Assistant Director of Public Health Nursing, Una Turbitt, and that this appointment would strengthen PHA's work in the area of public health nursing.	
68/14.2	The Chief Executive said that he had recently attended a session of the Education Committee at Stormont which focused on the area of special needs schools.	
68/14.3	The Chief Executive advised that he was involved in a workshop regarding a cancer prevention campaign and he commended the work of the PHA staff who had been involved in the organisation	

of this and for their inputs.

68/14.4 The Chief Executive said that he had visited the Balmoral Show to support the PHA staff who had organised a stand regarding PHA's Organ Donation campaign.

69/14 Item 7 – Finance Report
PHA Financial Performance Report (PHA/01/05/14)

69/14.1 Mr Christie was asked whether he was aware of any issues regarding staff payments to PHA staff following recent technical issues which had affected staff in some of the HSC Trusts. Mr Christie assured members that he was not aware of any issues regarding any members of PHA staff.

69/14.2 Mr Christie presented the end of year finance report and said that for the year 2013/14, PHA had a total expenditure of £95.2m against an income of £95.3m, thus ending the year with a surplus of £160k. He said that the anticipation that the surplus at the end of February would be spent before the year end had proved to be correct. He said that the final Annual Report and Accounts would be brought to the Board for approval in June.

69/14.3 Mr Christie drew members' attention to two issues within the non-Trust expenditure. He said that there had been overspends on the Lifeline contract and on campaigns, however these had been compensated by an underspend within management and administration.

69/14.4 Mr Christie said that the prompt payment statistics for March had shown a slight dip in performance, but this was mainly due to the transfer of payments to shared services. He noted that 74% of PHA invoices had been paid within 10 days, and he commended this outcome.

69/14.5 Mrs Erskine said she was surprised that the prompt payments figures were so high, given that there had been issues in other organisations. Mr Christie said that this showed that PHA's systems were working well.

69/14.6 Alderman Porter raised a concern that if PHA had not funded the pressure on Lifeline the year end surplus could have been greater. However, he queried whether in fact the pressure was

met by taking away funding from other projects. The Chief Executive assured members that PHA would not run with a financial underspend as there is a list of reserve projects should additional funding be identified. He added that there is significant work undertaken in terms of planning at the start of each year so that when a potential underspend or overspend is identified, action can be taken. He acknowledged that there is a risk with there being a large "tail" of expenditure projected in the last quarter, but he was content that there were no gaps and no unmet needs identified.

69/14.7 The Chief Executive advised members that a full Investment Plan would be brought to the next Board meeting.

69/14.8 Mrs Karp commended the work of the Finance department and PHA staff for achieving this outcome.

69/14.9 Members noted the Financial Report.

70/14 Item 8 – HCAI Target Monitoring Report (PHA/02/05/14)

70/14.1 Dr Harper introduced Dr Lourda Geoghegan and Mr Gerry McIlvenny to the meeting and invited Dr Geoghegan to present to members the HCAI report.

70/14.2 Dr Geoghegan began her presentation by giving members an overview of the number of cases of C Diff in Northern Ireland during 2013/14. She said that improvements had been made and that the target reduction of 22% in the number of cases had been exceeded.

70/14.3 Dr Geoghegan said that, although the Northern and South Eastern Trusts had missed their target for 2013/14, there had still been a significant reduction in numbers of cases since 2009. She said that the performance of the Belfast Trust compared favourably with comparable Trusts in England.

70/14.4 Dr Geoghegan moved on to give an overview of MRSA cases and said that the regional target for 2013/14 had not been met. She said that the Belfast Trust had met its target, and although the Southern Trust had not met its target, it had achieved a significant reduction in the number of cases in recent years. She added that discussions were on-going with Trusts regarding the

	numbers of cases.
70/14.5	Dr Geoghegan advised that in England, there are Trusts where no cases of MRSA are recorded, but she said that Trusts in England were much further on in their work to achieve this zero position. She said that PHA will continue to work with Trusts and highlighted areas where Trusts can improve. She added that a workshop is being arranged for June 2014 on MRSA.
70/14.6	Dr Harbison asked whether it was possible to do comparisons with Scotland and Wales. Dr Geoghegan advised that there are differences in terms of how each country collects its data. She said that as Northern Ireland uses the same surveillance system as England, it is easier to do comparisons with England. In summary, she said that Northern Ireland fares reasonably well in comparison.
70/14.7	Dr Harbison asked about MSSA. Dr Geoghegan said that this PHA also looks at cases of MSSA, and that there was a slight reduction in the number of cases in 2013/14.
70/14.8	Mr Coulter queried whether there were any issues relating to the governance arrangements within Trusts, in case there was under-reporting of cases. Dr Geoghegan said that in England there has been proactive work in reducing the numbers of cases, and there are good systems in place, for example undertaking root cause analysis and sharing learning.
70/14.9	The Chair asked about infection control procedures within the Northern Ireland Ambulance Service. Dr Geoghegan said that NIAS are required to have procedures in place, and she added that NIAS attends the quarterly HCAI forum.
70/14.10	Members noted the HCAI report.
71/14	**Item 9 – HALT Report 2013: Healthcare Associated Infections and Antimicrobial Use in Long-Term Care Facilities in Northern Ireland (PHA/03/05/14)**
71/14.1	Mr McIlvenney outlined to members the background to the HALT report and advised that 31 nursing homes and 11 residential homes in Northern Ireland had taken part. He said that the aim of the study was to evaluate the prevalence of HCAIs and to look

at the use of antibiotics in long term care facilities. He outlined the characteristics and care needs of residents within the facilities that had taken part in the study.

71/14.2 In terms of the main HCAIs identified, Mr McIlvenney said that for both nursing and residential homes the main HCAIs related to urinary tract and respiratory tract. The overall prevalence of HCAIs was 5.5% which was above the median. In terms of antimicrobial prevalence, Northern Ireland was also above the median with a rate of 10.6%, compared to the median of 9.5%.

71/14.3 Mr McIlvenny highlighted issues regarding antimicrobial prescribing, specifically relating to uroprophylaxis, which accounted for half of the prescribing in nursing homes.

71/14.4 Dr Geoghegan said that each facility that had taken part in the survey had received a report on their own facility in order to help make improvements. She said that reports were also shared with the pharmacy division within HSCB. She added that there is learning within the report, both in terms of TYC and for RQIA, as part of its inspection process.

71/14.5 Dr Geoghegan gave an overview of the recommendations from the report which fell into three broad categories – HCAIs, leadership and stewardship.

71/14.6 Mrs Karp said that the work undertaken was important but noted that the responsibility for implementing the recommendations fell on a lot of organisations and asked how PHA could be assured that they would be implemented. Dr Geoghegan acknowledged that a joined-up approach is needed but she said that PHA is taking a role in this and is working with HSCB, who will in turn provide support to nursing homes. She said that it is ultimately the responsibility of the homes to take forward the recommendations. In response to a query from Dr Harper, Dr Geoghegan confirmed that a follow up survey would be undertaken every five years.

71/14.7 Alderman Porter queried the logic of comparing nursing and residential homes, given the needs of the service users of each facility. Dr Geoghegan acknowledged this, but said that it was useful to have data from both types of facility.

71/14.8 Dr Harbison asked whether the results of the survey were expected. Dr Geoghegan said that, with respect to HCAIs, the outcome was expected, but not with regard to the rates of antimicrobial prescribing. Dr Harbison was disappointed at the low response rate from residential homes and also said that the rate of prescribing was very high. He asked about the role of RQIA in terms of picking up some of the issues highlighted in the report. Mr Coulter highlighted the same issue and asked about the role of PHA.

71/14.9 Dr Geoghegan said that the role of PHA is to advise and provide support for improvement and specialist expertise. She added that in the case of a major incident or outbreak PHA would chair the outbreak control team. Furthermore, if PHA felt that a nursing home was not taking account of PHA's advice, PHA would highlight this to RQIA.

71/14.10 Mr Coulter said he was concerned that the value of antibiotics would be diminished through overuse and inappropriate use. Dr Geoghegan advised that PHA would support an approach where pharmacies are aligned to GP practices which would pick up on these issues.

71/14.11 Mrs Cullen gave an overview of the role of RQIA and said that it is required to carry out reviews of medicines management. She said that within nursing and residential homes, each individual has a care plan and there should be a registered nurse responsible for that plan. She added that the nurse is responsible for ensuring that the management of medicines is part of the overall management of the home.

71/14.12 Mrs Cullen noted that it is not only GPs who prescribe antibiotics, these could be prescribed by an out of hours doctor or a prescribing nurse, but she added that it was important that the right call was made on behalf of the patient.

71/14.3 Members noted the HALT Report.

At this point Alderman Porter left the meeting.

72/14	**Item 10 – Performance Management Report – Corporate Business Plan and Commissioning Plan Direction Targets for Period Ending 31 March 2014 (PHA/04/05/14)**
72/14.1	Mr McClean presented the end of year Performance Management Report and advised that of the 93 targets, 80 had achieved a "green" rating, 10 an "amber" rating and 3 a "red" rating. The three rated red related to community capacity building, smoking cessation and telemonitoring.
72/14.2	Mrs Erskine said that it was disappointing that PHA had been unable to meet its target due to factors outside its control and proposed that a different colour be used to indicate those actions which fall outside PHA's control.
72/14.3	The Chair said that in relation to those targets about healthy choices, there was a need to consider not commissioning these on an annual basis as results could only be measured over a longer time period. She said that some of these areas would be more likely to be squeezed if cuts had to be made.
72/14.4	Dr Harper said that all services are currently squeezed but PHA's influence on the Commissioning Plan can ensure that funding can be secured in important areas, for example the rollout of FNP and the alcohol substance misuse liaison service.
72/14.5	Mr Coulter suggested that, with regard to capacity building, PHA should commission a third party to undertake this as there would be no element of prejudice and it would be open for all organisations to attend. Mr Coulter asked about PHA's position in relation to e-cigarettes, an issue also raised by Alderman Ashe.
72/14.6	Dr Harper advised that discussions are taking place at UK-level regarding e-cigarettes and a position paper will be available shortly. In response to Mrs Karp's query, she confirmed that the quit rates are for individuals who have quit smoking altogether, and have not moved on to the use of e-cigarettes.
72/14.7	The Chief Executive assured members that the objectives rated as red would continue to feature within PHA's priorities moving forward – capacity building, telemonitoring and smoking cessation.

72/14.8	Mrs Erskine thanked the work of all staff for achieving this outcome at the end of the year.
72/14.9	Members noted the Performance Management Report.
	During this item Mrs Erskine left the meeting.
73/14	**Item 11 – Health and Social Wellbeing Improvement Update (PHA/05/05/14)**
73/14.1	Dr Harper introduced Mary Black to the meeting and said that this presentation was an end of year report on the range of initiatives undertaken within health and social wellbeing improvement.
73/14.2	Mrs Black began by highlighting the context within which health and social wellbeing improvement directorate operates and some of the key challenges. In particular, Mrs Black identified procurement as a challenge going forward.
73/14.3	Mrs Black updated members on initiatives under the banner of "building sustainable communities", and drew particular attention to Resurgam, MARA and the community allotments programme. She also highlighted work in relation to BME, older people and LGBT.
73/14.4	Mrs Black moved onto "make healthy choices easier" and highlighted work done with regard to suicide prevention and mental health and wellbeing. She cited work PHA does in partnership with sporting bodies.
73/14.5	Mrs Black informed members about PHA's smoking cessation campaign and its obesity prevention campaign.
73/14.6	Mrs Black finished her presentation by giving members an overview of PHA's work with the Belfast Strategic Partnership under the banner of "Active Belfast".
73/14.7	Dr Harbison said that a huge amount of work had been achieved, but he asked how PHA can quantify its impact, for example in areas such as MARA. He asked whether baselines had been set against which PHA can measure activity to see whether PHA's work is making a dent in the areas it is working in. Mrs Black

said it is not an exact science and baselines had been developed for some areas. Dr Harbison said in terms of future planning, PHA needs to ensure that it uses its resources where they are most needed, by being able to identify where the problem areas are.

73/14.8 Mrs Karp noted that this update is presented annually, and she asked whether it would be possible to facilitate opportunities for individuals to come to the Board and present their stories in the same way as patients have done their experiences. Mrs Black said that this was something that could be done at a future meeting and cited an example of an individual who had benefitted from the MARA programme.

73/14.9 Mr Coulter asked how PHA maps its activity against social inequalities and how PHA knows if it is making a difference. Mrs Black said that PHA's work is largely based on the areas highlighted in the Marmot Review and as part of this work, it is important that PHA seeks to leverage resources from other government departments. She added that PHA will always seek to push on with its initiatives and regularly evaluate its progress.

73/14.10 Members noted the health and social wellbeing improvement update.

74/14 Item 12 – Child Development Programme Board Update (PHA/06/05/14)

74/14.1 Dr Harper advised members that the Child Development Programme Board (CDPB) has been running since 2010 and she introduced Maurice Meehan to the meeting and invited him to give members an overview of the recent work of the Board.

74/14.2 Mr Meehan said that one of PHA's objectives under "Building Blocks for a Healthy Life" is to work with others to ensure that every child and young people has the best start in life, thus the creation of the CDPB. He gave an overview of the different elements of the Board and some of the programmes.

74/14.3 In terms of looking forward, Mr Meehan said that PHA would seek to continue to inform policy through initiatives like Delivering Social Change and the Early Intervention Transformation Programme. He added that PHA will continue to analyse what

	works best and said that the secret of the success of the CDPB is working together.
74/14.4	Mrs Karp thanked Mr Meehan for the presentation and said that she was heartened by the amount of work that had been achieved thanks to the enthusiasm and hard work of all of those sitting on the CDPB.
74/14.5	The Chief Executive noted that as the work of the CDPB develops the interface with education will be important. Dr Harper said that the 5 Education and Library Boards are members of the Roots of Empathy Project and that there is a proposal to develop a strategic liaison with education. The Chief Executive added that the Education Committee at the Northern Ireland Assembly is becoming interested in PHA's work.
74/14.6	Dr Harbison noted the large membership of the Group and asked whether there was a good attendance at each meeting. Dr Harper said there is usually a very good turnout at each meeting and that there is a lot of energy and enthusiasm within the group.
74/14.7	Members noted the Child Development Programme Board update.
75/14	**Item 13 – Development of the PHA Corporate Strategy 2015-19**
75/14.1	The Chief Executive explained to members that a full proposal outlining the proposed development of the next PHA Corporate Strategy will be brought to the Board in June.
75/14.2	Reflecting on the range of presentations that had been brought to the Board meeting today, the Chief Executive said that this demonstrated the breadth of the work undertaken by PHA and it was now timely for PHA to consider the impact it was having and also to think about areas where PHA needed to make more impact.
75/14.3	The Chief Executive said that the next Corporate Strategy will run from 1 April 2016 as DHSSPS has allowed the current Strategy to run for another year, given that in the next few months, the Public Health Strategy will be launched and there will be a new Programme for Government. The Chief Executive

said that PHA needed to consider these in the development of its future core activities and align itself in order to make the desired impact.

75/14.4 The Chief Executive said that the Plan will be developed with input from non-executives and that there will be a formal project plan, with key milestones, developed. There will also be significant discussion at the away day later in the year.

75/14.5 Members noted the update on the development of the new Corporate Strategy.

76/14 Item 14 – ALB Self-Assessment Action Plan (PHA/07/05/14)

76/14.1 The Chair said that the Action Plan highlighted the actions that PHA is committed to following the completion of the ALB self-assessment questionnaire.

76/14.2 Members noted the Action Plan.

77/14 Item 15 – Draft Investment Plan (PHA/08/05/14)

77/14.1 Mr McClean said that this Plan was a high level summary in advance of the full Investment Plan being brought to the Board in June. It indicates areas of growth and where PHA is anticipating in-year funding.

77/14.2 The Chair stressed that PHA has a responsibility to ensure that it utilises its additional funding appropriately.

77/14.3 Members noted the draft Investment Plan.

78/14 Item 16 – Any Other Business

78/14.1 The Chair advised members that the OFMDFM Active Ageing Strategy was out for public consultation and a copy of PHA's draft response was circulated. Members were asked to forward any comments to Chris Totten by Friday 23 May.

78/14.2 Mrs Karp asked whether a date for an away day had been confirmed. The Chair said that a date would be finalised in advance of the June Board meeting.

79/14 **Item 17 – Date and Time of Next Meeting**

Date: Thursday 19 June 2014
Time: 1:30pm
Venue: Public Health Agency
Conference Rooms
2nd Floor
12-22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: ________________

Date: ________________

HSC Public Health Agency

PHA Board Report

June 2014

HSC Public Health Agency

Summary Position June 2014

Income

	Page Reference	Annual £000s	Year to Date £000s
Department Allocation*		92,545	17,752
Income from Other Sources		877	389
Total Income		93,422	18,141
Expenditure			
Non-Trust Programme	2	38,097	5,178
Trusts	3	34,655	8,000
PHA Administration (inc. BSO)	4	20,670	4,823
Total Expenditure		93,422	18,001
Surplus/(Deficit)		0	140

*Includes assumed allocations of £797k for the Safeguarding Board for NI (SBNI), £134k for Clinical Excellence Awards and £250k for Research & Develeopment projects from the Department for Social Development.

Position Synopsis:

After review of all budgets, PHA is projecting a breakeven position at the year end. However, it should be noted that decisions on a balance of funds held for 2014/15 investments is still to be made by PHA.

Year to date the financial position shows a small surplus of £141k, relating to the non Trust Programme budget (£55k) and Management and Administration budgets (£196k).

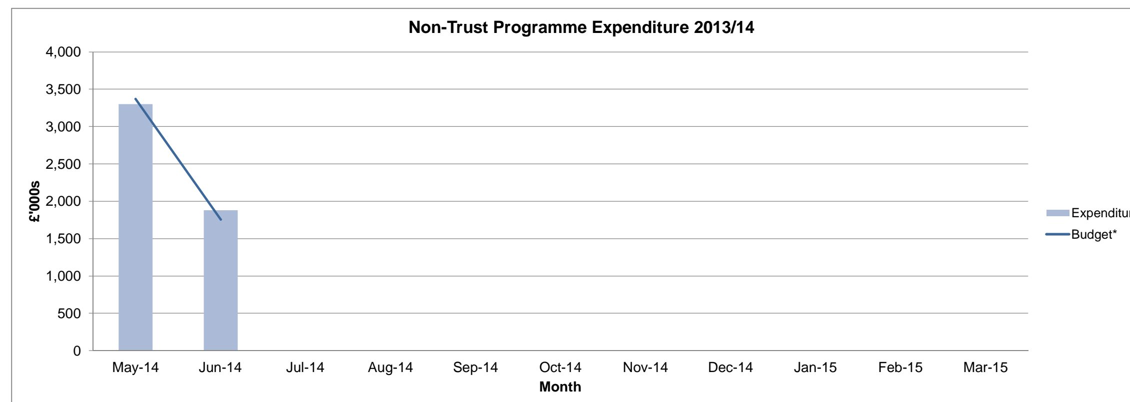
The PHA has yet to approve developments against a balance of £1.1m Full Year Effect and £0.6m Current Year Effect, remaining from the deployment of additional allocations received in 2014/15 and recycled baseline resources, decisions on priorities are currently being considered by PHA. The financial position above assumes that these resources will be fully expended within 2014/15.

Public Health Agency

Non-Trust Programme

June 2014

Non-Trust Programme Spend



	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total
Budget	3,368	1,755										5,123
Expenditure	3,299	1,879										5,178
Surplus/(Deficit)	69	(124)	0	0	0	0	0	0	0	0	0	(55)

Surplus/(Deficit) made up as follows:

	May-14	Jun-14	Total
Health Improvement - Belfast LCG	87	1	88
Health Improvement - South East LCG	(137)	(158)	(295)
Health Improvement - North LCG	(88)	68	(20)
Health Improvement - South LCG	135	(55)	80
Health Improvement - West LCG	249	(146)	103
Health Improvement - Lifeline Contract	(137)	14	(123)
Health Improvement - Smoking Cessation	0	0	0
Health Protection	(60)	(13)	(73)
Service Development & Screening	115	40	155
Research & Development	29	(28)	1
Campaigns	(96)	17	(79)
Nursing & AHP	(3)	8	5
Health Improvement - Regional Projects	(25)	130	105

Position Synopsis:

The current position shows an overspend of £55k at the end of June 2014 based on profiles shared by budget managers and the PEM system used by PHA to plan commitments. The Financial Management team have continued to meet with Budget Managers to review budgets, profiles and assumptions regarding expenditure for 2014/15.

At the end of Quarter 1 Budget Holders are expecting that all approved budgets, with the exception of the Lifeline contract, will breakeven at year end.

PHA Management Team continues to scrutinise in detail the pressure with respect to the Lifeline Service and the demand management measures in place. HSCB Financial Management team are being regularly briefed in order to allow an assessment of the potential financial impact that the pressure may have on the year end financial position.

HSC Public Health Agency

Revenue Resource Limits (RRLs) to Trusts

June 2014

	Annual Budget (per revised SBAs) £'000s	Budget to Date £'000s	Variance from Annual Budget £'000s	Main Reasons for Increase in Funding
Western Trust	5,113	5,476	363	
Northern Trust	6,129	6,595	466	
Belfast Trust	11,178	11,674	496	The funds shown against specific Trusts have been notified via Service & Budget Agreements.
South Eastern Trust	2,889	3,250	361	
Southern Trust	4,595	5,006	411	
Funds identified to Trusts in Budget Paper but not yet allocated	4,751	2,654	(2,097)	
Total	**34,655**	**34,655**	**0**	

HSC Public Health Agency

PHA Administration

June 2014

	Total		Current Month			Year to Date	
	Budget	Budget	Expenditure	Variance	Budget	Expenditure	Variance
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
Salaries	17,416	1,415	1,405	10	4,266	4,176	90
Goods & Services	2,698	281	150	131	614	507	107
Sub-Total Administration	20,114	1,696	1,555	141	4,880	4,683	197
BSO	556	47	47	0	139	139	0
Total Administration	**20,670**	**1,743**	**1,602**	**141**	**5,019**	**4,822**	**197**

Position Synopsis:

An overall management and administration surplus of £197k is reported at the end of June 2014 based on budgetary profile.

Prompt Payment Statistics

	June 2014 Value £'000	June 2014 Volume of Invoices	Cumulative position as at 30/06/14 £'000	Cumulative position as at 30/06/14 Volume of Invoices
Total bills paid (relating to Prompt Payment target)	2,888	764	7,406	2,183
Total bills paid on time (within 30 days or under other agreed terms)	2,691	656	6,495	1,926
Percentage of bills paid on time	**93.2%**	**85.9%**	**87.7%**	**88.2%**

The BSO has not yet been able to provide a comprehensive prompt payment report which is accurate for PHA. In the interim HSCB finance, on behalf of PHA, continue to generate a prompt payment report based on the audited method which was used to provide the Annual Accounts figures . This will ensure consistency of information reported to PHA on a monthly basis, while BSO works to produce a meaningful report.

PHA staff continue to make progress in utilising the new systems to clear invoices promptly, with 78.2% of all relevant invoices paid within 10 days of receipt. However, during May 2014 there was a drop in 30 day performance with 85.6% of the total value of invoices paid within 30 days, relating to 87.7% of the total volume of invoices.

The cumulative position for 2014/15 by volume of invoices is 88.2% and by value 87.7%, which remains short of the 95% DHSSPS target.

MINUTES
OF REMUNERATION COMMITTEE MEETING
ON 4 DECEMBER 2013
In Mary McMahon's Office, 4th Floor, 12-22 Linenhall Street, Belfast

Present: Mary McMahon, Jeremy Harbison, Cllr Billy Ashe
In attendance: Hugh McPoland

1. The minutes of the previous meeting were approved.
2. Matters Arising: The Chair advised that C Executive personal responsibilities on inequalities had not yet been agreed but would be circulated to Remuneration Committee members early in the New Year for approval and subsequent inclusion in Appraisal template.
3. The template, with Chair's comments, having been previously circulated to members, was discussed. Members agreed that the focus of today's discussion would be PHA Impact on Inequalities, subsequent to Away Day deliberations, addressing the gap on Pay Differentials within SMT and issues around Governance.

Inequalities - members believed that the Away Day had assisted in providing a renewed focus on this distinctive and unique PHA role. While there was agreement that smoking was the biggest single contributory factor in health inequalities, it was not evident that PHA was being particularly successful in addressing this matter. Members would ask Chief Executive for his view on how better PHA could tackle this issue.

Job Evaluation -Mr Mc Poland advised members that a Job Evaluation process had been activated with regard to the responsibilities of Director of Operations post, following the previous meeting. He further identified that exit interviews with departing HSC staff had identified pressure of work as the biggest single reasons for leaving. This was not PHA specific but he advised members that it could pose a threat to the stability of the HSC system if it were not properly addressed.

Governance- Difficulties had arisen within PHA about planning processes and Chief Executive had initiated action to address these. The Committee agreed that this was a matter of considerable importance in the context of a new Corporate Strategy being developed for the next 5 years.

The Chief Executive joined the meeting.

1 Impact on Inequalities

The Chief Executive agreed that smoking cessation was one of the most important areas on which to demonstrate progress. Smoking comprises 50% of the inequalities gap, smoking cessation and media campaigns are essential tools to having an impact. Constraints on media campaigns will impact the number trying to stop. He believed that there is strong international evidence from the World Health Organisation, as well as DHSSPSNI Strategy on Tobacco control and quit smoking features heavily in new public health policy. He identified for members that smoking cessation is amongst the largest investment areas for PHA. He agreed that a key challenge lies in trying to get the message out that out that smoking is not normal activity, especially among young people and preventing people from taking up smoking. There were still areas of policy and legislation which needed to be addressed to help improve public health including plain packaging for cigarettes and minimum pricing for alcohol.

In terms of PHA focus on key areas of investment to tackle inequalities he referenced the creation of 3 Programme Boards, modelled on the Child Development Programme Board which had been established early in the organisation's existence. The Local Government Programme Board would be convened following the appointment of Chief Executive's to new Shadow Councils and it was anticipated that this would be complete early in 2014. Cllr Ashe asked about evidence of good Local Government/PHA work outside of Belfast and the potential impact of community planning on that work. The Chief Executive recognised that there were particular difficulties in some areas but pointed out that this process could only work on a voluntary and agreed basis. He assured members that PHA was ready and willing to engage with all Councils as and when they were ready to participate.

With regard to the Older People's agenda, the Chief Executive reminded members that the Nursing Directorate was being assisted through a change process and that a little more time was needed to establish an Older People's Programme Board but he was confident it would be realised in 2014.

Dr. Harbison asked about the continued delay in the publication of a Draft Research and Development Strategy and the potential impact of such a delay on HSC evidence based studies as well as wider collaboration with our Universities. The Chief Executive recognised the continuing difficulties such delays at Departmental level created for the perception of the organisation but advised that as broad outlines were known we proceeded as best as possible.

Job Evaluation

Chief Executive advised members that he was working with Mr Mc Poland on a Job Evaluation review of the responsibilities of Director of Operations post, following the previous meeting. Members asked that this work be completed thoroughly and within a reasonable time frame. Members were reminded that secondment arrangements for Senior staff were due to end in 2014 but there was no indication from the Department of the time scale or certainty of this happening.

Mr Mc Poland left the meeting

Governance and Forward Planning

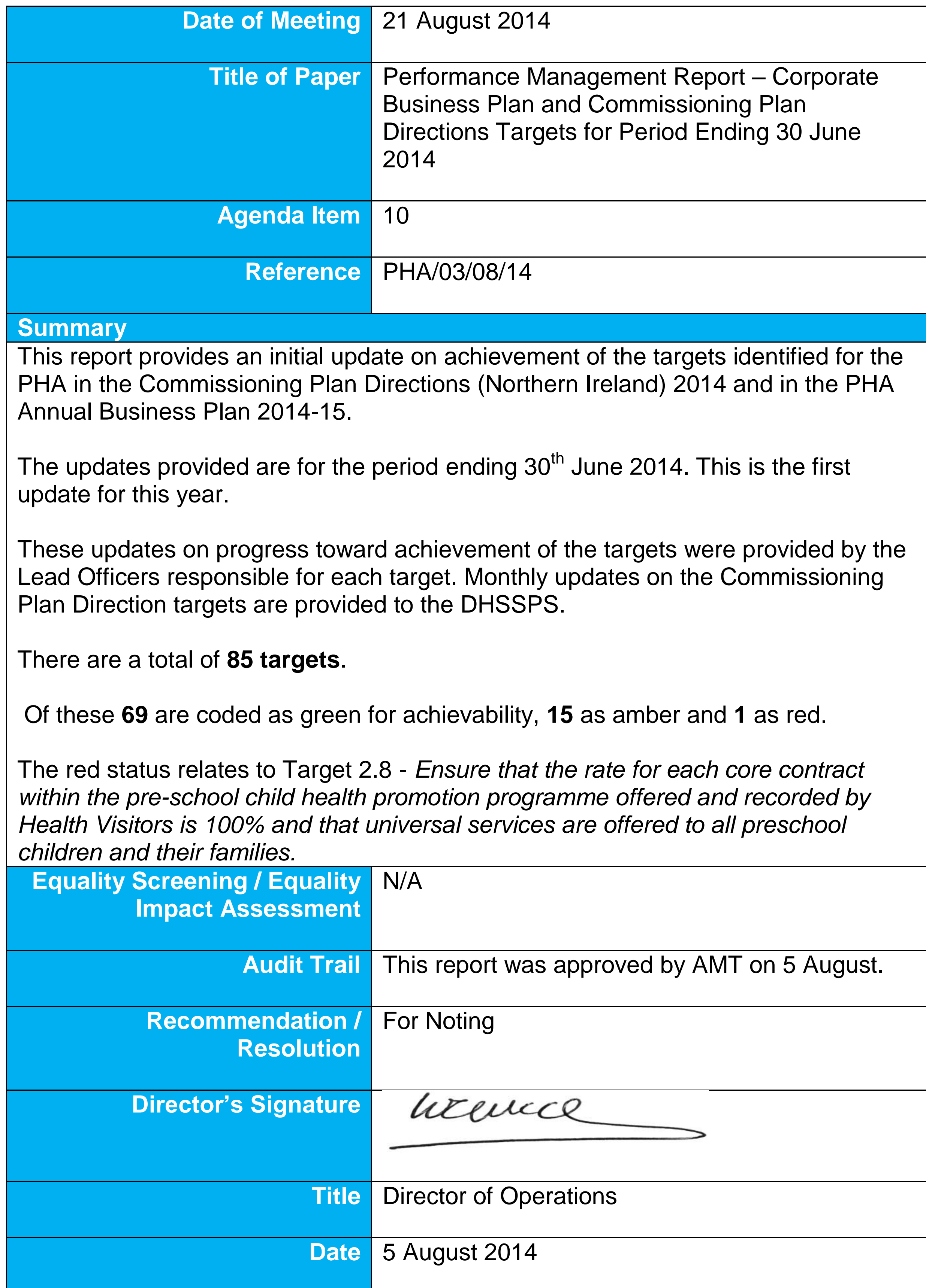
The Chief Executive advised members of the steps he had taken, and on which work was on-going, to address flaws in PHA planning processes which impacted on some aspects of programme delivery. External assistance had been sought and provided to assist this process which was critical to the development of a new 5 year corporate strategy in 2014-2015. He was satisfied that PHA Governance arrangements generally were robust and effective.

Other

The Chief Executive reported on steps he had taken with DHSSPSNI and HSCB following on from the Away Day discussions on Health Inequalities and PHA role in Commissioning.

The Chief Executive left the meeting

The Committee considered the Chief Executive responses to matters raised and were satisfied that this mid-year appraisal was satisfactory in all respects.



Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 30 June 2014
Agenda Item	10
Reference	PHA/03/08/14

Summary

This report provides an initial update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2014 and in the PHA Annual Business Plan 2014-15.

The updates provided are for the period ending 30th June 2014. This is the first update for this year.

These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

There are a total of **85 targets**.

Of these **69** are coded as green for achievability, **15** as amber and **1** as red.

The red status relates to Target 2.8 - *Ensure that the rate for each core contract within the pre-school child health promotion programme offered and recorded by Health Visitors is 100% and that universal services are offered to all preschool children and their families.*

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was approved by AMT on 5 August.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	5 August 2014

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Commissioning Plan Directions &

Corporate Business Plan 2014 - 2015

June 2014

Overview

This report provides an initial update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2014 and in the PHA Corporate Business Plan 2014-15.

The updates provided are for the period ending 30th June 2014. This is the first update for this year.

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1. PROTECTING HEALTH

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
1.1) Successfully implement the 2nd phase of the children's seasonal flu immunisation programme by achieving a 60% uptake rate for all pre-school children aged 2 years old and over and a 75% uptake rate for all primary school children	Detailed planning is on-going with all the Trusts and Integrated care for the primary care aspects. Additional staff are being appointed by Trusts and the Child Health Computer system is being updated. Training is being organised for primary care and school health staff. Arrangements have been put in place for distribution of vaccine to schools. A launch for the school based programme has been planned for early September. Specific leaflets have been produced for the different groups.	*G*				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
1.2) **Secure a further reduction of 9% in the total of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and of in-patient episodes of MRSA bloodstream infection compared to 2013/14.** **(DHSSPS Commissioning Directions target)**	This HCAI reduction target is a composite target comprising individual Trust reductions in MRSA and CDI cases to be delivered during 2014-15. The regional CDI position is slightly above trajectory for delivery at 30th June – 76 cases have been reported compared to an upper trajectory limit of 72 cases for the 3 months Apr - June. Within this regional position two Trusts (Northern & South-Eastern) are below their individual trajectory limits. The other three Trusts are slightly above their individual trajectory limits. The regional MRSA position is slightly above trajectory for delivery at 30th June - 13 cases have been reported compared to an upper trajectory limit of 12 cases for the 3 months Apr - June. Within this regional position three Trusts (South-Eastern & Western) are on or below their individual trajectory limits. The other three Trusts are above their individual trajectory limits – Belfast Trust 5 cases (limit = 4), Northern Trust 4 cases (limit = 3) and Southern Trust 2 cases (limit = 1 case).	*A*				The MRSA position was discussed at CMO/Medical Leaders Forum meeting on 24th Feb and at DPH/Med Directors meeting on 10th Mar 14. PHA is leading a short-study of MRSA across all Trusts. This work will identify areas for focus and targeted improvement going forward. Peer group analyses were shared and discussed in detail with Lead Directors/teams in all Trusts during Apr/May. Each Trust has identified areas for improvement in MRSA prevention to be taken forward as a priority during 2014-15. An MRSA improvement workshop will be held in Autumn.
1.3) Test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruptive events	Testing and servicing arrangements to respond to emergencies is a continuing on-going process.	*G*				

2. IMPROVING HEALTH AND WELLBEING & TACKLING HEALTH INEQUALITIES

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.1) Develop a strategic level implementation plan supported and agreed by a Regional Project Board and local strategic partnerships, to take forward implementation of the Public Health Strategic framework (Making Life Better.)	DHSSPS wrote to PHA asking for Regional Project Board to be established after the summer. Meetings have been held with District Council Chief Executives. A letter will be issued to Chief Executives by 21/08/14, to highlight the need to have these meeting completed before the end of September 14. Recruitment of Project Manager is underway.	G				
2.2) Provide a summary report of how the PHA have used the NICE public health guidance published up to end March 2014 to improve the health of the population of NI through its health improvement, health protection and service development functions. Following the establishment of a Regional endorsement process the PHA will also highlight for priority endorsement those pieces of recent guidance which have already been published.	In respect of the implementation of the NICE guidelines on **Improving diet, physical activity and weight loss,** the PHA has identified specific areas of work which include: • Give children a healthy start in life; • Improve community access to healthy affordable food; and, • Increase peoples' skills in maintaining a normal weight through good nutrition and physical activity. Regarding the **Stop Smoking** guidelines, the PHA has been at the fore in ensuring that smoking cessation support is available for smokers who want to quit, protecting non-smokers from the dangers of second hand smoke, and helping to ensure that young people don't start smoking. The PHA has been working with the Trusts to develop	G				

	new or enhance existing specialist smoking cessation services for pregnant women. The **Reduce Alcohol Intake** guideline is currently being delivered by the PHA under the themes outlined in the New Strategic Direction. PHA facilitates partnership working at HSCT and Voluntary/Community Sector level and undertakes a number of specific programmes. The key operational areas for the implementation of the guidelines are around a number of key population age groups and specific settings including: • Education and Prevention programmes on a universal basis and targeting those at risk; • Young People's Early Intervention and Treatment Services; • Family support and specialist treatment services for those affected by Hidden Harm; • Piloting of One Stop Shops; and, • Inpatient treatment provision in the NHSCT.					
2.3) With the HSCB, (a) make an action plan and (b) deliver on the outcomes in the implementation plan for the 'Making it Better Through Pharmacy Services in the Community' Strategy.	DHSSPS has convened a meeting of the implementation steering group for 17 September '14, at which the action plan for the strategy will be discussed and agreed. After this, PHA and HSCB should be in a position to begin to consider the actions required and to agree the steps required for implementation and delivery of strategy.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.4) Work with the HSCB to progress the programme of training and accreditation for health plus pharmacies during 2014/15 and agree priorities for commissioning public health services through these pharmacies during 2015/16.	The PHA and HSCB have established the Health + Pharmacy Alliance. A training programme has been developed and successfully delivered to the first phase of pharmacists and health advisers. An accreditation process has been drafted but is awaiting final approval due to difficulties on criteria for acceptable merchandise at risk of contradicting NICE guidance. Discussions are still on-going on the issue. A draft evaluation framework has been prepared. Draft communication materials have also been prepared. A directory of other relevant training has been developed.	A				
2.5) Pilot and monitor the roll-out of two brief alcohol intervention programmes in two different settings outside the health and social care sector, with appropriate arrangements in place for subsequent evaluation.	Criminal Justice sector based proposal progressing. Acute hospital based service development proposal agreed 'in principle' by Hospitals Related Commissioning Group. Awaiting decision re potential additional funding – 2yr incremental service development proposal agreed to build upon existing services already in place within Trusts.	A				Criminal Justice Setting on track for delivery. Difficulty in securing an additional setting outside of HSC due to poor evidence base in other settings and competing pressures due to need to implement commissioning framework. (2.19 target from business plan) Delivery of brief intervention programmes in acute hospitals dependant on funding being secured for expansion of existing service

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.6) Provide the Department with a written progress report on the implementation of the recommendations arising from the National Confidential Inquiry into Suicide and Homicide (NCISH) report on its longitudinal study into suicide in Northern Ireland.	Recommendations being implemented: • ***Maintain services for dual diagnosis patients and the use of CTOs***- CTOs are not available in NI. Dual Diagnosis services are available. Being subject to STO would not exclude access to dual diagnosis service if clinically indicated; • **Address economic difficulties of patients who might be at risk of suicide** - Social circumstances such as housing /debt /employment included in PQC risk assessment and management process. C&V sector advice agencies widely available and accessed / signposted when appropriate as part of risk management/support planning; • ***Improve safety in CRHT–live alone or refuse treatment*** - Living alone is noted as risk indicator in PQC. HSCB is currently undertaking an audit of CRHT in all trust areas; • ***Vigilant about the risk of suicide from opiates – check access to opiates -*** Use of prescription and non-prescription meds is a core component of needs and risk assessment processes. Integrated care pathways describe best practice prescribing for specific conditions across primary and secondary care. Addiction and substitute prescribing services available; • ***Continue safety focus on wards, including measures to prevent absconding and ensure safe detention -*** Inpatient AWOL procedures are in place. Individual breeches / failures are addressed through SAI review process. No current indicators of regional systemic failure in this regard. Trust specific issue subject to level 3 SAI independent review; • ***Strengthen specialist services and risk management for patients misusing drugs or drugs -*** Statutory Addictions and Substance Misuse services are using PQC risk assessment and management tools. Review of Tier 4 addictions service completed;	A G A G G A NA A				

	• ***Use CTOs more effectively*** - Not available in NI; • ***Assess risk of violence to spouse and family members -*** Risk of violence to others included in PQC framework. Think Family Project addresses the needs of children and young people as a priority.MH services enjoined in MARAC processes for joint agency management of Domestic Violence; • ***All inpatients, including younger inpatients are included in reviews of physical health and poly pharmacy -*** Review of physical health monitoring guidance and clarification of responsibilities on-going; • ***Introduce or maintain assertive outreach services -*** Assertive outreach function is included in the Core Mental Health Care Pathway for all MH services. IEAP also addresses assertive outreach function at the point of referral. There would be concern that a stand-alone service for assertive outreach would a) encourage a culture where individual practitioners or services could abrogate their responsibilities for their patients; b) create yet another service interface and all the associated communication, delay, lost to service risks; • ***Engage in the debate about public concern about the risk of homicide and the limits of prevention by mental health services*** - HSCB/PHA are participating in the discussions around the new Protect Life Strategy.	R A A				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
Give Every Child the Best Start in Life						
2.7) Improve long-term outcomes for the children of teenage mothers by continuing to roll out the Family Nurse Partnership Programme, by expanding to the two remaining Trusts and rolling out the new Information System.	The Northern and South Eastern Trusts are in the preparatory phase for the establishment of two new Family Nurse Partnership Teams. Both Trusts have arranged staff awareness information days. The Trusts are also establishing their local Family Advisory Boards and the first meetings of this local stakeholder forum will be in September. When Trusts receive financial allocation letters, team recruitment can begin. The information system is in the final stages of development. The system is live and all the Family Nurses are using either the desktop or tablet version. The development of the reports is currently underway. Hewlett Packard have raised concerns about their capacity to finish the project within the current resource.	A				Some additional resources may be required. Discussions with Hewlett Packard are underway to understand the issues and agree a solution.
2.8) Ensure that the rate for each core contract within the pre-school child health promotion programme offered and recorded by Health Visitors is 100% and that universal services are offered to all preschool children and their families.	100% compliance with CHPP will not be achieved this year. Improved compliance is expected year on year against DHSSPS IoP. DHSSPS targets against each core contact are expected to commence next year. Arrangements have been agreed with DHSSPS, RUAG, BSO and Trusts to facilitate the collection of Child Health Promotion Programme (CHPP) on a quarterly basis using regionally agreed data tolerances. Reports using regionally consistent data are expected from September 2014. Work force planning issues affecting capacity to deliver 100% of CHPP contacts are being addressed, including the recruitment of additional Student Health Visitors and permanent Health Visitors into vacant posts.	R				Compliance with CHPP is on HSC Trust Risk Registers; Discussions with DHSSPS, HSCB & PHA colleagues to secure additional funding as outlined in Pressures funding applications in order to improve CHPP compliance; Assurances to be sought from Directors of Children's Services at Bi-monthly monitoring meeting (Chairperson: Michael Bloomfield); Standing item on Healthy Futures Programme Board meetings.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.9) Take forward the commissioning of health visiting services within Trusts, to ensure that the services in place reflect the model of service detailed within the Departmental Strategy, 'Health Futures	PHA AD Public Health Nursing &, Nurse Consultants working with Trusts to ensure that plans are in place including the recruitment into permanent vacancies using all available Student Health Visitors on this year's course into permanent posts. Regional guidance being developed regarding competencies for Band 5 Public Health Nurses to support the health visiting workforce.	A				Funding for backfill relating to additional student Health Visitor placements for 2014/15 course being negotiated; Recruitment of Health Visitors and School Nurses and vacancy levels will continue to be monitored; Information software is being developed that will support caseload management, performance monitoring and commissioning against Healthy Futures.
2.10) Support implementation of the Early Intervention Transformation programme and parenting programs under Delivering Social Change (DSC).	EIS proposals have been sought and secured from five Health and Social Care Trust localities and related stakeholder workshops have been organised.	G				
2.11) Roll out of Infant Mental Health training to HSC and early years workforce.	Infant Mental Health Training is on scheduled. Regional Plan launch date set for 22 September 2014.	G				
2.12) Coordinate implementation of the Breastfeeding Strategy for Northern Ireland.	Continuous progress being made via the workstrands of Breastfeeding Strategy Implementation Steering Group.	G				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
Ensure a Decent Standard of Living						
2.13 Develop and implement programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services, including delivery of the detailed action plan for the MARA programme.	Locality contracts for poverty programmes in place with locality teams. MARA project progressing as planned with all locality offices now engaged.	G				
2.14) Support the Building Shared Communities programme of DSD and the associated work in 6 pilot sites.	PHA are participating in the Building Successful Communities Programme Board and have engaged with the six local areas, five of which are located in Belfast. Plans are at an early stage but seek to link the quality of life objective with improving health and wellbeing alongside improvements to physical infrastructure, in particular housing.	G				
Build Sustainable Communities						
2.15) Develop the skills and capacity of social enterprises and communities to respond to HSC procurement opportunities, including exploration of social clauses and community benefit plans.	Representatives of Operations and Health and Social Wellbeing Improvement have met with colleagues from HSCB, BSO and HSC Trusts to discuss a co-ordinated approach to social clauses and community benefits. A paper outlining social clauses to be included in all contracts will be issued in due course.	A				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.16) Take forward with partners the PHA approach to healthy ageing including: reducing isolation; signposting and referral to services; falls prevention; and health and wellbeing improvement programmes.	Each locality is working with LCGs and Trusts to agree a shared model and investment programme aimed at reducing social isolation. All localities are delivering falls prevention programmes that meet NICE guidelines and continue to influence the development of age friendly communities.	G				
2.17) Contribute to the implementation of the Learning Disability Healthcare and Improvement action plan. The PHA will also establish and lead a new Regional Learning Disability Health Care and Improvement Steering Group to progress the impact of the Directly Enhanced Service (DES) providing for an annual health screening for every person with a learning disability. This group will ensure the application of evidenced based care, oversee the standardisation of practice across all providers and evaluate progress being made.	The Regional Health and Social Wellbeing Improvement Forum (RHSWIF) and Regional Health Facilitator Forum (RHFF) have developed two-year workplans to deliver and implement the recommendations and actions contained in the regional learning disability Health Care and Improvement Steering Groups Action Plan. A Regional Learning Disability Healthcare and Improvement Steering Group has been established with PHA/HSCB providing strategic leadership and joint monitoring of the implementation of recommendations from the evaluation of the Directed Enhanced Service (DES).	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.18) Implement the DARD Farm Family Check scheme to meet the needs of farmers and their families in rural areas.	Since 1 April 2014, 756 clients have presented for a health check. Of those clients 381 (50.4%) were advised to see their GP, 67% referred to the MARA project and 146 expressed an interest in attending a farm safety course.	G				
Make Healthier Choices Easier						
2.19) Commission drug and alcohol services across all 4 tiers of provision to support implementation of the New Strategic Direction on Alcohol and Drugs 2011-16 and the PHA/HSCB Drug and Alcohol Commissioning Framework 2013-16	Commissioning Framework Consultation completed. Actions being taken forward to implement the framework include; 1. Business cases and service specifications currently being developed for AMT approval. New contracts to be in place by 1st April 2015 2. Review of Tier 4 in-patient services completed, including public consultation (Jan 2014). HSC.Board endorsed revised proposals based upon a 3 site/30 bed arrangement – aim to initiate new regional Network process early 2015. 3. A review of Tier 3 (community based) specialist services is being initiated – progress to be updated later in 2014. 4. Acute hospital based service development proposal agreed 'in principle' by Hospitals Related Commissioning Group. Awaiting decision re potential additional funding – 2yr incremental service development proposal agreed to build upon existing services already in place within Trusts	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.20) Develop and implement the Hidden Harm Action Plan.	Regional and local delivery on track.	G				
2.21) Implement the DHSSPS Tobacco Strategy including Brief Intervention Training, smoking cessation services, enforcement control and public information.	On target. New training services scheduled to be commissioned from 2015-16 in line with the new Training Framework for Smoking Cessation. Smoking cessation services are being delivered across the region and the quality monitoring of services in community pharmacy has produced significant improvement in quit rates. The Tobacco Enforcement work delivered by Council's is progressing well and further plans for public information on tobacco are being developed.	G				
2.22) Implement the DHSSPS Obesity Strategy including, weight management programmes for children, adults, and pregnant women; development of a common regional Physical Activity Referral programme; implementation of Active Travel programme in schools; and public information.	Tendering process underway for weight management programmes. Pilot programme for pregnant women is operational. Year one programme of 'Active Travel' has been delivered, schools currently being recruited for year two.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.23) Develop a commissioning plan with agreed standards and commission a range of mental health promotion and suicide prevention services.	Commissioning plan progressing in line with procurement protocols. Standards complete. Timetable remains uncertain due to procurement process.	A				

3. IMPROVING THE QUALITY OF HSC SERVICES

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.1) Implement the Quality 2020 Strategy across the agreed work streams and publish both a PHA Annual Quality Report for 2013/14 and, with HSCB, a 2013/14 Annual Quality Report for the HSC sector.	A draft annual quality report has been developed and will be ready to go to the Q2020 steering group and other relevant committees by September 2014	G				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.2) **Continue to lead and monitor the programme of work, and delivery of care, to develop and implement Normative Nurse Staffing including:** **•develop normative staffing ranges for district/community nursing with minimum data sets and monitoring arrangements developed** **•apply the Normative Nurse Staffing Tool to all inpatient and specialist adult hospital medical and surgical care settings** **•develop and introduce Normative staffing ranges for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy Healthy Futures.** **(DHSSPS Commissioning Directions target)**	*Phase 1 – Medical and Surgical wards* A final paper was presented at SMT in June. An exercise is underway to determine funding implications for implementation. A launch date is being agreed with CNO. Communication is underway to get NICE endorsement of the NI toolkit. PHA Communications staff are working on final publication *Phase 2 - ED* A masterclass took place in June and an option appraisal has been presented to the Steering Group on 23 June. *Phase 3 – District Nursing* Aim is to have this phase completed by March 2015. First draft of a literature review has been received from the University of Ulster. Data collection is on-going. Date has been agreed with Keith Hurst to visit in July for a further workshop. *Phase 4 – Health Visiting* A draft report including academic editing is underway to include the evidence base from the UK. This will be shared with the working group in June. Normative Health Visitor caseload range being developed and will inform normative Health Visitor staffing levels.	A				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.3) Develop, with the HSCB, the regional e-health and care strategy to support transitional change in how and where care is delivered reflecting public health, nursing and other priorities.	The E-health and Care Strategy has been drafted and will be released for public consultation Mid-September with the view to being published in Spring 2015.	G				
3.4) **Deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. (DHSSPS Commissioning Directions target)**	At the end of June 2014 a total of 128,081 Monitored Patient Days have been delivered to 1,645 patients. On that basis it is anticipated that the regional Target is on track to be achieved.	G				
3.5) **Deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract. (DHSSPS Commissioning Directions target)**	At the end of June 2014 a total of 224,216 Monitored Patient Days have been delivered of target) to 2,770 patients. We have exceeded the target for approximate number of patients by 470 patients – whilst it is anticipated that the regional Target is on track to be achieved, there will be limited scope for any further increase in the number of patients.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.6) Support the development of a highly trained professional workforce with adherence to appropriate standards and robust accountability arrangements	PHA supports fully the development of a highly trained professional workforce. Specifically, PHA Medical Director/DPH and the Director of Nursing and AHPs meet regularly with professional colleagues in DHSSPS, Trusts, under and post graduate training bodies, professional organisations and RQIA as the regulator. Related work is proceeding through a range of mechanisms, notably the implementation arrangements for Q2020.	G				
3.7) Promote the use of PEWS across Paediatric settings and provide a report to the Department on progress towards agreed regional system(s) in paediatric settings.	Draft PEWS agreed and being tested by Trust teams	G				
3.8) Produce a report assessing the impact of the work undertaken by the Safety Forum to promote and ensure compliance with the use of VTE risk assessment in hospitalised patients and report to the Department.	Draft report written regarding Safety Forum's role in VTE risk assessment which finished in 2012. Will finalise and share before sending to Department	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.9) **Assist the Department to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements (DHSSPS Commissioning Directions target)**	The PHA has met with the DHSSPS and provided comments and assistance in relation to the development of the regional survey of inpatient and A&E patient experience. Throughout 2014/15 The PHA will continue to provide any assistance to the DHSSPS in relation to the analysis of the survey results. In addition, the PHA has worked with HSC Trusts to develop a comprehensive improvement patient experience programme of work for 2014/15 to complement and support the DHSSPS regional survey. At this time we believe the target will be achieved	G				
3.10) Continue the roll out and implementation of the 10,000 Voices Project, providing strategic direction, collaborating with HSC Trusts regarding implementation of outcomes and producing an Annual report.	The first phase of 10'000 Voices, which focused on unscheduled care, has been completed. The results have been analysed in collaboration with HSC Trusts, both local and regional reports are currently in draft and will issued by September 2014. A nursing and Midwifery KPI survey has been developed and is currently running in conjunction with phases 1 & 2. Phase 2 of the initiative focuses on care in your own home and commenced in April 2014. The results from phase 2 and the nursing and midwifery KPI survey will be analysed in conjunction with HSC Trusts and a report developed. At this time we believe the target will be achieved.	G				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.11) Establish a process to monitor and demonstrate improved outcomes based on the four key regional priorities identified in the Public Health Agency Annual report (2013/14) Patient Experience Standards	A process has been agreed with the HSC Trusts to monitor and demonstrate improvement outcomes based on the four key regional priorities identified in the Public Health Agency Annual report (2013/14). At this time we believe the target will be achieved	G				
3.12) Take forward the Mixed Gender Accommodation work which provides assurance of gender segregation in inpatient accommodation based on an agreed regional policy statement on gender segregation / gender appropriate accommodation which will be developed in partnership with DHSSPS	A regional policy statement has been developed in conjunction with the DHSSPS, this is currently in draft and will be issued to HSC Trusts. An assurance template for scoping the management of mixed gender accommodation has been agreed and is due to be issued to Trust. At this time we believe the target will be achieved	G				

Target from Corporate Business Plan	• Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.13) Lead the Regional implementation of the DHSSPS Promoting Good Nutrition Strategy and lead a process across Trusts to identify the percentage of patients who have nutritional screening undertaken within 24 hours of admission to hospital.	• Promoting Good Nutrition Regional Steering Group meet regularly • Work plan is well underway and will have a focus on protected mealtimes and food first • Promoting Good Nutrition will continue to link with the specialist services team members to progress the regional model for parenteral nutrition. • Trusts continue to implement the 10 key characteristics across services • A scoping exercise of progress of implementation of the 10 key characteristics across all Trusts and representative organisations has been completed. • Regular meetings have been held with CNO regarding the three strands of Promoting Good Nutrition. In addition, further meetings between PHA and CNO have been arranged to discuss progress and how to advance this work.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.14) Continue to work with NIPEC and Trusts to agree and monitor key KPIs for nursing	The Public Health Agency and DHSSPS Chief Nursing Officer (CNO), through the Regional Nursing KPI Steering Group, has agreed those indicators on which Trusts will be required to report on in the coming year 2014/15; the purpose being to measure and monitor nurses contribution to the patient experience of care. These indicators have been developed using best evidence-based practice and research and agreed audit tools have been designed to measure compliance with processes indicating the level of outcomes achieved. It has been agreed that Trusts will report on compliance with the agreed regional KPIs to the PHA quarterly who will provide CNO with bi-annual reports. In addition a number of Key Performance Indicators for nursing and midwifery have been identified to assist us to measure, monitor and evidence the impact and contribution nursing	G				
3.15) Ensure adherence to statutory midwifery supervision	Final report awaited from NMC for the Mott MacDonald review of the PHA in March 2014. Draft report - all standards passed, but with some areas for improvement. Facilitation of CPD for SoMs continues along with multidisciplinary work with NIPEC around a toolkit and DVD/app - Midwives and Medicines. LSAMO following up with RQIA on legislative requirements for independent midwives. Quarterly returns to NMC/Mott MacDonald, annual report to NMC beIng prepared (new format), communication with FtP and registration as needed.	G				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.16) Lead on phase 2 of the review of AHP support for Children with statements of Special Educational Needs within Special Schools and Mainstream Education	Phase 2 of the review of AHP support for children with statements of special educational needs (SEN) is underway. Phase 2 is focusing on AHP support for children with statements of SEN enrolled in mainstream schools. Letters communicating the commencement of phase 2 have been sent from the Chair of the Project Board to Trust Chief Executives and ELB Chief Executives. A letter communicating the commencement of phase 2 has also been issued to mainstream schools from the Permanent Secretary for the Department of Education. Project Initiation Document and Engagement plan for phase 2 have been drafted and are with the Project Board for further consideration.	G				
3.17) Take forward any DHSSPS agreed actions for implementation within the Regional Learning System and continue to implement arrangements to support learning from SAIs throughout the region.	The Public Health Agency sit on the RLS Steering Group to agree actions for implementation within the Regional Learning System. The PHA work closely with the HSCB to continue to implement arrangements to support learning from SAIs throughout the region. This is done in a variety of ways for example learning letters, learning matters newsletter and bi-annual learning report.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.18) Take forward a program of quality improvement work including Safety Forum initiatives and Quality Improvement Plans.	All SF work streams progressing satisfactorily except Primary care work which has exhausted the non-recurrent funding for GP 1 day/week. All work streams beginning to suffer due to dramatically expanded workload over period 2011-2014 but no increase in resource.	A				
3.19) With HSCB, support the implementation of the Northern Ireland Maternity Strategy, including promoting safe and effective care.	The Maternity Strategy Implementation Group (MSIG) met in May 2014. This group approved the implementation action plan and agreed a number of actions to take forward the objectives in the Maternity Strategy. Several initiatives focusing on higher risk pregnancy have happened. A workshop for clinicians providing care for pregnant women with Diabetes took place in April with the outcome that each Trust would submit IPTs to secure funds to improve their compliance with the NICE Guidelines on Diabetes in Pregnancy. A draft regional pathway for Multiple Pregnancy has been developed and a successful workshop took place in June to progress this with Trusts, at the end of which each Trust had identified ongoing work needed to ensure closer compliance with the NICE Guideline on Multiple Pregnancy. It was also agreed to link in with the NIMATS work to ensure appropriate collection of data on Multiple Pregnancy to support ongoing monitoring. Development work on NIMATS has continued. It is now possible to generate data to populate most of the Robson Group categories; these provide a detailed breakdown of the profile of women who have a caesarean section and will be helpful in targeting variation in section rates in NI. Work is	G				

	also ongoing with RCOG to produce indicators for NI. The Community Maternity Services Review led jointly by PHA and NIPEC continues and has now engaged with nearly 1,500 women and professionals in the course of taking forward the objectives that the Review is focusing on. Focus group and survey data have been captured and an initial report on findings will be produced in summer 2014. The Scoping Report of Maternity Needs of Minority Ethnic and Migrant Women in Northern Ireland has been approved by HRSCG and AMT and has been forwarded to the Department. It will now be disseminated more widely. The review of antenatal education has been undertaken, examining current provision and carrying out focus groups with new parents to understand their needs. The MSIG has taken on the ongoing distribution of the Maternity dashboard information and the first circulation of this to trusts took place in June. It is intended that regional comparative data showing the position of each trust will be provided monthly to all trusts in the next few months. Maternity QI Collaborative continues with Trusts all producing Action Cards for initiatives they intend to take forward especially for promoting normality. The second learning set focused on Sepsis with excellent work presented on identifying and treating sepsis within maternity. The specific NI Early Warning score has been launched and shortly an antenatal CTG sticker and Vaginal examination sticker will be available for Trusts to use.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.20) Commission patient and carer education programmes for people with long term conditions, subject to funding.	An Action plan has been developed for implementation of the Long Term Conditions (LTC) policy framework. Subject to additional funds being made available there is an expectation to investment is additional patient education and self-management programs in cardiac, diabetes and respiratory conditions as well as commissioning generic self-management programs such as the Stanford model that could be offered to patients with other LTCs. **This development is subject to additional funds being made available to HSC.**	G				
3.21) Work with HSCB to take forward implementation of Service Frameworks specifically for cardiovascular, respiratory and cancer, where the PHA has the lead role.	**Service Framework for Cardiovascular Health and Wellbeing** – Revised Framework issued by DHSSPS on 25 April 2014. Plan for phased implementation sent to DHSSPS on 12 June & agreement given at the SFPB on 19 June to proceed with implementation plan **Revised Service Framework for Respiratory Health and Wellbeing –** the revised framework was shared with the DHSSPS on the 9 June without prejudice to the outcome of HSCB and PHA Board discussions on the 14 and 21 August respectively. The Framework will be issued for public consultation in September 2014. **Service Framework for Cancer Prevention, Treatment and Care –** Correspondence received from the DHSSPS on the 10 July asked that the HSCB and PHA undertake a fundamental review of this framework. Review plan to be submitted to the DHSSPS by 30 September.	G				

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.22) Work with HSCB to take forward relevant recommendations from the Hyponatraemia Inquiry Report and Francis Inquiry.	The report of the Hyponatraemia Inquiry has not yet been published. Themes/recommendations from the Francis Inquiry are being prepared through PHA work to support improvements in the safety and quality of HSC services.	G				
3.23) Take forward the introduction of self-referral physiotherapy in South Eastern Trust as an early implementer, and assess the outcomes of early implementation to inform a decision on whether and how to roll out self-referral physiotherapy to all Trusts. (This will be dependent on improved performance, on the basis of current access arrangements, against the 9 week target.)	• Project has been presented at SE LCG & received LCG support on 15th May • IPT has been submitted to commissioning Board for approval. • SET in state of readiness • Awaiting allocation of TYC funding to enable Trust to recruit staff	G				
3.24) Take forward the implementation of independent prescribing within podiatry and physiotherapy, through the working group, agreeing the action plan and commencing implementation.	Independent prescribing legislation for Allied Health Professions has not yet been signed off in Northern Ireland. The first cohort of students, previously trained in supplementary prescribing, has been recruited to the independent prescribing module at the University of Ulster. This module, a top-up to supplementary prescribing, will commence in Sept 14.	A				

4. IMPROVING THE EARLY DETECTION OF ILLNESS						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		June	Sept	Dec	Mar	
4.1) Continue to improve informed choice in cancer screening (particularly amongst groups in greatest need.)	Good progress being made on implementing the Informed Choice Action Plan.	G				
4.2) **Introduce the extension of the Bowel Cancer Screening Programme to invite people up to the age of 74 years with a screening uptake of at least 55% in those invited. (DHSSPS Commissioning Directions target)**	Age extension was introduced from 1st April 2014. 13.6% of the eligible population were invited to participate in screening during quarter 1 (April – June 2014). Uptake is measured at 12 weeks and 6 months after the issue of an invite. The 12 week uptake for quarter 4 of 2013/14 (Jan-Mar) by trust is as follows: Belfast: 53.58% Northern: 61.36% South Eastern: 63.44% Southern: 50.36% Western: 56.81% Northern Ireland: 58.26%	G				
4.3) Complete the roll out of digital mammography.	Roll out of digital mammography on course to be completed by end of September 2014.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
4.4) Lead the implementation of the new UK Newborn Blood Spot Screening Programme standards.	Progressing developments to adopt revised UKNSPC standards	G				
4.5) Develop, in conjunction with the BSO and Trusts, the Child Health System (CHS) to a level where it can comprehensively report on activity across the Child Health Promotion programme (0-19 years). In addition, put in place mechanisms to ensure timely and continuous update to the CHS to reflect changes within the child health promotion programme.	In 2014/15 the planned work program is 1. Support changes to the immunisation schedule for influenza and HPV 2. Build an electronic interface with C2k in Department of Education and eliminate the need for manual data entry of school attended in P1 and Year 8. All pupils will be notified of this change via an information leaflet to be distributed via schools and a data sharing agreement between CHS systems and Education information system is being finalised 3. Amend CHS software so that records of children who are adopted can be retired and information transferred to new record with new health and care number 4. Test electronic interface between CHS and laboratory for bloodspot screening 5. Put CHS in the Data warehouse starting with Modules 1 and 3.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
4.6) Implement actions allocated to the PHA arising from the agreed Community Resuscitation Strategy for Northern Ireland.	An IPT for in-year investment in Community Resuscitation (CR) has been sent to the Ambulance service asking them to be the single provider of community resuscitation services. PHA will participate in regional group to be convened by NIAS to oversee developments in CR. PHA will work with PMSI to develop a dataset using existing information systems to monitor outcomes of Out of Hospital Cardiac Arrest OHCA)	G				

5. USING EVIDENCE, FOSTERING INNOVATION AND REFORM

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
5.1) Publish the new HSC R&D Strategy and its implementation plan including metrics to assess success of implementation.	Strategy not yet issued for consultation by DHSSPS, implementation plan to follow	A				Implementation plan to follow
5.2) Consolidate the infrastructure for accessibility of routinely collated datasets and support the establishment of the Administrative Data Research Centre & Honest Broker service for HSC research purposes.	On-going active support being given to all such initiatives through committee membership and liaison with key stakeholders	G				
5.3) Support researchers to secure research funding from external sources including NIHR evaluation, trials & studies co-ordinating centre (NETSCC), Horizon 2020 & US Ireland Partnership.	On-going support and initiatives to improve applications and success rates	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
5.4) Work with HSCB to promote a research culture in Social Care and work towards commissioning a call in Social Care Research.	There have been a number of opportunities identified and planned activity to promote social care research and work towards commissioning a call in Social Care is on track	G				
5.5) Work with stakeholders to explore themes for a potential call in obesity research.	Active engagement with PHA colleagues through membership of obesity leads group to identify areas for future research	G				
5.6) Work with stakeholders to explore themes for a potential call in Suicide research.	Active engagement with stakeholders in NI and national funding partners on-going	G				
5.7) Ensure the delivery of a commissioned research to evaluate Telemonitoring NI.	Project is progressing on schedule within the revised timeframe	G				

6. DEVELOPING OUR STAFF AND ENSURING EFFECTIVE PROCESSES

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.1) Review the existing PHA Corporate Strategy and develop a new PHA Corporate Strategy for the next 4 years.	While the publication of the next PHA Corporate Strategy will be put back to align with NI Executive timescales (as per DHSSPS advice), work has commenced on the development of the PHA corporate priorities and subsequent development of the corporate strategy (2016 – 2020). The PID was approved by PHA board (19 June 2014), with the first meeting of the project board (chaired by Dr J Harbison) on 27 June 2014	G				
6.2) Continue to take forward actions to embed a culture which places value on staff, ensures clear and known organizational priorities and establishes a clear, transparent leadership and accountability framework.	Team meetings, Team development events, OWD working group, dissemination of information via Connect, E-learning and bespoke training developed and implemented. Health & Well-being Group established. Involvement of staff in development of Annual Business Plan and dissemination to all staff about the ABP and progress.	G				
6.3) Ensure that by 30th June 2014 90% of staff will have had an annual appraisal of their performance during 2013/14.	As at June 30th 2014 approximately 95% of PHA had received their annual appraisal for 2013/2014.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.4) Ensure that by 31 March 2015 100% of doctors working in PHA have been subject to an annual appraisal.	On target. All doctors in PHA undergo annual appraisal every year in line with DHSSPS guidance.	G				
6.5) Reduce or maintain staff absence rates to 3.75%	The cumulative staff absence rate for the PHA for the period April – June 2014 was 2.24%	G				
6.6) Work through the ICT programme board (in conjunction with NIPEC) to meet the recording care requirements for nurses and midwives to work effectively within the integrated system of care.	Work is moving forward through a regional clinical noting group that has been set up by the E-Health and Care Directorate, HSCB. Claire Buchner, Informatics Nurse Consultant, is the link to this group.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.7) Continue to lead on the implementation of PPI policy across the HSC and produce a report summarising best practice in PPI across all HSC bodies, as well as identifying any barriers to effective personal and public involvement and means of overcoming same.	The PHA continues to provide leadership on the implementation of PPI policy across HSC, primarily through work with the Regional HSC PPI Forum. A number of work streams are being progressed including: • PPI Training – Design & development of a HSC wide generic PPI training programme has been commissioned. • Forum Action Plan / Communications Plan - This facilitates the identification and sharing of best practice and co-operation to address common issues in respect of PPI. • Research – the PHA has commissioned research into the identification of barriers to involvement and ways of overcoming this. The PHA also has an internal PPI Action Plan which includes a number of actions which are being progressed, including: 1.The Establishment of a PHA PPI Leads Group (completed) 2.The Development of internal PHA PPI Monitoring and Performance arrangements (Underway). 3.Provision of professional advice/guidance on PPI (On-going) 4. Development of PPI tools (On-going)	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.8) Pilot a model to monitor PPI compliance across HSC in accordance with the agreed PPI Standards	The PHA has developed indicative process based PPI Standards and associated KPIs which the DHSSPS has endorsed and is finalising the development of indicative outcome based PPI standards and KPIs for Departmental consideration. The PPI Standards form the basis of the Monitoring and Performance Management Templates and processes for both internal and external monitoring. Internal An initial pilot monitoring and performance management template was developed for use in the process. Returns from across the various PHA Divisions have been reviewed and analysed. The findings have informed a review of the template and monitoring arrangements. These are being updated in partnership with the Divisional PPI Leads before being taken to AMT for consideration and authorisation to deploy from the Autumn of 2014. External The Monitoring and Performance Sub-group of the Regional HSC PPI Forum, has worked with the PHA in the development of a draft monitoring and performance template and arrangements which are aligned to the PPI Standards. This has been piloted with HSC Trusts and after review and analysis, is being updated, before being taken to AMT for consideration and submission to DHSSPS for formal departmental endorsement and issue. It is anticipated that the monitoring & performance programme will commence in Autumn 2014.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.9) Achieve substantive compliance with the information management controls assurance standard.	Following the assessment of the information management CAS for 2013/14 (substantive compliance), an action plan has been developed to identify any gaps and the necessary work that needs to be undertaken to address these, and therefore improve the score for 2014/15. The action plan will be discussed at the next Information Governance Steering Group (September 2014).	G				
6.10) Carry out an independent evaluation of the Board governance arrangements in line with DHSSPS requirements.	The PHA is awaiting guidance from the DHSSPS on the proposed independent evaluation of the Board governance arrangements. The PHA will comply with the guidance, working with the independent evaluators.	G				
6.11) Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	The PHA is currently updating the corporate business continuity plan in line with the new standards, and to ensure that it remains up to date. The BCP will be tested once the initial review is complete, with further refinement as necessary.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.12) Continue to ensure that business cases are prepared for capital/revenue/external consultancy expenditure in line with Departmental guidance, and approved within the Agency structures or submitted to the Department where appropriate in line with delegated limits, on a timely basis. An annual assurance that effective processes are in place for the production of business cases will be brought to the PHA Board.	Updated and revised business case guidance was brought to AMT 20 May 2014 and subsequently issued to staff and placed on the Connect, reminding them of the correct processes. Advice continues to be provided by Finance and Operations Directorates.	G				
6.13) Establish a process by June 2014 to provide assurance to the PHA board that the PHA has adopted and maintained good procurement practice in line with DHSSPS requirements, and report to the board accordingly in September 2014 and March 2015.	The PHA SFI set out the required processes for procurement. The SODA was updated in 13/14, and the e-procurement system ensures that only authorised staff can order and approve. Single Tender Actions must be approved by the Chief Executive or Director of Operations, following PALS advice; monitoring reports on STA are brought to GAC (last report was brought to GAC in June 2014). Social care procurement continues to be developed, with reporting the PHA procurement board. Reports on progress against the procurement plan are also brought to the PHA board on April 17th 2014.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.14) Prepare and submit a Property Asset Management Plan, in line with Department requirements.	The PAM plan was approved by AMT (6th May 2014) and submitted to DHSSPS in line with the required timescales. Following DHSSPS queries, a revised plan was submitted in July 2014.	G				
6.15) Prepare and submit a Sustainable Development Report, in line with Department requirements.	A sustainable development report, in line with Department requirements was submitted to the DHSSPS within the required timescales	G				
6.16) Continue to implement the PHA Procurement Plan.	PHA continues to work with PALS and Legal Services to progress the procurement plan in line with the relevant regulations. It is anticipated that the RSE tender will be advertised early August 2014.	A				PHA continues to liaise closely with both PALS and DLS, to progress queries, and to finalise the documentation.
6.17) Continue to manage and review PHA facilities, in particular ensuring arrangements are in place to manage the end of the lease for Anderson House, and to put appropriate arrangements in place for the management of 21 Linenhall street	*Anderson House lease reviewed, SOC prepared and preferred option to retain agreed by Agency management Team given pressures in Gransha Park. Awaiting DHSSPS approval.* *Negotiation of lease, business case for resourcing and condition appraisals under way for 21 Linenhall Street.* PHA is working with other regional organisations to procure a new facilities management contract for all Belfast properties.	A				PHA is currently liaising with LPS to identify proposed new rental terms for Anderson House, prior to resubmitting for DHSSPS approval. PHA continues to liaise with LPS, Health Estates and the proposed new landlord, to progress the proposed new Belfast accommodation

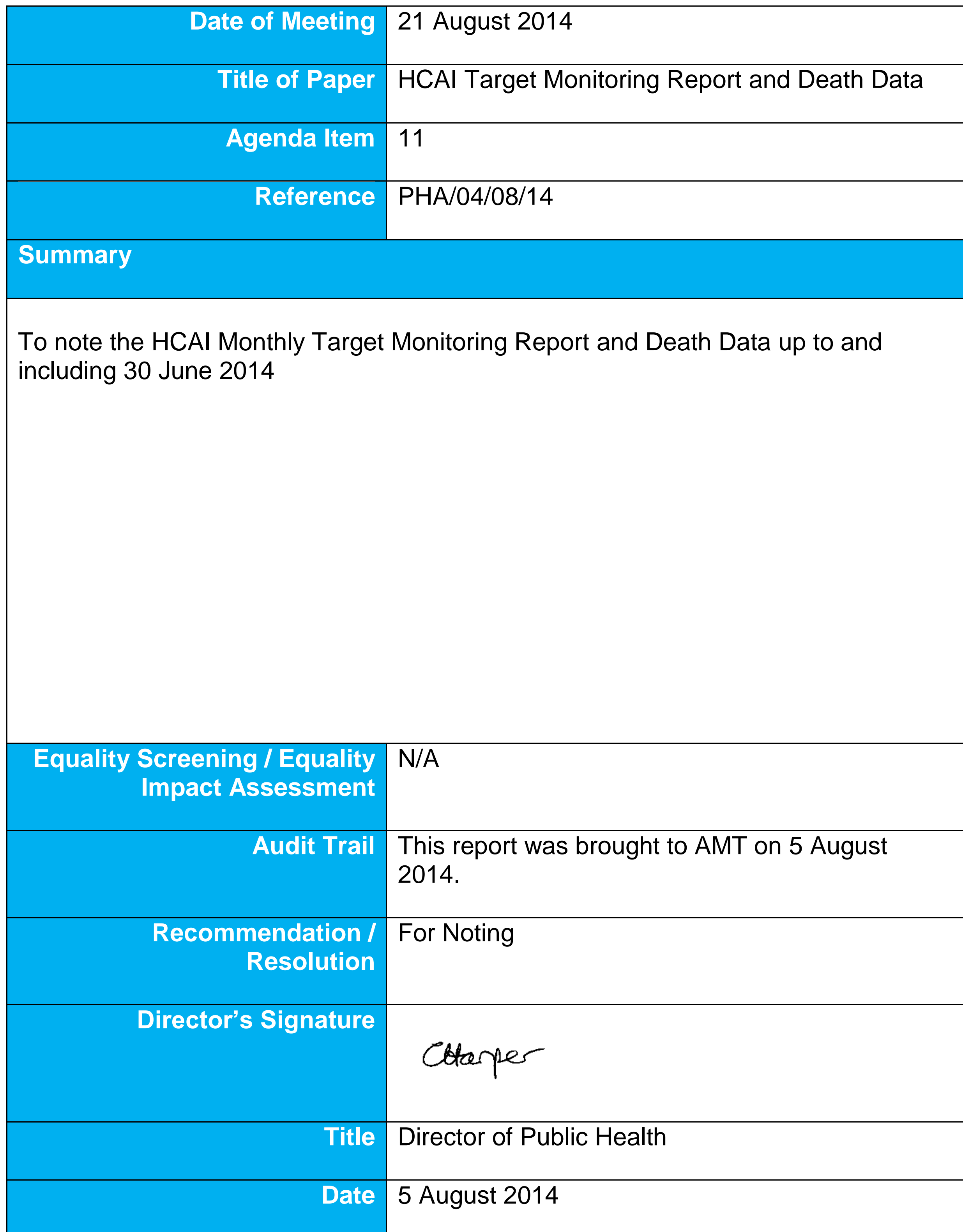
Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.18) Develop and agree a new Internal communications strategy to ensure PHA business is supported by efficient and effective internal communication systems.	The internal communications audit has now been completed (by 215 members of staff) and will help influence the development of the internal communications strategy and action plan which is being looked at by a small sub-group of the Internal Communications Working Group.	G				
6.19) Develop the PHA external communications mix to ensure that PHA digital communications and social media channels are further enhanced to reach new audiences and maximise the delivery of key messages to the public.	Corporate & Public Affairs has increased its use of social media channels for disseminating and sharing information, engaging with groups and individuals, and highlighting key issues. Bespoke rich content has been developed to enhance digital communications, such as 'infographics' and video and online output is used to complement more traditional communications methods such as the issuing of news releases. This has helped the PHA reach new audiences in a targeted, efficient and economical way.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.20) Develop and deliver a range of integrated communication solutions to target audiences in line with key PHA priorities. Public Information Campaigns to include smoking cessation, mental health promotion, obesity prevention, seasonal flu, cancer awareness, organ donation, sexual health & bowel cancer screening programme subject to DHSSPS approval, will be taken forward.	Development of public information campaigns (smoking, obesity, mental health, organ donation, flu, bowel cancer screening, sexual health and cancer awareness) approved by DHSSPS/NI Executive subject to budgetary ceiling, and underway. Mass media advertising key component of integrated communications mix which includes development/refresh of health topic websites, PR and social media.	G				
6.21) Ensure effective finance systems, processes and forecasts are in place, consistent with best practice and agreed Departmental requirements and timescales. These will take into account savings delivery plans where appropriate.	Financial forecasts are in line with best practice and kept under continuous review to ensure effective & consistent with best practice. This is especially important in light of new finance systems and Shared Services implementation by BSO. In 2014/15 a focus will be maintained on the development of the new Collaborative Planning (CP) budgetary control system.	G				

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.22) Ensure the prompt payment of invoices in line with Departmental standards and timescales.	Significant work has taken place to ensure PHA staff are able to expedite clearance of invoices on the FPM system. Training and user guides have been delivered and regular follow-ups have been made at the staff / Director & AMT level and follow-ups will continue in 2014-15. While payment of 95% of all undisputed invoices within 30 days will remain a challenge in 2014-15 (current Year is 88.2%), PHA is able to pay over 70% of undisputed invoices within 10 days. Key to achieving this target is the embedding of effective processes & controls by Shared Services (BSO), which is kept under continuous monitoring.	A				

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	21 August 2014
Title of Paper	HCAI Target Monitoring Report and Death Data
Agenda Item	11
Reference	PHA/04/08/14
Summary	
To note the HCAI Monthly Target Monitoring Report and Death Data up to and including 30 June 2014	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 5 August 2014.
Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	5 August 2014

NISRA Death Data – *Clostridium Difficile* and MRSA Charts

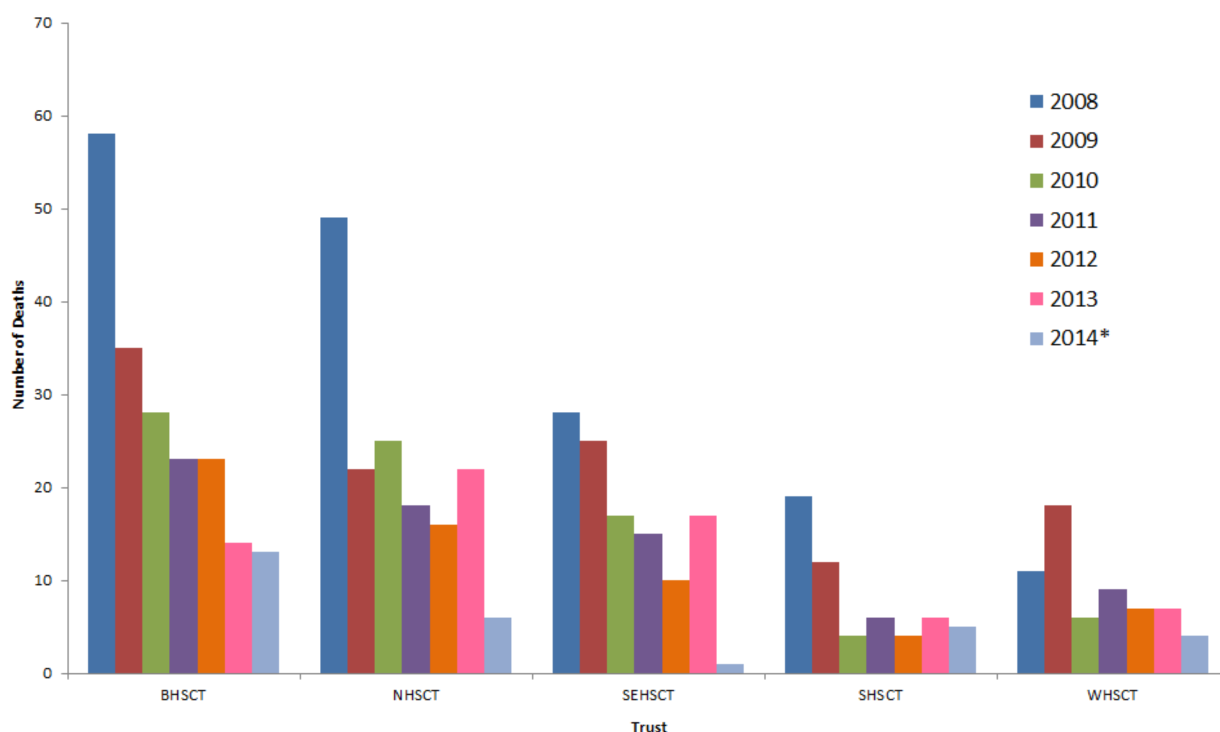


Fig 1: Deaths Registered Where *Clostridium Difficile* was mentioned on the Death Certificate, by Trust of Hospital, 1st January 2008 – 30th June 2014

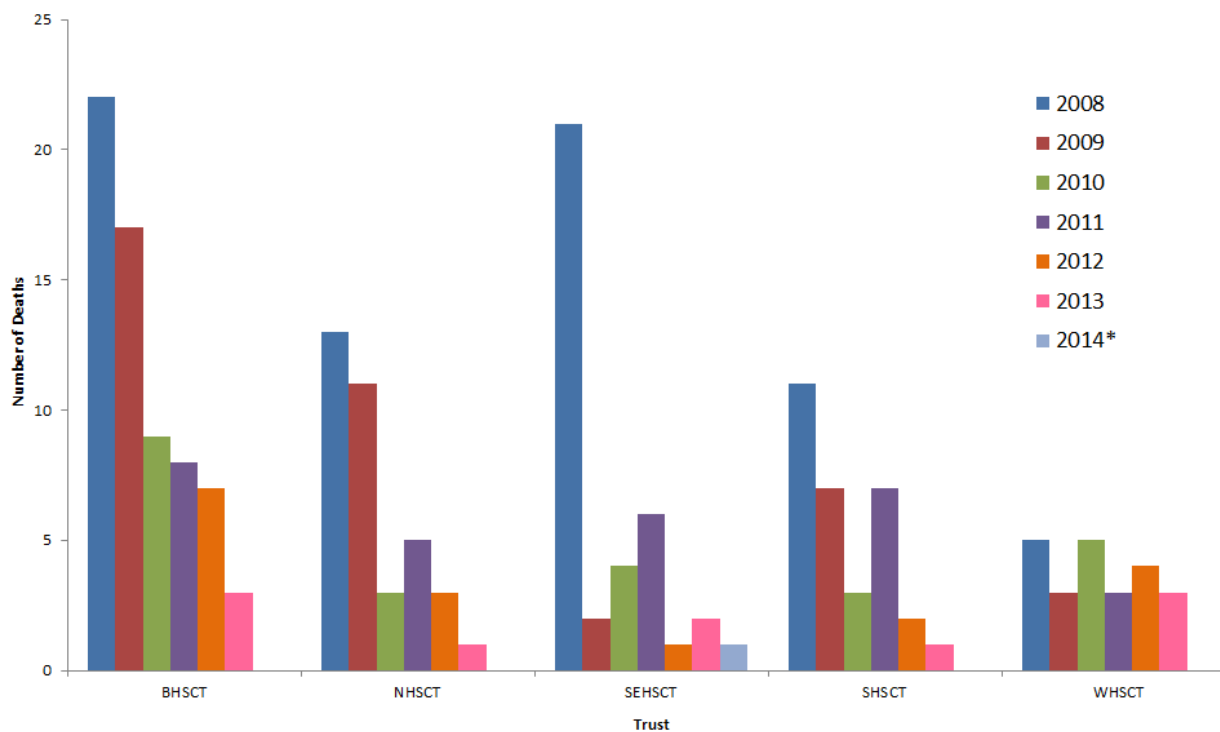


Fig 2: Deaths Registered Where MRSA was mentioned on the Death Certificate, by Trust of Hospital, 1st January 2008 – 30th June 2014

**Data for 2014 remains provisional until the publication of the 2014 Annual Report of the Registrar General.*

Public Health Agency

Target Monitoring Report

S.aureus and *C.difficile*

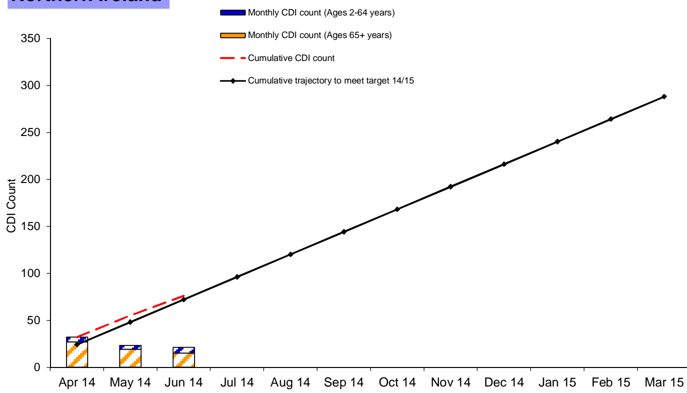
June 2014

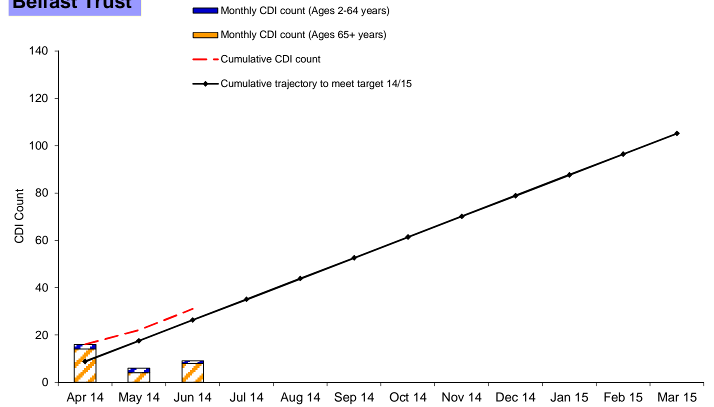
(Information up to 30/06/2014)

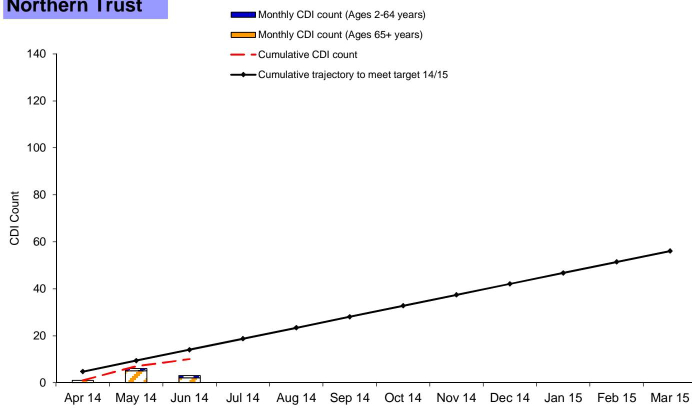
Please note:

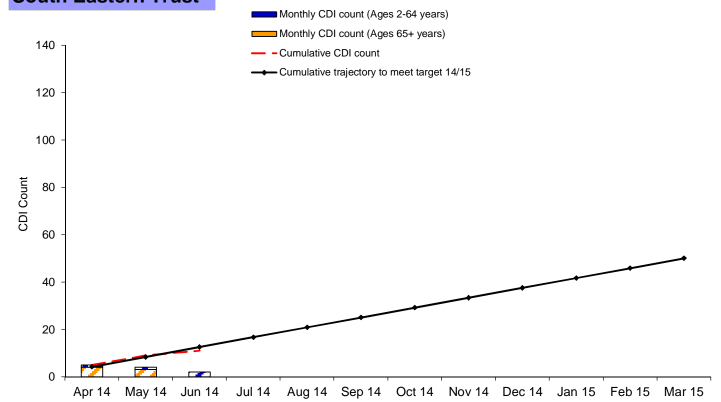
- HCAI monthly monitoring reports issued to Trusts include cases reported through the HCAI web surveillance system per calendar month.
- HCAI monthly monitoring reports will be issued by PHA during the 3rd week of the following month. This is to ensure that HCAI data included in monitoring reports has been verified during Chief Executive sign-off (which occurs on the 15th of each month).
- *C. difficile* performance target for 2014/15 includes hospital in-patients aged 2 years and over – note this is a change from 2009/10 when *C. difficile* performance target included hospital in-patients aged 65 years and over.
- *S. aureus* performance target for 2014/15 includes patients whose specimens were taken in an Acute Trust Hospital setting only e.g. Hospice records will not be counted towards targets.
- Surveillance of MSSA bacteraemias remains mandatory – however there is no performance target associated with MSSA during 2014/15. To facilitate ongoing surveillance of MSSA bacteraemias during 2014/15 MSSA data for 2013/14 has been used as a comparison.
- There has been a change in the monitoring and reporting arrangement of *C.difficile* from 1st April 2013. All *C.difficile* isolates now reported are both GDH and toxin positive (previous reporting was based on toxin positivity only).

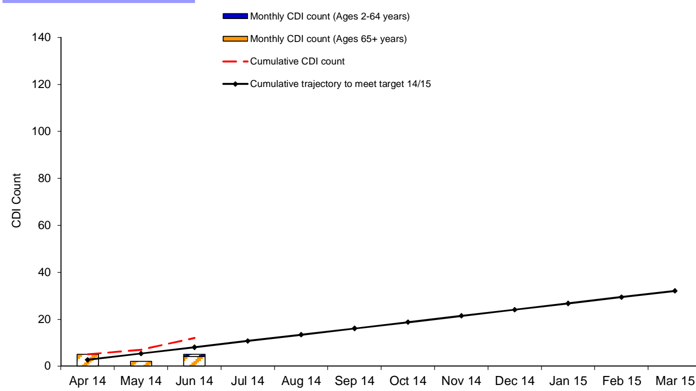
Figure 1: CDI (inpatients 2 years and over) trajectory figures based on cumulative counts (see Appendix 1 for derivation).











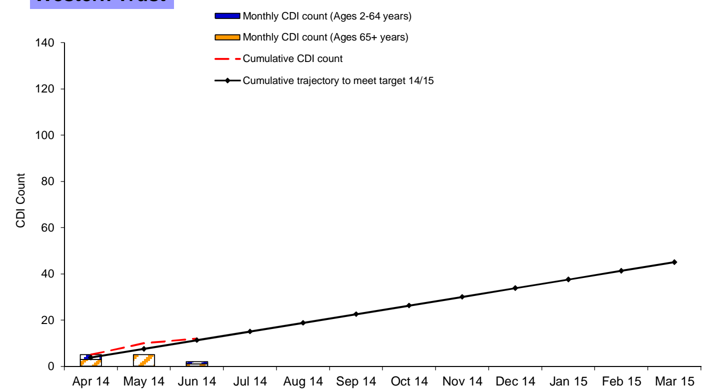
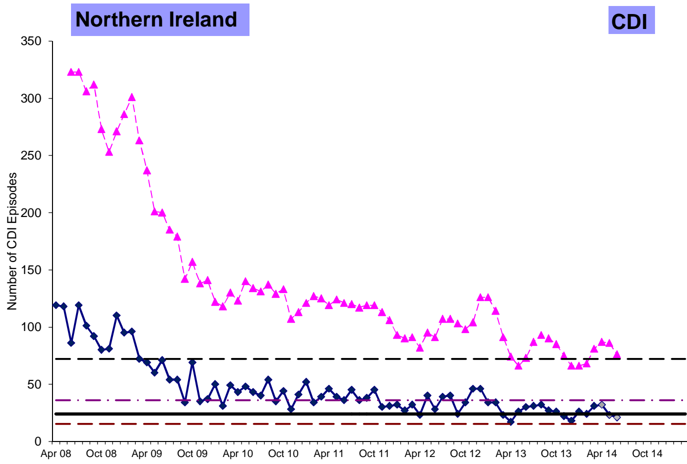
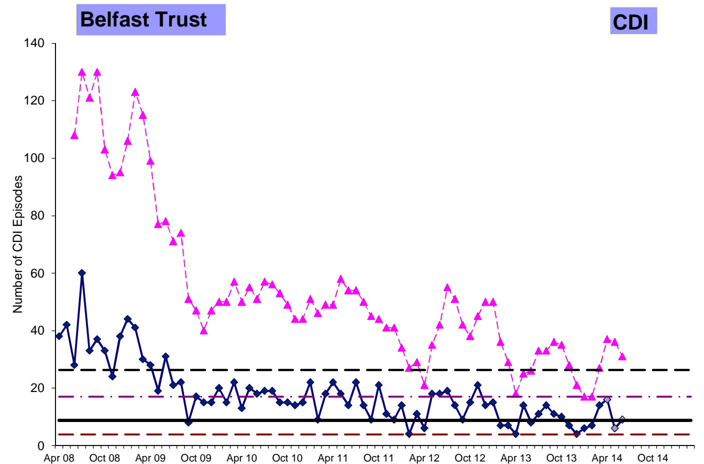
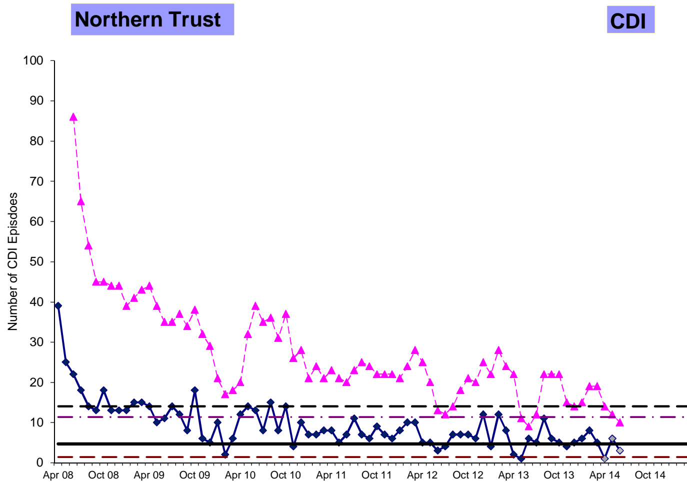
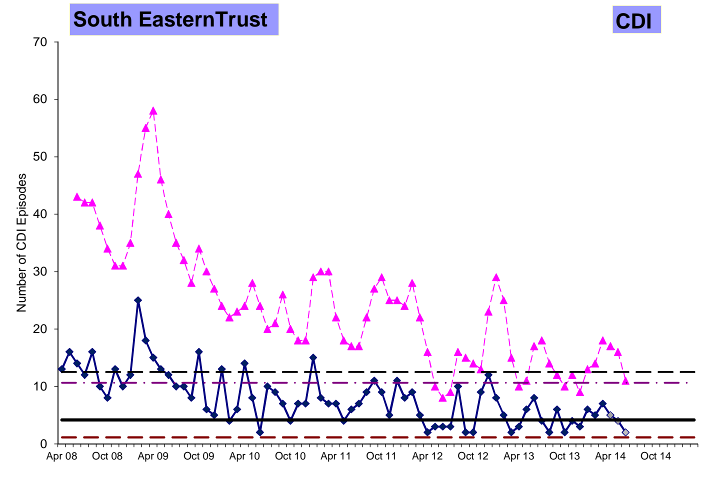


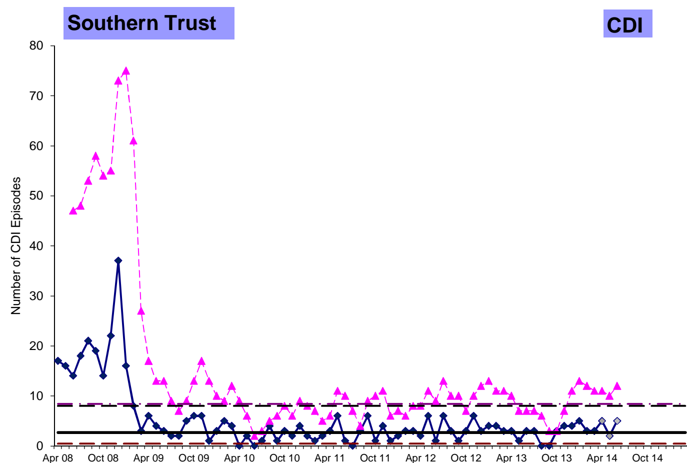
Figure 2: CDI (inpatients 2 years and over) performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).











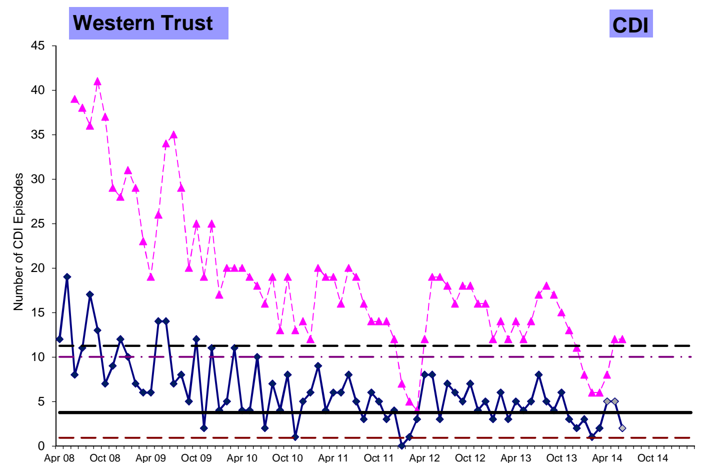
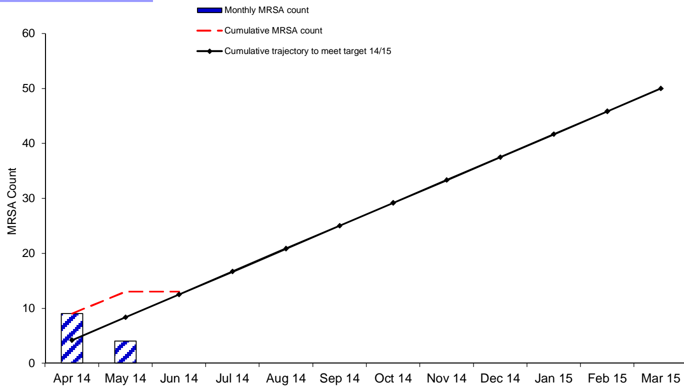
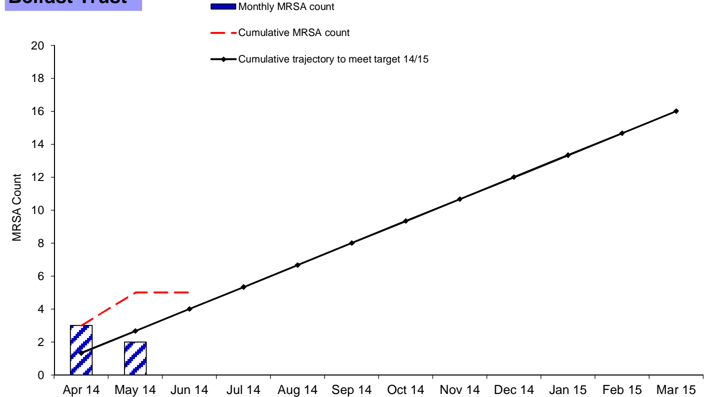


Figure 3: MRSA trajectory figures based on cumulative counts (see Appendix 1 for derivation).

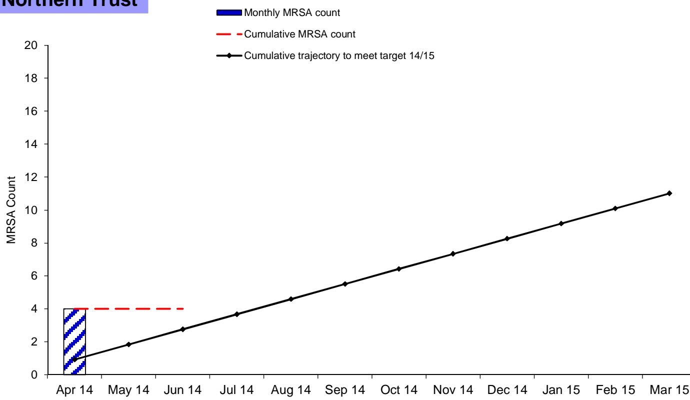
Northern Ireland



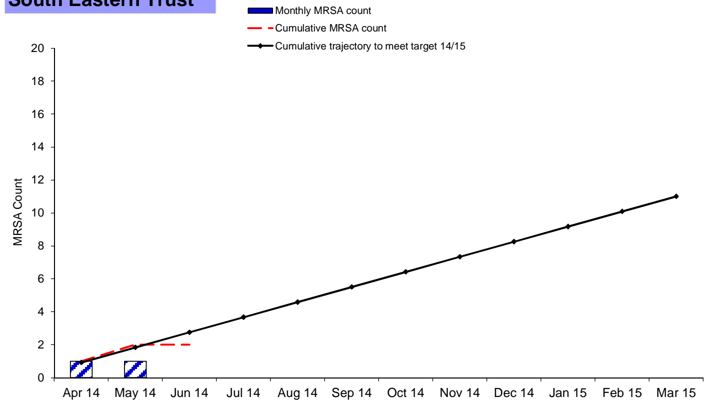
Belfast Trust



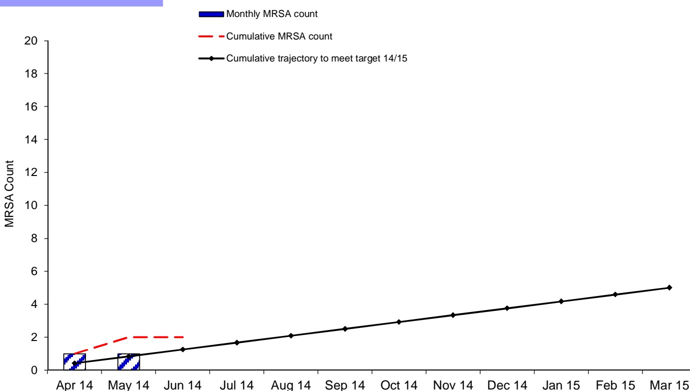
Northern Trust



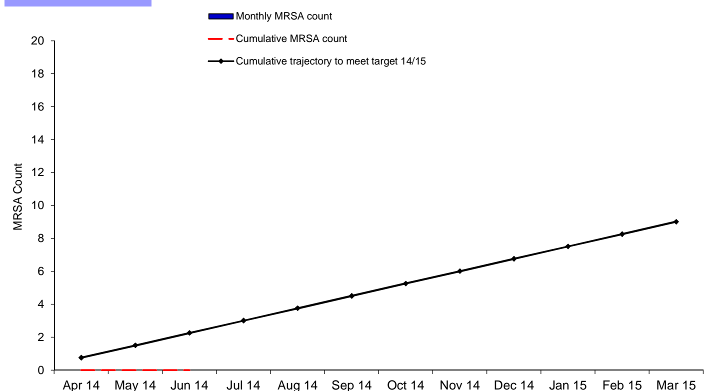
South Eastern Trust



Southern Trust



Western Trust



Key

Validated

Un-validated

Figure 4: MRSA performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).

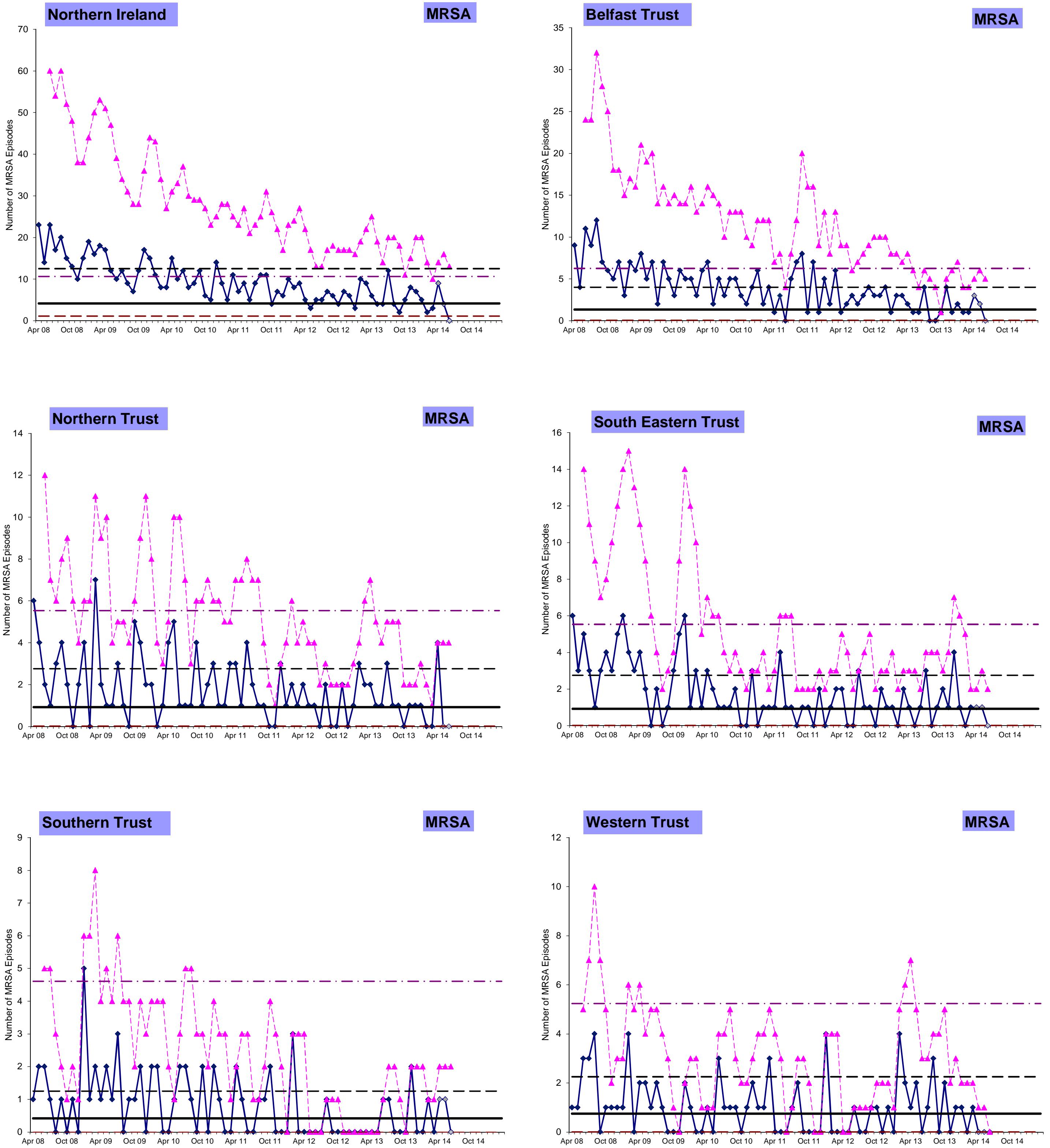
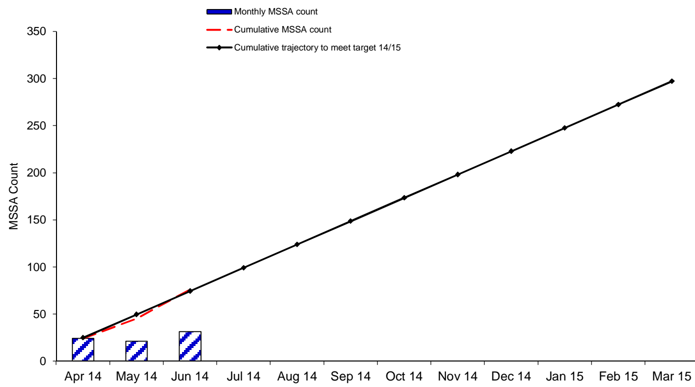
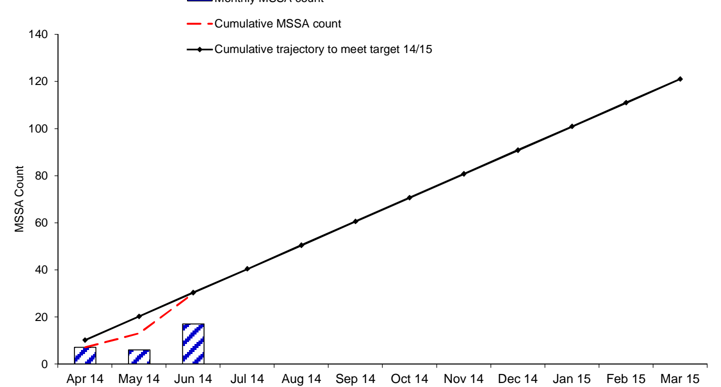


Figure 5: MSSA trajectory figures based on cumulative counts (see Appendix 1 for derivation).

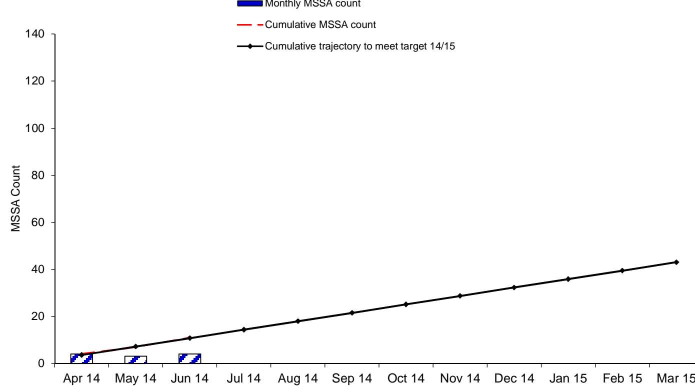
Northern Ireland



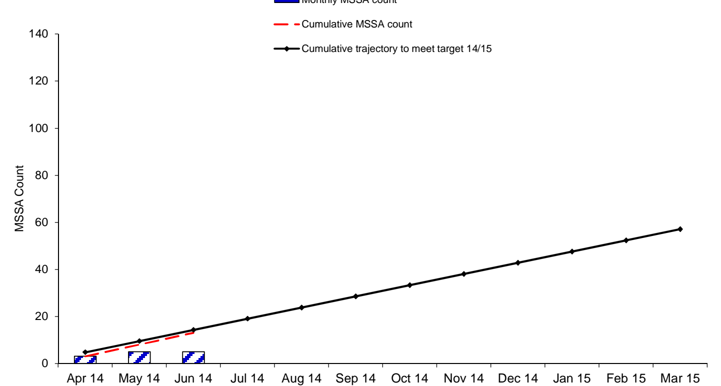
Belfast Trust



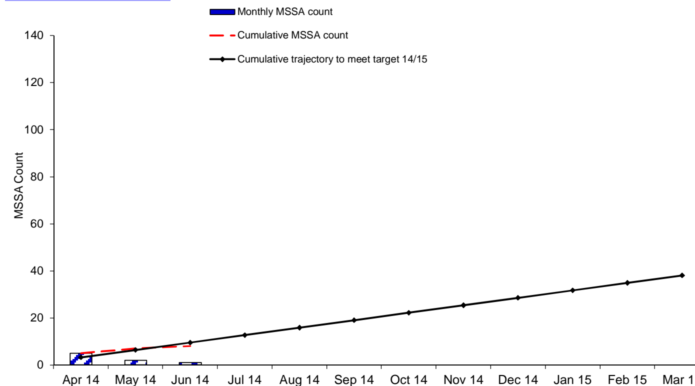
Northern Trust



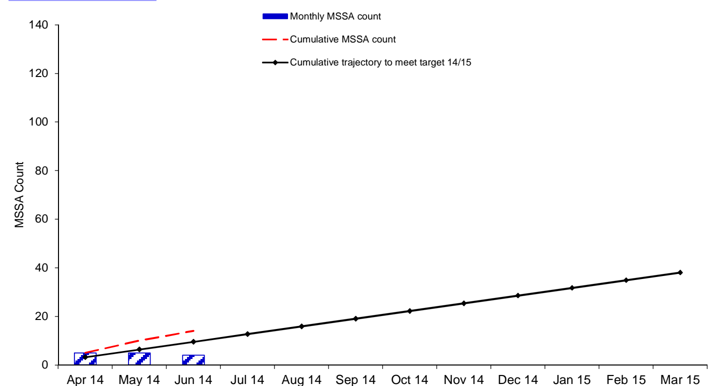
South Eastern Trust



Southern Trust



Western Trust

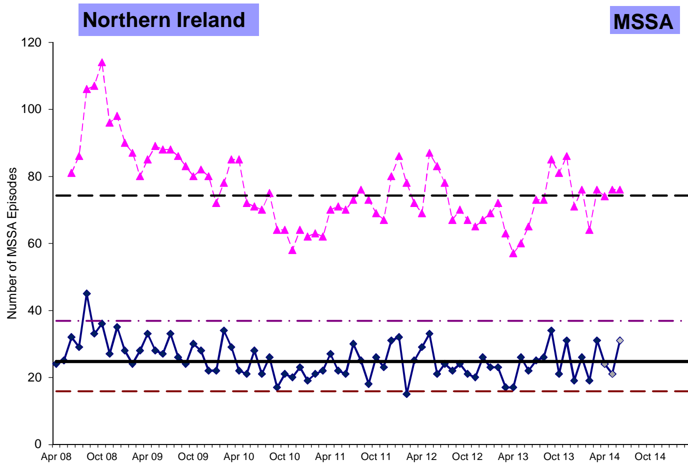


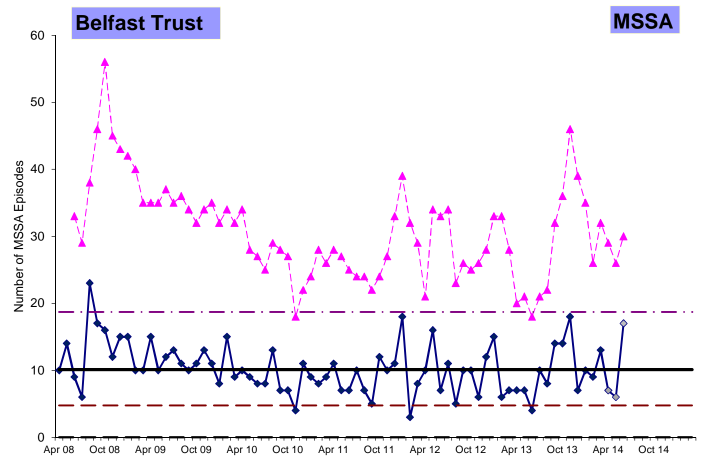
Key

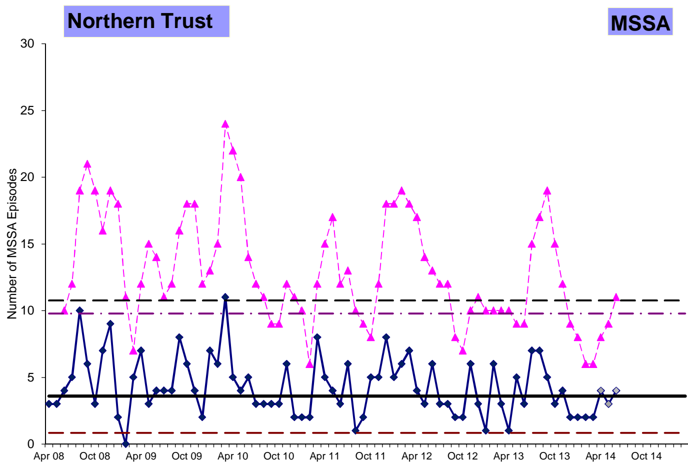
Validated

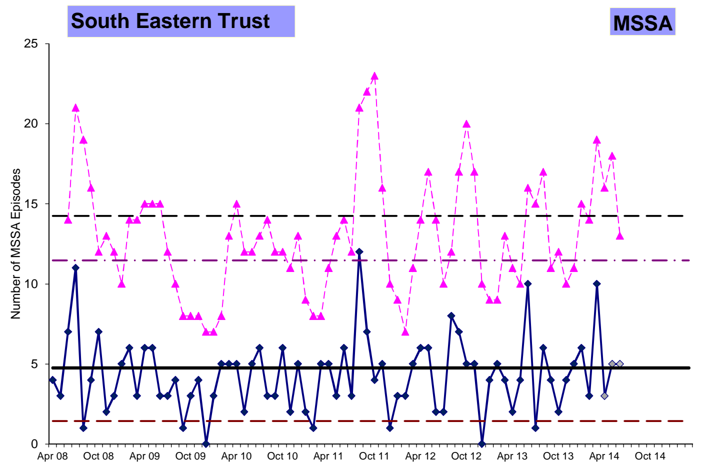
Un-validated

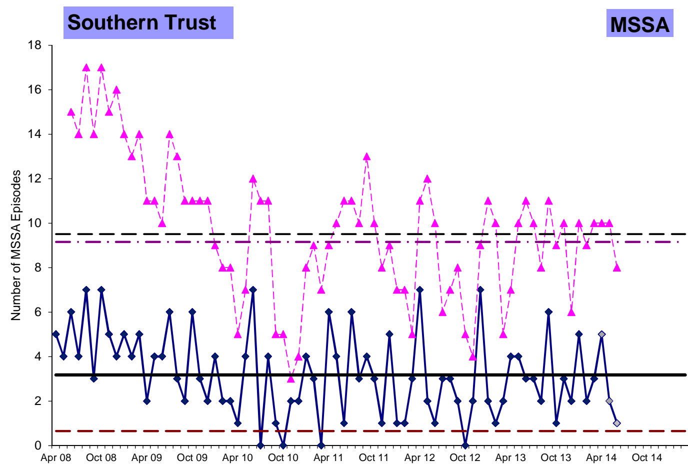
Figure 6: MSSA performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).

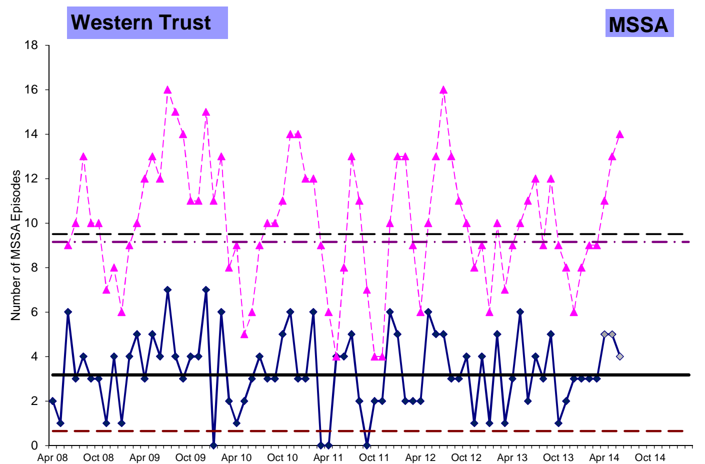












Priorities for Action Targets

Northern Ireland

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
*C. difficile**	310	288	24	21	72	76
MRSA	62	50	4	0	12	13

Belfast Trust

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
*C. difficile**	110	105	9	9	26	31
MRSA	18	16	1	0	4	5

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2014/15 figures are provisional.
*** Target number of cases per month have been rounded up.

Northern Trust

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
*C. difficile**	64	56	5	3	14	10
MRSA	12	11	1	0	3	4

South Eastern Trust

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
*C. difficile**	56	50	4	2	13	11
MRSA	15	11	1	0	3	2

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2014/15 figures are provisional.
*** Target number of cases per month have been rounded up.

Southern Trust

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
C. difficile*	32	32	3	5	8	12
MRSA	5	3	1	0	1	2

Western Trust

	BASELINE 2013/14 (FYR)	TARGET 2014/15 (FYR)	Target no. of cases per month***	June 2014 Episodes**	Apr 2014 - Jun 2014 Trajectory Episodes	Apr 2014 - Jun 2014 Actual Episodes**
C. difficile*	48	45	4	2	11	12
MRSA	12	9	1	0	2	0

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2014/15 figures are provisional.
*** Target number of cases per month have been rounded up.

Appendix 1

Trajectory figures (figures 1, 3 and 5)

- The bar chart represents monthly numbers derived from figures supplied to Public Health Agency during the quarterly validation process. Shaded bars show un-validated figures.
- The cumulative trajectory line shows the monthly cumulative total based on the monthly trajectory figure.
- The cumulative count (dashed line) is the cumulative total of the monthly figures. If this line rises above the trajectory line, it indicates that the target will not be met.

Performance Figures (figures 2, 4 and 6)

Key

- Monthly count
- 3 month rolling total
- Trajectory
- Quarterly Sum of Trajectory
- Upper Monthly Warning Limit
- Lower Monthly Warning Limit

- The circular points on the chart represent the monthly number of MRSA/MSSA or *C. difficile* episodes that have been reported by the Trust. These figures have been calculated using the validated quarterly figures supplied to the Public Health Agency. Points in lilac represent un-validated monthly figures.
- The trajectory line has been calculated for each Trust and represents the maximum number of episodes that a Trust can report in a month to remain on target.
- Due to the natural variation that can occur upper and lower warning limits have been calculated based on the **monthly trajectory target**. If the upper limit is exceeded and repeated this suggests that special cause variation is occurring, for example, an outbreak.
- A 3 monthly rolling total has been calculated to smooth out variation that can occur over shorter times (denoted by a triangle in each figure) and this can be compared to the quarterly sum trajectory line to determine if the Trust is on target over a 3 monthly period (represented by an x). These points will change as they require 3 months data to generate one point.

Email Distribution List (Updated 24.06.2014)

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HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	Northern Ireland Breast Screening Programme Annual Report 2012/13
Agenda Item	12
Reference	PHA/05/08/14

Summary

Introduction
This annual report and statistical bulletin describes key issues relating to the Northern Ireland Breast Screening Programme and its performance in 2012/13.

Timescale for production
Production of the report takes almost 18 months form the end of the financial year. Performance data are collated from Trusts in October 2013, allowing six months from year end for completion of screening episodes and analysis of data. National audit data are published by The Association of Breast Surgery (ABS) in May each year. This information is included in the report for comparison against local performance.

Developments
Two significant developments were:

- A review of the information provided to women, and health care professionals, about breast screening and the development of new leaflets and posters; and
- The introduction of digital mammography.

Performance
The report describes the performance of the programme as a whole (as well as by individual unit) against a number of national standards. The 4 key performance indicators are uptake, invasive cancer detection rate, small invasive cancer detection rate (cancers <15 mm) and round length.

- A total of 83,551 women aged 50-70 were invited for breast screening in 2012/13. Of these 61,766 women attended for screening. This gives an uptake rate of 74% (standard .70%). The uptake for England was 72.2%.
- The invasive cancer detection rate for women, aged under 53, screened for the first time was 4.2 per 1,000 (standard ≥ 3.6). The comparative rate for England was 5.7.
- The invasive cancer detection for women attending subsequent screening tests was 5.9 per 1,000 (standard ≥ 4.1). The English rate was 6.2.
- The small invasive cancer detection rate for women, aged under 53, screened

for the first time was 1.5 per 1,000, which does not meet the standard (standard ≥2.0). Rates tend to fluctuate from year to year due to very small numbers. There were only 14 small invasive cancers detected during the prevalent screen in Northern Ireland during 2012/13.The comparative rate for England was 2.7.

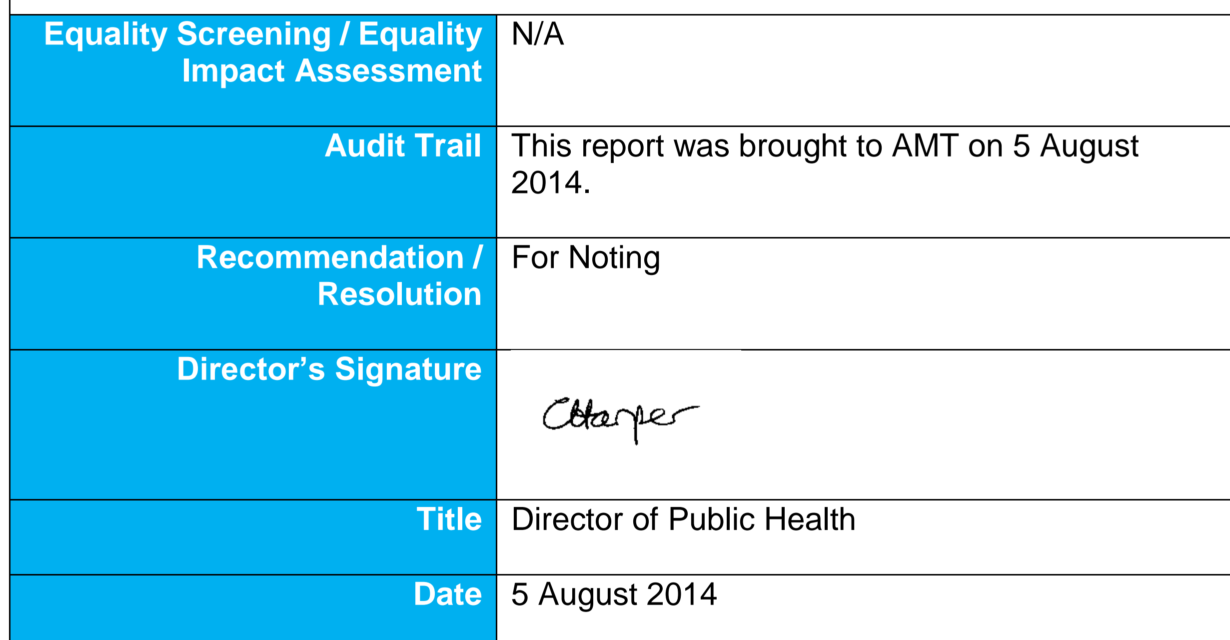
- The small invasive cancer detection for women attending subsequent screening tests was 3.2 per 1,000 (standard ≥ 2.3). The English rate was 3.3.
- The round length was 83.2% (standard .90%).

Promoting Informed Choice

Significant progress has been made implementing an agreed action plan to promote informed choice about breast screening. This includes specific actions relating to groups that can have difficulty accessing the breast screening programme. These are described in section 7.

Conclusion

Overall, while there are some areas that require improvement (e.g. screen to assessment and round length), these are good statistics, which compare well with the English programme and show that the Northern Ireland Breast Screening Programme is providing a good quality service.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 5 August 2014.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Public Health
Date	5 August 2014

NORTHERN IRELAND BREAST SCREENING PROGRAMME

ANNUAL REPORT & STATISTICAL BULLETIN 2012-2013

August 2014

QUALITY ASSURANCE REFERENCE CENTRE

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1 Summary

This annual report and statistical bulletin describes key issues relating to the Northern Ireland Breast Screening Programme and its performance in 2012/13. It compares performance with previous years and with data from the English NHS Breast Screening Programme.

The Quality Assurance Reference Centre (QARC) monitors, and quality assures, the Northern Ireland Breast Screening Programme to ensure women have access to a high quality service that meets agreed national standards.

The aim of breast screening is to prevent deaths from breast cancer. Breast screening, like all screening programmes, results in both benefits and harms. The main benefit is that screening saves about 1 life from breast cancer for every 200 women screened. This adds up to about 1,300 lives saved from breast cancer each year in the UK.

The main harm is overdiagnosis, as about 3 in every 200 women screened are diagnosed with a cancer that would never have been found without screening and would never have become life threatening. This adds up to about 4,000 women each year in the UK who are offered treatment they did not need.

In 2012/13 QARC began a review of the information provided to women about breast screening. New leaflets and posters have now been published and additional information has been added to the QARC website, including an expanded FAQ section. In addition a revised information booklet has been published for health care professionals. This is also available on the website (http://www.cancerscreening.hscni.net/).

Another significant development during 2012/13 was the production of a business case to replace the existing analogue mammography equipment with digital equipment. It also covered replacing the existing fleet of 5 mobile screening trailers with a fleet of 7 new trailers of much higher specification. The new equipment and trailers will all be installed and operational by September 2014.

In 2012/13 a total of 83,551 women aged 50-70 were invited and 61,766 were screened; giving an uptake of 74% (standard > 70%). This compares with 73.3% in 2011/12 and 75.8% in 2010/11. Uptake is the percentage of women who attend each year, following an invitation. This means that just over a quarter of women who were invited did not take up the offer of screening mammography.

Significant progress has been made implementing an agreed action plan to promote informed choice about breast screening. This includes specific actions relating to groups that can have difficulty accessing the breast screening programme. These are described in section 7.

Most women who attend for breast screening mammography (96 out of every 100) will be identified as having normal mammograms. 97.1% of these women received their test results within 2 weeks (standard >90%). 3.7% of women who were screened were found to have an abnormality on their mammograms and were referred for further assessment. 90.6% of these women were offered an assessment clinic appointment within 3 weeks (standard >90%). As of 1 January 2014 units should ensure 100% of women are offered an appointment within 3 weeks. 83% of women attended their appointment within 3 weeks. This figure needs to be increased to 90% and units should now meet this figure. Younger women are more likely to be called back for assessment, but cancer is more likely to be found in older women.

Diagnosis before surgery is made by taking a biopsy at the assessment clinic, 96.5% of women with cancers detected by screening had the diagnosis confirmed before surgery (standard >80%). The diagnostic accuracy of biopsies taken at assessment clinics is high. 99.5% of women only required one visit to the assessment clinic to obtain a diagnosis.

A total of 443 cancers were detected in 2012/13. Of these 372 were invasive cancers and 67 were ductal carcinoma in situ (DCIS), 2 were micro-invasive and in 2 the invasive status was not known. Of the 372 invasive cancers 187 (50.3%) were less than 15 mm in diameter (small invasive cancers).

A proportion of cases of DCIS will eventually become invasive. However, it is not yet possible to identify which ones will, and which won't, become invasive. All women diagnosed with this disease are therefore offered treatment.

4.2 per 1,000 women screened for the first time (aged under 53) were diagnosed with an invasive breast cancer (standard > 3.6). The rates for 2010/11 and 2011/12 were 6.4 and 4.0 respectively. The comparative rate for England for 2012/13 was 5.7. The figure for women attending subsequent screening tests was 5.9 per 1,000 (standard > 4.1). The rates for 2010/11 and 2011/12 were 4.8 and 5.8 respectively. The English rate for 2012/13 was 6.2.

The main aim of breast screening is to detect small invasive breast cancers at a time in their natural history when treatment is more likely to reduce the risk of death from the disease. 1.5 per 1,000 women screened for the first time (aged under 53) had a small invasive cancer identified (standard ≥2.0). This does not meet the standard - which was increased from 1.5 to 2.0 in 2011. However, the numbers involved are very small (n=14) and the standard was met in the previous 2 years. In addition the incident small cancer detection rate is above the target and the standardised detection ratio for small invasive cancers meets the standard. The figure for England for 2012/13 was 2.7 per 1,000. Performance in this area will continue to be monitored.

The small invasive cancer detection rate for women attending for subsequent screening tests was 3.2 per 1,000 (standard ≥2.3). The rates for 2010/11 and 2011/12 were 2.8 and 3.4 respectively. The figure for England for 2012/13 was 3.3 per 1,000

73.9% of women diagnosed with an invasive cancer had breast conserving surgery; 25.2% had a mastectomy and 0.8% had no surgery.

The proportion of women who had a surgical operation for what turned out to be benign disease was 1.0 per 1,000 for the prevalent (first) screen (standard < 3.6 per 1,000) and 0.4 per 1,000 for incident (subsequent) screens (standard < 2 per 1,000).

26% of women with invasive cancer required a repeat surgical operation. This is slightly higher than the UK average of 23% (range 16%-27%).

The screening round length is the interval between each offered invitation for screening mammography. The NHS Breast Screening Guidance Publication No. 60 (Version 2) *Consolidated Guidance on Standards for the NHS Breast Screening Programme , April 2005*[1] states that, to ensure women are recalled for screening at appropriate intervals, the percentage of eligible women whose first offered appointment is within 36 months of their previous screen should be 90% or more. Measurement of screening round length provides an indicator of the efficiency with which a screening programme is managed. The long-term effectiveness of the programme is dependent on women in the target age group continuing to be screened at regular intervals. In 2012/13, 83.2% of women were offered an appointment for mammography screening within 36 months of their previous normal screen (standard >90%). The Eastern Unit's round length began to slip in June 2011. QARC worked with the unit and the Belfast HSC Trust to agree an action plan to bring it back to standard. This was achieved in the third quarter of 2012/13.

[1] Available at http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp60v2.pdf

A number of factors had contributed to slippage of the Southern Unit's round length in the first quarter of 2012/13, including staff leave. The unit brought its round length back to standard in the second quarter of 2012/13.

The replacement of all mammography equipment throughout Northern Ireland with new digital equipment during 2014 will adversely impact on the 2014/15 round length.

Overall, while there are some areas that require improvement (e.g. screen to assessment and round length), these are good statistics and show that the Northern Ireland Breast Screening Programme is providing a good quality service.

Dr Adrian Mairs
Quality Assurance Director
NI Breast Screening Programme

Miss Claire Armstrong
Support Officer
NI Breast Screening Programme

2 Introduction

Regular breast screening reduces the risk of death from breast cancer.

For every 1 woman who has her life saved from breast cancer, about 3 women are diagnosed with a cancer that would never have become life-threatening.

The aim of breast screening is to prevent deaths from breast cancer. Breast screening, like all screening programmes, results in both benefits and harms. The main benefit is that screening saves about 1 life from breast cancer for every 200 women who are screened. This adds up to about 1,300 lives saved from breast cancer each year in the UK.

The main harm is overdiagnosis, as about 3 in every 200 women screened are diagnosed with a cancer that would never have been found without screening and would never have become life threatening. This adds up to about 4,000 women each year in the UK who are offered treatment they did not need.

In Northern Ireland eligible[2] women aged 50 – 70 are invited for breast screening , by GP practice, every 3 years. Due to this three yearly round of invites about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53 birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Everyone receives a total of 7 invitations.

Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every 3 years by phoning their local screening unit and requesting an appointment.

[2]Women who have had bilateral mastectomy are excluded from the eligible population.

Figure 1: Locations of the Breast Screening Units

There are four breast screening units in Northern Ireland (figure 1).

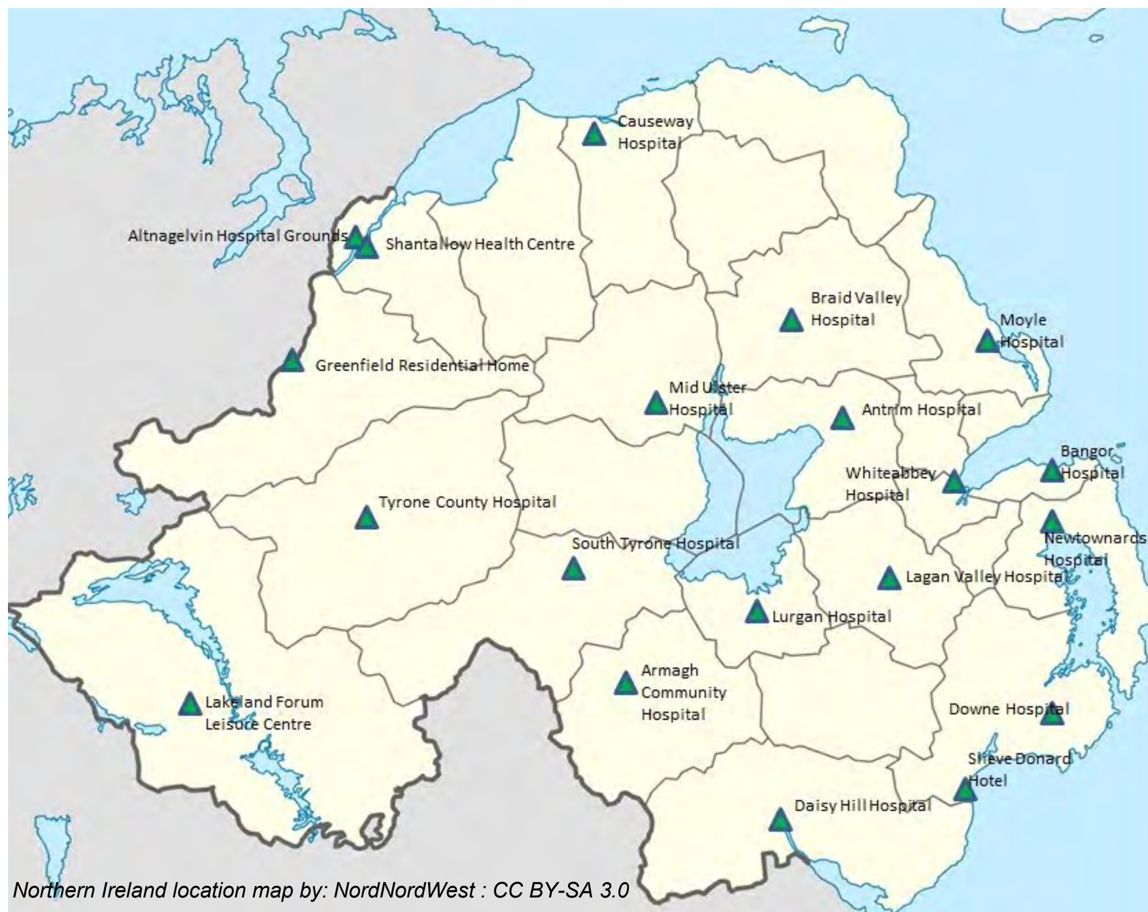
These are the:

- Eastern Breast Screening Unit at 12-22 Linenhall Street, Belfast (covers the Belfast and South Eastern Trust areas). Tel: 028 9033 3700.
- Northern Breast Screening Unit at Antrim Area Hospital (covers most of the Northern Trust area). Tel: 028 9442 4425.
- Southern Breast Screening Unit based at Craigavon Area Hospital (covers the Southern Trust area) with static units at both Lurgan and Daisyhill Hospitals. Tel: 028 3834 7083.
- Western Breast Screening Unit at Altnagelvin Area Hospital (covers the Western Trust, and part of the Northern Trust area). Tel: 028 7161 1443.

Some breast screening is carried out in the Eastern Unit and in the Western Unit. However, most breast screening in Northern Ireland is now carried out on mobile breast screening trailers at a variety of locations throughout Northern Ireland. Indeed the number of trailers will increase from 5 to 7 as a new fleet of breast screening trailers is introduced in 2014.

These new trailers will have digital mammography equipment on board and will further increase accessibility to the programme. Figure 2 shows the locations that will be visited by the new mobiles from 2014.

Figure 2: Locations of the Mobile Breast Screening Units from 2014



The Quality Assurance Reference Centre (QARC) is part of the Public Health Agency. It provides the quality assurance function for the three cancer screening programmes (breast, bowel and cervical).

The purpose of quality assurance in the breast screening programme is the:

- maintenance of minimum standards; and
- continuous improvement in the performance of all aspects of the screening programme

in order to ensure that women have access to a high quality service wherever they reside.

The Northern Ireland Breast Screening Programme operates to the same standards as the NHS Breast Screening Programme in England. These quality standards can be found at http://www.cancerscreening.nhs.uk/breastscreen/publications/publication-topics.html

3 Key Developments in 2012/13

The old analogue mammography equipment is being replaced by new digital mammography equipment. In addition the existing fleet of 5 mobile screening trailers is being replaced by a fleet of 7 new trailers of much higher specification.

A new set of information leaflets and posters for the public has been developed, as has a booklet for health care professionals.

Digital Mammography

During 2012/13 a business case was developed to replace all of the old analogue mammography machines with new digital equipment. It included the need to replace the existing 5 mobile breast screening trailers with a new fleet of 7. It also covered the cost of storing digital mammograms on the Northern Ireland Picture Archiving System (NIPACS). This allows all x-ray images taken by the HSC to be stored on, and retrieved from, a single regional system.

The new digital mammography equipment and trailers will be introduced in different areas between April and September 2014.

Digital mammography offers a number of advantages over analogue mammography. These include:

- Ease of storage/retrieval of images and ability to view the images at different locations (through NIPACS) - images will be in the right place at the right time to facilitate patient care;
- The capability to manipulate the images eg magnify them or adjust the contrast;
- Better visualisation of dense breasts in younger women, as well as the ability to detect more cancers (better sensitivity);
- A reduced need for women to be asked to return to have additional mammograms taken (technical recalls) as the quality of the image can be checked immediately (the image being digital does not need to be processed like the analogue mammograms).

The new mobile trailers are a significant improvement on the existing trailers and provide access for women with disabilities.

Figure 3: One of the new mobile breast screening trailers

New Breast Screening Leaflets

Work started on a new set of information leaflets in 2012/13. These were developed in light of the findings of an Independent Review of Breast Screening (the Marmot review). This concluded that the UK breast screening programmes confer significant benefit, by reducing breast cancer mortality, and should continue. However, it also recommended that women should be given clear and balanced information about the benefits and harms of breast screening (see page 7). We have therefore taken this opportunity to update and revise each of our leaflets. One of the revised leaflets "Breast Screening – Helping You Decide" replaces the old leaflet "Breast Screening Can Save Lives". This is sent to women with their invitation to attend breast screening.

4 Statistics

The Quality Assurance Reference Centre regularly monitors the performance of the Northern Ireland Breast Screening Programme

The Quality Assurance Reference Centre (QARC) monitors the performance of each of the four breast screening units against national standards using Körner returns:

KC62 – This is an annual return made by trusts on: outcome of initial screen, outcome of assessment (including cytology and histology), cancers diagnosed (by size and type) and overall outcome measures (uptake, referral rate, non-invasive cancers, benign biopsy rate, invasive cancer detection rate, referral for cytology/biopsy, malignant:benign ratio for surgery, early recall rate); by 1st invitation, previous non-attenders, last screen within 5 years, last screen more than 5 years, early recall, self referrals, all women; by age.

KC62 data are obtained from the National Breast Screening System (NBSS). This is the IT system that supports the breast screening programme.

KC63 – This is an annual return made by trusts on: numbers of eligible women, invited and screened by age, numbers recalled, numbers self or GP referred, and time since most recent screen in 12 month blocks.

In December 2010 an electronic link was established between NBSS and the IT system that supports primary care (NHAIS/Exeter system). It will also enable the establishment of better failsafe procedures to ensure that all women who should be invited for breast screening are invited. It will allow us to provide KC63 data. KC63 will provide information on the coverage of the programme. Coverage is defined as the proportion of women resident and eligible for screening who have had a screening mammogram at least once in the previous three years. KC63 data will not be available until late 2014 when the system will be populated with 3 (financial) year's worth of data (as the breast screening programme is a 3 yearly rolling programme).

Women with a date of first offered screening appointment between 01/04/2012 and 31/03/2013 were used to produce this report. Comparative figures for the previous 2 years (5 years for uptake) and from the English NHS Breast Screening Programme are also shown.

These data allow the Quality Assurance Reference Centre to evaluate the quality of the Northern Ireland Breast Screening Programme. Performance is compared to the minimum standards and targets set out in NHSBSP Publication No. 60 (Version 2) *Consolidated Guidance on Standards for the NHS Breast Screening Programme* , *April 2005.*[3]

The standards are summarised in **Appendix 1**. It should be noted that these quality assurance data provide information on the performance of the four breast screening units and the programme as a whole: they do not provide information on the performance of individual staff.

Minimum standards: These figures represent the levels of performance which are the minimum acceptable for any breast screening unit. Where the minimum standard is shown "greater than or equal to", any level of performance below that standard is investigated by the Quality Assurance team. Where the minimum standard is shown as "less than or equal to", any level of performance above that standard is similarly investigated.

Targets: These are the quantitative goals that are considered to be achievable individually by one third of units within the NHSBSP. All units should aim to achieve the targets. If the specified cancer detection rates etc. are achieved, then the programme will be on target to replicate the mortality reduction achieved in the original clinical trials.

The KC 62 data for women aged 50 – 70 are shown in **Appendix 2**.

Before March 2009 women aged 50-64 were invited for breast screening. Since that date invitations have gone to women aged 50-70 (age extension).

English data are taken from the NHS Information Centre for Health and Social Care, *Breast Screening Programme, England 2012-13* Report.[4]

[3] Available at http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp60v2.pdf

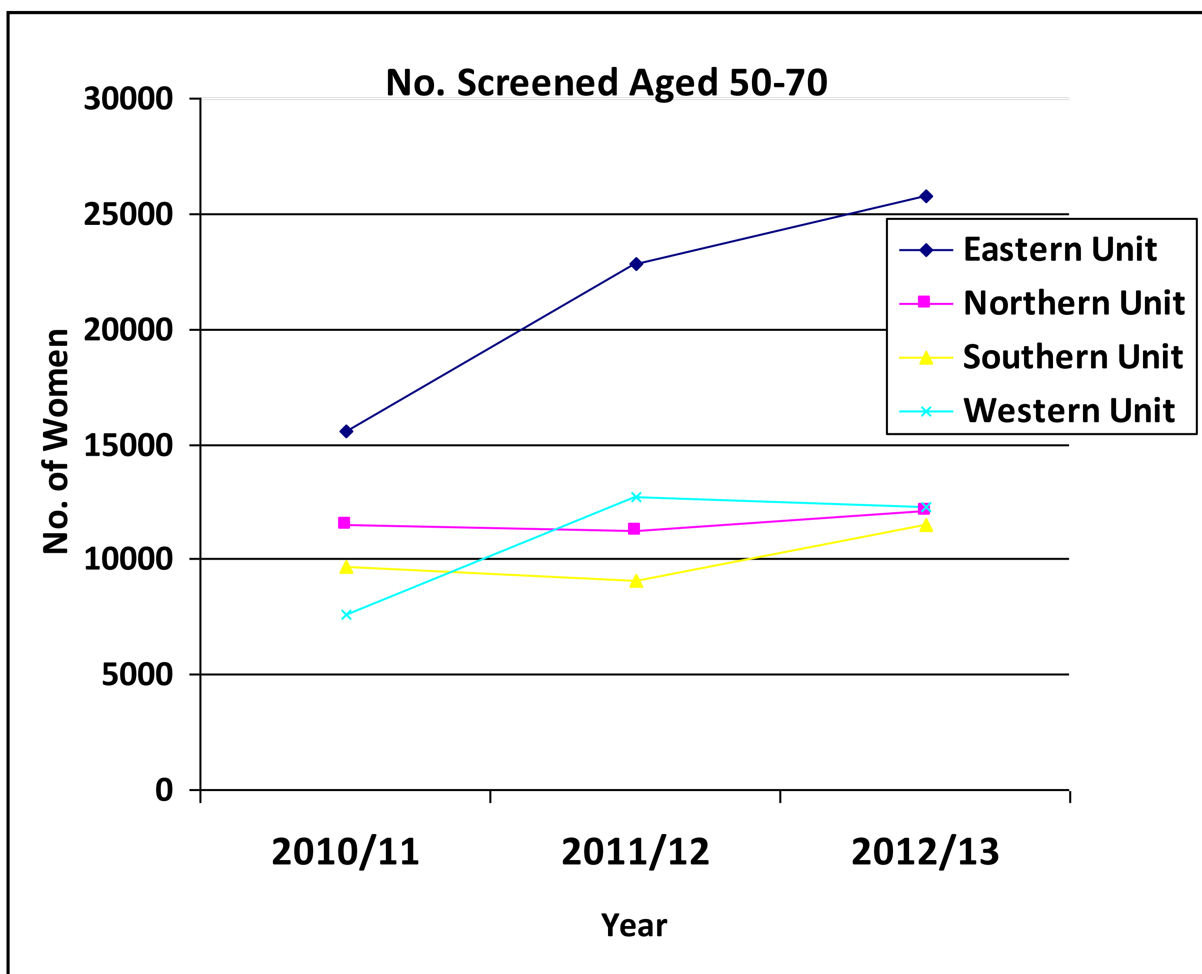
[4] Available at http://www.hscic.gov.uk/catalogue/PUB13567/bres-scre-prog-eng-2012-13-rep.pdf

5 Number of Women Screened

83,551 women were invited for breast screening in 2012/13 and 61,766 of these women attended for breast screening

A total of 83,551 women aged 50-70 were invited for breast screening in 2012/13. Of these 61,766 women attended for screening. Figure 4 below illustrates how many women aged 50-70 were screened by each unit over a three year period.

Figure 4: Number of women aged 50-70 who were screened each year from 2010/11 to 2012/13



The 4 breast screening units cover screening populations of different sizes. The screening populations for each unit in 2012/13 were:

Eastern unit - 89,409

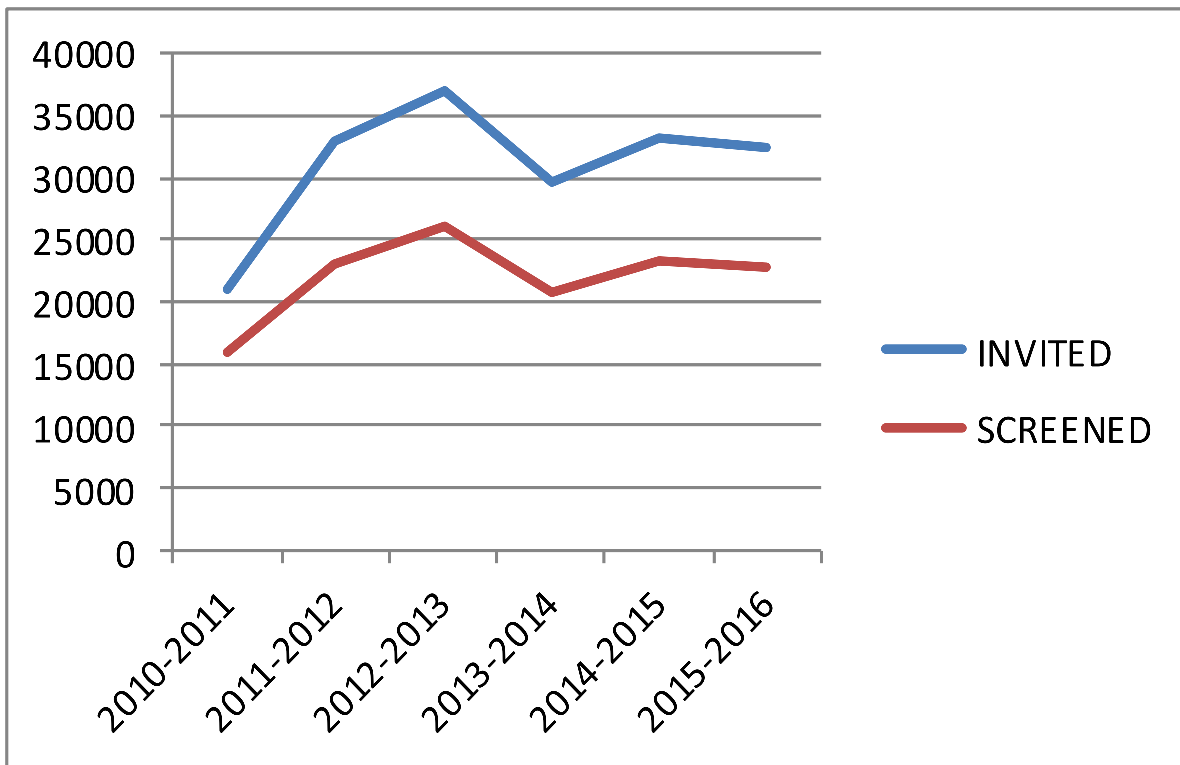
Northern unit - 54,271

Southern unit - 43,414

Western Unit - 36,450

Approximately 1/3 of the eligible screening population is invited each year. However, for historical reasons, a series of peaks and troughs in the numbers of women invited year have developed in the Eastern Unit. The unit is working to even out these fluctuations and figure 5 shows the predicted numbers of invites (and numbers attending) over the 3 year period 2013/14 - 2015/16.

Figure 5: Number of women invited and number of women screened by year 2010/11- 2012/13, with predicted numbers for 2013/14 - 2015/16, for the Eastern Breast Screening Unit



6 Uptake

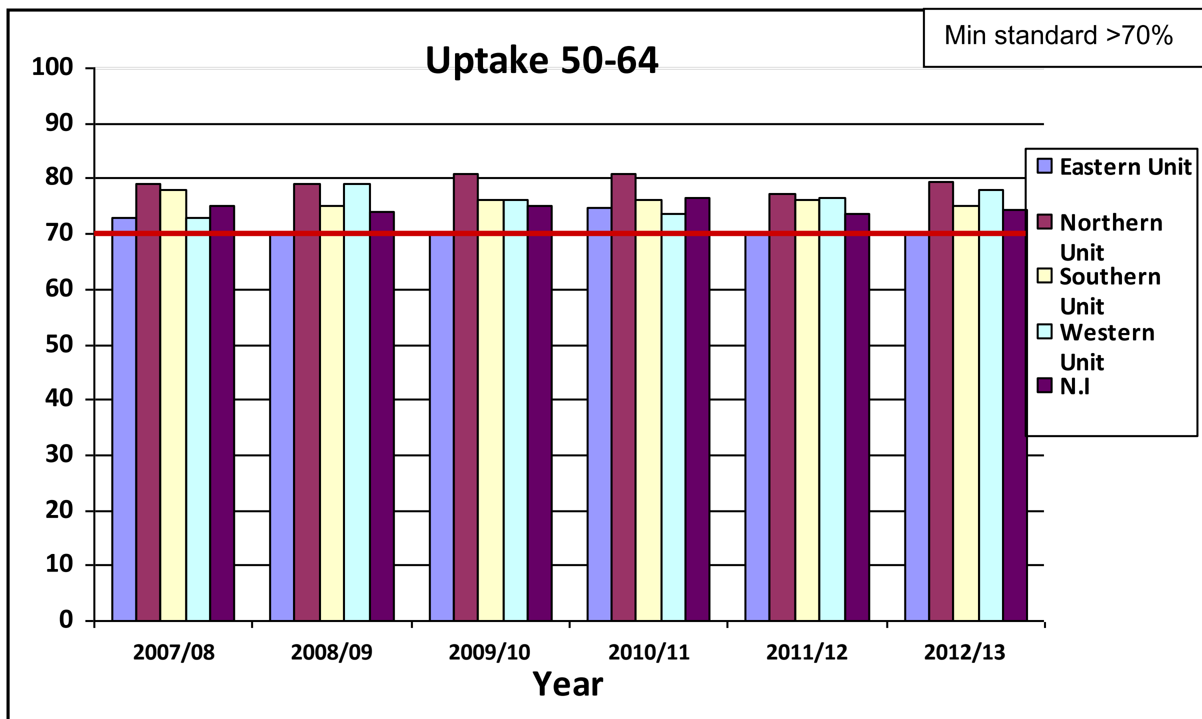
Each year around 75% of women invited take up the offer and attend for breast screening .

Attendance is lowest in Derry/Londonderry and in Greater Belfast.

Uptake measures the percentage of women who attend for breast screening each year, following an invitation. Figure 6 shows the uptake rates over a 6 year period. The age range 50-64 is used to compare results with those obtained before age extension in March 2009.

In 2012/13 each of the 4 breast screening units achieved an uptake of over 70% for women aged 50 - 64, which is the national minimum standard. Overall the Northern unit has the highest uptake and the Eastern unit the lowest. The average figure for Northern Ireland in 2012/13 was 74.2%. This means that just under three quarters of all women who were invited accepted the offer of breast screening (a total of 61,766 women).

Figure 6: Uptake for women aged 50-64 by unit and for Northern Ireland 2007/08 – 2012/13



The uptake for women aged 50–70 between 2010/11 and 2012/13 is shown in figure 7.

The overall uptake for this age range in Northern Ireland was **73.9%** in 2012/13. This compares with 73.3% in 2011/12 and 75.8% in 2010/11.

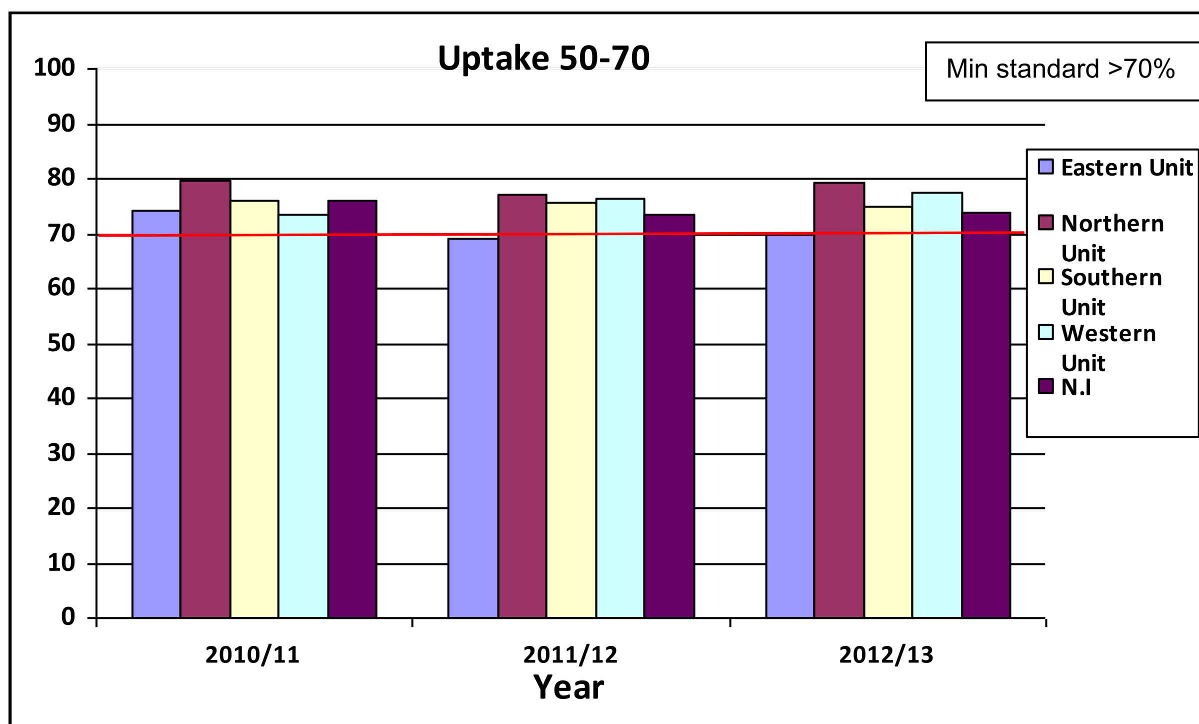
The comparative figure for England was **72.2%**. This compares with 73.1% in 2011/12 and 73.4% in 2010/11.

The comparative figure for Wales was **71.2%**. This compares with 73.2% in 2011/12 and 74.3% in 2010/11.[5]

Scotland publishes a 3 yearly average uptake figure. This was **73.5%** for the period 2010/13.[6]

The breast screening programme in the Republic of Ireland is not strictly comparable. It invites women aged 50-64 every 2 years. Uptake in 2011/12 (the most recent published figures) was 74.5% based on the population known to the programme and excluding certain groups of women.[7] Without the exclusions the figure is 72.2%.

Figure 7: Uptake for women aged 50-70 by unit and for Northern Ireland 2010/11 to 2012/13



[5] http://www.breasttestwales.wales.nhs.uk/sitesplus/documents/1025/btw_programme_performance_2012-13.pdf
[6] https://isdscotland.scot.nhs.uk/Health-Topics/Cancer/Publications/2014-04-29/2014-04-29-SBSP-Cancer-Summary.pdf?56365603209
[7] http://www.breastcheck.ie/sites/default/files/bc_pr.pdf

7 Promoting Informed Choice

Significant progress has been made implementing an agreed action plan to promote informed choice about breast screening. This includes specific actions relating to groups that may have difficulty accessing the breast screening programme.

There are a number of reasons why women may not attend for breast screening. This can be due to organisational and communication issues, as well as individual factors, including personal choice. The PHA, in partnership with other stakeholders, is implementing an action plan to help ensure all eligible women can make an informed choice about attending for breast screening and that the service is as accessible as possible.

The action plan was developed following a workshop and series of meetings with groups representing minority ethnic communities; people living in deprived circumstances; people with learning difficulties; lesbian, gay, bisexual and transgender communities; people with physical and sensory disabilities, prisoners and Travellers.

The following actions have been taken:

1. The number of breast screening mobile units will increase from 5 to 7 in 2014. This will mean that the service can be brought into more communities improving accessibility (the new locations are shown in figure 2).
2. Women are now given more than 2 weeks' notice of their screening appointment date so that they have more time to make arrangements to attend (women are encouraged to phone the breast screening unit to request a more convenient appointment if the one offered doesn't suit).
3. The Eastern Breast Screening Unit and the Northern Breast Screening Unit have introduced a system of text prompts to remind women about the appointment the day before. Plans are underway to introduce similar systems in the Southern and Western Breast Screening Units.
4. Each of the breast screening units has developed an action plan for community and primary care engagement.

5. The Quality Assurance Reference Centre (QARC) has established a regional group, with representation from each of the breast screening units, to promote informed choice in breast cancer screening.
6. The invitation letter to women has been revised. It will now be reviewed annually.
7. A new set of breast screening information leaflets has been produced (see page 10). The information leaflet for health care professionals has also been revised and is on the QARC website.
8. Screening appointment cards (the size of business cards) have been produced to give to women when they attend for their last invited screening mammogram. This aims to encourage older women to make an informed choice about continuing to attend for breast screening as the risk of breast cancer continues to rise with age (see figure 8). In addition an over 70s leaflet is being developed; as is an over 70s page on the QARC website.

Figure 8: The risk of getting breast cancer continues to increase with age.

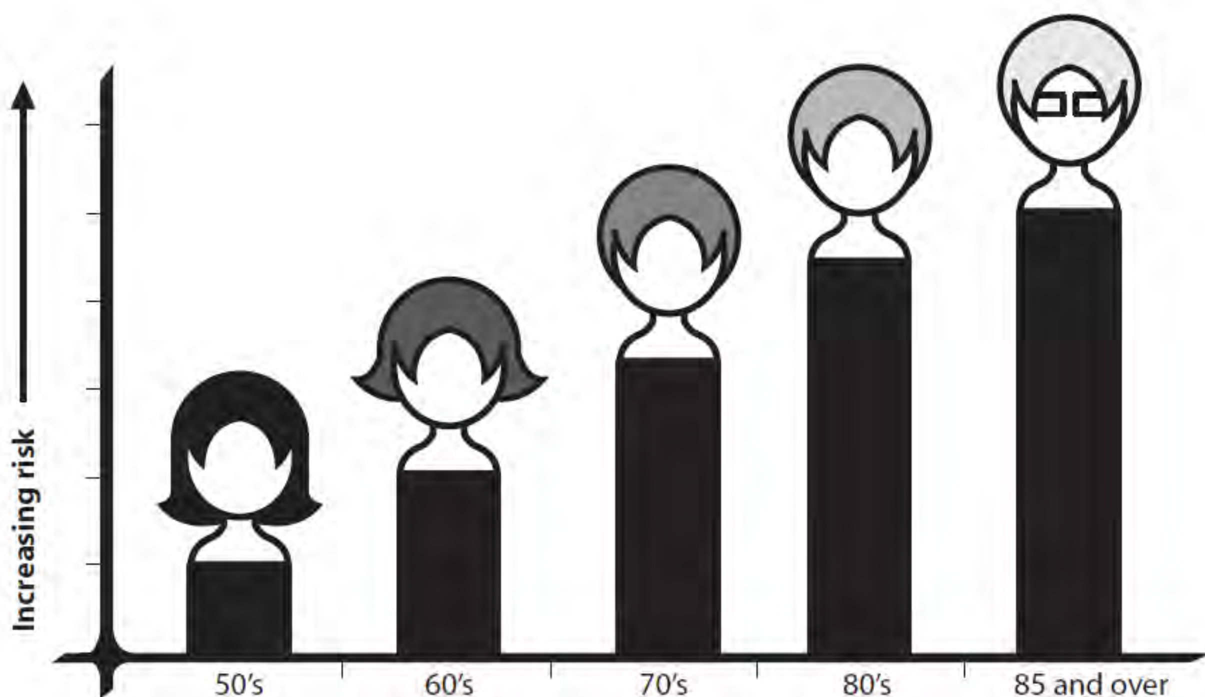


Illustration courtesy of NHSBSP

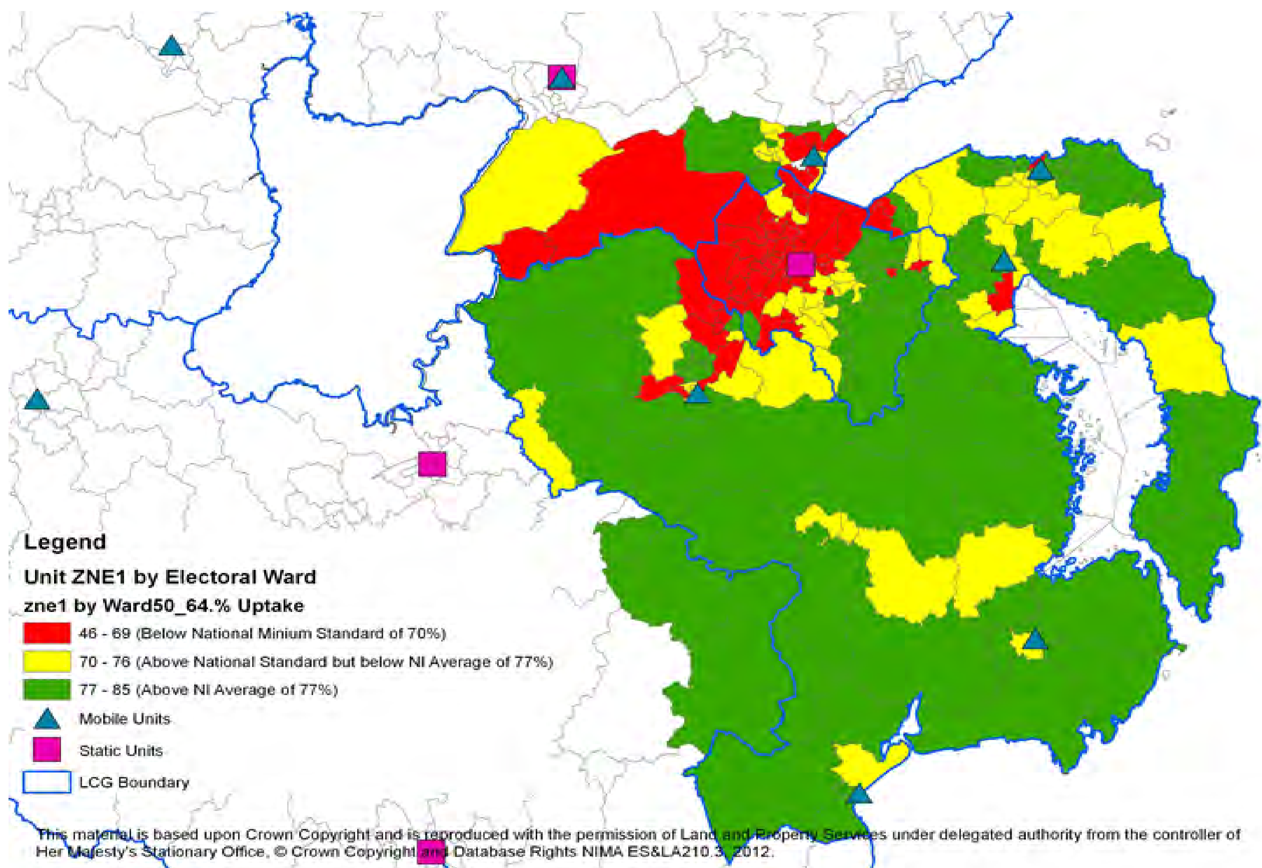
9. Collaboration with the Royal National Institute for the Blind (RNIB) has resulted in the development of a Braille version of the "Breast Screening—Helping You Decide" leaflet; as well as an audio version which will be on the cancer screening website. This collaboration has also resulted in a feature on the breast screening programme appearing on Sound Vision Ulster; an audio magazine for people with visual impairment http://www.soundvisionulster.com/listen_to_svu/listen_to_svu.html

10. Three tweets are being issued by the PHA each month about the Breast Screening Programme. A couple of examples are shown below:

    - Make an informed choice about attending for breast cancer screening find out more @ bit.ly/FAQ-Breastscreening
    - Check out www.cancerscreening.hscni.net to see when breast cancer screening is taking place for your area.

11. A set of geomaps was produced showing the uptake of breast screening at small area levels (super output area and electoral ward) to assist in targeting resources at low uptake areas. An example is shown in figure 9 below. The maps are at http://www.cancerscreening.hscni.net/2094.htm

Figure 9: Uptake for women aged 50-64 by electoral ward Belfast and South Eastern Trust areas 2008-2011

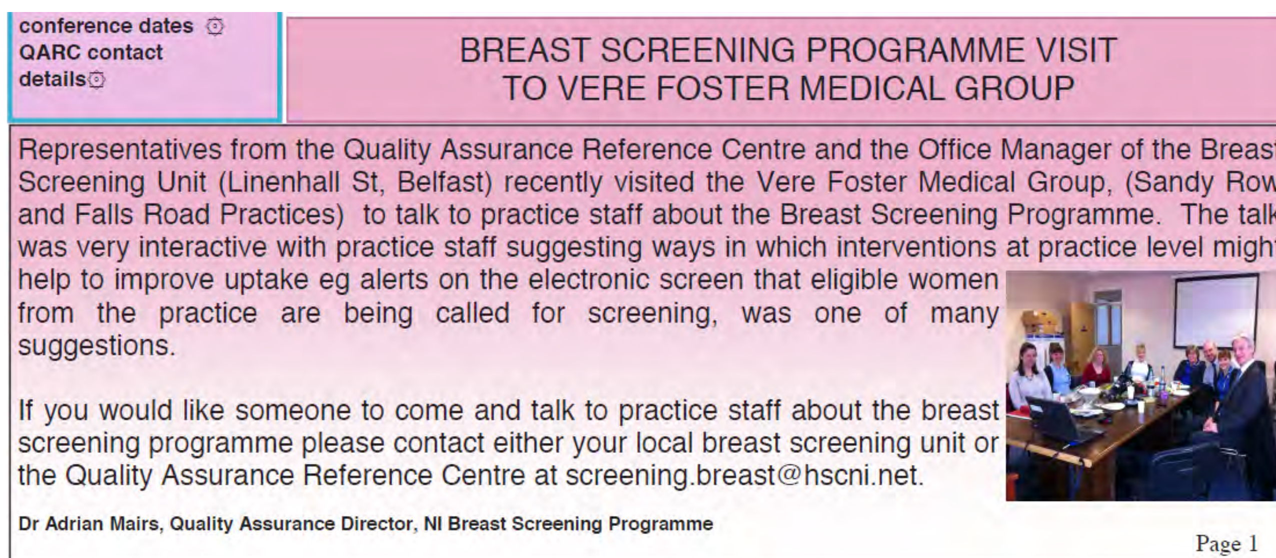


12. An equality questionnaire was piloted on women attending for breast screening in a selected area. It aimed to capture information on the categories set out in Section 75 of the Northern Ireland Act 1998. There were issues concerning the distribution of the questionnaire, negative feedback from radiographers and from some women attending for screening. Following a revision of the questionnaire, and the protocol for its distribution and return, it will be piloted in a different area during 2014/15.

13. A thousand questionnaires will be issued during 2014 to women who have not attended for their first (prevalent) screen to try to identify the reasons why these women do not attend. The results of this survey will inform focus group work later in 2014.

14. QARC and the Breast Screening Units are identifying and actively offering support to individual GP practices with a low uptake of breast screening; as well as offering to provide support and advice to any GP practice that requests it.

Figure 10: Article from QARC Newsletter April 2014



conference dates
QARC contact details

BREAST SCREENING PROGRAMME VISIT TO VERE FOSTER MEDICAL GROUP

Representatives from the Quality Assurance Reference Centre and the Office Manager of the Breast Screening Unit (Linenhall St, Belfast) recently visited the Vere Foster Medical Group, (Sandy Row and Falls Road Practices) to talk to practice staff about the Breast Screening Programme. The talk was very interactive with practice staff suggesting ways in which interventions at practice level might help to improve uptake eg alerts on the electronic screen that eligible women from the practice are being called for screening, was one of many suggestions.

If you would like someone to come and talk to practice staff about the breast screening programme please contact either your local breast screening unit or the Quality Assurance Reference Centre at screening.breast@hscni.net.

Dr Adrian Mairs, Quality Assurance Director, NI Breast Screening Programme

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15. The PHA has approved a business case for a service to promote informed choice in relation to the breast, bowel and cervical cancer screening programmes across Northern Ireland. The service will deliver community educational sessions to raise awareness of each of the cancer screening programmes. In addition special breast screening clinics will be facilitated for groups of women to attend together for mammography screening.

The service will focus on groups of people that find cancer screening services more difficult to access than the rest of the population for a variety of cultural, educational or historic reasons. This will include people from deprived communities; people belonging to an ethnic minority; Travellers; lesbian, gay and transgender people; and people with learning, physical or sensory disabilities. This list is not exhaustive.

16. A project to support Travellers make an informed choice about breast screening has been developed by QARC, the Southern Health & Social Care Trust and An Munia Tober (a Traveller support group). This will involve raising awareness of breast cancer and of the breast screening programme; and the provision of a special breast screening clinic for Travellers. The clinic will be arranged on a date and at a location to enable a group of Traveller women to attend for breast screening together. If successful the project will be rolled out to other areas.

17. QARC is also leading another project. This one focuses on women with learning difficulties. The aim is to identify all women, who have been registered as having a learning difficulty, in advance of them being invited for screening. This will enable the development of a service more tailored to the needs of these women, which could be achieved in a number of ways:

- A revised more appropriate invitation letter
- Provision of more appropriate literature to enable the woman/her carer to make an informed choice
- Organising a visit to the unit before coming for screening
- Providing information to the Community Learning Disability Service
- A longer appointment time (normally appointments last 6 minutes)
- The potential in the longer term to establish special clinics, i.e. inviting eligible women within a particular area/residential care home to a specific clinic.

8 Medical Physics Standards

Each of the mammography x-ray machines meets the standards for image quality and radiation dose.

Mammograms are taken using low dose x-rays. The Northern Ireland Breast Screening Programme has a number of performance standards relating to:

- the image quality (spatial resolution and low contrast detectability); and
- the radiation dose provided by the x-ray equipment.

These are shown in table 1 below. These parameters are measured during regular medical physics surveys of the mammography equipment.

Table 1: Mammography Equipment Performance Standards

Parameter		Standard
Spatial Resolution [line pairs per mm] *		≥ 12
Low Contrast Detectability (%)	6 mm detail	≤ 1.2
	0.5 mm detail	≤ 5
	0.25 mm detail	≤ 8
Mean Glandular dose to Standard Breast (mGy)		≤ 2.5

* Note: The Spatial Resolution standard does not apply to the digital mammography units in Antrim & Craigavon Area Hospitals.

The following charts indicate the performance of the units in the Northern Ireland Breast Screening Programme against the standards. All units meet the applicable standards.

Figure 11: Spatial Resolution of Mammography Images by Machine

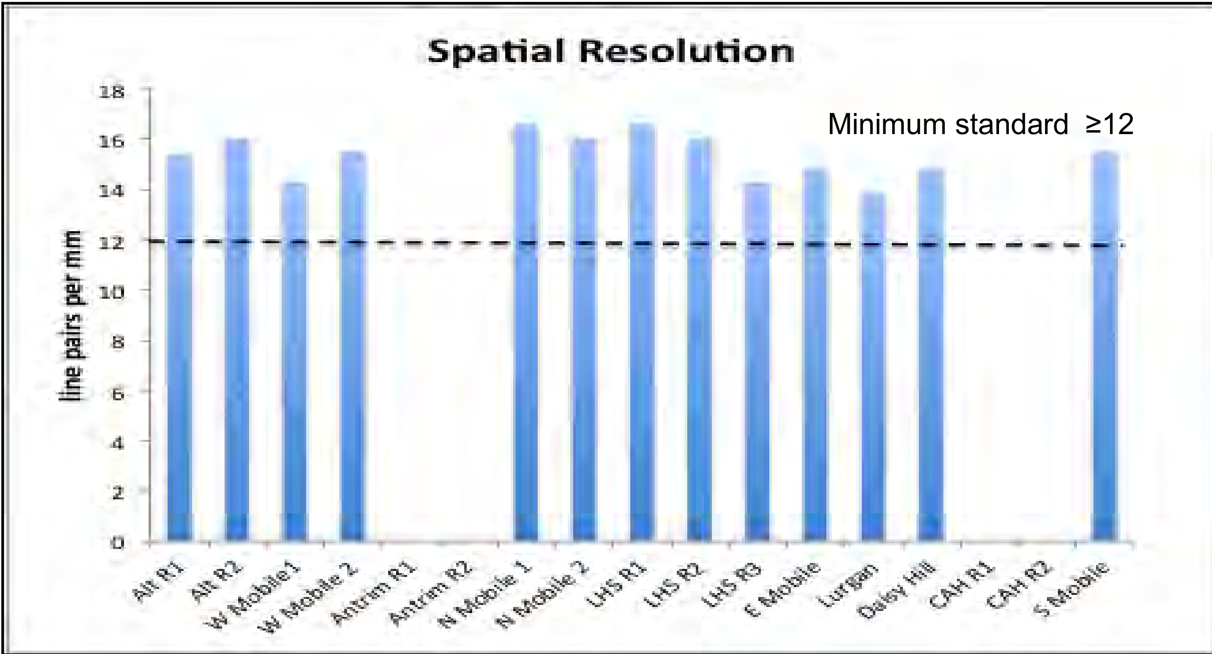


Figure 12: Low Contrast Detectability by Mammography Machine – 6 mm Details

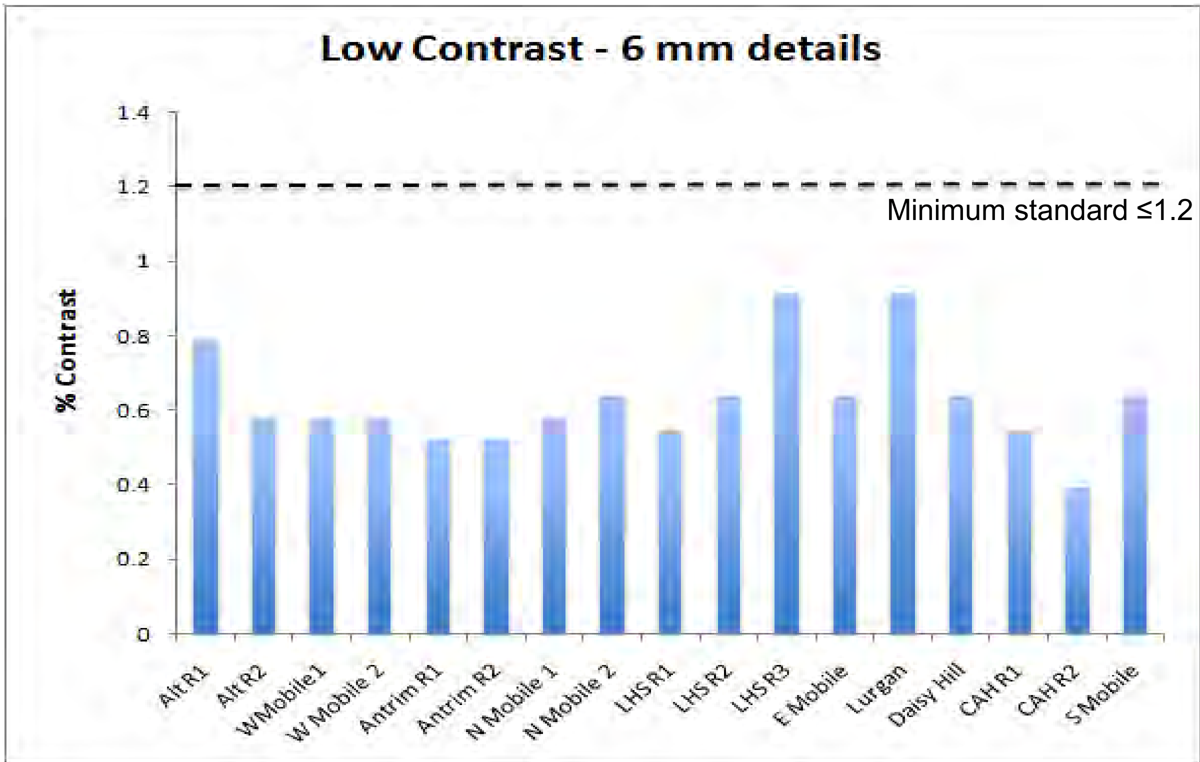


Figure 13: Low Contrast Detectability by Mammography Machine – 0.5 mm Details

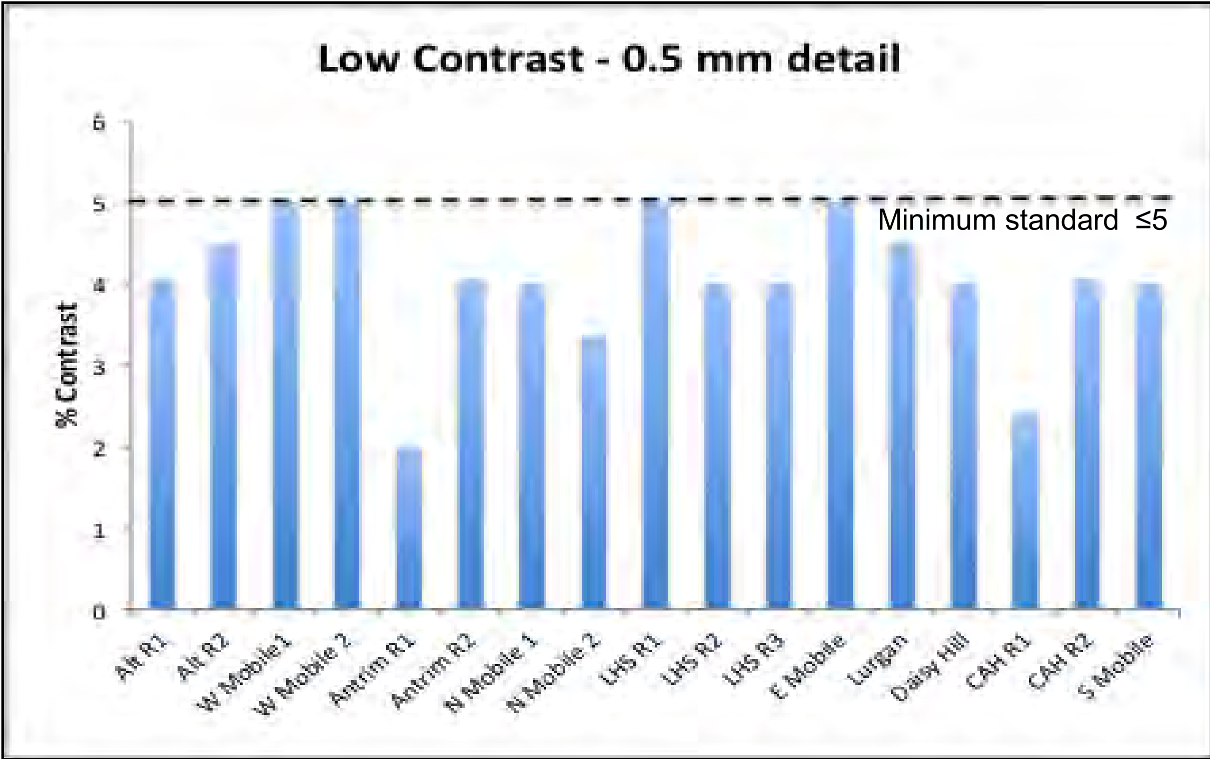


Figure 14: Low Contrast Detectability by Mammography Machine – 0.25 mm Details

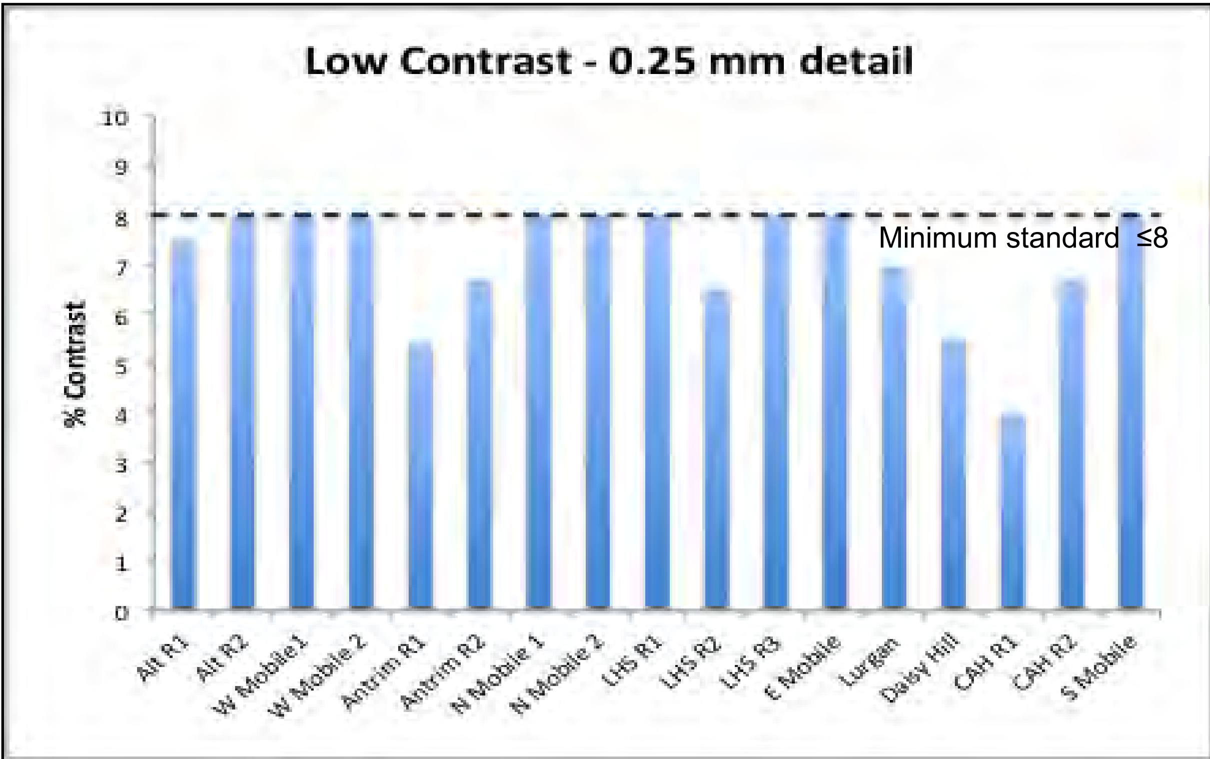
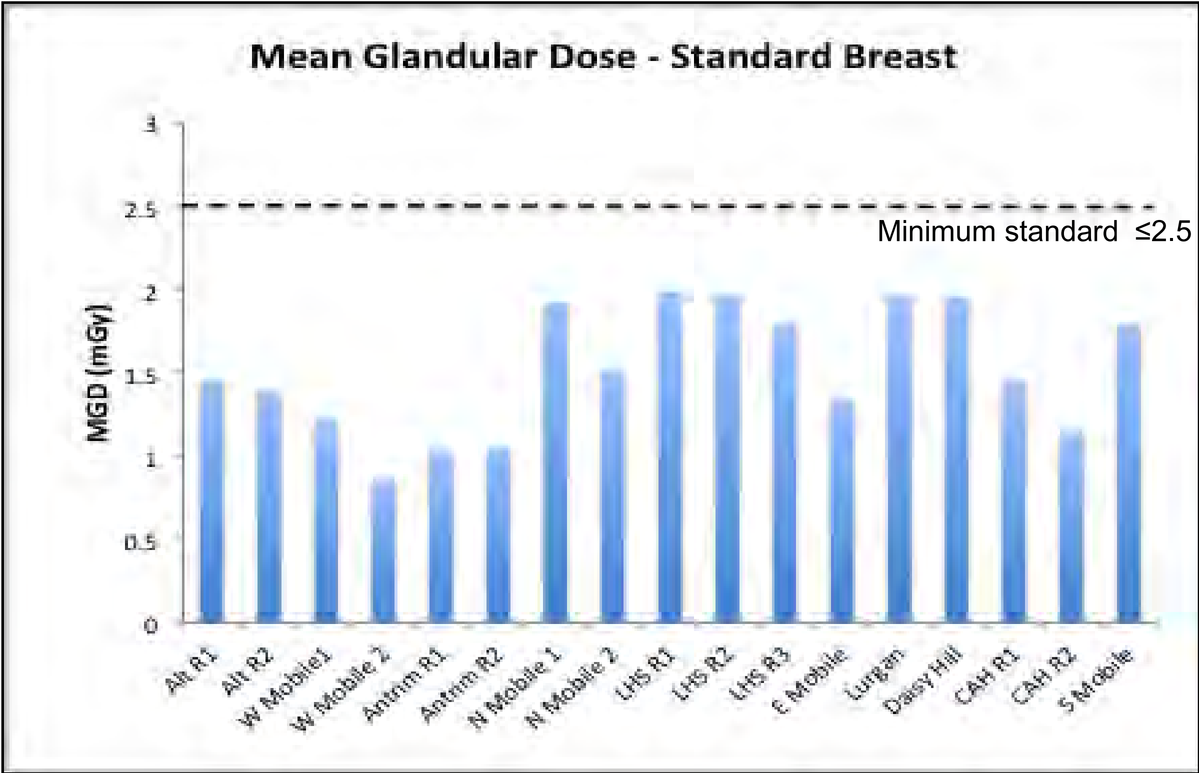


Figure 15: Mean Glandular Dose by Mammography Machine



9 Screen to Routine Recall

97.1% of women (who had a normal test result) received their results within 2 weeks

Most women who attend for breast screening mammography (96%) will be identified as having normal mammograms. Screen to routine recall measures the interval between the date a woman attended for screening (the date her mammograms were taken) and the date her episode is closed on the NBSS i.e. the date the result is entered (taken as a proxy for the date she is sent her results letter). The minimum standard is for ≥ 90% of women to receive their results within two weeks, with a target of 100%.

Figure 16 shows the overall results for Northern Ireland over a 6 year period. In 2012/13, 97.1% of women received their results within 2 weeks. Performance against this standard has improved considerably over the past few years.

Figure 16: Screen to routine recall for Northern Ireland by year from 2007/08 to 2012/13

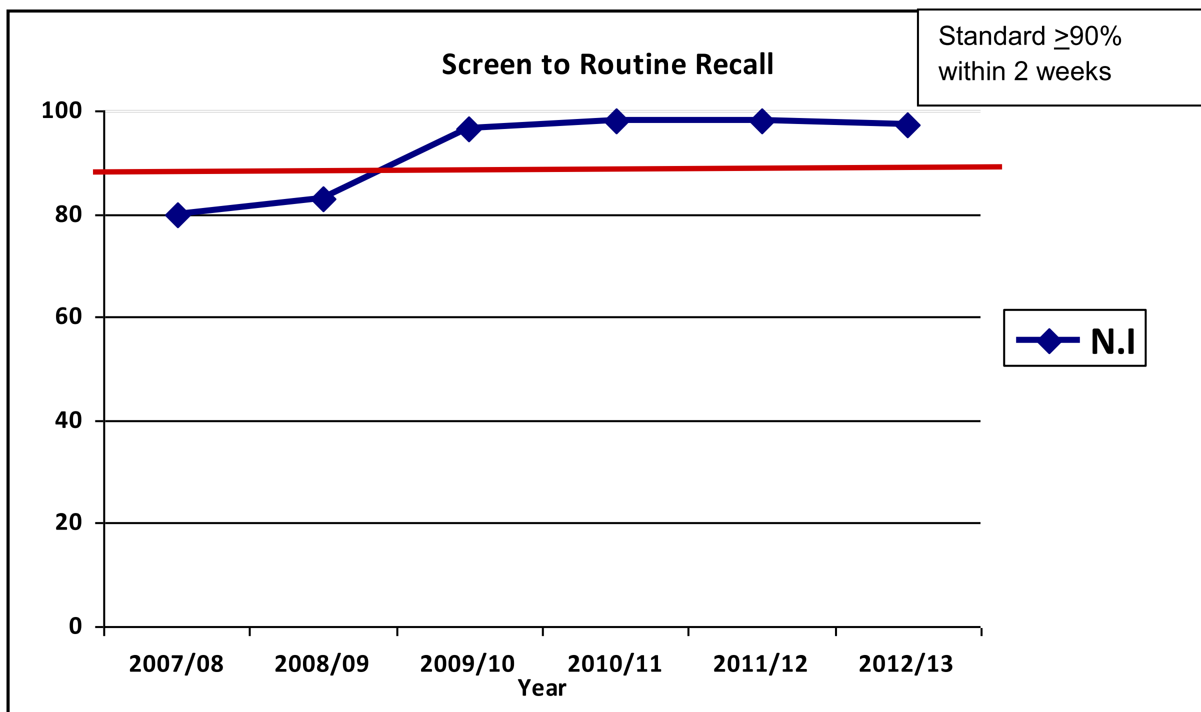
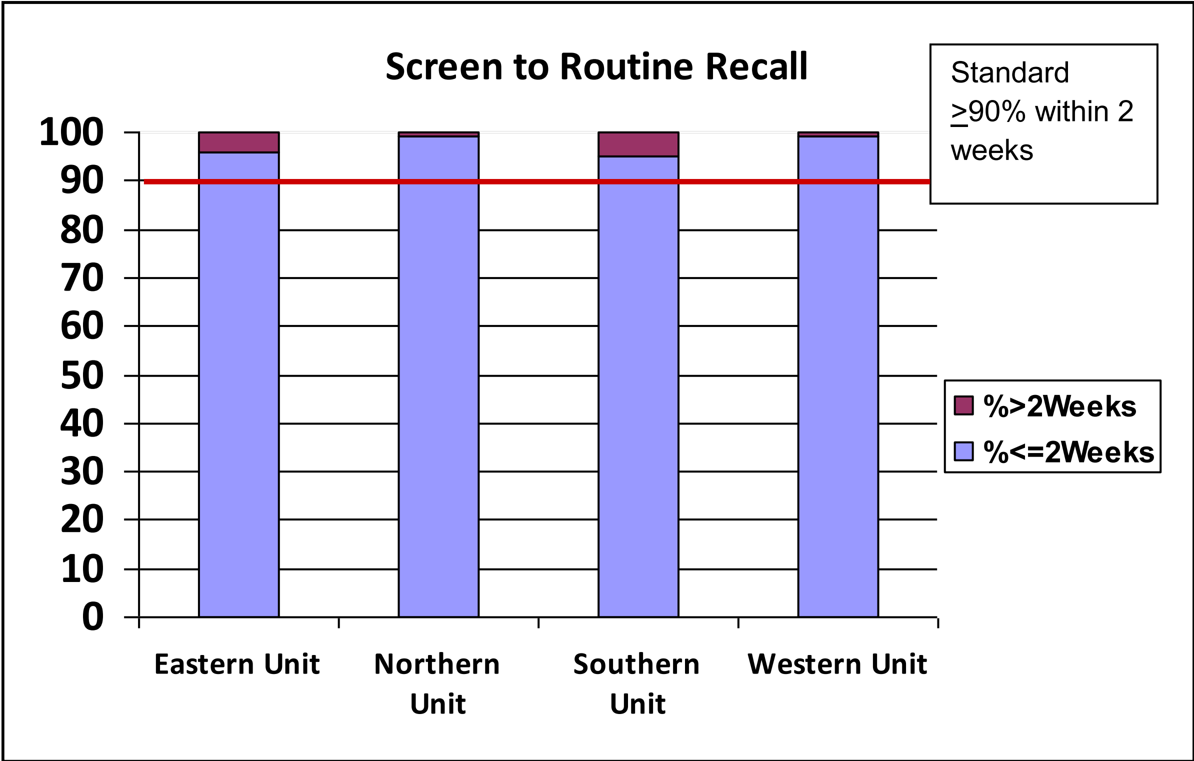


Figure 17 shows the performance of each unit in 2012/13. All units exceeded the standard.

Figure 17: Screen to routine recall by unit in 2012/13



10 Screen to Assessment

90.6% of women referred for assessment were offered an appointment within 3 weeks

About 4 women in every 100 women are asked to come back for more tests after screening. These women are invited to attend an assessment clinic. On average 1 out of 4 women called back will be found to have cancer. The rest will not have cancer and will go back to having routine screening invitations every 3 years.

Screen to assessment (date of first offered appointment) measures the interval between a woman's screening mammogram and the date she is offered an appointment for the assessment clinic. The minimum standard is for ≥ 90% of women to be offered an appointment within 3 weeks of attendance for mammography, with a target of 100%. Figure 18 shows the results for Northern Ireland over a 6 year period. Performance had been improving but has dropped a little recently, largely due to the Eastern unit not meeting the standard (figure 19). It was 90.6% in 2012/13. As from 1 January 2014, in line with advice from the National Screening Office in England, units should be achieving a figure of 100% for this standard.

Figure 18: Screen to assessment for Northern Ireland by year from 2007/08 to 2012/13—date of first offered appointment

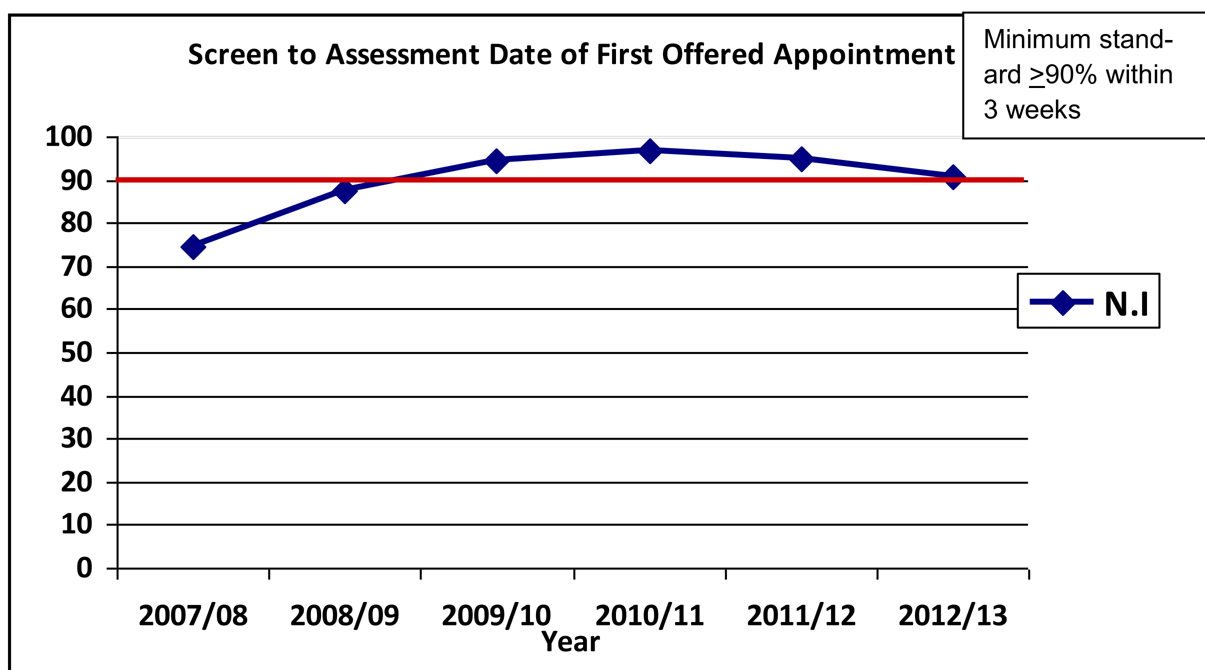
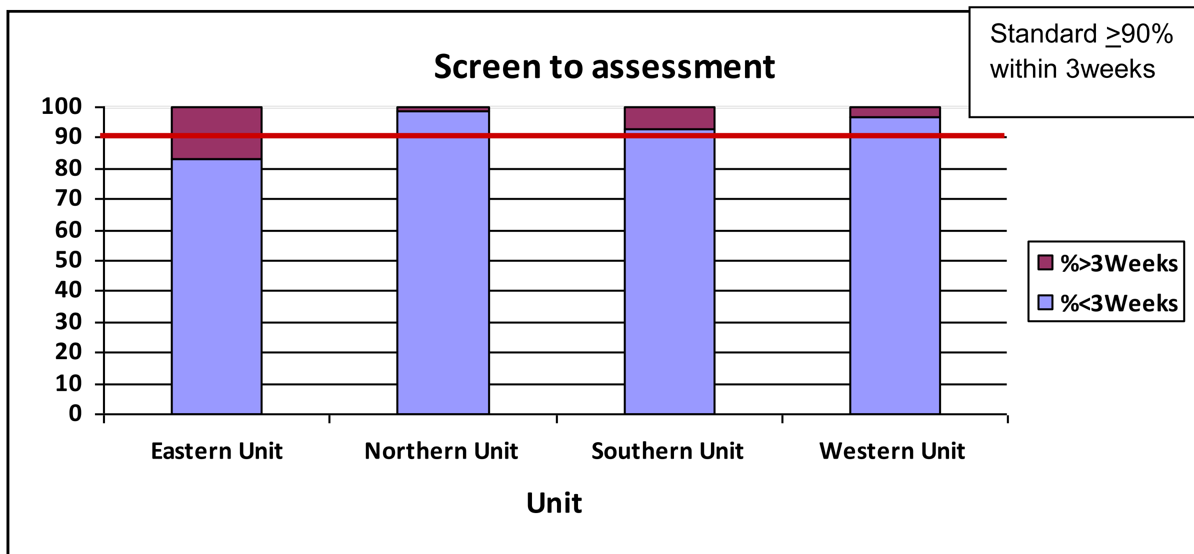
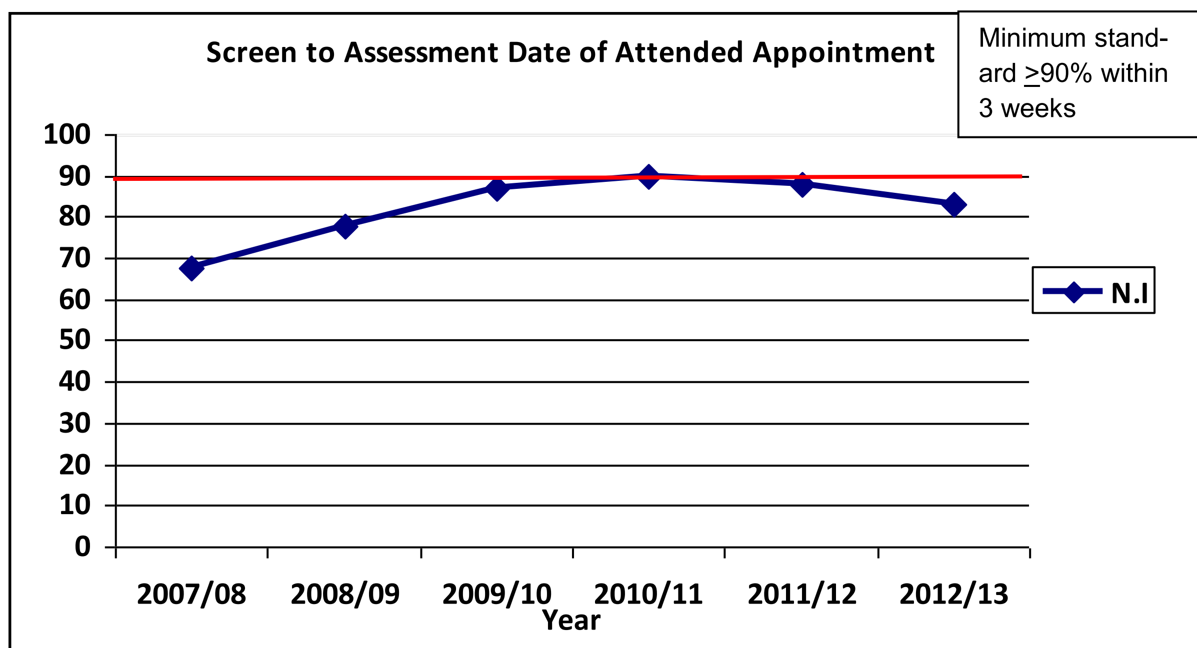


Figure 19: Screen to assessment (date of first offered appointment) by unit 2012/13



QARC also monitors the interval between a woman's screening mammogram and the date she actually attends her appointment (figure 20). This differs from the previous measurement, as some women may choose to change their appointment to a later time; some women may not turn up (DNA) and be offered another appointment date, or (rarely) because an assessment clinic is cancelled. Units should aim to achieve a figure of ≥90% for this standard. The figure achieved in 2012/13 was 83%. QARC is working with units to improve performance against this standard

Figure 20: Screen to assessment for Northern Ireland by year from 2007/08 to 2012/13 — date attended appointment



11 Referred for Assessment

2,336 women were referred for assessment in 2012/13 – 3.7% of the women screened

The percentage of women who are recalled to an assessment clinic is normally higher in those women who are attending for their first screening mammogram (known as the prevalent screen) than in those attending for subsequent screening mammography (incident screens). Table 2 shows the performance by unit. The objective is to minimise the number of women referred for further tests. However, a recall rate that is too low can reduce the number of cancers detected.

Prevalent screen

The minimum standard for the percentage of women recalled for assessment in the prevalent (first) screen is <10%, with a target of <7%. The Northern Ireland figure was 7.7%, which meets the standard.

Incident screen

The minimum standard for the percentage of women recalled for assessment for incident (subsequent) screens is <7%, with a target of <5%. The Northern Ireland figure for incident screens was 2.5%, which meets the standard and the target.

Table 2: Percentage of women aged 50–70 recalled for assessment, by unit, in 2012/13

Unit	Prevalent %	Incident %
Eastern	8.7	2.4
Northern	11.2	3.0
Southern	5.5	2.6
Western	5.0	2.1
Northern Ireland	7.7	2.5
	Standard < 10% Target < 7%	Standard < 7% Target < 5%

Table 3 below shows that Northern Ireland compares well with the performance of the English regions (green indicates that the standard and the target have been met; orange indicates that the standard has been met).

Of the 80 breast screening units in England, 73 met the minimum standard of <10% recall for the prevalent screen in 2012/13.

Table 3: Percentage of Women Aged 50-70 Recalled to Assessment by Region.

NHS BREAST SCREENING PROGRAMME INCLUDING NORTHERN IRELAND: % RECALLED TO ASSESSMENT BY REGION PREVALENT SCREEN AGE 50 – 70 2012 - 2013 Standard <10% Target <7%	
East Midlands	5.9
North East	6.5
West Midlands	6.7
Yorkshire & Humber	7.1
East of England	7.2
Northern Ireland	**7.7**
England	**7.8**
South West	8.1
South East Coast	8.3
London	8.6
North West	8.7
South Central	9.1

NHS BREAST SCREENING PROGRAMME INCLUDING NORTHERN IRELAND: % RECALLED TO ASSESSMENT BY REGION INCIDENT SCREEN AGE 50 – 70 2012 - 2013 Standard <7% Target <5%	
West Midlands	2.4
East Midlands	2.5
East of England	2.5
Northern Ireland	**2.5**
North East	2.6
England	**2.9**
Yorkshire & Humber	3.0
South Central	3.1
South West	3.2
London	3.2
North West	3.3
South East Coast	3.4

Figures 21 and 22 show the trends over the 6 year period 2007/08 to 2012/13. The Northern unit tends to have the highest recall rates and the Western the lowest. The Northern Unit did not meet the standard in 2012/13 with a figure of 11.2%. However, performance in other areas is satisfactory and the unit, and QARC, are monitoring this.

Figure 21: % referred to assessment for prevalent (first) screen by unit and for Northern Ireland, 2007/08 to 2012/13

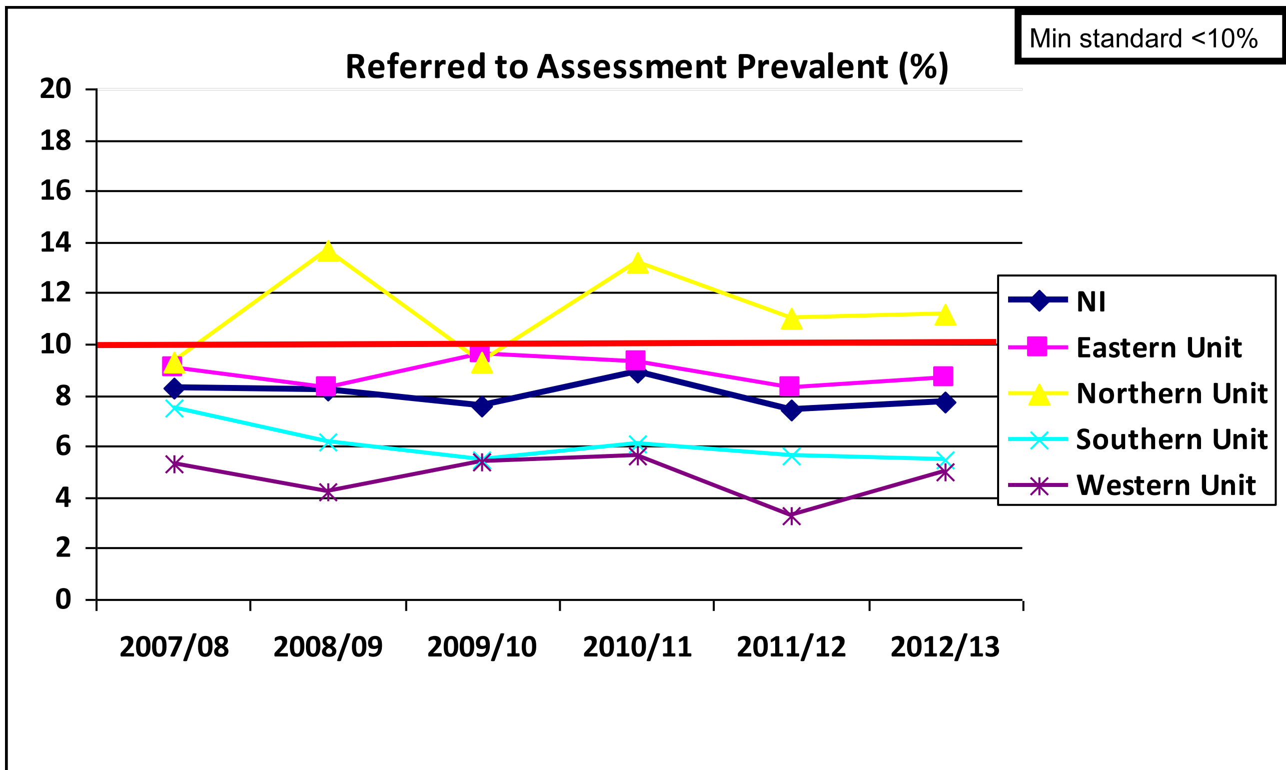
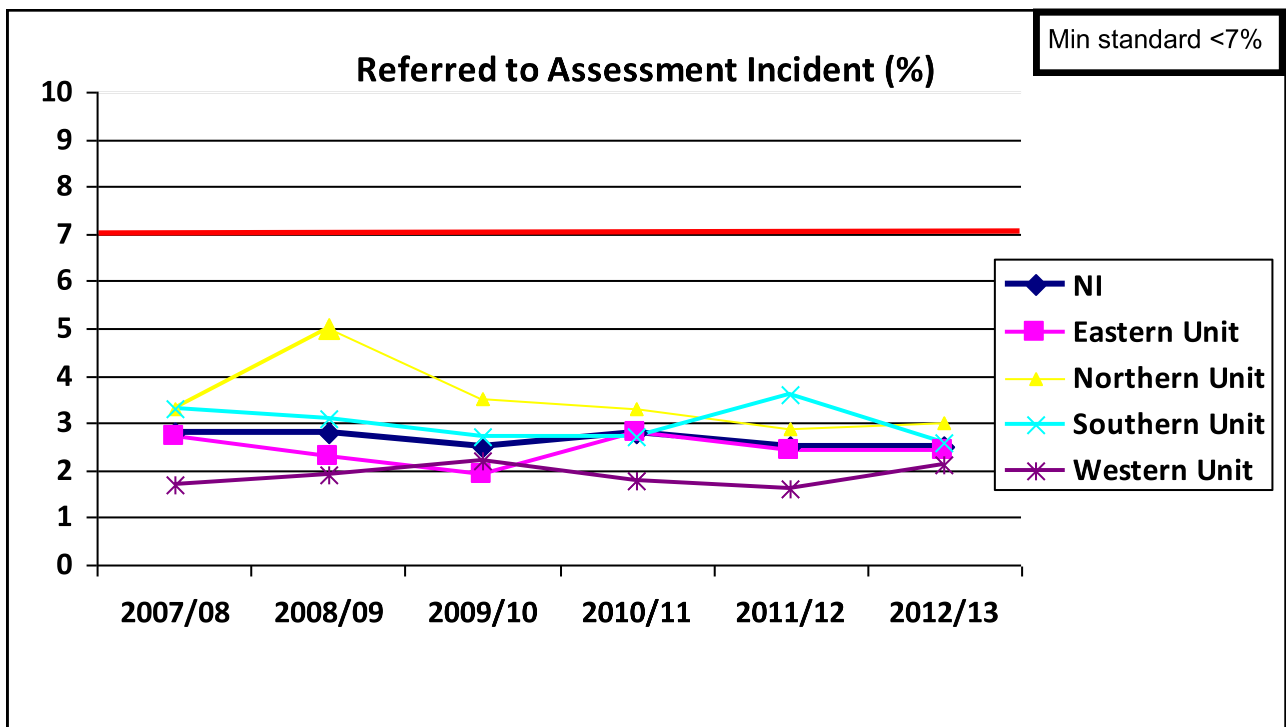


Figure 22: % referred to assessment for incident screen for women aged 50-70 by unit and for Northern Ireland, 2007/08 to 2012/13



By age band
Table 4 shows the percentage of women who are returned to routine recall after screening; and the corresponding percentage sent for further investigation at an assessment clinic, split by age bands.

Table 4: Percentage of women invited and screened aged 50–70 returned to routine recall & referred for assessment by age band

Age Group	No. Screened	Routine Recall (%)	Referred to Assessment (%)
45 - 49*	1728	1576 (91)	152 (9)
50 - 52	10863	10118 (93)	745 (7)
53 - 54	7058	6841 (97)	217 (3)
55 - 59	15409	15001 (97)	408 (3)
60 - 64	14313	13925 (97)	388 (3)
65 - 69	13026	12644 (97)	382 (3)
70	1097	1053 (96)	44 (4)
71 - 74	2	2 (100)	0 (0)
>=75	0	0 (0)	0 (0)
Target Group (50-70)	61766	59582 (96)	2184 (4)
Total all ages	63497	61161 (96)	2336 (4)
Age group 50 - 64	47643	45885 (96)	1758 (4)

* As women can receive their first invite in the year they turn 50 some women are invited when they are 49.

12 Visits to the Assessment Clinic

99.5% of women only required one visit to the assessment clinic to achieve a definitive diagnosis

The number of assessment clinic visits required to achieve a definitive diagnosis should be kept to a minimum, with no more than 2 for interventional procedures, such as a core biopsy.

Table 5 shows how Northern Ireland compares with other parts of the UK. 99.5% of women in Northern Ireland, who needed a biopsy, only required a single visit to the assessment clinic. This is better than the UK average of 96%.

Table 5: The assessment visit with the earliest cytology / core biopsy for all cancers - data for 2012/13

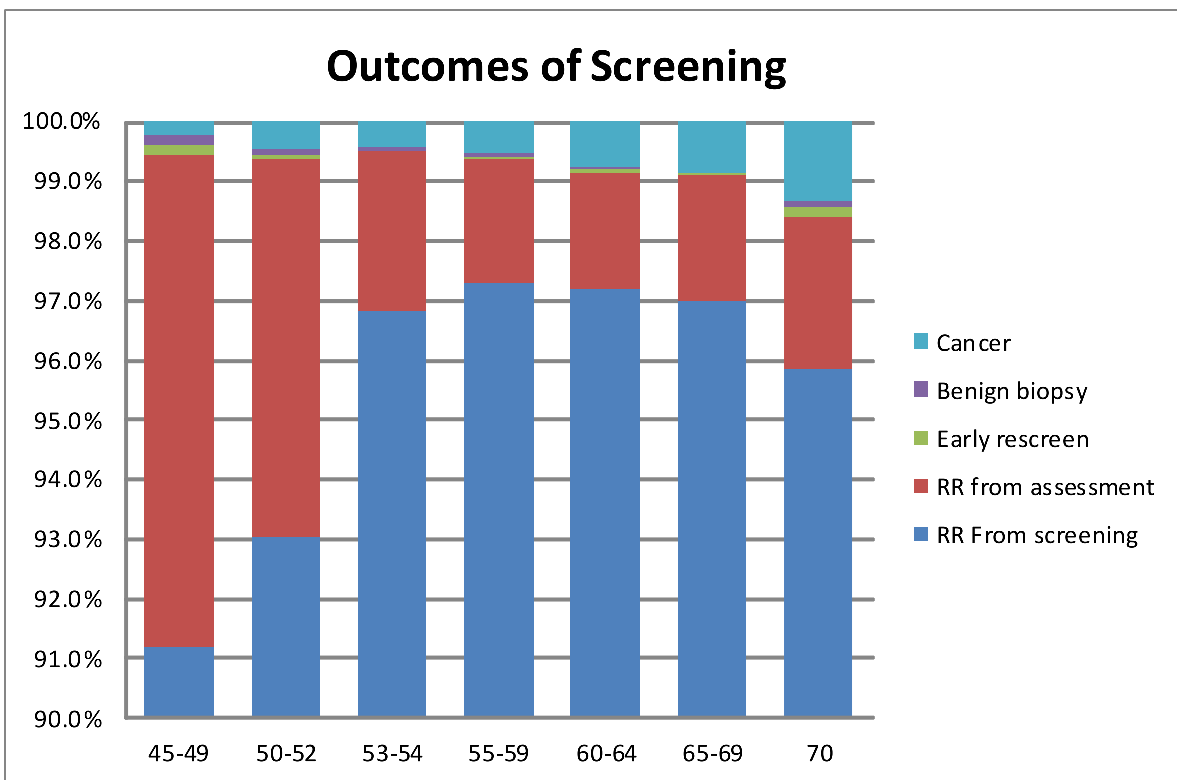
	1 (%)	2 (%)	3+ (%)	Total (%)	2 or more visits to achieved the diagnosis (%)
Eastern Unit	185 (99)	1 (1)	0 (0)	175 (100)	1 (1)
Northern Unit	81 (100)	0 (0)	0 (0)	81 (100)	0 (0)
Southern Unit	66 (100)	0 (0)	0 (0)	66 (100)	0 (0)
Western Unit	106 (99)	1 (1)	0 (0)	107 (100)	1 (1)
Northern Ireland	438 (100)	2 (0)	0 (0)	440 (100)	2 (0)
UK	16294 (96)	732 (4)	6 (0)	17032 (100)	738 (4)

13 Outcomes of Screening

Younger women are more likely to be called back for assessment, but cancer is more likely to be found in older women.

Figure 23 shows the outcomes of screening by age bands. Younger women are more likely to be called back to an assessment clinic for further testing. The result of this further testing is, for most women, reassurance. These women are returned to routine recall and invited for routine screening again in 3 years' time ("RR from assessment" on the graph). Note that the y-axis of the graph starts at 90%; as more than 90% of all women screened have normal mammograms.

Figure 23: Outcomes of Breast Screening by Age Band 2012/13



Early re-screen involves bringing a woman (who has attended an assessment clinic) back for repeat screening mammography sooner than the normal three yearly screening interval. This is a rare event and these cases are monitored and reviewed by QARC.

14 Preoperative Diagnosis Rate

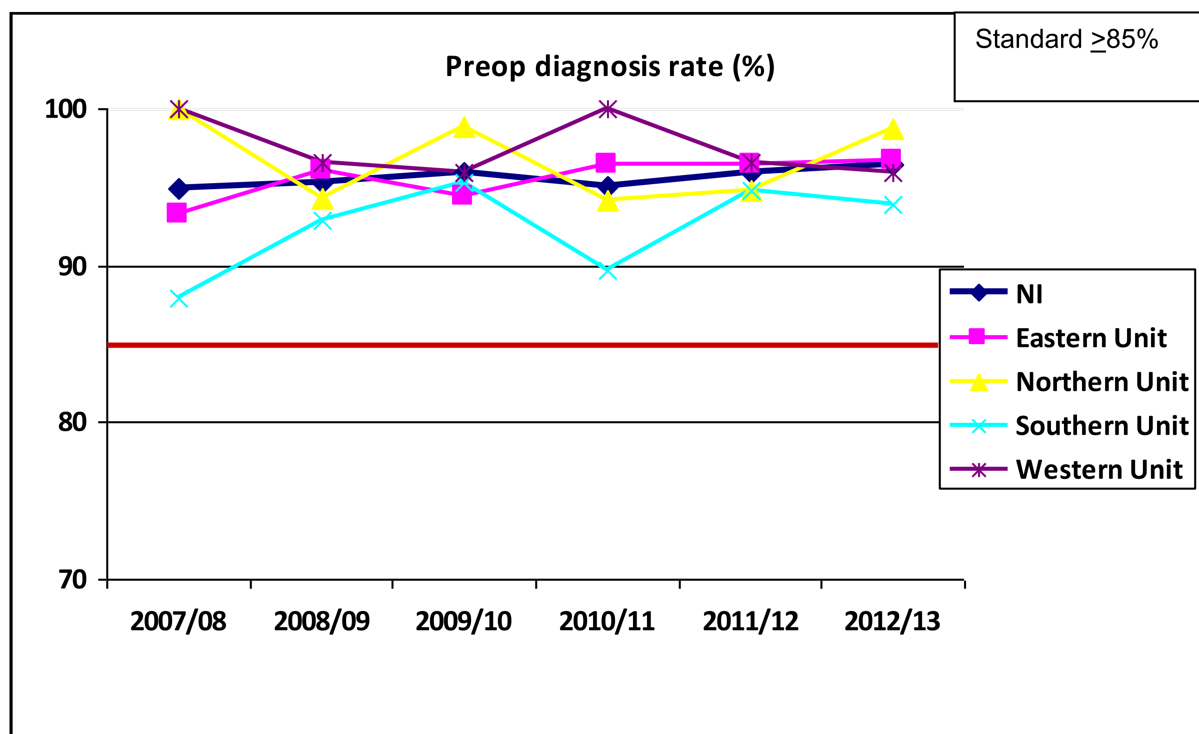
96.5% of women with cancers detected by screening had the diagnosis confirmed before surgery

The pre-operative diagnosis rate measures the percentage of screen detected cancers where the diagnosis was established prior to surgery. Diagnosis before surgery is made by taking a biopsy at the assessment clinic (usually by core biopsy, but increasingly by vacuum assisted biopsy).

Some women need to have a surgical biopsy (a biopsy taken during surgery). This can be because the diagnosis is difficult to establish. The minimum standard is ≥85% of cancers should be diagnosed before surgery, with a target of ≥90%.

Figure 24 shows each unit's performance over a 6 year period. The figure for women aged 50-70 in Northern Ireland was 96.5% in 2012/13. It has remained around 95% for a number of years.

Figure 24: Preoperative diagnosis rate by unit and for Northern Ireland from 2007/08 to 2012/13



15 Pathology

The diagnostic accuracy of biopsies taken at assessment clinics is high

The breast biopsies taken at the assessment clinic are examined and categorised by a pathologist as:

B1 or C1 – Normal
B2 or C2 – Benign disease
B3 or C3 – Uncertain malignant potential
B4 or C4 – Suspicious
B5 or C5 – Malignant

The letter B refers to core biopsy or mammotomy (taking a sample of breast tissue) and C refers to fine needle aspiration cytology (taking a sample of breast cells).

The assessment clinic biopsy results are subsequently compared with the definitive diagnosis of tissue removed during surgery (further histology). The table shows the results for Northern Ireland for 2012/13.

Table 6: Comparison of assessment clinic biopsy result with final diagnosis (further histology)

		Assessment clinic biopsy results					
		B or C5	B or C4	B or C3	B or C2	B or C1	Total
Further histology	**Malignant**	426	3	12	0	0	441**
	Invasive	370	0	0	0	0	370
	Non-invasive	56	3	12	0	0	71
	Benign	3	2	25	4	2	36
	No Further Histology	5*	0	38	526	57	626
	Total B or C Results	434	5	75	530	59	1103

* These are considered to be cancers.
**This figure differs from the total number of cancers (430) in the next section due to the way the pathology QA data are processed.

Absolute sensitivity = 96.6%
This is the percentage of all the cancers diagnosed (441+5*) that were categorised as being malignant (B or C 5) on the assessment clinic biopsy (426+5*). As can be seen from the table some cancers were initially categorised as uncertain or suspicious.

The minimum threshold is >70% and the preferred threshold is >80%.

Complete sensitivity = 100.0%
This is the percentage of all cancers diagnosed (441+5*) that were categorised as uncertain (B or C 3), suspicious (B or C 4) or malignant (B or C 5) (426+5*+3+12).

The minimum threshold is >80% and the preferred threshold is >90%.

Positive predictive value = 99.3%
This measures the likelihood of having a final diagnosis of cancer (426+5*) if the assessment clinic biopsy is categorised as malignant (B or C 5) (434).

The minimum threshold is >99% and the preferred threshold is >99.5%.

16 Total Number of Cancers Detected

372 invasive cancers were detected in 2012/13 – of these 187 were small (less than 15 mm in diameter).

A total of 443 cancers was detected in 2012/13. Of these:

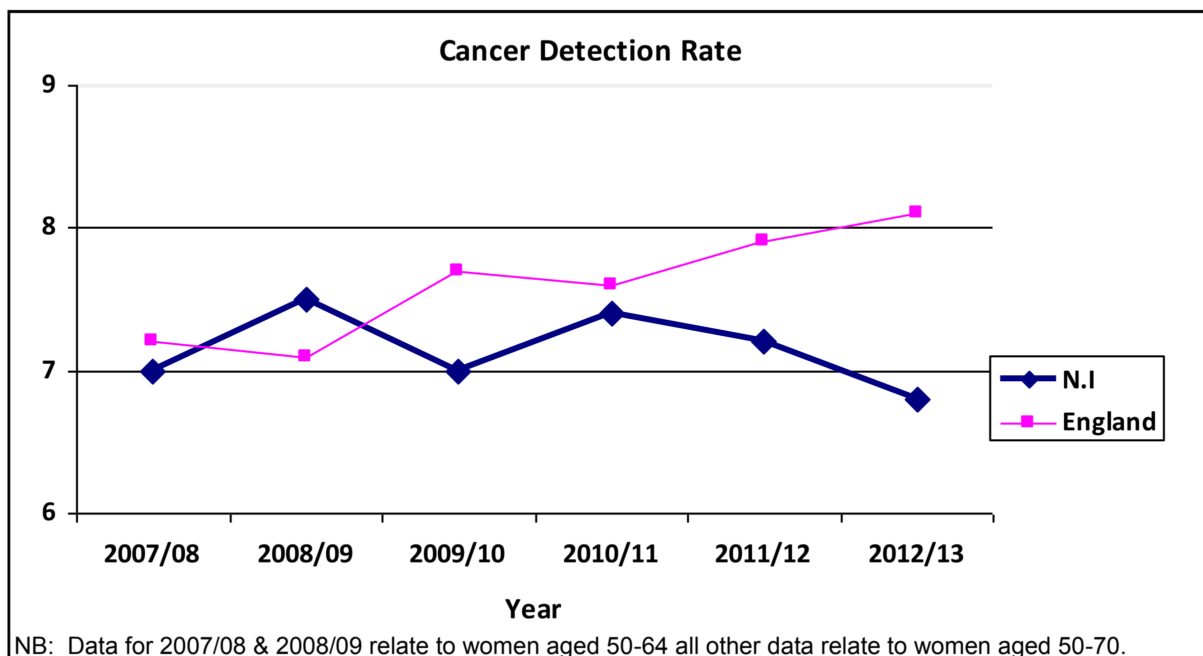
- 372 were invasive cancers;
- 67 were ductal carcinomas in situ (DCIS);
- 2 were micro invasive cancers; and
- 2 were invasive status not known.

A proportion of cases of DCIS will eventually become invasive. However, it is not yet possible to identify which ones will and which won't. Therefore all women diagnosed with this disease are offered treatment (surgery with or without radiotherapy).

Of the 372 invasive cancers that were detected, 187 (50.3%) were under 15 mm in diameter. These are known as small invasive cancers and they are usually around 55% of the invasive cancer figure. In the UK 52.5% of invasive cancers were categorised as small invasive cancers in 2012/13.

The total cancer detection rate for the 50 -70 age group in 2012/13 was 6.8 per 1,000 women screened. The comparative figure for England for 2012/13 was 8.1 per 1,000 women screened.

Figure 25: Total cancer detection rate for Northern Ireland and England from 2007/08 to 2012/13



NB: Data for 2007/08 & 2008/09 relate to women aged 50-64 all other data relate to women aged 50-70.

17 Invasive Cancer Detection Rate

4.2 per 1,000 women screened for the first time (aged under 53) were diagnosed with an invasive breast cancer. The figure for women attending for subsequent screening tests was 5.9 per 1,000

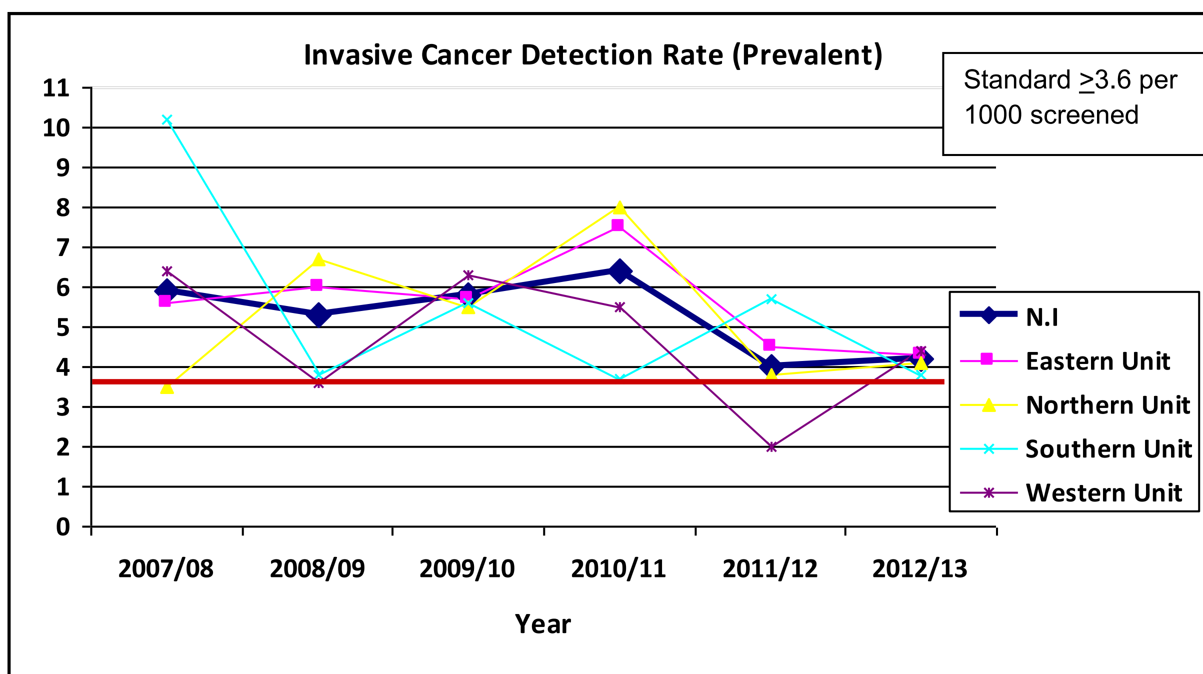
This measures the number of invasive cancers detected per 1,000 eligible women who were invited and screened.

Prevalent Screen

The minimum national standard for the invasive cancer detection rate is ≥3.6 per 1,000 women for the prevalent (first) screen; with a target rate of ≥5.1 per 1,000 women screened.

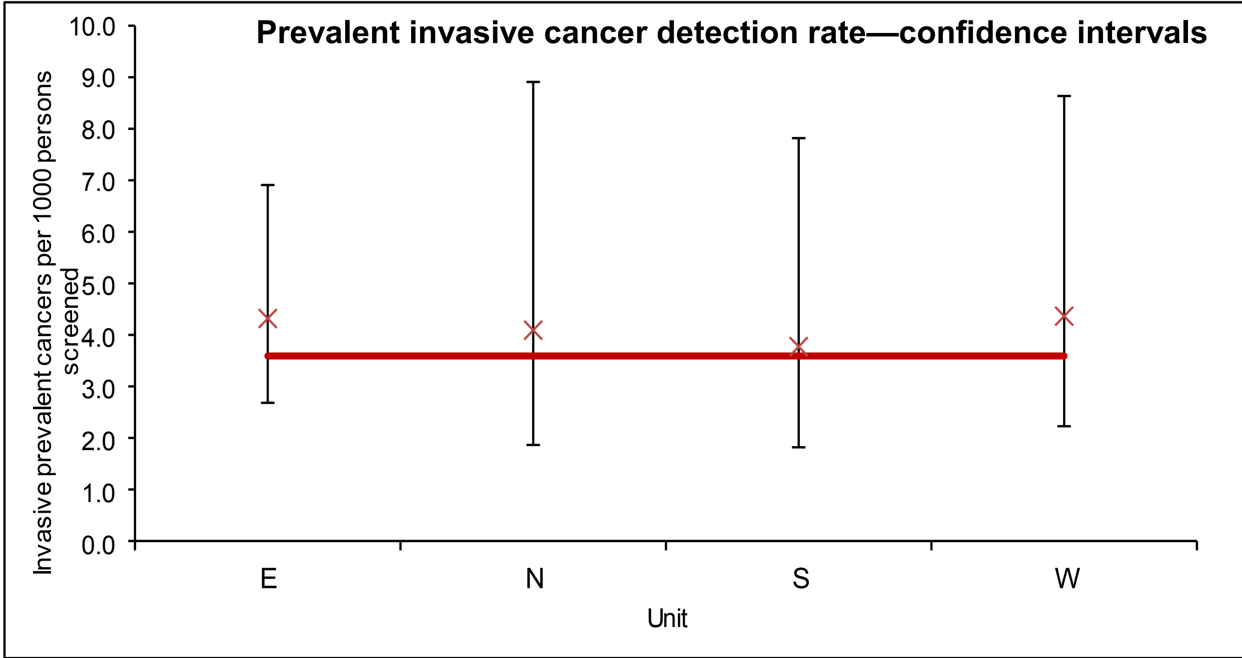
Figure 26 shows that over a 6 year period the Northern Ireland rate has been consistently above the minimum standard. All units exceeded the target in 2012/13. These figures tend to fluctuate from year to year due to the very small numbers involved e.g. the 2012/13 rate for the Western Unit is based on only 8 invasive cancers. The rate for Northern Ireland was 4.2 per 1,000 women screened. The comparative rate for England was 5.7 per 1,000 in 2012/13.

Figure 26: Invasive cancer detection rate for the prevalent (first) screen by unit and for Northern Ireland, 2007/08 to 2012/13



The invasive cancer detection rates for each breast screening unit in 2012/13 are shown again in figure 27. The vertical bars are 95% confidence intervals around each of the rates. These show us how confident we can be that true rate is above the minimum standard. Due to the small numbers each of the confidence intervals cross over the minimum standard. However, as noted above the rates have been consistently above the minimum standard in previous years.

Figure 27: Prevalent invasive cancer detection rate by unit with confidence intervals 2012/13



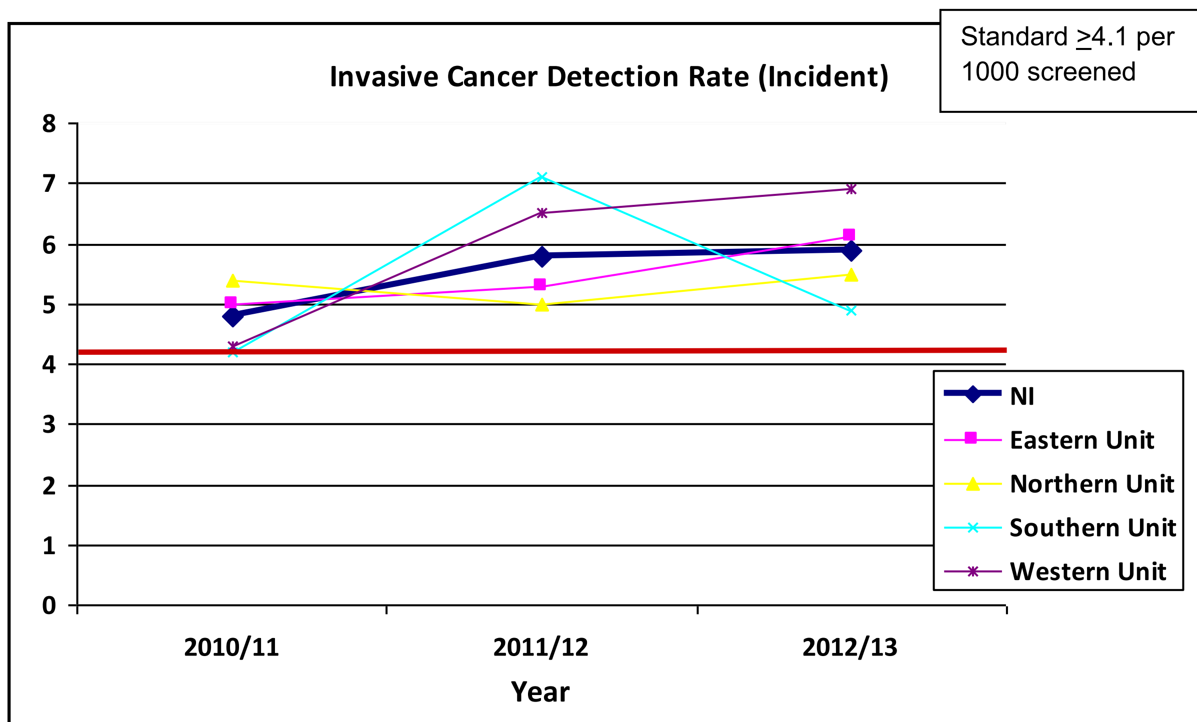
Incident Screen

The minimum national standard for the invasive cancer detection rate is ≥4.1 per 1,000 women for incident (subsequent) screens; with a target of ≥5.7 per 1,000 women screened.

Figure 28 shows that each of the units met the standard for women aged 50-70 in 2012/13. The numbers involved are larger than for the prevalent screen e.g. the Western Unit's rate of 6.9 is based on 62 invasive cancers. Three years' worth of data are shown as prior to 2009/10 it was only women aged 50-64 who were invited for breast screening.

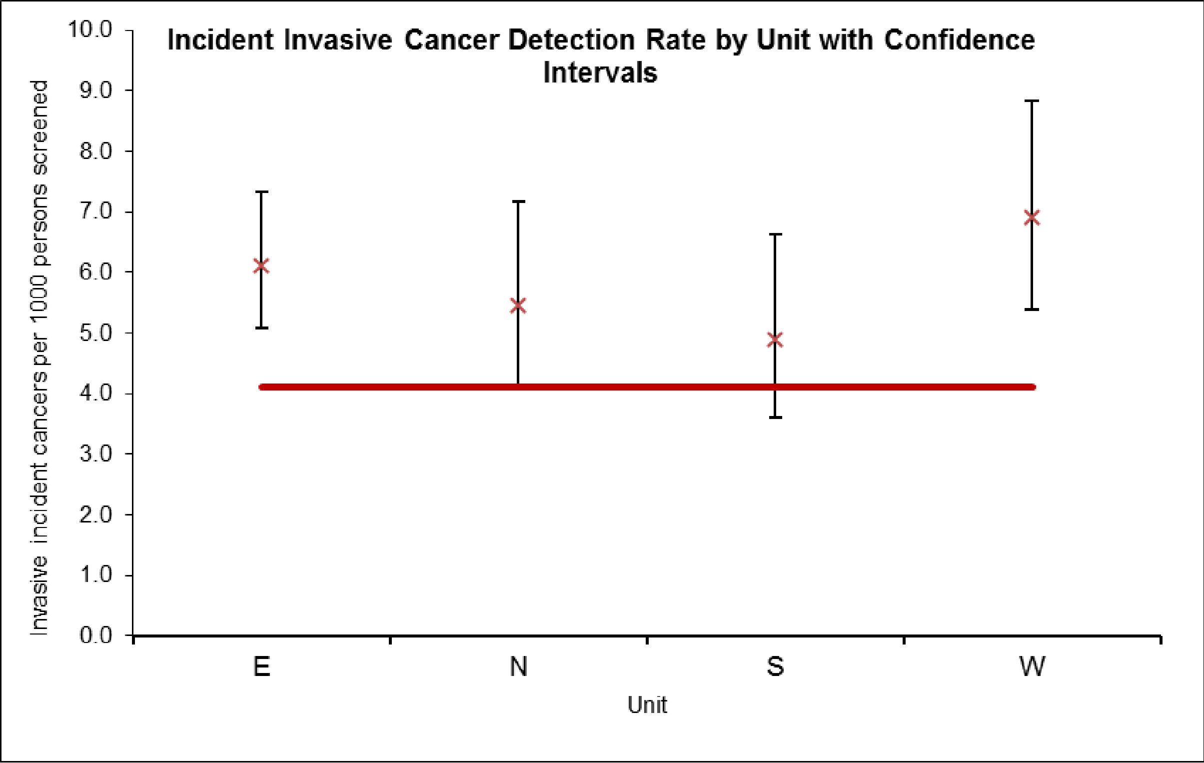
The Northern Ireland rate was 5.9 which exceeds the target. The comparative English rate was 6.2 per 1,000 in 2012/13.

Figure 28: Invasive cancer detection rates (incident screen) for women aged 50-70 by unit & for Northern Ireland 2010-2013



The rates for 2012/13 are shown again in figure 29 with the associated confidence intervals. This shows that we can be confident that the rate for 3 of the units exceeded the minimum standard in 2012/13. Due to the relatively small numbers involved there is a possibility that the true figures for the SHSCT is below the standard.

Figure 29: Incident invasive cancer detection rate by unit with confidence intervals 2012/13



18 Small Invasive Cancers

1.5 per 1,000 women screened for the first time (aged under 53) had a small invasive cancer. The figure for women attending for subsequent screening was 3.2 per 1,000.

The main aim of breast screening is to detect small invasive breast cancers at a time in their natural history when treatment is more likely to reduce the risk of death from the disease. Small cancers are defined as being less than 15 mm in their maximum diameter.

Prevalent

Figure 30 shows the small invasive cancer detection rates for the prevalent (first) screen over a six year period. The Northern Ireland programme as a whole did not meet the minimum standard with a figure of 1.5 per 1,000 women screened (minimum standard ≥2.0 per 1,000 / target ≥2.8 per 1,000). The figure for England was 2.7 per 1,000. It should be noted that the minimum standard was increased from ≥1.5 to ≥2 per 1,000 in 2011.

Rates tend to fluctuate from year to year due to very small numbers. There were only 14 small invasive cancers detected during the prevalent screen in Northern Ireland during 2012/13.

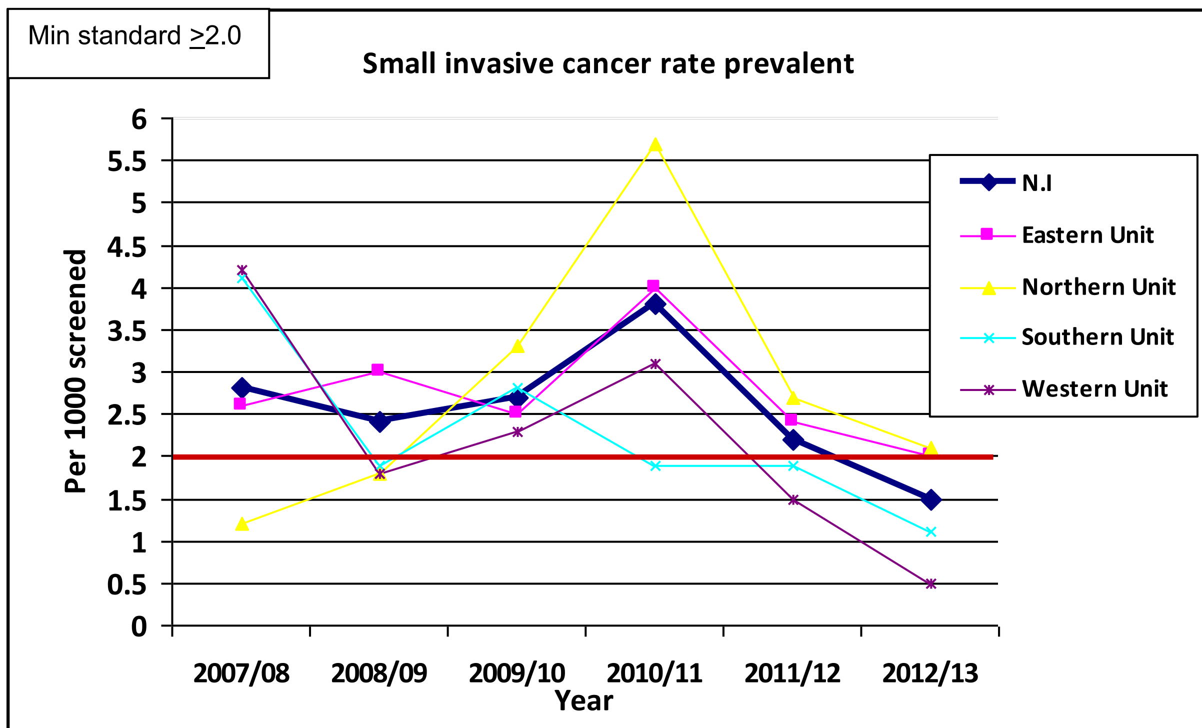
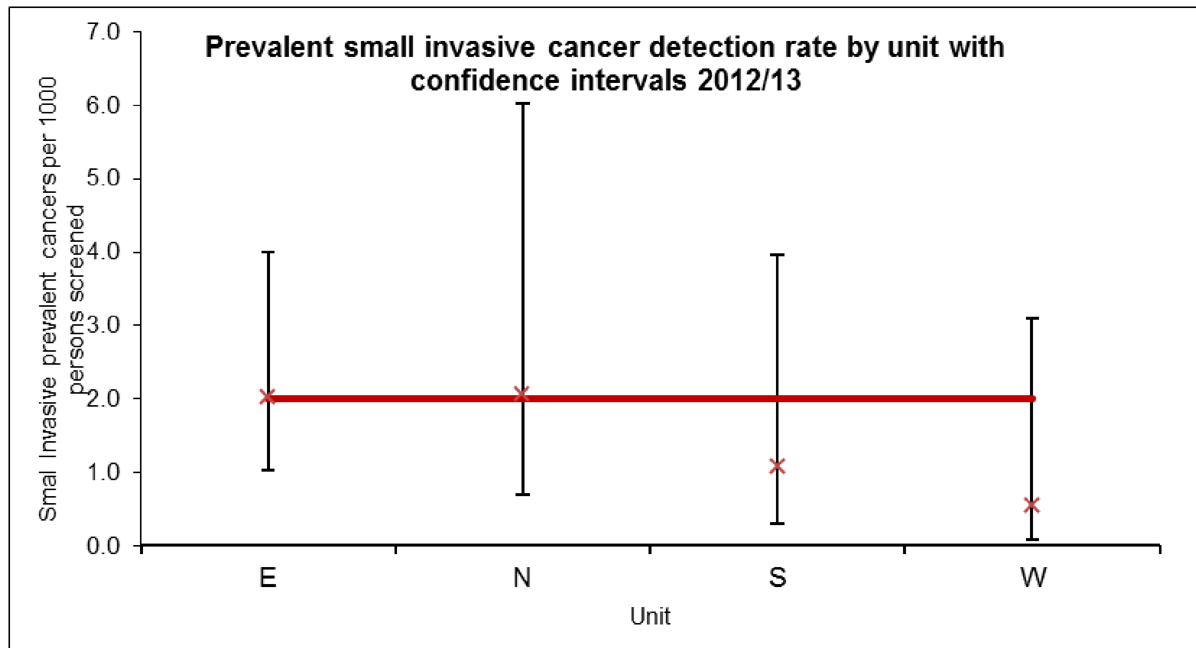


Figure 31 shows the small invasive cancer detection rate for the prevalent screen for each breast screening unit in 2012/13, with the associated confidence intervals. The red line is the minimum standard (2).

Figure 31: Prevalent small invasive cancer detection rate by unit with confidence intervals 2012/13



Incident

The small invasive cancer rate for the incident (subsequent) screens is shown in figure 32. The Northern Ireland programme as a whole had a rate of 3.2 per 1,000. This exceeded the minimum standard (≥2.3 per 1,000) and the target of ≥ 3.1 per 1,000 women screened.

The comparative figure for England was 3.3 per 1,000.

Figure 32: Small invasive cancer detection rates (incident screen) for women aged 50-70 by unit & for NI 2010/2013

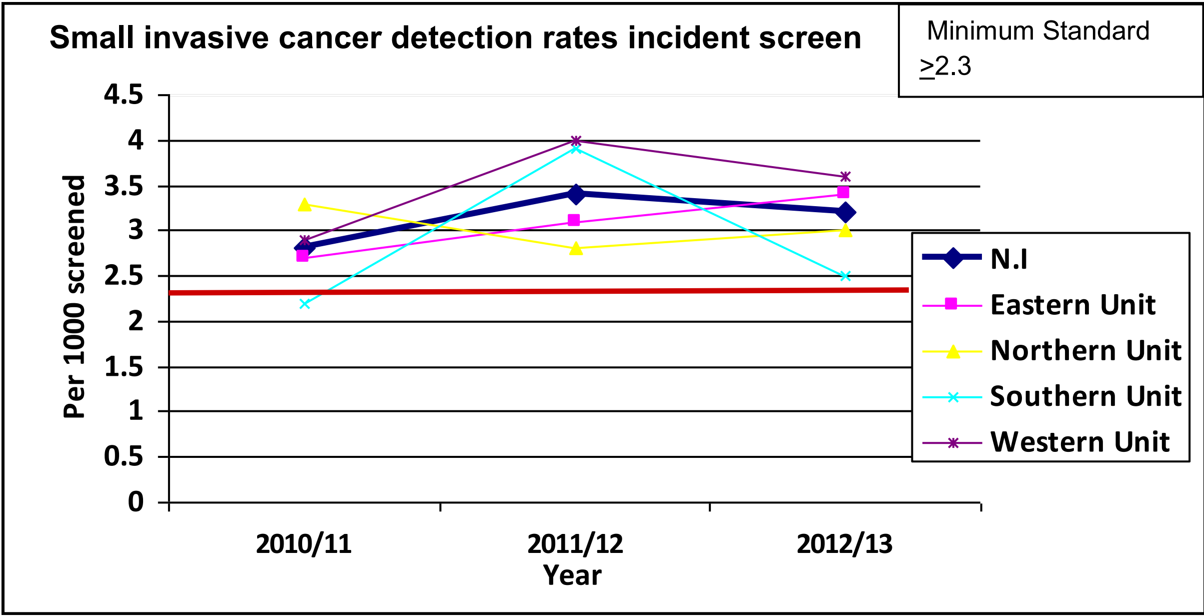
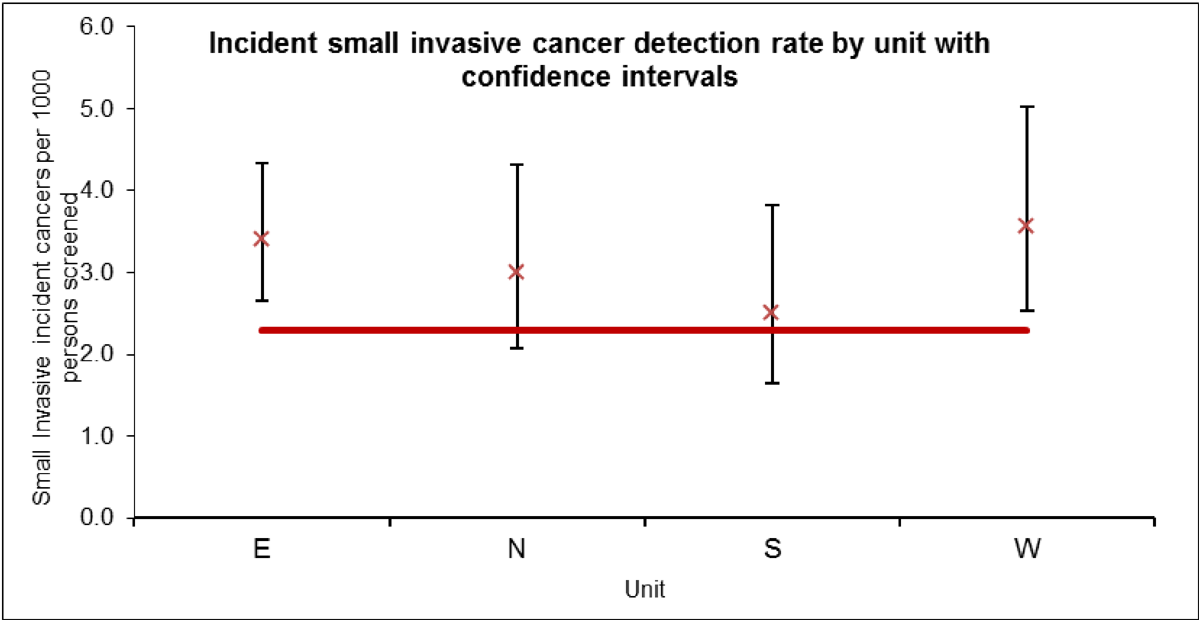


Figure 33 shows the small invasive cancer detection rate for the incident screen for each breast screening unit in 2012/13 with the associated 95% confidence intervals. The red line is the minimum standard of 2.3 per 1,000 women screened.

Figure 33: Incident small invasive cancer detection rate by unit with confidence intervals 2012/13



19 Treatment of Invasive Cancers

73.9% of women diagnosed with an invasive cancer had breast conserving surgery

Of the 372 invasive cancers detected by the Northern Ireland Breast Screening Programme in 2012/13, 275 (73.9%) were treated using breast conservation surgery, while 94 (25.2%) were treated by mastectomy. Three women (0.8%) had no surgery. This can be due to patient choice or because the patient is too unwell for surgery. Figure 34 shows the percentages by screening unit. Figures for the same year, for the whole of the UK, show that 77.6% of women underwent conservation surgery and 20.4% had a mastectomy (1.8% had no surgery). Figure 35 shows the proportion of women treated by different methods in Northern Ireland over the past 3 years.

Figure 34: Treatment of invasive cancers by unit and for Northern Ireland 2012/13

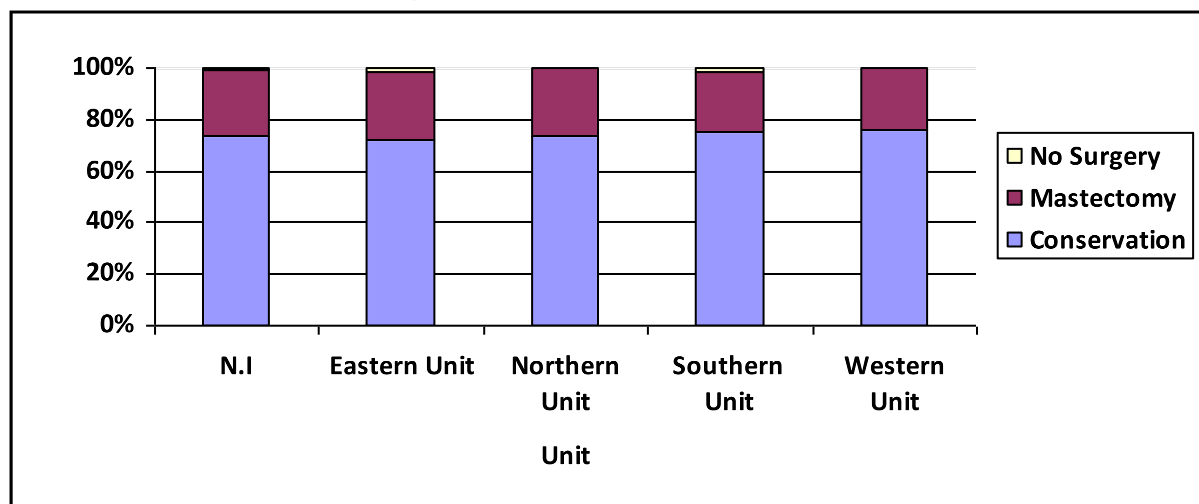
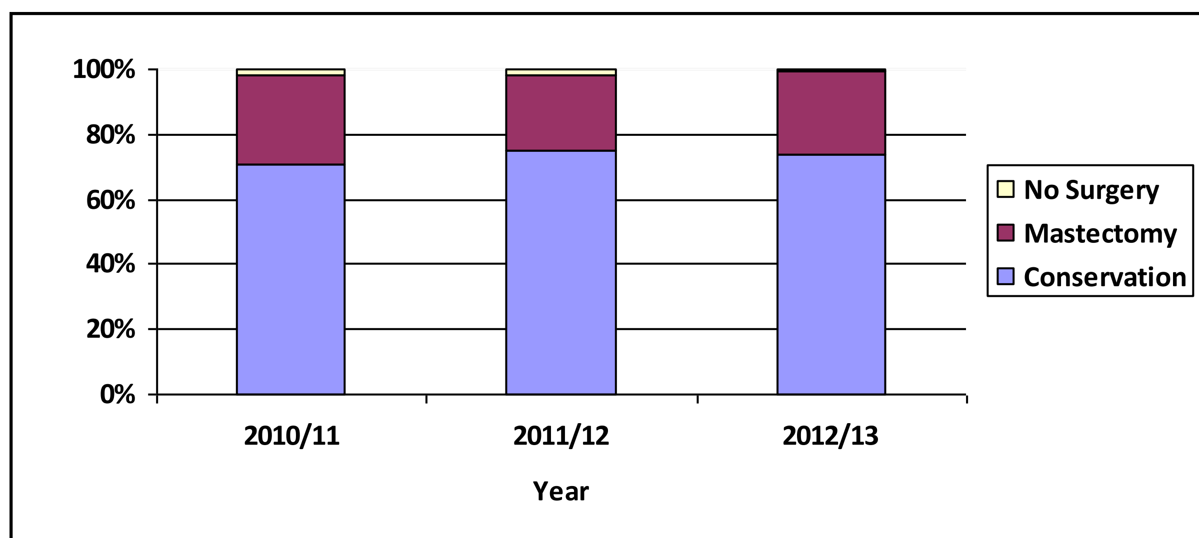


Figure 35: Treatment of invasive cancers over 3 year period for Northern Ireland



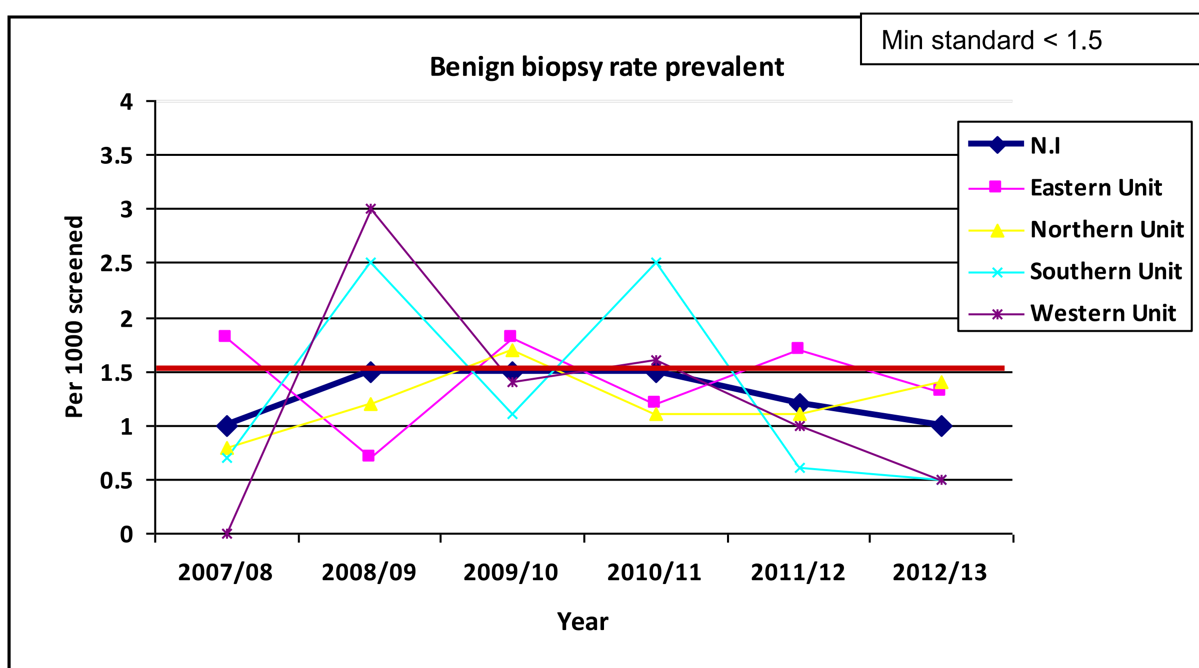
20 Benign Biopsy Rates

The proportion of women who had a surgical operation for what turned out to be benign disease was 1.0 per 1,000 screened for the prevalent (first) screen and 0.4 for the incident (subsequent) screen

This is a measure of the number of women per 1,000 women screened who had surgery for benign breast disease. The aim is to keep this rate as low as possible. However, with some lesions (e.g. fibroadenomas) the patient may choose to have surgery to remove a lump, even though it has been diagnosed as benign at the assessment clinic. In addition radial scars (a star shaped thickening of breast tissue which shows up on mammograms) are removed due to their association with tubular carcinoma of the breast; even though they are intrinsically benign.

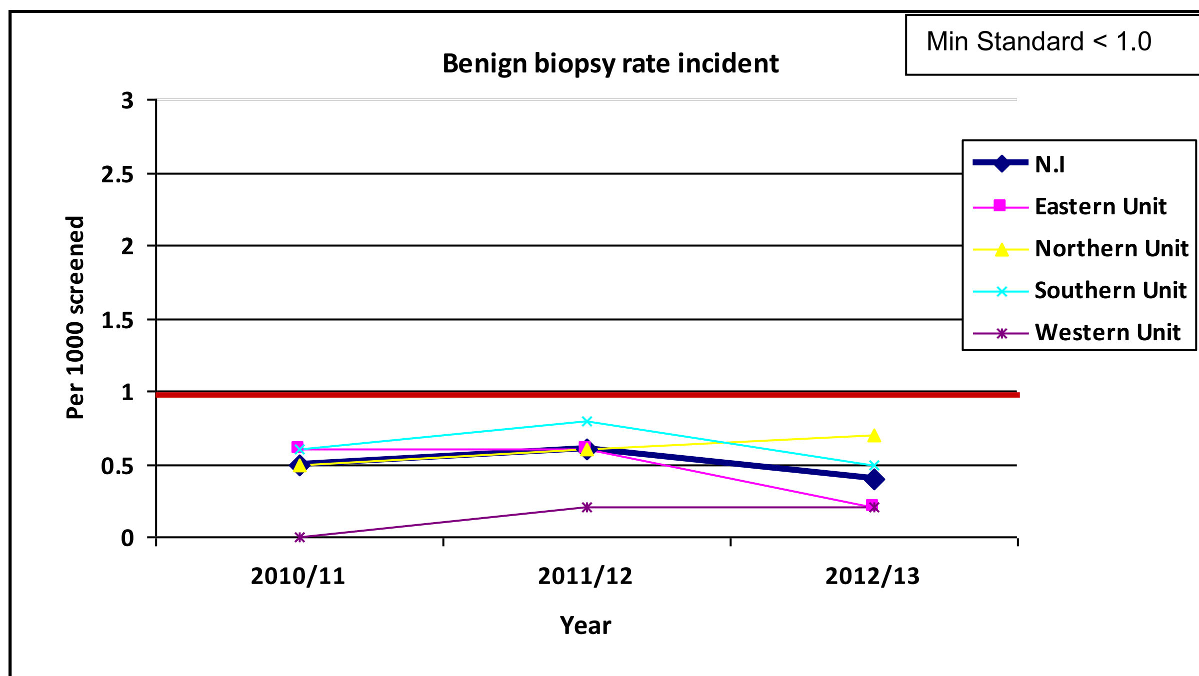
The benign biopsy rates for the prevalent (first) and incident (subsequent) screening rounds over a six year period are shown in figures 36 and 37. For the prevalent screen each of the units met the minimum standard (<1.5 per 1,000) in 2012/13 and two of units met the target (<1.0) .

Figure 36: Benign biopsy rate for the prevalent (first screen) 2007/08-2012/13



For the incident screen each of the units met the minimum standard (<1.0 per 1,000) and all meet the target figure of <0.75.

Figure 37: Benign biopsy rate for the incident (subsequent screens) 2010/11-2012/13 in women aged 50 - 70



21 Repeat Surgical Operations

26% of women with invasive cancer required a repeat surgical operation.

Most women diagnosed with breast cancer by the Northern Ireland Screening Programme require a single surgical operation to remove the disease. Some women need repeat surgery e.g. to ensure complete removal of the cancer following the initial pathology report. However, the objective is to minimise the number of therapeutic operations.

Table 7 below shows that the reoperation rate in 2012/13 for women with invasive cancer was 26% in Northern Ireland. This is slightly higher than the UK average of 23% (range 16%-27%)

The reoperation rate for women with non-invasive, or micro-invasive, cancers is 21%, which is lower than the UK average of 25% (range 21%-33%).

Table 7: Repeat operations of surgically treated invasive and non/micro-invasive cancers*

	Invasive			**Non/micro invasive**		
	Total	Re-op	%	Total	Re-op	%
Eastern Unit	157	43	27	26	5	19
Northern Unit	65	17	26	16	3	19
Southern Unit	60	17	28	5	1	20
Western Unit	86	18	21	20	5	25
Northern Ireland	368	95	**26**	67	14	**21**
UK	14381	3373	23	3793	965	25

**excludes previous cancers and no surgery cases*

22 Screening Round Length

83.2% of women were offered an appointment for mammography screening within 36 months of their previous normal screen

The screening round length is the interval between each offered invitation for screening mammography. The NHSBSP Publication No. 60 (Version 2) *Consolidated Guidance on Standards for the NHS Breast Screening Programme* states that, to ensure women are re-called for screening at appropriate intervals, the percentage of eligible women whose first offered appointment is within 36 months of their previous screen should be 90% or more.

Measurement of screening round length provides an indicator of the efficiency with which a screening programme is managed. The long-term effectiveness of the programme is dependent on women in the target age group continuing to be screened at regular intervals.

Figure 38 shows the percentage of women screened within 36 months, by quarter, for the year 2012/13. The minimum standard was not met during the first two quarters or for the year as a whole (see figure 40). Figure 39 shows the data broken down by unit. Both the Eastern and the Southern units had problems maintaining their round length in 2012/13 and this affected the Northern Ireland figure.

Figure 38: Screening round length by quarter for Northern Ireland 2012/13

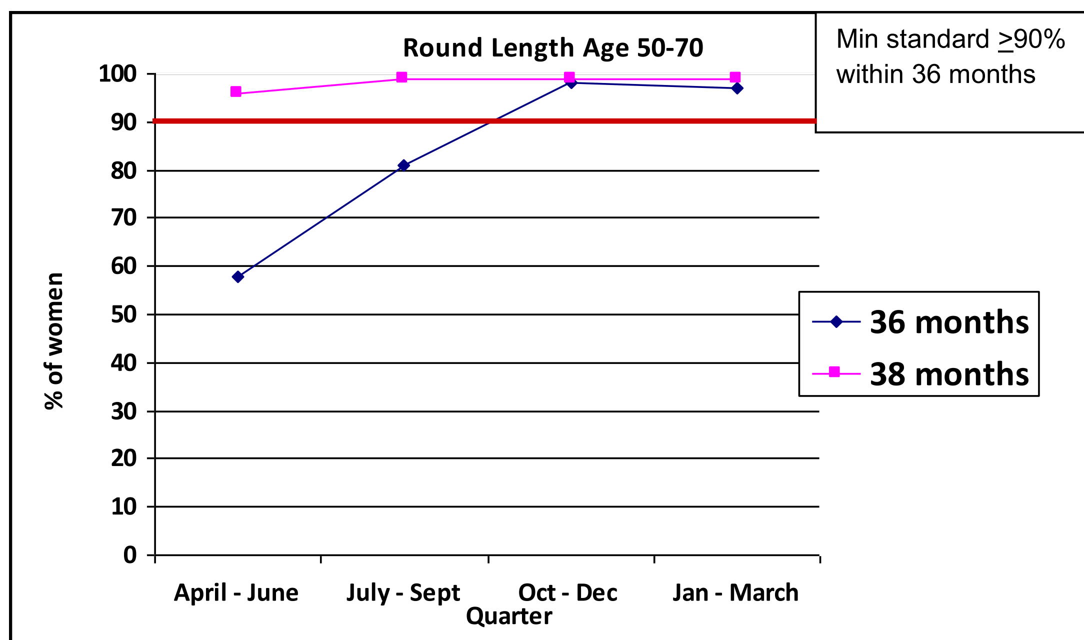
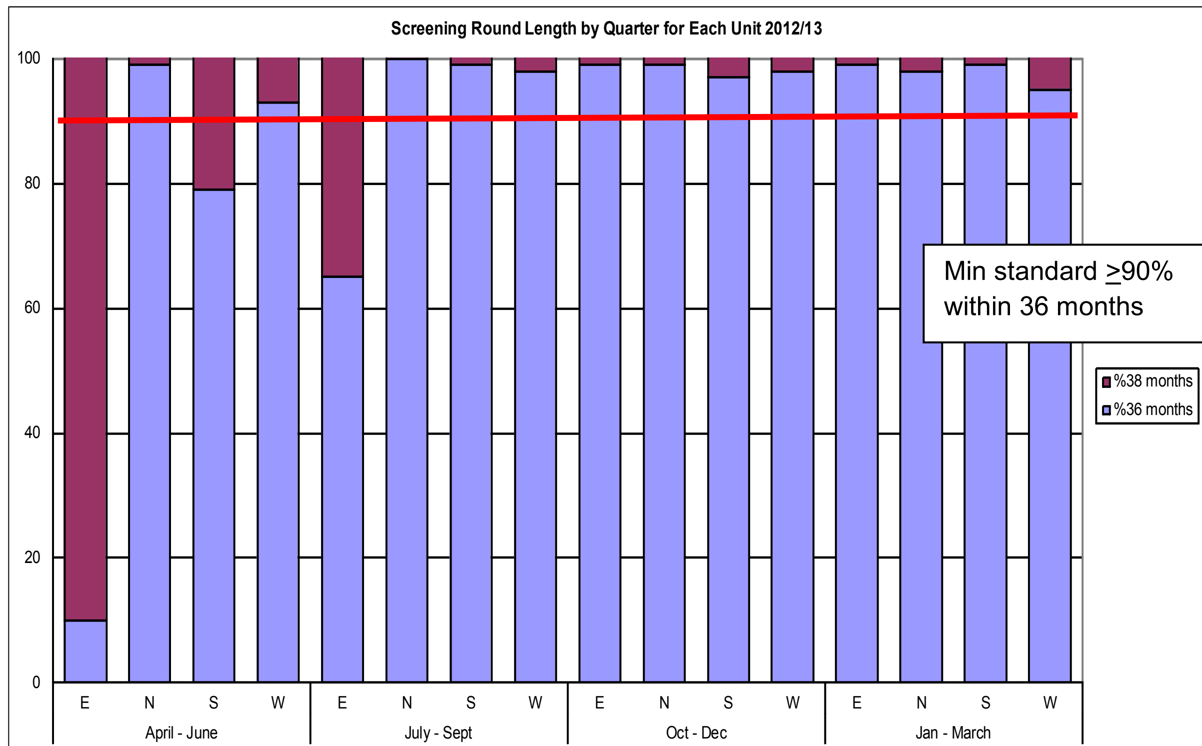


Figure 39: Screening round length 50-70 by quarter for each unit 2012/13



The Eastern Unit's round length began to slip in June 2011. QARC worked with the unit and the Belfast HSC Trust to agree an action plan to bring it back to standard. This was achieved in the third quarter of 2012/13.

A number of factors had contributed to slippage of the Southern Unit's round length, including staff leave. The unit brought its round length back to standard in the second quarter of 2012/13.

Figure 40: Northern Ireland round length 2006/07 to 2012/13

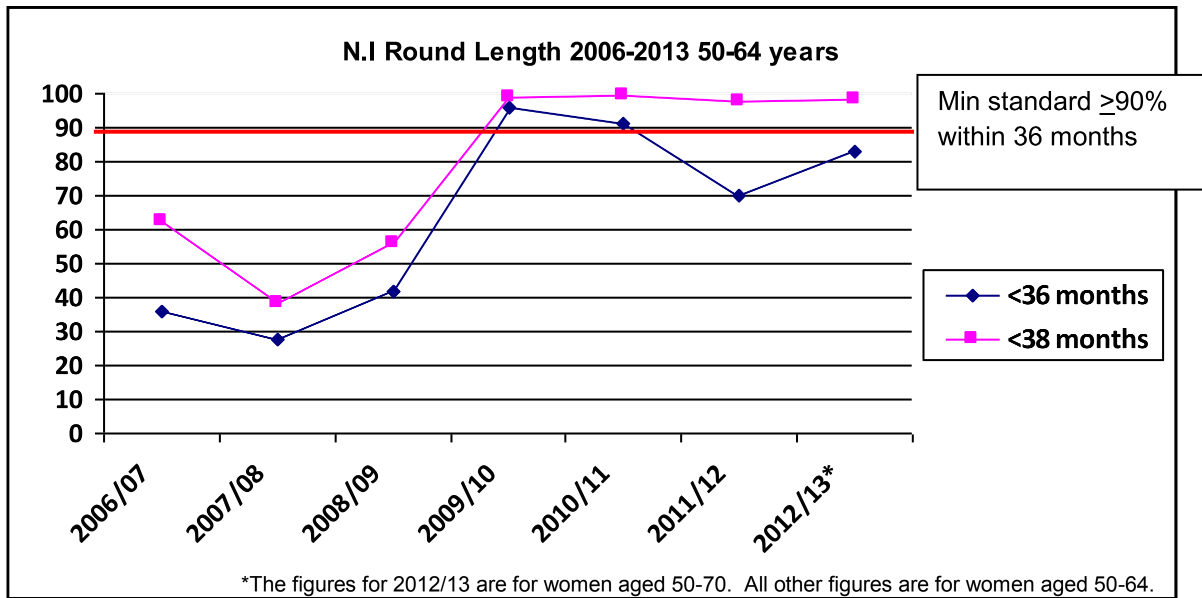
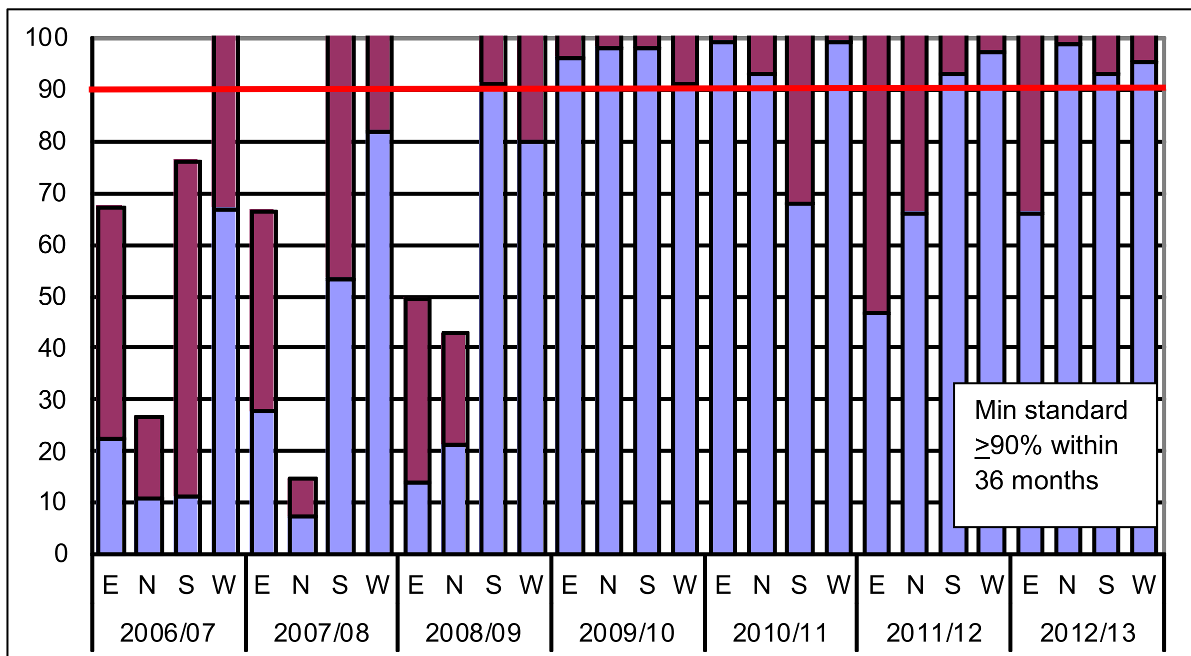


Figure 40 shows the round length for Northern Ireland over the six year period 2006/07 to 2012/13. Figure 41 shows the breakdown by unit. There have been problems maintaining the round length. A wide range of factors can affect it including staffing issues and closing a unit for refurbishment. QARC is working with units to ensure that they have robust round length plans in place to minimise the likelihood of falling below the standard. However, it is recognised that the replacement of all mammography equipment throughout Northern Ireland with new digital equipment, in 2014, will adversely impact on the round length.

Figure 41: Unit round length 2006/07 to 2012/13



APPENDIX 1 - Consolidated Guidance on Standards for the NHS Breast Screening Programme 50-70

Summary of KC62 source tables and age groups to be used in the calculation of standards (50-70)

Objective	Criteria	Calculation	Minimum Standard	Target
1. To maximise the number of eligible women who attend for screening	The percentage of eligible women who attend for screening	Tables: A, B, C1, C2 Age: 50-70	≥70% of invited women to attend for screening	80%
2. To maximise the number of cancers detected	(a) The rate of invasive cancers detected in eligible women invited and screened	Table: A Age: 50-52	Prevalent Screen ≥3.6 per 1,000	Prevalent Screen ≥5.1 per 1,000
		Table: C1 Age: 53-70	Incident screen ≥4.1 per 1,000	Incident screen ≥5.7 per 1,000
	(b) The rate of cancers detected which are in situ carcinoma	Table: A Age: 50-52	Prevalent screen ≥0.5 per 1,000	
		Table: C1 Age: 53-70	Incident screen ≥0.6 per 1,000	
	(c) SDR	Tables: A and B Age: 50-70	Prevalent screen ≥1.0	Prevalent screen ≥1.4
		Table: C1 Age: 50-70	Incident screen ≥1.0	Incident screen ≥1.4
		Tables: A, B, C1 Age: 50-70	Overall ≥1.0	Overall ≥1.4
3. To maximise the number of small invasive cancers detected	The rate of invasive cancers less than 15mm in diameter detected in eligible women invited and screened	Table: A Age: 50-52	Prevalent screen ≥2.0 per 1,000	Prevalent screen ≥2.8 per 1,000
		Table: C1 Age: 53-70	Incident screen ≥2.3 per 1,000	Incident screen ≥3.1 per 1,000
7. To minimise the number of women screened who are referred for further tests	(a) The percentage of women who are referred for assessment	Table: A Age: 50-52	Prevalent screen <10%	Prevalent screen <7%
		Table: C1 Age: 53-70	Incident screen <7%	Incident screen <5%
	(b) The percentage of women screened who are placed on short-term recall	Table: T Age: 50-70	<0.25%	<0.12%
8. To ensure that the majority of cancers, both palpable and impalpable, receive a nonoperative tissue diagnosis of cancer	The percentage of women who have a non-operative diagnosis of cancer by cytology or needle histology after a maximum of two visits	Table: T Age: 50-70	≥85%	≥90%
9. To minimise the number of unnecessary operative procedures	The rate of benign biopsies	Table: A Age: 50-52	Prevalent screen <1.5 per 1,000	Prevalent screen <1.0 per 1,000
		Table: C1 Age: 53-70	Incident screen <1.0 per 1,000	Incident screen <0.75 per 1,000

APPENDIX 2 - KC62 Data 2012/13 for women aged 50-70

Northern Ireland Breast Screening Service
KC62 Data 2012/13

Activity Data		Invited	Screened	As-sessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	25750	13341	1029	11	15	77	16	60	24
	Incident (C1&C2)	60258	50156	1307	18	18	348	49	298	158
	Early recalls	49	49	49	4	0	4	2	2	1
	Self/GP referrals	0	1363	67	0	1	14	2	12	4
	Total	**86057**	**64909**	**2452**	**33**	**34**	**443**	**69**	**372**	**187**
50-70	Prevalent (A:50-52 only)	12396	9059	699	7	9	51	13	38	14
	Incident (C1:53-70 only)	51555	45559	1152	15	17	313	44	269	145
	Early recalls	49	49	49	4	0	4	2	2	1
	Self/GP referrals	0	756	43	0	1	6	1	5	1
	Total	**64000**	**55423**	**1943**	**26**	**27**	**374**	**60**	**314**	**161**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2010/11**	**2011/12**	**2012/13**	**Minimum**	**Target**
Uptake %	Prevalent (A)	74.6	72.6	73.1	≥70%	80%
	Incident (C1)	89.5	88.6	88.4		
	Overall (A-C2)	75.8	73.3	73.9		
Technical recall/repeats%	Overall	1.5	1.0	0.9	<3%	<2%
Recall to Assessment %	Prevalent	8.9	7.4	7.7	<10%	<7%
	Incident	2.7	2.5	2.5	<7%	<5%
Early Recall %	Overall	0.05	0.07	0.04	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	1.5	1.2	1.0	<1.5	<1.0
	Incident	0.5	0.6	0.4	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	2.1	1.6	1.4	≥0.5	NA
	Incident	1.3	1.3	1.0	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	6.4	4.0	4.2	≥3.6	≥5.1
	Incident	4.8	5.8	5.9	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	3.8	2.2	1.5	≥2.0	≥2.8
	Incident	2.8	3.4	3.2	≥2.3	≥3.1
Pre-operative diagnosis rate %	Overall	95.0	95.9	96.5	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.6	1.2	1.1	≥1.00	≥1.4
	Incident	1.2	1.4	1.4		
	Overall	1.3	1.4	1.4		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.3	1.3	1.2	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.47	1.4	1.3	≥1.0	≥1.4
	Incident	1.26	1.3	1.4		
	Overall	1.31	1.3	1.3		
Round Length ≤ 36 months	Overall	81.2	64.6	83.2	≥90% first offered appts within 36 months	100%
≤ 38 months	Overall	89.4	90.4	98.1		
Screening to Results - (Date of screen)	Overall	98.0	98.0	97.1	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	96.9	94.9	90.6	≥90% within 3 weeks	100%

Belfast Health & Social Care Trust Breast Screening Service
KC62 Data 2012/13

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	12303	5751	497	9	9	33	10	23	11
	Incident (C1&C2)	25702	20731	524	13	4	146	16	129	70
	Early recalls	35	35	35	0	0	3	1	2	1
	Self/GP referrals	0	531	22	0	0	6	0	6	2
	Total	**38040**	**27048**	**1078**	**22**	**13**	**188**	**27**	**160**	**84**
50-70	Prevalent (A:50-52 only)	5695	3935	343	6	5	26	9	17	8
	Incident (C1:53-70 only)	21812	18841	458	10	4	130	15	115	64
	Early recalls	35	35	35	0	0	3	1	2	1
	Self/GP referrals	0	334	15	0	0	4	0	4	1
	Total	**27542**	**23145**	**851**	**16**	**9**	**163**	**25**	**138**	**74**

Performance against National Standards					**National Standards**	
Routine Screen Women aged 50 - 70		**2010/11**	**2011/12**	**2012/13**	**Minimum**	**Target**
Uptake %	Prevalent (A)	73.8	69.2	69.1	≥70%	80%
	Incident (C1)	89.4	87.5	86.4		
	Overall (A-C2)	74.2	69.3	69.8		
Technical recall/repeats%	Overall	1.5	1.1	1.3	<3%	<2%
Recall to Assessment %	Prevalent	9.3	8.3	8.7	<10%	<7%
	Incident	2.7	2.4	2.4	<7%	<5%
Early Recall %	Overall	0.12	0.14	0.07	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	1.2	1.7	1.3	<1.5	<1.0
	Incident	0.6	0.6	0.2	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	2.4	1.2	2.3	≥0.5	NA
	Incident	1.3	1.7	0.8	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	7.5	4.5	4.3	≥3.6	≥5.1
	Incident	5.0	5.3	6.1	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	4.0	2.4	2.0	≥2.0	≥2.8
	Incident	2.7	3.1	3.4	≥2.3	≥3.1
Pre-operative diagnosis rate %	Overall	96.4	96.4	96.7	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.86	1.4	1.1	≥1.00	≥1.4
	Incident	1.23	1.3	1.5		
	Overall	1.37	1.3	1.4		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.33	1.3	1.4	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.64	1.6	1.4	≥1.0	≥1.4
	Incident	1.31	1.2	1.4		
	Overall	1.40	1.3	1.4		
Round Length ≤ 36 months	Overall	87.5	41.1	66.2	≥90% first offered appts within 36 months	100%
≤ 38 months	Overall	87.8	86.5	96.9		
Screening to Results - (Date of screen)	Overall	99.0	98.0	95.9	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	96.9	93.9	83.0	≥90% within 3 weeks	100%

Northern Health & Social Care Trust Breast Screening Service
KC62 Data 2012/13

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	3795	2172	228	0	4	11	1	9	5
	Incident (C1&C2)	11921	10267	322	1	7	71	15	56	32
	Early recalls	4	4	4	0	0	0	0	0	0
	Self/GP referrals	0	173	7	0	0	0	0	0	0
	Total	**15720**	**12616**	**561**	**1**	**11**	**82**	**16**	**65**	**37**
50-70	Prevalent (A:50-52 only)	1875	1460	163	0	2	6	0	6	3
	Incident (C1:53-70 only)	10296	9354	282	1	7	65	14	51	28
	Early recalls	4	4	4	0	0	0	0	0	0
	Self/GP referrals	0	97	5	0	0	0	0	0	0
	Total	**12175**	**10915**	**454**	**1**	**9**	**71**	**14**	**57**	**31**

Performance against National Standards					**National Standards**	
Routine Screen Women aged 50 - 70		**2010/11**	**2011/12**	**2012/13**	**Minimum**	**Target**
Uptake %	Prevalent (A)	78.2	75.7	77.9	≥70%	80%
	Incident (C1)	91.7	89.6	90.9		
	Overall (A-C2)	79.8	77.2	79.3		
Technical recall/repeats%	Overall	2.0	1.1	0.9	<3%	<2%
Recall to Assessment %	Prevalent	13.2	11.0	11.2	<10%	<7%
	Incident	3.3	3.0	3.0	<7%	<5%
Early Recall %	Overall	0.0	0.04	0.01	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	1.1	1.1	1.4	<1.5	<1.0
	Incident	0.5	0.6	0.7	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	2.3	3.2	0.0	≥0.5	NA
	Incident	1.5	1.0	1.5	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	8.0	3.8	4.1	≥3.6	≥5.1
	Incident	5.4	5.0	5.5	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	5.7	2.7	2.1	≥2.0	≥2.8
	Incident	3.3	2.8	3.0	≥2.3	≥3.1
Pre-operative diagnosis rate %	Overall	94.2	94.8	98.7	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.7	1.3	1.0	≥1.00	≥1.4
	Incident	1.3	1.2	1.3		
	Overall	1.4	1.2	1.3		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.3	1.4	1.4	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.4	1.4	1.4	≥1.0	≥1.4
	Incident	1.2	1.3	1.3		
	Overall	1.3	1.3	1.3		
Round Length ≤ 36 months	Overall	84.1	64.2	99.0	≥90% first offered appts within 36 months	100%
≤ 38 months	Overall	90.3	95.1	99.2		
Screening to Results - (Date of screen)	Overall	98.0	99.0	98.9	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	98.6	98.3	98.9	≥90% within 3 weeks	100%

Southern Health & Social Care Trust Breast Screening Service
KC62 Data 2012/13

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	4805	2599	155	1	1	15	2	13	5
	Incident (C1&C2)	10979	9214	248	3	4	49	2	47	23
	Early recalls	1	1	1	0	0	0	0	0	0
	Self/GP referrals	0	276	16	0	0	2	1	1	0
	Total	**15785**	**12090**	**420**	**4**	**5**	**66**	**5**	**61**	**28**
50-70	Prevalent (A:50-52 only)	2452	1841	102	0	1	8	1	7	2
	Incident (C1:53-70 only)	9490	8383	221	3	4	42	1	41	21
	Early recalls	1	1	1	0	0	0	0	0	0
	Self/GP referrals	0	154	13	0	0	2	1	1	0
	Total	**11943**	**10379**	**337**	**3**	**5**	**52**	**3**	**49**	**23**

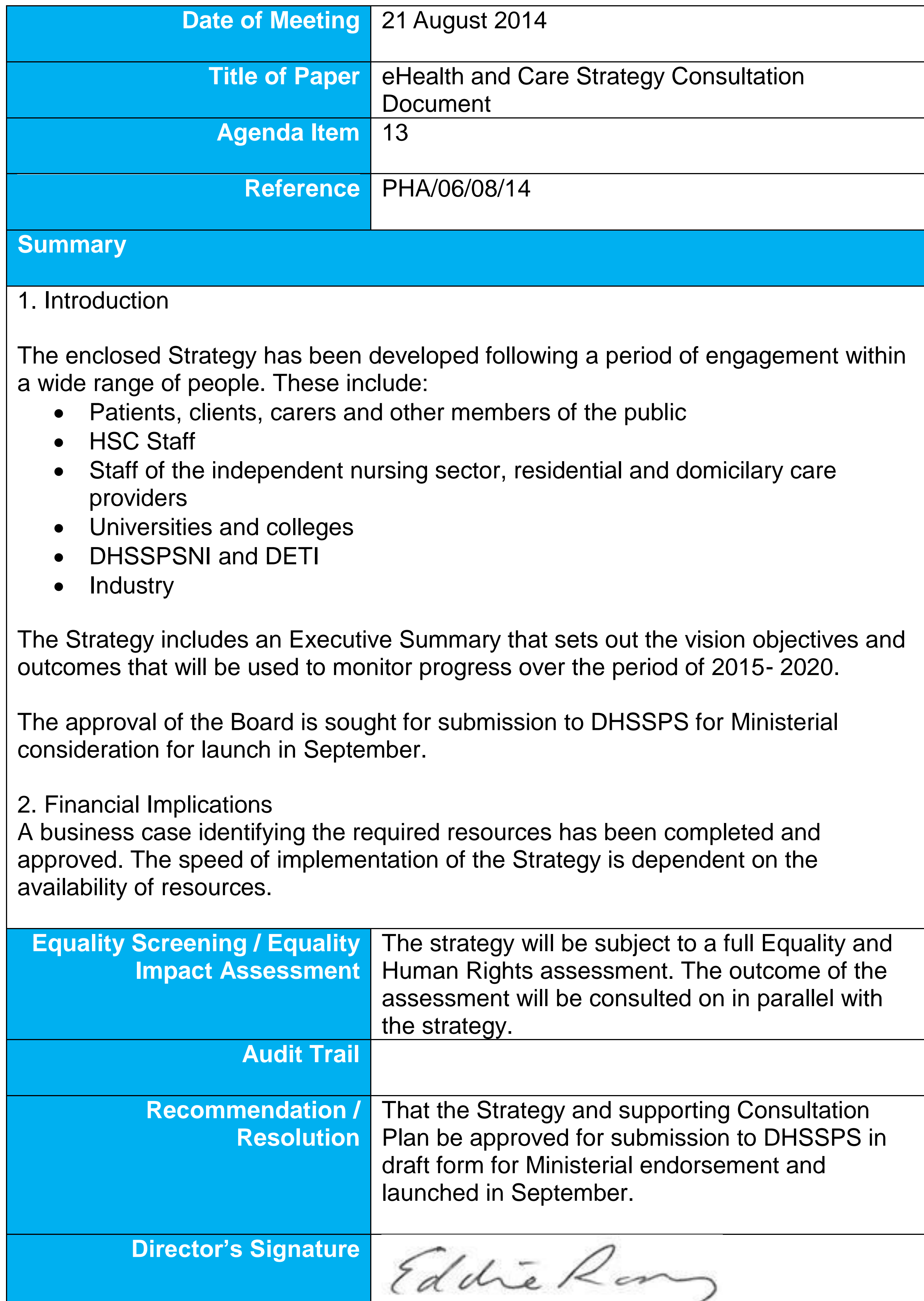
Performance against National Standards					**National Standards**	
Routine Screen Women aged 50 - 70		**2010/11**	**2011/12**	**2012/13**	**Minimum**	**Target**
Uptake %	Prevalent (A)	73.8	75.8	75.1	≥70%	80%
	Incident (C1)	89.1	88.7	88.3		
	Overall (A-C2)	76.1	75.6	74.9		
Technical recall/repeats%	Overall	1.6	1.2	0.8	<3%	<2%
Recall to Assessment %	Prevalent	6.1	5.6	5.5	<10%	<7%
	Incident	2.7	3.5	2.6	<7%	<5%
Early Recall %	Overall	0.0	0.00	0.03	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	2.5	0.6	0.5	<1.5	<1.0
	Incident	0.6	0.8	0.5	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	1.9	1.3	0.5	≥0.5	NA
	Incident	1.7	1.2	0.1	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	3.7	5.7	3.8	≥3.6	≥5.1
	Incident	4.2	7.1	4.9	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	1.9	1.9	1.1	≥2.0	≥2.8
	Incident	2.2	3.9	2.5	≥2.3	≥3.1
Pre-operative diagnosis rate %	Overall	89.7	94.8	93.9	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.2	1.57	1.3	≥1.00	≥1.4
	Incident	1.0	1.79	1.2		
	Overall	1.1	1.73	1.2		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.2	1.3	1.2	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.3	1.4	1.3	≥1.0	≥1.4
	Incident	1.3	1.4	1.3		
	Overall	1.3	1.4	1.3		
Round Length ≤ 36 months	Overall	58.5	84.0	93.3	≥90% first offered appts within 36 months	100%
≤ 38 months	Overall	88.6	89.6	99.2		
Screening to Results - (Date of screen)	Overall	97.0	95.0	95.4	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	97.7	91.1	92.6	≥90% within 3 weeks	100%

Western Health & Social Care Trust Breast Screening Service
KC62 Data 2012/13

	Activity Data	Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	4847	2819	149	1	1	18	3	15	3
	Incident (C1&C2)	11656	9944	213	1	3	82	16	66	33
	Early recalls	9	9	9	4	0	1	1	0	0
	Self/GP referrals	0	383	22	0	1	6	1	5	2
	Total	**16512**	**13155**	**393**	**6**	**5**	**107**	**21**	**86**	**38**
50-70	Prevalent (A:50-52 only)	2374	1823	91	1	1	11	3	8	1
	Incident (C1:53-70 only)	9957	8981	191	1	2	76	14	62	32
	Early recalls	9	9	9	4	0	1	1	0	0
	Self/GP referrals	0	171	10	0	1	0	0	0	0
	Total	**12340**	**10984**	**301**	**6**	**4**	**88**	**18**	**70**	**33**

Performance against National Standards					**National Standards**	
Routine Screen Women aged 50 - 70		**2010/11**	**2011/12**	**2012/13**	**Minimum**	**Target**
Uptake %	Prevalent (A)	72.3	74.9	76.8	≥70%	80%
	Incident (C1)	87.0	89.6	90.2		
	Overall (A-C2)	73.6	76.3	77.4		
Technical recall/repeats%	Overall	0.4	0.7	1.0	<3%	<2%
Recall to Assessment %	Prevalent	5.6	3.3	5.0	<10%	<7%
	Incident	1.9	1.8	2.1	<7%	<5%
Early Recall %	Overall	0.03	0.03	0.02	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	1.6	1.0	0.5	<1.5	<1.0
	Incident	0.0	0.2	0.2	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	1.6	1.0	1.6	≥0.5	NA
	Incident	0.8	1.0	1.6	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	5.5	2.0	4.4	≥3.6	≥5.1
	Incident	4.3	6.5	6.9	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	3.1	1.5	0.5	≥2.0	≥2.8
	Incident	2.9	4.0	3.6	≥2.3	≥3.1
Pre-operative diagnosis rate %	Overall	100.0	96.6	95.9	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.5	0.5	1.2	≥1.00	≥1.4
	Incident	1.0	1.6	1.6		
	Overall	1.1	1.3	1.5		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.2	1.3	1.4	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.34	1.2	1.0	≥1.0	≥1.4
	Incident	1.16	1.2	1.5		
	Overall	1.20	1.2	1.4		
Round Length ≤ 36 months	Overall	91.9	93.6	95.4	≥90% first offered appts within 36 months	100%
≤ 38 months	Overall	92.0	94.1	98.6		
Screening to Results - (Date of screen)	Overall	98.0	98.0	99.1	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	90.6	97.0	97.0	≥90% within 3 weeks	100%

HSC Public Health Agency



PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	eHealth and Care Strategy Consultation Document
Agenda Item	13
Reference	PHA/06/08/14

Summary

1. Introduction

The enclosed Strategy has been developed following a period of engagement within a wide range of people. These include:

- Patients, clients, carers and other members of the public
- HSC Staff
- Staff of the independent nursing sector, residential and domicilary care providers
- Universities and colleges
- DHSSPSNI and DETI
- Industry

The Strategy includes an Executive Summary that sets out the vision objectives and outcomes that will be used to monitor progress over the period of 2015- 2020.

The approval of the Board is sought for submission to DHSSPS for Ministerial consideration for launch in September.

2. Financial Implications

A business case identifying the required resources has been completed and approved. The speed of implementation of the Strategy is dependent on the availability of resources.

Equality Screening / Equality Impact Assessment	The strategy will be subject to a full Equality and Human Rights assessment. The outcome of the assessment will be consulted on in parallel with the strategy.
Audit Trail	
Recommendation / Resolution	That the Strategy and supporting Consultation Plan be approved for submission to DHSSPS in draft form for Ministerial endorsement and launched in September.
Director's Signature	Eddie Rooney

Title	Chief Executive
Date	11 August 2014

eHealth & Care Strategy

FOR NORTHERN IRELAND

Improving health and wealth through the use of information and communication technology.

CONSULTATION DOCUMENT

HSC Health and Social Care

Acknowledgements

We wish to acknowledge the support and contributions of the members of the Steering and Expert Advisory Group who monitored the progress of the strategy and actively helped in all aspects of its development.

We particularly wish to acknowledge the major part played by the public, representatives from the community and voluntary sector, independent sector, universities and industry in developing the strategy.

We would also like to thank our colleagues in the Health and Social Care Trusts who gave their time, support, expertise and knowledge throughout the process and many other members of staff at each Trust who participated in our workshops and focus groups which lead to the development of the strategy.

To our colleagues in the HSCB and PHA whose timely and useful proofing and comments were invaluable, we thank for their support.

eHealth & Care Strategy Project Team

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HSC Health and Social Care

Foreword

Health and wellbeing is important to us all – 'healthy body, healthy mind'. We must strive to make Northern Ireland a place where everyone can access the support they need, where and when they need it.

In 2009, the Health and Social Care (Reform) Act (Northern Ireland) placed public health and wellbeing firmly at the centre of the new system, with a greater emphasis on prevention and support to help vulnerable people live independently for as long as possible. Person-centred care is described in three key strategic documents for Northern Ireland: Transforming Your Care; Quality 2020; and the new strategic framework for public health 'Making Life Better'. I believe that eHealth and Care will mean that people will be able to make better health and wellbeing decisions because they have easy access to the information they need. I also believe that assistive and connected health technologies will further develop independent living and self-care opportunities.

Organisations in health and social care (HSC), as well as services provided by the independent and the community and voluntary sector, hold information that can help everyone make better decisions about their own health and wellbeing. This information can also help staff make better decisions. Much of the information held on paper, and some information held on computer systems, is not always available to those who need it. Ensuring that relevant information is securely available when and where it is needed for better, safer care is at the heart of this eHealth and Care Strategy.

Northern Ireland has made a good start on this, and some of what we have achieved is envied by health systems around the world. Investment in computerised systems to support GPs means that the vast majority of GP practices can access and manage their patient records electronically. The introduction of the Northern Ireland Electronic Care Record (NIECR) for each citizen creates a connection between this information and other information we hold. This means doctors and other care professionals looking after patients in hospital and in the community, as well as in General Practice, can get immediate access to a summary of the important information they need to make safe decisions. Seeing this information can prevent the need for patients to repeat their story multiple times and be subjected to repeat tests.

These are examples of what we have achieved, and there are others in this strategy. There is much more we can and must do to support better health and care. As people move around our health and care system their information must move with them to ensure continuity of care and the best possible health outcomes. An important part of achieving this is embracing innovation and looking at new ways of doing things. There is much to be proud of in our local universities and companies, as well as within HSC itself. They can all play a vital role in supporting HSC to improve services.

I am confident that through working together, with Health trusts, the voluntary sector, Independent medical contactors, industry, universities, colleges and the numerous other agencies and departments we can deliver world class eHealth support to everyone.

About this document

Who should read this document

This document is for anyone who wants to contribute to the development of the strategy or wants to learn more about the potential for technology to:

- help people make decisions about their own health and wellbeing
- support new ways of arranging services around the patient, such as care pathways
- help change the way care professionals work to give them more time and the information they need to make better, faster care decisions for their patients or clients.

The document is divided into a number of sections which will provide an introduction to eHealth and the need for an eHealth and Care strategy for Northern Ireland. We outline our vision and principles before discussing each of the strategy's objectives in turn. Within the objective sections we ask:

- where are we now?
- where do we want to go?
- how are we going to get there?

How we developed the strategy

We asked the following people to tell us what we needed to do for the future of health services:

- Citizens (including patients, carers and clients).
- Community and voluntary sector organisations.
- HSC staff and organisations including primary care.
- Internal Local and national ICT suppliers.
- DHSSPS(NI).

We also used the 'National eHealth Strategy Toolkit' published by the World Health Organisation. A regional steering group and an external panel of experts oversaw the strategy. For more details and our methods, please see Appendix 1.

Responding to the strategy

A feedback form in Appendix 2 provides a framework for your responses. You do not need to respond to all questions if any are not relevant to you. There are a number of ways that you can send us your responses:

- on-line – (insert survey monkey address)
- email (insert email address)
- post (address)
- phone (phone number)
- taking part in public meetings (advertised in the press)
- taking part in specific stakeholder meetings
- social media posts and comments.

If you need this document and feedback form in an alternative format, please contact us by email, phone or post.

The HSCB will publish a summary of what we heard during this process in a response to the consultation document. Responses to the consultation may be made public if we receive a Freedom of Information request for this information.

We will finalise the eHealth and Care Strategy for Northern Ireland after we receive the feedback from this consultation process.

The eHealth and Care strategy will be reviewed at least twice during its lifetime, to reflect changing technology and accommodate new requirements from the public and staff as they engage with the process. The strategy will be evaluated during and after the five-year period.

This document should be read with the accompanying Equality Impact Assessment, available on the website or in other versions by request.

Executive Summary

'eHealth and Social Care' is the use of information that is needed by people and care professionals to make better decisions about prevention, treatment and care. This includes:

- information provided by you and your caregivers
- information held within our systems
- information generated by self-monitoring devices and sensors
- information needed for management and administration.

Northern Ireland has the unique advantage of having an integrated health and social care system. To make this document easier to read, we use the word eHealth to mean both health and social services' use of technology and information.

This document sets out a draft eHealth and Care Strategy for Northern Ireland 2015-2020. The Strategy describes how the Department of Health, Social Services and Public Safety (DHSSPS) and the wider Health and Social Care organisations in Northern Ireland (HSC), want to make the best use of information and communications technology (ICT) in order to:

- improve the safety and quality of patient and client care
- improve public health
- promote opportunities that support the Northern Ireland economy.

The strategy outlines how eHealth will support people, current services and help information to flow around the system to improve decision making for better care. It describes how eHealth will support the changes that must be made to improve health and wellbeing in Northern Ireland, set out in health and social care legislation and 'Transforming Your Care' and 'Quality2020', 'Making Life Better'.

We want to build on the good foundations that Northern Ireland already has. There are skilled and committed staff providing health and social care across Northern Ireland, who have a strong desire to use technology to support better care. Northern Ireland has strong universities and colleges that provide first-class research and education and a growing local technology sector that can support eHealth innovation. Citizens, patients, clients and carers have told us they want to use eHealth information and systems to support their health, wellbeing and independence.

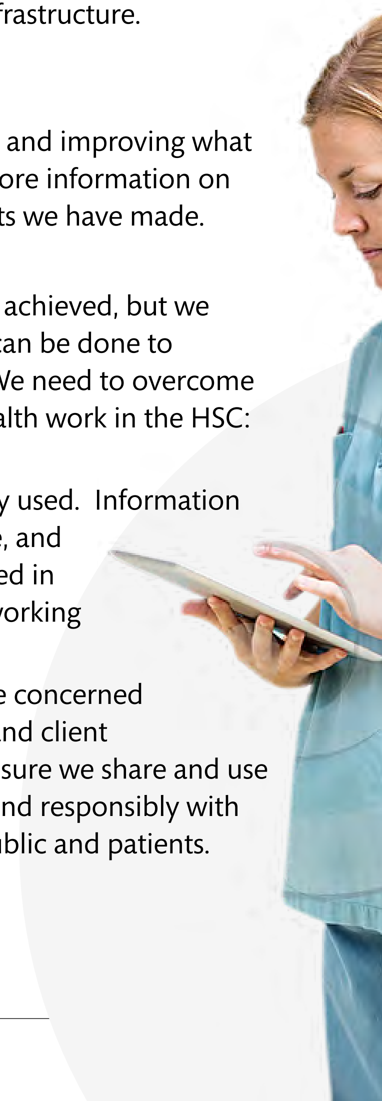
Over the last ten years, the HSC has invested in improved eHealth, leading to a dramatic improvement in eHealth support for better care. Across Northern Ireland this includes:

- a Health and Care number for everyone which is used by the HSC to maintain data quality
- a world-class electronic care record, providing care staff with an up-to-date record covering a range of patient and client information
- the regional X-ray system, NIPACS, allowing all X-rays to be viewed and reported electronically
- computerisation, networking and the introduction of two-way electronic communication for all GP practices
- major improvements to networks, data centres and other major eHealth infrastructure.

In this document's "Maintaining and improving what we have" section, we provide more information on some of the other improvements we have made.

We are proud of what has been achieved, but we know there is much more that can be done to support health and wellbeing. We need to overcome several difficulties to make eHealth work in the HSC:

- Paper records are still widely used. Information on paper is difficult to share, and the use of paper is embedded in many HSC staff members' working practices.
- The public and HSC staff are concerned about maintaining patient and client confidentiality. We must ensure we share and use information appropriately and responsibly with the understanding of the public and patients.



- eHealth can change relationships and working practices for the public, patients, clients, their carers and HSC staff. If we are asking staff and the public to do things differently, we need to make sure we are bringing real benefits to the people affected and demonstrate those benefits to justify the investment in eHealth.
- Some people may have difficulty accessing eHealth through disability, age or ethnicity or through lack of technology. We will examine these issues in the equality impact assessment.

In the objectives and outcomes, we set out how we will deal with these difficulties across Northern Ireland, providing benefits for the public and improvements for the HSC.

This strategy covers the full range of eHealth needed for Northern Ireland, from public communications, through large-scale information technology systems and personalised assistive technology, to the contribution health and social care technologies could make to developing a vibrant eHealth commercial sector. Successfully implementing the strategy will mean that the right care will be given to the right person at the right time with the right resources. eHealth success will also allow local industry to grow, innovate and compete globally, contributing to Northern Ireland's prosperity.

Strategy vision

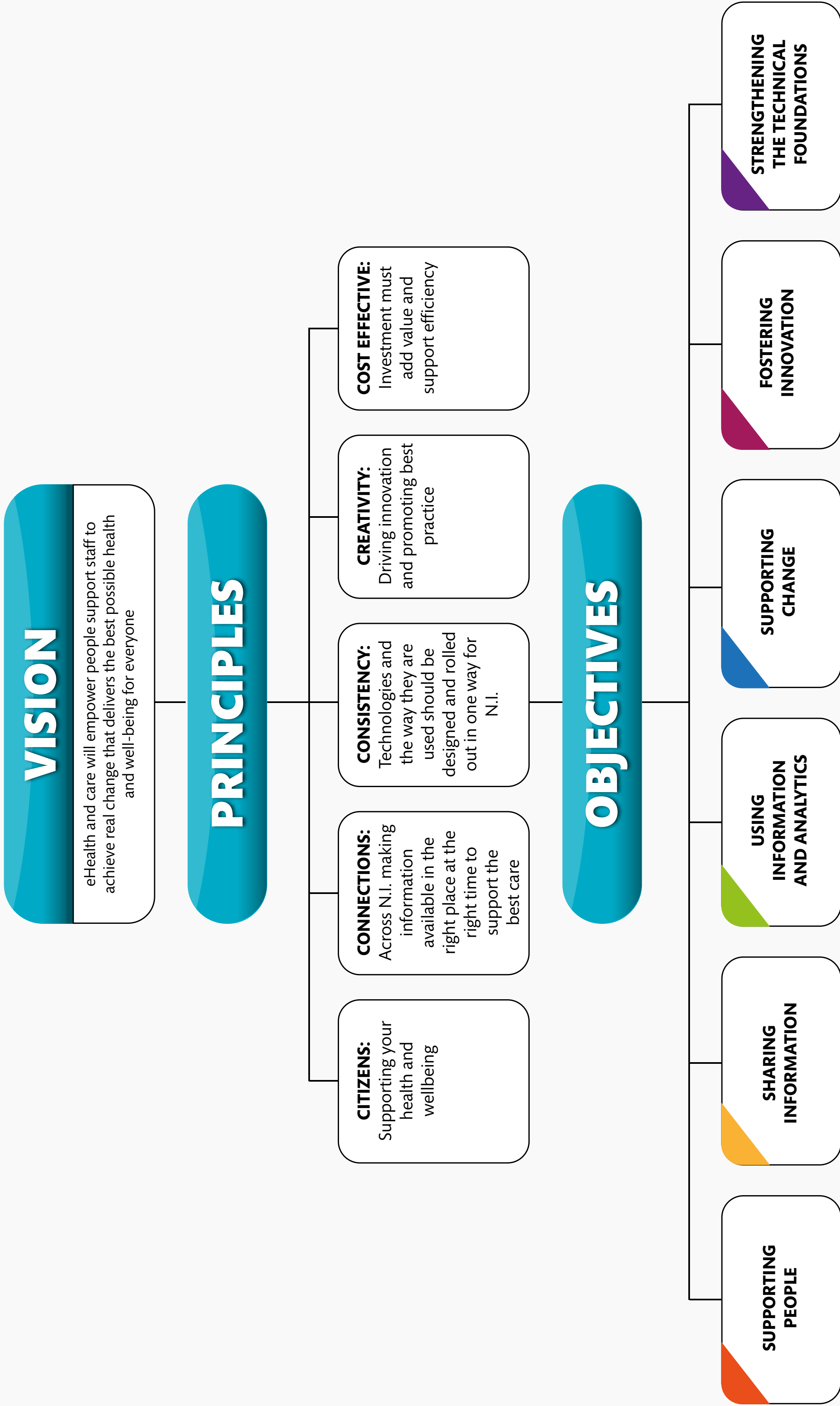
Through eHealth, we will empower people to be more active in their own care and support health and social care staff to achieve real change that delivers the best possible health and well-being for everyone.

Principles

Five key principles underpin the strategy:

- Citizen centred: supporting your health and wellbeing.
- Connections: across Northern Ireland, making information available in the right place; at the right time to support the best care, with the right safeguards in place.
- Consistency: technologies and the way they are used should be designed and rolled out in one way for Northern Ireland; any variations from this will need to justified.
- Creativity: driving innovation and promoting best practice.
- Cost effectiveness: investment must add value and support efficiency.

These principles have guided the development of objectives for the strategy and will underpin plans to implement the strategy.



VISION
eHealth and care will empower people support staff to achieve real change that delivers the best possible health and well-being for everyone
PRINCIPLES
CITIZENS: Supporting your health and wellbeing
CONNECTIONS: Across N.I. making information available in the right place at the right time to support the best care
CONSISTENCY: Technologies and the way they are used should be designed and rolled out in one way for N.I.
CREATIVITY: Driving innovation and promoting best practice
COST EFFECTIVE: Investment must add value and support efficiency
OBJECTIVES
SUPPORTING PEOPLE
SHARING INFORMATION
USING INFORMATION AND ANALYTICS
SUPPORTING CHANGE
FOSTERING INNOVATION
STRENGTHENING THE TECHNICAL FOUNDATIONS

Objectives

1. **Supporting people**
   Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.

2. **Sharing information**
   Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.

3. **Using information and analytics**
   Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.

4. **Supporting change**
   Make thinking about eHealth central to planning any changes to health and care services to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.

5. **Fostering innovation**
   HSC will work with businesses colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth to help improve health and wellbeing, recognising there may be opportunities where such work contributes to developing sustainable economic growth in Northern Ireland.

6. **Strengthening the technical foundations**
   Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed.

You will find detail on each of these objectives, including how we propose to achieve them, in the sections of the strategy. Under each of the objectives we have a number of important outcomes which we plan to deliver in the strategy period. The level of available resources will determine the pace of implementation and transformation of services. A summary table sets out the objectives on page 27.

In this strategy we balanced all these elements to show the future of eHealth in Northern Ireland. We want you to have your say on this strategy as part of an active consultation on its contents including how eHealth could be developed and delivered. The responses to the consultation will be used to improve the eHealth and Care strategy before we issue it in spring 2015. In the "How to use this document" section we show a range of ways to contribute to this consultation and we would encourage you to respond.

What is eHealth?

eHealth is the use of information needed by people and by care professionals so they can make better decisions about prevention, treatment and care. This includes information provided by you and your caregivers, information held in our systems, information generated by self-monitoring devices and sensors, and information needed for management and administration.

This use of information is made easier by information technology-based systems that allow the information to flow and be shared between people and organisations. Northern Ireland has the unique advantage of an integrated health and social care system; therefore we have called our plan for change an eHealth and Care Strategy. Throughout this document, we use the word eHealth to cover both health and social services.

eHealth is important for a number of reasons:

We live increasingly in an 'information society' with nearly every aspect of our daily lives touched by technology – whether this is in our homes, in our wider communities or in our working lives. How we book holidays, how we read the news, and how we keep in touch with our families and friends have all been revolutionised. eHealth is about bringing the benefits of that revolution to bear on our health and wellbeing.

Of course, not everybody has access to the internet or technology or is happy using them. The use of eHealth will supplement face-to-face services with a more diverse mix of e-enabled services.

Why do we need an eHealth and Care strategy?

Health and social care has seen many changes in recent years, but more needs to be done to make sure we continue to meet the needs of the people of Northern Ireland. Northern Ireland has strategies setting out what these changes should be, including 'Transforming Your Care'; 'Quality 2020'; and the new strategic framework for public health 'Making Life Better'. The changes we know we will face with a growing and ageing population, and an increasing burden of disease mean we need to find smarter ways of doing things.

eHealth technology will support the vital changes in how health and social care is delivered to meet the challenges of the future. It can help to provide services remotely and also improve communications between care professionals and with patients clients and their carers. By improving access to information both citizens and care professionals will be able to make better health and wellbeing decisions.

A clear eHealth plan to support care transformation will make it easier to develop partnerships with universities, colleges and industry that support better care. The Connected Health and Prosperity Board Task and Finish Group Report has outlined how this will develop opportunities for employment, business and export-led growth.

What are the challenges?

We need to overcome several difficulties to make eHealth work in the HSC:

- It often takes too long for the good ideas that support new models of health and care delivery to become mainstream practice. We need to encourage and support the adoption of successful innovations.
- eHealth can change relationships and working practices for the public, patients, clients, their carers and HSC staff. Most people are naturally resistant to change. We need to make sure we are bringing real benefits to the people affected.
- Paper records are still widely used. Information on paper is difficult to share, and the use of paper is embedded in many HSC staff members' working practices.
- We need more standardisation and structured data if we are to make best use of the information being collected.
- Some of our older ICT systems in use in the HSC are not able to link to other systems.
- The public and HSC staff are concerned with maintaining patient and client confidentiality. Some people feel that sharing information digitally may be less secure and put them at greater risk of having their confidentiality breached.
- The current system of planning and paying for heath and care services do not take account of the changes which eHealth will support.
- Not everybody has access to the internet or technology.
- There may be access difficulties for people with a disability, older people and people from a minority ethnic background, particularly those for whom English is not a first language or have other communication needs.
- It is not always easy to prove the benefits of eHealth to the public and to HSC decision makers. We need to be able to justify using scarce HSC resources in this way if we are to allow eHealth systems to support innovative new ways of providing services.

In the objectives and outcomes, we set out how we will overcome these difficulties across Northern Ireland, providing benefits for the public and improvements for HSC.

Current eHealth developments

Northern Ireland has strong foundations for eHealth to develop in ways that will support health and well-being improvement. Since the HSC ICT Strategy was published in 2005, the use and availability of ICT systems have greatly improved, forming the foundation for this eHealth and Care strategy.

Across Northern Ireland, care-delivery is already supported by eHealth in the following ways:

- a world-class electronic care record (NIECR), providing care staff with an up-to-date medical record covering a range of clinical information
- the regional X-ray system, NIPACS, allowing X-rays to be taken, reviewed and reported electronically

- a system to support operating theatres in hospitals
- patient tracking and bed-management systems across all Trusts
- new and redeveloped community information systems across all Trusts.
- computerisation, networking and introduction of two-way electronic communication for all GP practices in Northern Ireland
- Electronic Prescribing and Eligibility System (EPES) using systems and bar codes to simplify prescriptions and payments
- a Health and Care number for everyone, and then making sure that HSC uses it to maintain data quality
- specialised ambulance systems designed to improve patient care
- a data warehouse for data in Northern Ireland, allowing analysis for research, audit, service development and performance management
- major improvements to networks, data centres and other major eHealth infrastructure
- a number of pilots, trialling eHealth technologies across Northern Ireland, some of which we will be rolling out as part of this strategy.

You can read more about our current eHealth technologies in the section "Maintaining and improving what we have".

What do we want to achieve?

Strategy vision

Through eHealth, we will empower people to be more active in their own care and support health and social care staff to achieve real change that delivers the best possible health and well-being for everyone.

Principles

Five key principles underpin the strategy:

- Citizen centred: supporting your health and wellbeing.
- Connections: across Northern Ireland, making information available in the right place; at the right time to support the best care; and with the right safeguards in place.

- Consistency: technologies and the way they are used should be designed and rolled out in one way for Northern Ireland; any variations from this will need to justified.
- Creativity: driving innovation and promoting best practice.
- Cost effective: investment must add value and support efficiency.

These principles have guided the development of objectives for the strategy and will underpin plans to implement the strategy.

To successfully achieve these objectives, a number of key factors will need to be addressed:

- There must be ongoing, meaningful engagement with the public to make sure we continue to do the right things in the right way.
- The strategy implementation plans at regional and at Trust level must uphold the five key principles and engage health and care professionals in order to promote a culture of 'doing things differently'.
- The pace of implementation and the level of transformation of services will be determined by the timing and level of available resources.

  The objectives and related outcomes are shown in a summary table on page 27.

Supporting People

Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.

Where are we now?

eHealth services for the public in Northern Ireland are currently limited. At the moment, we do not make it easy for people to seek out information for themselves or make decisions about their own health and wellbeing. We tend to rely on three methods of communication with patients: paper, phone and in person. Contacting health and social care services about appointments or test results for example, is still mainly done by telephone or letter.

Where do we want to go?

Supporting healthy citizens

eHealth has a role in health promotion, protection and improvement. Using ICT well to provide quality information services is very important to this.

People have told us they would like to use eHealth technologies to add to traditional ways of contacting and using health and care services. Trusted online health portals can provide access to a variety of health information and signposting services. Online booking can be used to make appointments. Mobile apps can be developed to help monitor health conditions and to supplement patient-held records.

Alice is a new mum who is well supported by her health visitor but wants to get some more information about healthy eating and exercise after pregnancy. Alice logs on to the HSC web portal and follows the signposts to information and links for recipes and fitness guides. She also finds a list of groups in her area where she could go to meet other new mums.

A personal health portal could let people store information such as healthy-eating advice, self-recorded data that they might have gathered through the use of health and lifestyle apps on their mobile phones. When needed they may share some of this data with their care team to help take more informed decisions together.

Bronagh is a fit and healthy 30-year-old who enjoys looking after her health. She has recently bought a fitness tracker and now keeps an online record of all her fitness activity and her diet. At a recent visit to a physiotherapist for a minor sports injury, Bronagh was able to share her recorded data through a patient portal and jointly make a decision about a new fitness plan.

e-Learning programmes and podcasts can offer a new way for people to receive education regarding health and lifestyle issues and condition-specific information. For example someone diagnosed with diabetes will be able to supplement face-to-face patient education with online sessions.

Supporting communication

Many people are increasingly comfortable with self-service models as we use them every day to shop and book holidays, for example. Traditional ways of contacting the HSC will still be available for people who prefer these but there will be a range of digital services, for example:

- online appointment booking
- online self-referral
- text message reminders
- emails
- social media.

Brian was discharged from hospital four weeks ago following surgery. He has just received an email with a link for booking an outpatient's appointment for two weeks' time. Brian logs on to the new HSC portal via the emailed link and is able to 'click and book' a convenient appointment that suits him.

A Social Media and Alternative Communications Plan will be developed to look at how we can best use these technologies for the greatest benefit to all patients and service users.

Virtual health communities are developing in Northern Ireland. These social media groups or applications help people support each other in dealing with a shared health condition.

Hassan is a 40-year-old who was recently diagnosed with a respiratory condition called COPD. He is well supported by his GP, specialist respiratory nurse and hospital consultant, but Hassan gets a lot out of 'meeting' other people with his condition on a local online discussion forum. He enjoys the peer support and advice that others give him, especially if he is having a bad day.

During the development of the strategy, people we talked to said having some access to their own electronic care records would help them to keep track of their own hospital letters, appointments and test results. There is also the opportunity to let people add information to their records and to help make sure the information we hold is accurate.

Supporting independence

Helping people stay independent is important to older people, those with long-term conditions, mental health problems or a learning disability, to carers and for everyone wanting to look after their own health and wellbeing.

- **Telemonitoring technologies** can be effective support tools for people with long-term conditions, helping them live independently at home with an improved quality of life. As telemonitoring becomes more widely used and embedded into health care, patients who have monitoring needs such as high blood pressure, heart rate and blood sugar can benefit from being monitored remotely. Those with potential maternity complications such as gestational diabetes and people wanting to monitor their weight can also benefit from telemonitoring.

- **Telecare** is a tool that supports people – particularly the elderly or those with physical or mental health conditions or a learning disability – to live at home for as long as they want. Sensors in the home or worn by the individual inform the care team about certain key information, such as if a person may have had a fall, or another safety issue so that the person can be visited when needed.

Susan is a family carer who looks after her elderly parents. From time to time Susan can feel overwhelmed with the numerous physical, emotional, and financial challenges she faces. The social worker suggests that Susan considers telecare for her parents which would allow her to have a break during the day knowing that her parents are still safe even if she is away from them. Telecare devices for falls and exit alerts are installed in Susan's parents' home following a discussion with them to explain the benefit of the equipment for their safety. Susan can now leave them for periods during the day knowing that if alerts are raised, someone will call her immediately.

Telecare can also be used to send messages to the individual, such as prompts to take medications. Virtual coaching through video technology could also help keep older people fit and active both physically and mentally.

• **Electronic assistive technologies** (eAT) are increasingly available to help support or improve daily living for people with physical, sensory or cognitive impairment. eAT includes a broad range of technologies, from 'low-tech' to 'high tech'. For older people and others with limited mobility who may be housebound and living away from their family and friends, it is easy to lose touch and become isolated and lonely. Using eHealth could enhance the quality of life and social wellbeing of these people in their own homes. Using SMART technology such as TVs, phones and computers including hand-held devices. Communication can be improved by creating online 'clubs' or social networks as well as allowing these people to stay in touch with family and friends. For care professionals, these technologies can also allow them to contact isolated patients and clients.

eAT includes devices that help control the physical environment, such as opening doors and curtains, controlling heating, lighting and entertainment at the click of a button. Intelligent use of home technology can take care of the little tasks and make a big difference to day-to-day life.

The development of eAT provides a wealth of opportunity to support independence and help people to maintain their health and wellbeing.

For these opportunities to be fully exploited, new arrangements for funding will need to be set up across a range of agencies and account taken of self-funding opportunities.

How are we going to get there?

- HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services by 2017.
- HSC will provide online access to your own health records.
- HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically.
- HSC will optimise the use of current GP systems to facilitate access to GP records and other ways of communicating and interacting with GPs, e.g. prescription ordering and online booking.
- HSC will encourage the development and use of mobile health apps to support, facilitate and extend the relationship between care professionals and users for self-care and management.
- HSC will promote the use of eAT, telemonitoring and telecare to enable people to live independently.
- Along with other appropriate agencies such as housing and councils, HSC will develop new ideas to enhance the quality of life and well-being of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly SMART Living technologies.
- The HSC will develop a Social Media and Alternative Communications Plan, evaluating the use of social media, smart phone technology and self-service technologies for communication with citizens.

Sharing information

Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.

Where are we now?

Information about you is needed to make sure you get the best care possible. Sharing your information between members of the care team or between different care professionals is often essential in the delivery of health and social care. Your information is already recorded on paper and increasingly on secure computer systems in HSC organisations such as GP surgeries and hospitals.

The HSC still generates large amounts of paper records, which often duplicates the information we have in our computer systems. Paper records are difficult to share quickly and securely. Whenever a person attends a new hospital or clinic, it is likely that a new paper record is created and these different records are difficult to join up.

When information is held electronically, it is often only available to staff using that computer system within that organisation or department. Lots of our computer systems do not talk to each other, even for sharing basic details such as your name and address, date of birth, and GP practice.

Paper records and the fact that many computer systems do not talk to each other make it hard for us to make sure your information follows you throughout the HSC. It can lead to members of your care team not having all the information they need to best treat or care for you. It can mean you having to needlessly repeat your details and care professionals having to needlessly spend time collecting your information.

We put in place the Northern Ireland Electronic Care Record (NIECR) in 2013 and this been successfully adopted across HSC. NIECR links core information systems from hospitals and clinics throughout Northern Ireland and includes lab tests, x-rays, appointments, discharge and clinic letters and details of any drugs prescribed and allergies recorded from your GP's system.

With NIECR in place, Northern Ireland is in a strong position to further develop digital records. NIECR is bringing in additional information to benefit the shared record as it becomes electronically available, building links with old and new HSC systems and technologies. This is improving care coordination, reducing delays to treatment and decision making caused by information not being available and improving patient safety. NIECR is reducing unnecessary duplication across the HSC, meaning less patient and staff time wasted and less inconvenience.

The Electronic Northern Ireland Single Assessment Tool (eNISAT) is another example of information being collected electronically and consistently across the HSC. eNISAT allows care professionals to contribute to the one assessment for a patient or client in the community sector. This helps to avoid duplication and improve the co-ordination of a person's care across different HSC services.

The benefits of NIECR and eNISAT are considerable, but are still limited by difficulties that some HSC staff have getting basic access to a secure HSC PC, laptop or mobile device and a reliable network connection that allows them to connect to these systems.

Jean is a 79-year-old woman who lives alone in her own house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Jean has been assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse and is seeing consultants in two different hospitals. Jean found it frustrating that she had to provide the same information each time she was assessed. Using the Northern Ireland Electronic Care Record (NIECR), all the care professionals involved in looking after Jean can now share information and coordinate her care. Jean doesn't have to repeat "her story" to everyone. She's having to have fewer blood tests as recent results are available to all the care team and, if there's a crisis, the Out of Hours or Emergency Department team have enough information to let them make the best possible decisions about Jean's care.

Where do we want to go?

eHealth will enable electronic communication between care professionals. Expanding the use of mobile technologies and moving towards fully electronic records, building on the NIECR and other core HSC computer systems, will help make this happen across HSC.

Information that is useful to:

- In developing electronic records we will ensure that: information that is useful to the citizen and those caring for them will be recorded digitally
- information "blockages", such as when a patient moves from one care setting to another, will be identified and addressed. Information will flow electronically with the patient
- electronic records will be easy to use, and will help HSC staff spend more time doing their jobs
- appropriate security measures, the ability to check how the system is being used and confidentiality safeguards will all be put in place to make sure electronic records are used and viewed correctly
- the public and patients will be kept informed about how their digital information is used and shared. Sharing a person's identifiable information for any reason other than for their direct care will require explicit, informed consent except in rare situations such as the cancer registry where information is used to improve the quality of care.
- there will be secure, reliable and well-maintained HSC data centres and networks to keep this information safe, make sure our systems run well and minimise the risk of technical failure
- there will be investments in mobile technology pilot schemes to improve how staff access shared information and to increase the potential benefits from these systems.
- Develop new ways for patients, clients and their carers to receive services from the HSC and access services for example through videoconferencing, email and text messaging.

Annette is a member of the nursing team on a busy medical ward. Annette is concerned about the amount of time she and other members of the team are spending away from the patients' bedsides to complete paperwork and worries that this could be harming the quality of patient care. The nursing team agrees to use handheld devices to record information at the bedside. The digital form is already filled in with key information pulled in from NIECR for Annette to check with the patient. She is able to add and update new or changed information using predictive lists, often only needing to type the first few letters. Annette captures valuable information on weight, mobility, cognitive function and risk scores. Instead of this information existing on paper forms, when patients are discharged home or to another ward it will travel electronically with them, allowing the wider care team to understand how the patients' health has been recently.

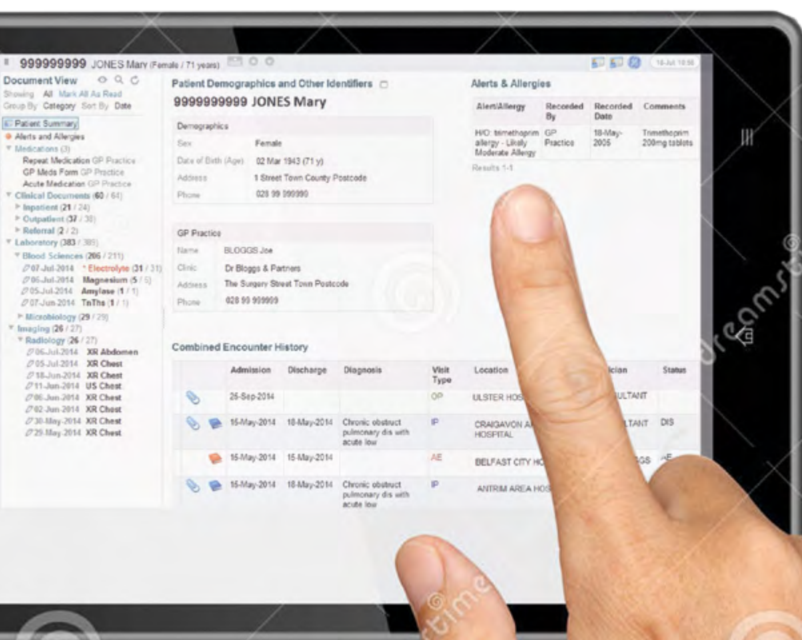
Sean is a social worker working in West Belfast. He is currently involved with a family and needs to make an assessment of their needs for additional support with their children. Sean has always been frustrated that he has had to complete the paperwork when he is in his clients' home and then type out the information again when he gets back to the office and his computer. Since the introduction of mobile working, Sean can now use his laptop computer when sitting with the family and complete the documents immediately. As he also has internet connections he is able to help the family find online information and services that they can look at when he leaves them.

Electronic communication, such as video conferencing, e-Learning and electronic requests for advice between primary and secondary care will support better patient care and reduce travel time for patients and staff. An example of the way this technology can be used is Project ECHO. This uses video-conferencing technology to link GPs with hospital care teams to help manage the care of patients who have complex needs, bringing specialist expertise into primary care and avoiding trips to the hospital for the patient.

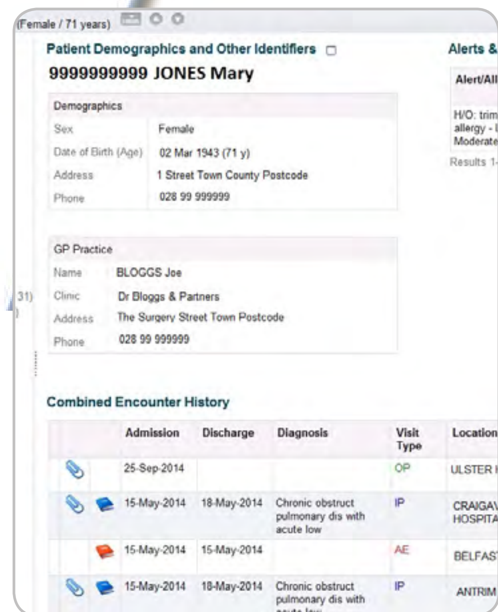
Dr Jones, a GP in Fermanagh, wants to learn more about how to look after his patients with complex conditions so he joins Project ECHO. The project brings together a number of specialist doctors and nurses as well as the GPs and community teams via video meetings. Over a series of meetings the GP and community teams learn from the specialists. The specialist teams also learn from them about what is needed to allow patients' care to improve outside hospital. Together the specialist and primary care teams work together to ensure that patients with complex conditions get the care they need, closer to home, and with less travelling to hospital for planned or emergency care.

How are we going to get there?

- Continue enriching NIECR, with a three-year programme from 2014 to link in more HSC clinical and care information systems and develop NIECR functionality, including providing care professionals with appropriate role-based access to clinical and care information systems including NIECR.
- Provide an additional 6,000 staff with mobile access to the HSC network and systems in 2015/16, as part of a three-year investment plan to ensure mobile access for all staff that require it.



- Provide secure and appropriate access to NIECR information for community pharmacists, dentists, opticians and independent health and social care providers, such as nursing homes.
- Build links with independent health and social care providers to allow them to contribute to the NIECR to help make sure all relevant patient information is captured and able to be shared.
- Digitalise manual processes and paper records to allow information to be shared and re-used appropriately.
- Develop plans for linking citizen-captured information into shared care records, including data from telemonitoring and information directly input by the patient or carer.



Use of information and analytics

Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.

Where are we now?

Information about you and your care is gathered electronically in many parts of the HSC but some is still collected on paper. Some electronic information such as attendances at hospital, drugs prescribed by your GP and visits from community nurses is collected to help the HSC to support research, audit, service development and performance management. This information goes to a central database (the HSC Data Warehouse), where it is held securely and is pseudonymised or anonymised before use.

Work is going on using limited, summary-level information from GP systems to let GPs find out who in their practice is at risk of starting to have problems with their health. This lets the GP offer additional support to these patients to help them stay healthy for longer.

Where we want to go?

In future we will collect more information electronically. Health analytics is about making best use of this information to benefit the wider population by:

- supporting better decisions about the services we provide to get the most benefits for patients and clients
- informing technical and medical evaluations of new therapies and treatment plans
- making sure the services we provide are equitable and high quality

- identifying those at risk of health problems and taking early steps with the patient to keep them in good health (risk stratification)
- letting us model the future, forecasting needs and planning care delivery to meet the identified need.

Pavel has managed his diabetes successfully over the last few years and he feels fine keeping busy at work and at home. As he feels so well, Pavel does not attend the diabetic clinic as often as he should. Information on the care of people with diabetes in his GP practice area is analysed. It picks up a group of people at risk of diabetic complications, including Pavel. The data links information about his blood-sugar levels and his non-attendance at clinics. Next time Pavel asks for his repeat prescription he's asked to make an appointment with his GP who notices a small red mark on the sole of his foot, which could be the start of an ulcer. The GP refers Pavel electronically to the podiatrist for foot care and Pavel books electronically at a time he can attend. Seeing the podiatrist means the ulcer does not develop.

For this to work, HSC needs information standards so that the right information is collected in the right way and is correctly entered into information systems. This means information can be linked across HSC. We need information systems that work well with each other so there are no blockages in the flow of information. All of the work we do and will do involving the use of information about you will comply with data protection policy, obligations and relevant codes of practice.

How are we going to get there?

- Develop links between HSC information systems that improve how we can analyse information. An Information and Analytics strategy will examine the legal and ethical frameworks needed, the standardisation and coding of HSC information needed, and the training and education needs of staff. This strategy will take account of the outcome of the DHSSPS consultation on secondary use of information - "Caring for Your Information".
- Through a rolling programme from 2015, use risk-stratification techniques to provide early-intervention support to help citizens keep healthy.

Supporting Change

Make eHealth central to planning any changes to health and care services, to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.

Where are we now?

HSC Trusts and staff are already using technology to help them transform their services for patients and clients. However, some areas are not aware of or have limited access to eHealth systems that could better support their daily work, even though they may use technology extensively outside work.

Too often, the technology needed to support changes has not been included in the plan for improvement. In the past, ICT has been seen as something for technical specialists. This view is changing: our staff that deliver and manage frontline patient and client care are increasingly taking an active role in using technology to help them.

An HSC ICT Programme Board has been governing the last 10 years' progress. However, this was largely technically focused and had limited contact with care professionals.

Where do we want to go?

We need effective leadership and a shared governance structure across the HSC organisations. This needs to:

- place care professionals at the heart of decision making, focusing on the impact of eHealth on health and wellbeing
- involve the public in setting the direction of the eHealth and Care programme
- use the excellent technical knowledge and experience within the HSC
- involve business, academic, and community and voluntary sectors
- deliver projects supporting transformational change, service improvements and benefits to patients and clients

- ensure consistency and equity in access to eHealth services across HSC
- minimise waste, duplication and divergence from best practice
- create space for innovation and support the roll-out of successes across HSC
- identify policy changes that may be needed to help bring in the strategy.

An eHealth and Care Strategic Board, led by the HSCB, will replace the HSC ICT Programme Board and direct the grouped programmes and projects. The eHealth and Care Strategic Board will make sure stakeholders, particularly citizens, can influence the direction of the programme and the implementation plan.

A Design Authority will oversee proposals for projects and investments to ensure we stay on the strategic and technical track across HSC and make the best use of the resources we are given.

Using eHealth may mean changes in traditional roles and the ways of working of some HSC staff. Some may need training and support to make best use of the technology and information. Adaptations may be needed to support staff whose lack of computer skills may hinder their use of eHealth technology. As well as working within their recognised professional codes of conduct and competency frameworks, all care staff should be supported by adequate clinical supervision, training and ongoing support. To help identify and meet the training and skills needs of staff, this strategy recommends the setting up of and coordination of activities with relevant professional bodies and education providers.

How are we going to get there?

- Develop an eHealth strategy implementation plan by Spring 2015.
- Demonstrate that eHealth can improve patient-centred care.
- Develop eHealth Clinical Lead roles to drive and direct the use of eHealth to support care delivery.
- Put in place a new leadership and governance structure, with care professionals at the heart, and design it to ensure consistency and equity in service delivery.
- Support the development of staff to allow them to best use eHealth technologies, through training and support, working with professional bodies and existing training providers. This will integrate with current DHSSPS and professional workforce planning and education strategies.

Fostering innovation

HSC will work with businesses, colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth and help improve health, wellbeing, prosperity and job creation.

Where are we now?

In Northern Ireland we have dynamic businesses, internationally recognised universities and strong community and voluntary organisations. HSC has worked with these partners for many years, bringing innovation into health and social care which benefits patients, clients and public health.

In 2011 a Memorandum of Understanding (MOU) on Connected Health and Prosperity was agreed between Northern Ireland's Health and Enterprise Ministers. The agreement sets out how the DHSSPS and DETI will continue to work together in developing connected health solutions that will improve the wellbeing of patients and help support the Northern Ireland economy. As a result of the agreement, the Northern Ireland Connected Health Ecosystem (NICH ECO) was established in 2012 to bring together the health, academic and industry sectors, along with patients and the voluntary and community sector. Its aim is to identify the challenges in bringing about transformative change to our health and social care services and to consider potential solutions.

The Economy and Jobs Initiative was agreed by the NI Executive in 2013. This included a focus on the contribution health could make to the economy. A Task and Finish Group was established to provide an assessment of the potential opportunities for employment and business development from Health and Social Care through greater innovation and export-led growth. In May 2013 the T&F Group published its Report along with a number of proposals that Health and Social Care could make to being a major driver for innovation and economic growth. The report's recommendations include developing an International Health Analytics Centre (IHAC) to make the most of the data generated by the health and social care sector to support global advances in health and social care research. The report also recommends setting up a Connected Health Integration Platform (CHIP) which could link digital care records to applications running on smart devices such as phones, tablets and computers.

We are also working with the health community in other European regions and the US:

- Northern Ireland has been given 3* Reference Site status through the European Commission's European Innovation Partnership on Active and Healthy Ageing (EIP-AHA) initiative. We are working on a number of EIP-AHA projects to develop new technologies and innovative approaches to improve patient care.
- DHSSPS has established an EIP-AHA Reference Site Collaborative Network, bringing together all European Reference Sites to exchange and share best practice in the development of health and care strategies, policies and service delivery models.

- DHSSPS has eHealth Memorandum of Understanding agreements with a number of European Regions and the New York State Health Department, with others in development.
- These partnerships mean we can benefit from sharing ideas and best practice. They also mean Northern Ireland is best placed to maximise support from Europe that will help us take forward further research and projects.

Where we want to go?

We want Northern Ireland to be a global centre of excellence in the field of eHealth, with:

- improved access to information for the public and HSC staff
- models of health and care designed and delivered around patients
- patients and clinicians better able to monitor and manage health conditions
- improved outcomes for the public
- more support for innovative businesses and social entrepreneurs wanting to work with us in developing innovative eHealth solutions
- better opportunities for businesses, universities and community and voluntary organisations bringing new jobs to Northern Ireland.

How are we going to get there?

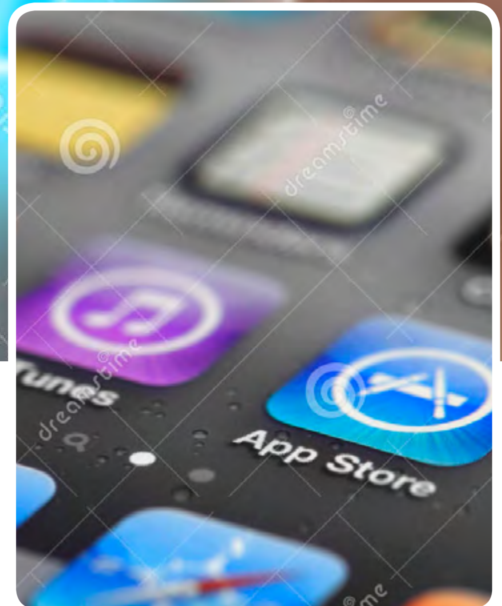
- We will continue to develop both the Northern Ireland Connected Health Ecosystem and our partnerships outside Northern Ireland. We will develop our own capacity to innovate, using local and international partnerships to access the expertise needed to develop solutions to problems affecting our patients.

- We will work with other partners to take forward the recommendations in the Economy and Jobs Initiative Task and Finish Group's report. This can be found at www.dhsspsni.gov.uk/t_f_final_report.pdf

- We will work with local eHealth industry to develop and use innovative products and systems we can sell worldwide, supporting the local economy and increasing local employment.

- We will build on our success in developing and delivering EU programmes, drawing funding, ideas and expertise into Northern Ireland.

- We will support an annual eHealth Innovation Award and Conference to celebrate and promote best practice in the use of eHealth.



Maintaining and improving what we have

Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed.

Where are we now?

We have developed a strong ICT foundation for eHealth over the last 10 years as a result of the 2005 HSC ICT Strategy and investment in many regional and Trust-level projects:

- The Northern Ireland Electronic Care Record (NIECR) and the expansion of systems across the community sector, including the delivery of Community Information Systems and the development of the electronic Northern Ireland Single Assessment Tool (eNISAT) are bringing real benefits to patient and client care. They are a strong starting point for developing more tools to support high-quality integrated care.
- Health and Care Number (HCN), the unique identifier for everyone in Northern Ireland. This unique identifier is important as it allows your health and social care information to be safely linked together and helps the HSC work together to keep your basic demographic details (name, address, date of birth) accurate and up to date.
- Northern Ireland Picture Archiving and Communications System (NIPACS), our regional system for x-rays.
- Theatre Management System (TMS), managing operating theatres in hospitals.
- Cancer Patient Pathways System (CaPPS), improving cancer diagnosis and treatment.
- Electronic Prescribing and Eligibility System (EPES), supporting primary-care medicines management.
- ICT infrastructure improvements including secure HSC and GP networks, desktop and mobile devices and consolidated regional HSC data centres.

- Several Trusts have developed electronic clinical noting systems, aimed at replacing paper-based inpatient care records. Other excellent local innovations continue to be developed across Northern Ireland including:
- electronic discharge correspondence, where information needed by GPs, nurses and other care professionals in the community can be sent electronically rather than in a letter that has to be hand delivered by the patient when they go home
- bed-management systems – an interactive whiteboard on hospital wards that allows staff to deal with admissions, transfers to others wards and discharges
- electronic patient check-in in outpatient departments, where patients can use a touch-screen to let staff know they have arrived
- for care professionals in some hospitals, bedside computing, which allows them to collect and connect to information needed when they are with patients, while the use of mobile technology allows staff who move about hospitals or work in the community to do the same
- patient websites, providing information on hospital services, which are now available for all Trusts
- the Northern Ireland Ambulance Service (NIAS), which has invested resources in implementing systems required by a modern ambulance service, including Call Line Identification (CLI) integrated with hospitals and a pilot of an Electronic Patient Report Form system (EPRF) using digital-pen technology
- electronic patient monitoring, also used by NIAS to send clinical information to the Emergency Department before the ambulance and patient arrives.

All general practices in Northern Ireland are computerised and connected to the secure HSC network. The results of tests that the GP has asked for are sent electronically. GPs are able to send electronic referrals to consultant services in Trusts. Information on patients' drugs and allergies is sent from GP systems to NIECR.

The current Telemonitoring NI service supports patients with long-term conditions. This regional service lets patients self-monitor and better manage their condition with care-professional support when needed. The regional Telecare service supports people to live independently at home for longer, for example by using sensors to alert care workers to possible problems, like a fall.

Pharmacists, dentists and opticians have also invested in ICT to support their services.

The community and voluntary sector are making good use of the internet for providing information. They lead the way in developing apps to help support people to stay healthy and happy.

Where do we want to go?

Maintaining our underlying infrastructure and systems is one of the main challenges for Northern Ireland as an advanced eHealth economy. We will need to renew or upgrade parts of this eHealth foundation during 2015-2020. Our principles will guide investment in the maintenance and renewals process, delivering consistently efficient services across Northern Ireland. This will include, where appropriate, the use of single systems, data structures and technologies to reduce complexity and cost. We plan to complete two technical strategies to inform the implementation - an Application Strategy and an Infrastructure Strategy. These will examine the existing infrastructure and systems, creating a clear picture of the current position and linking it to the implementation plan.

How are we going to get there?

- Develop and extend HSC ICT access to all parts of the health economy that need it, either through mobile, wireless or fixed networks including improvements in access and bandwidth to be completed by 2016.
- Develop an Infrastructure Strategy. This strategy will set out the future direction for HSC infrastructure including networks, datacentres and storage, including the appropriate adoption of cloud computing and cloud storage.
- Develop an Application Strategy. This strategy will set out the future development and replacement pathway for HSC applications, including the adoption when appropriate of open-source applications.
- Deliver the eHealth technologies needed to support service change; areas identified include medicines management and pathology services.

STRATEGIC OBJECTIVE	OUTCOMES
Supporting people Provide eHealth services, supporting electronic access for everyone where that is their choice. This will include electronic information services, electronic records access, on-line support and care services, appointment booking and remote care.	• HSC will develop a web portal providing trusted advice, self-care information, information on HSC services and secure access to online services by 2017. • HSC will provide online access to your own health records. • HSC will build on existing pilot schemes to reduce paper and develop ways of allowing citizens to interact with the HSC electronically for example booking clinic appointments on-line. • HSC will optimise the use of current GP systems to facilitate access to GP records and other ways of communicating and interacting with GPs, e.g. prescription ordering and online booking. • HSC will encourage the development and use of mobile health apps to support, facilitate and extend the relationship between care professionals and users for self-care and management. • HSC will promote the use of eAT, telemonitoring and telecare to enable people to live independently. • Along with other appropriate agencies such as housing and councils, HSC will develop new ideas and funding opportunities to enhance the quality of life and well-being of older people and those who care for them. This will include more integrated community-oriented services, more sustainable home and neighbourhood design, and more age-friendly SMART Living technologies. • The HSC will develop a Social Media and Alternative Communications Plan by, evaluating the use of social media, smart phone technology and self-service technologies for communication with citizens.
Sharing information Give care professionals appropriate access to information to improve the speed and quality of the care decisions they make, and the outcomes for the individual.	• Continue enriching NIECR, with a three-year programme from 2014 to link in more HSC clinical and care information systems and develop NIECR functionality, including providing care professionals with appropriate role-based access to clinical and care information systems including NIECR. • Provide an additional 6,000 staff with mobile access to the HSC network and systems in 2015/16, as part of a three-year investment plan to ensure mobile access for all staff that require it. • Provide secure and appropriate access to NIECR information for community pharmacists, dentists, opticians and independent health and social care providers, such as nursing homes. • Build links with independent health and social care providers to allow them to contribute to the NIECR to help make sure all relevant patient information is captured and able to be shared. • Digitalise manual processes and paper records to allow information to be shared and re-used appropriately. • Develop plans for linking citizen-captured information into shared care records, including data from telemonitoring and information directly input by the patient or carer.

STRATEGIC OBJECTIVE	OUTCOMES
Using information and analytics Develop ways to transform data and information into knowledge (informatics) that supports care, from being able to suggest personalised preventative care through to supporting population-level health and care planning.	• Develop links between HSC information systems that improve how we can analyse information. An Information and Analytics strategy will examine the legal and ethical frameworks needed, the standardisation and coding of HSC information needed, and the training and education needs of staff. This strategy will take account of the outcome of the DHSSPS consultation on secondary use of information - "Caring for Your Information". • Through a rolling programme from 2015, use risk-stratification techniques to provide early-intervention support to help citizens keep healthy.
Supporting change Make thinking about eHealth central to planning any changes to health and care services to make sure we are making the most of technical opportunities and the potential for improved information flows to support improvements.	• Develop an eHealth strategy implementation plan by Spring 2015. • Demonstrate that eHealth can improve patient-centred care for example collecting patient experiences of the HSC to help improve services. • Develop eHealth Clinical Lead roles to drive and direct the use of eHealth to support care delivery. • Put in place a new leadership and governance structure, with care professionals at the heart, and design it to ensure consistency and equity in service delivery. • Support the development of staff to allow them to best use eHealth technologies, through training and support, working with professional bodies and existing training providers. This will integrate with current DHSSPS and professional workforce planning and education strategies . • Develop new ways for patients, clients and their carers to receive services from the HSC and access services for example through videoconferencing, email and text messaging.

STRATEGIC OBJECTIVE	OUTCOMES
Fostering innovation HSC will work with businesses colleges and universities, community and voluntary organisations, other government departments and international partners to develop uses of eHealth to help improve health and wellbeing, recognising there may be opportunities where such work contributes to developing sustainable economic growth in Northern Ireland.	• We will continue to develop both the Northern Ireland Connected Health Ecosystem and our partnerships outside Northern Ireland. We will develop our own capacity to innovate, using local and international partnerships to access the expertise needed to develop solutions to problems affecting our patients. • We will work with other partners to take forward the recommendations in the Economy and Jobs Initiative Task and Finish Group's report. This can be found at *www.dhsspsni.gov.uk/t_f_final_report.pdf* • We will work with local eHealth industry to develop and use innovative products and systems we can sell worldwide, supporting the local economy and increasing local employment. • We will build on our success in developing and delivering EU programmes, drawing funding, ideas and expertise into Northern Ireland. • We will support an annual eHealth Innovation Award and Conference to celebrate and promote best practice in the use of eHealth.
Strengthening the technical foundations Maintain a modern, reliable eHealth infrastructure, including investment in supporting, modernising and replacing key systems and HSC networks and hardware as needed	• Develop and extend HSC ICT access to all parts of the health economy that need it, either through mobile, wireless or fixed networks including improvements in access and bandwidth to be completed by 2016. • Develop an Infrastructure Strategy. This strategy will set out the future direction for HSC infrastructure including networks, datacentres and storage, including the appropriate adoption of cloud computing and cloud storage. • Develop an Application Strategy. This strategy will set out the future development and replacement pathway for HSC applications, including the adoption when appropriate of open-source applications. • Deliver the eHealth technologies needed to support service change; areas identified include medicines management and pathology services.

Glossary

AHA	Active and Healthy Aging. A stream of work funded by the European Union to allow countries to work together to transform services.
BSO	Business Services Organisation
CaPPS	Cancer Access and Patient Protocol System
CCG	Clinical Communications Gateway
CIS	Community Information System. A system which brings together a wide range of community data and information.
DHSSPS	Department of Health, Social Services and Public Safety
eAT	Electronic Assistive Technology
ECS	Emergency Care Summary
EDT	Electronic Document Transfer
eNISAT	(Electronic) Northern Ireland Single Assessment Tool
EPES	Electronic Prescribing and Eligibility System
EIP	European Innovation Partnership. EIPs are a new approach to EU research and innovation to help bring together countries working in particular areas to transform services.
HSCB	Health and Social Care Board
HSC	Health and Social Care in Northern Ireland
ICT	Information and Communication Technology
ITS	Information Technology Services
KIS	Key Information Summary
MoU	Memorandum of Understanding is an agreement between countries to work together and benefit from the collaboration.
NIAS	Northern Ireland Ambulance Service
NICH	Northern Ireland Connected Health
NIECR	Northern Ireland Electronic Care Record
NIMATS	Northern Ireland Maternity System
NIPACS	Northern Ireland Picture Archiving and Communications System
NIRAES	Northern Ireland Regional Accident and Emergency System
PAS	Patient Administration System
RISOH	Regional Information System for Oncology and Haematology
TMS	Theatre Management System
TYC	Transforming Your Care is the strategy which outlines the plans for making changes in health and social services from 2012 – 2017.
Care pathway	Also known as clinical pathways, critical pathways, integrated care pathways, or care maps, are one of the main tools used to manage the quality in health and social care because their use their use reduces the variability in clinical practice and improves outcomes. Pathways promote organised and efficient patient care based on evidence based practice. in the hospital or community care setting.

Care Professional	An individual health and/or social care provider within any professional group e.g. medicine, nursing, allied health professional, social work, dentistry, pharmacy, etc. The practice of care professionals is regulated by appropriate regulatory bodies.
Citizen	An individual living in Northern Ireland.
Design Authority	This is a care professional led group within the governance structure of the strategy which will provide momentum and guidance to the various projects involved in implementing the strategy.
Informatics	The use of information science, computer science, and health care. It deals with the resources, devices, and ways to improve the gathering, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include computers, clinical guidelines, formal medical terminologies, and information and communication systems.
IT Infrastructure	Information technology infrastructure is the framework needed to support the flow and processing of information.
Mobile working	Mobile working with the use of smart devices such as phones, iPads and tablets.
Network coverage	Is the term used to describe how good or bad the mobile "signal" is in a particular geographical area.
Paper-light	An organisation that will have less reliance on paper would be called paper light.
Web portal	A specially designed web site that brings together information from different sources so that it can be easily accessed e.g. a website giving information about health and social care services in Northern Ireland.
Telecare/ Telemonitoring/ Telehealth	Telehealth is the delivery of health-related services and information via technology. Telemonitoring allows patients to monitor their own condition by using health devices at home and then results are sent electronically to their care professional. Telecare ensures people can be safe at home by using environmental sensors to meet a risk for example a falls monitor.

References

- DHSSPS (2009) Health and Social Care (Reform) Act (Northern Ireland) available at http://www.legislation.gov.uk/nia/2009/1/notes/contents
- DHSSPS (2011) Quality 2020 – A 10 year strategy to proect and improve quality in health and social care in Northern Ireland available at http://www.dhsspsni.gov/quality 2020 - a 10 year strategy for health and social care in northern ireland.pdf
- DHSSPS (2012) Transforming Your Care – A review of health and Social Care in Northern Ireland available at http://www.dhsspsni.gov.uk/tyc.htm
- DHSSPS (2013) Connected Health and Prosperity Board Task and Finish Group Report available at www.dhsspsni.gov.uk/t_f_final_report.pdf
- DHSSPS (2014) Making Life Better – A Whole System Framework for Public Health 2013-2023 available at http://wwwdhsspsni.gov.uk/making-life-better
- World Health Organisation (2012) National eHealth Strategy Toolkit available at www.who.int/ehealth/publications/overview.pdf

Appendix 1

Strategy Development details

The development of the eHealth and Care Strategy for Northern Ireland includes the following:

1. Stakeholder engagement.
2. Review of strategic context and future of health and care in Northern Ireland.
3. Best practice and the future of technology.
4. Current situation.
5. Lessons learned from previous strategies, both IT and within health care.
6. Leadership and governance.
7. Consultation process on strategy content.
8. Consultation process on an Equality impact assessment.
9. Completion and launch of strategy.

This method is based on previous strategic development in the HSC and the use of the National eHealth Strategy Toolkit published by the World Health Organisation.

1. Stakeholder engagement

The main aspect of the development process was a large-scale engagement with stakeholders across Northern Ireland. The groups consulted included:

- citizens (including patients, carers and clients – all ages and sections of the community)
- community and voluntary sector organisations
- HSC staff and organisations
- internal local and national ICT suppliers
- DHSSPS(NI).

Each of these groups provided a different context for eHealth and Care services in Northern Ireland and enabled us to incorporate local and regional innovations into the consultation document.

2. Review of strategic context

Northern Ireland has a well-developed strategic framework for the future of HSC services. Transforming Your Care (DHSSPS, 2012), Quality 2020 (DHSSPS, 2011) and the new strategic framework for public health, Making Life Better (DHSSPS, 2014). Each of these, along with other professional strategies, was reviewed to ensure the content of the consultation document was relevant and in line with regional health and social care directions.

3. Best practice and the future of technology

We gathered best practice from four sources:

- The local innovations accessed through the stakeholder workshops.
- The national and international best practice through review of existing information.
- Previous visits nationally and internationally.
- Engagement with major IT suppliers.

4. Current situation

From the stakeholder engagement and direct engagement with Trust ICT staff, the current eHealth situation was outlined. This included both strengths and weaknesses and what staff felt was the way forward to improve service delivery.

5. Lessons learned from previous strategies

We reviewed the lessons learnt from the previous ICT strategy period. We also reviewed other countries' eHealth strategies, including Scotland, England, Ireland, Australia and South Africa. We used the external reference group to provide their personal experience of managing and delivering eHealth in their countries to improve what we had learned.

6. Leadership and governance

The steering group acted as a project board and provided leadership and governance for the development process. An external reference group of experts in the area of eHealth and service change gave additional quality assurance. The project delivery team was made up of clinical, technical and management staff.

Steering group

The steering group provided the overall direction for the strategy development and demonstrated the HSC's commitment to the eHealth and Care strategy.

Mr John Compton	Chief Executive HSCB (retired 31/03/14) (Chair)
Mr Eddie Rooney	Chief Executive PHA
Mrs Julie Thompson	Deputy Secretary DHSSPS(NI)
Mrs Catherine Daly	Deputy Secretary DHSSPS(NI)
Mr Hugh McCaughey	Chief Executive South East HSCT
Mrs Mairead McAlinden	Chief Executive Southern HSCT
Mr Liam McIvor	Chief Executive Northern Ireland Ambulance Service
Mr Sean Donaghy	Director of eHealth and External Collaboration – HSCB
Mr Eddie Ritson	Programme Director – CCHSC PHA
Mr David Bingham	Chief Executive Business Services Organisation

External reference group

The external reference group provided advice and challenge to the project team and the steering group.

Mr Paul Wickens	Chief Executive NICS Enterprise Shared Services Centre
Mr Gwyn Thomas	Ex CIO Wales and UKCHIP Chair
Dr Charles Gutteridge	CCIO Barts and the London Trust
Mr Bill McCluggage	Ex CIO Ireland

7. Consultation process

The strategy will be subject to a full public consultation process. This will be developed and at the end of the consultation a response document will be prepared.

8. Equality impact assessment

We are aware of the need to respect the human rights of individuals and we have sought advice from and met the Equality Unit at the BSO. The Unit detailed the requirement to promote equality of opportunity and good relations in carrying out our functions as a public authority, under Section 75 and Schedule 9 of the Northern Ireland Act 1998. We are also obliged to ensure that all decisions comply with the Human Rights Act 1998.

The Unit's advice and assistance has ensured that we take a human-rights-based approach in this consultation.

9. Strategy launch

The strategy will be launched and managed by the HSCB after including the responses from the public consultation.

Appendix 2

Consultation response form

This consultation document seeks your views about how we respond to the proposals arising from the eHealth & Care Strategy for Northern Ireland. During the consultation process there will be a series of engagement events. We aim to ensure that everyone is informed and involved in this process and has the opportunity to make their views known. We therefore encourage you to engage with this important consultation, let us know your views, and so contribute to improvements to our eHealth and Care services.

We are seeking your views on the proposals and questions in the strategy. This questionnaire is available to help you record your comments and this can be filled in online via our website or downloaded and sent to us. You can send us your answers or comments, by post or email to:

eHealth and care strategy consultation
Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Please note we will list the responses received through this consultation in the response to the consultation and will prepare a response to the consultation document. All responses to this consultation can be requested through a Freedom of Information request and may be made public, with very limited exceptions. If you are concerned about this issue, please contact us for further information.

However you choose to give us your views, we want to hear from you. Please send us your comments by web survey, email, phone or in writing.

I am responding:

◯ as an individual

◯ on behalf of an organisation

It would be helpful if you provided more information:

Name: ....

Address:...

....

....

....

Job title: ....

Organisation:...

Please note we will list the responses received through this consultation in the response to the consultation.

All responses to this consultation can be requested through a Freedom of Information request and may be made public, with very limited exceptions. If you are concerned about this issue, please contact us for further information.

Consultation on the eHealth and Care Strategy for Northern Ireland

In the strategy we have described our vision, principles and objectives.
To what extent do you agree with these? Please select one option

◯ Completely or mostly disagree ◯ Slightly disagree ◯ Slightly agree ◯ Completely or Mostly agree

HAVE YOU ANY OTHER COMMENTS?

To what extent do you think we should be using eHealth technologies to help people look after their own health and wellbeing?

Examples include: websites, mobile apps, online support tools, social media and personal text/email messaging. Please select one option.

◯ Not at all ◯ Sometimes ◯ Frequently ◯ All the time

HAVE YOU ANY OTHER COMMENTS?

To what extent do you agree that the implementation of eHealth technologies such as online booking of appointments and requests for prescriptions, email, video consultations or texting care professionals for advice will be useful? Please select one option

◯ Completely or mostly disagree ◯ Slightly disagree ◯ Slightly agree ◯ Completely or Mostly agree

HAVE YOU ANY OTHER COMMENTS?

Are there any other areas you would propose?

Will the proposals in the strategy support independent living? Please select one option

- ◯ Not at all
- ◯ Very little
- ◯ Somewhat
- ◯ To a great extent

COMMENTS?

While communicating with patients and clients, care professionals may use a computer to support their decision making. Do you think that the computer: Please select one option

- ◯ Would get in the way of the discussion
- ◯ Could improve the quality of care provided
- ◯ Would make no difference at all

COMMENTS? (how might the computer be used? How do you feel it may help?)

Do you feel that eHealth will change the way professionals work? Please select one option

- ◯ Yes
- ◯ No
- ◯ Don't know / no views

COMMENTS? (will eHealth make professionals work more efficiently? Will eHealth allow professionals to have access to better information?)

How useful would it be to have access to your eHealth records? Please select one option

◯ Very useful ◯ Slightly useful ◯ Useful ◯ Not useful at all

COMMENTS? (if you had access to your eHealth records what might you want to do or look at

How useful would it be to have access to your eHealth records? Please select one option

◯ Completely useful ◯ Slightly useful ◯ Useful ◯ Not useful at all

COMMENTS? (if you had access to your eHealth records what might you want to do or look at

Do you expect that information about the health and care of patients and clients would be shared among professionals to improve decisions about care? Please select one option

◯ Yes ◯ No ◯ Don't know / no views

How confident are you that we will keep information about you safe and secure, so that only those who need to access it can do so. Please select one option

◯ Completely confident ◯ Slightly confident ◯ Confident ◯ Not confident at all

To what extent do you feel that the adoption of eHealth will encourage innovation and economic development in Northern Ireland? Please select one option

◯ Not at all ◯ Very little ◯ Somewhat ◯ To a great extent

COMMENTS

Do you have any comments about the adoption of eHealth?

COMMENTS

Equality Impact Assessment

Equality and human rights implications

Do you agree with the conclusions reached by the HSCB in the draft Equality Impact Assessment, which is on the consultation web page.

(If no, please give further information, along with any supporting evidence)

Is there any other evidence that you think we should have taken into account?

ADDITIONAL COMMENTS

eHealth and care strategy consultation

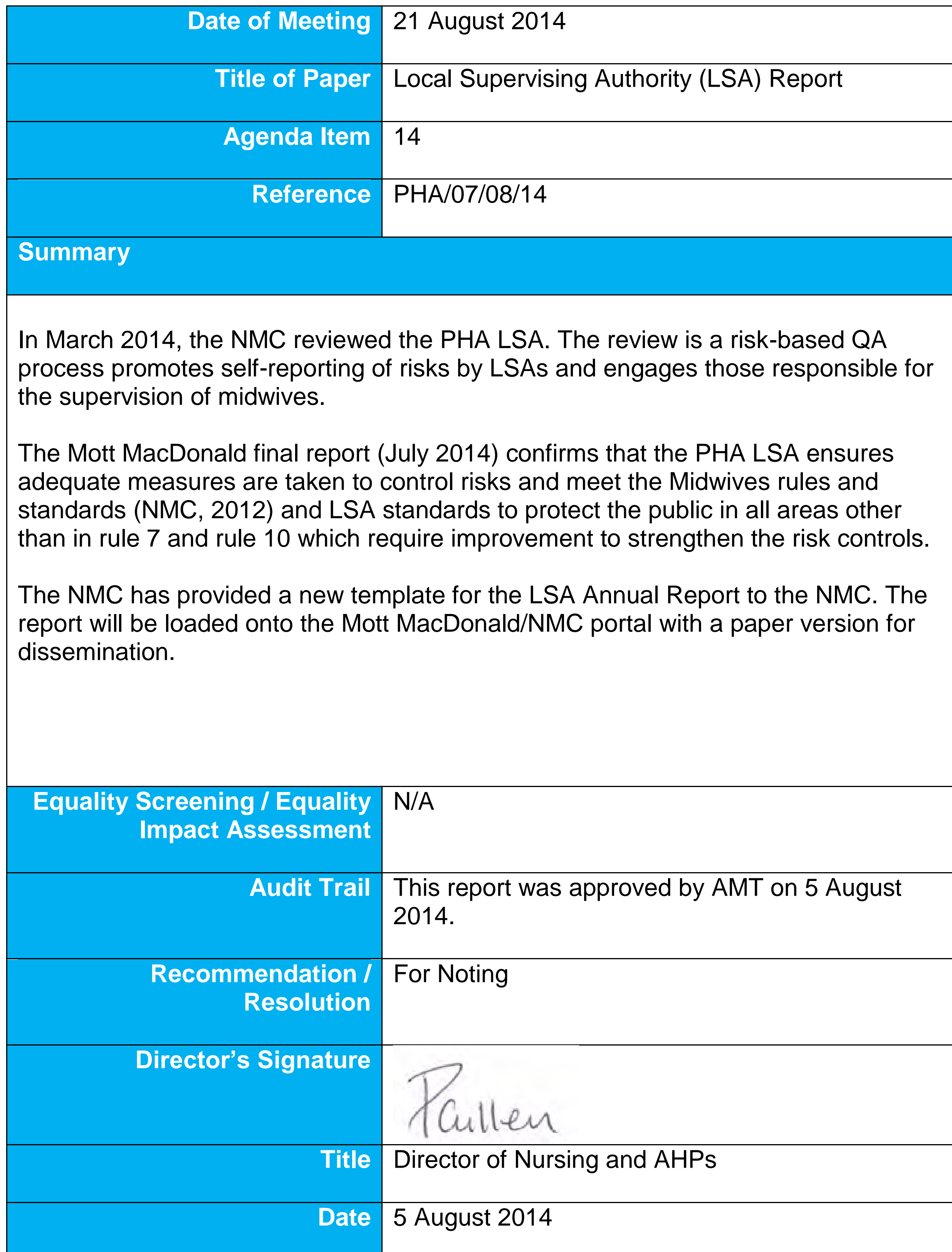
Health and Social Care Board
12-22 Linenhall Street
Belfast BT2 8BS

Tel: 028 90 321 313
Web: www.hscboard.hscni.net/

HSC Health and Social Care

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	21 August 2014
Title of Paper	Local Supervising Authority (LSA) Report
Agenda Item	14
Reference	PHA/07/08/14

Summary

In March 2014, the NMC reviewed the PHA LSA. The review is a risk-based QA process promotes self-reporting of risks by LSAs and engages those responsible for the supervision of midwives.

The Mott MacDonald final report (July 2014) confirms that the PHA LSA ensures adequate measures are taken to control risks and meet the Midwives rules and standards (NMC, 2012) and LSA standards to protect the public in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls.

The NMC has provided a new template for the LSA Annual Report to the NMC. The report will be loaded onto the Mott MacDonald/NMC portal with a paper version for dissemination.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was approved by AMT on 5 August 2014.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Nursing and AHPs
Date	5 August 2014

2013-14
Annual review of performance in mitigating key risks identified in the NMC Quality Assurance framework for local supervising authorities for midwifery supervision.

LSA	Northern Ireland
Date of review	12-13 March 2014
Managing Reviewer	Peter McAndrew
Lay Reviewer	Jane Suppiah
Registrant Reviewer(s)	Jessica Read, Annette Lobo
	Areas visited during LSA review: Ulster Maternity Unit, South Eastern Trust: Antenatal Clinic; Emergency Obstetric Unit; Labour Ward; Home from Home Unit; Maternity Ward. Craigavon Area Hospital, Southern Health and Social Care Trust: Midwifery Services. **Areas covered by the LSA:** Belfast Health and Social Care Trust, Royal Jubilee Maternity Hospital Belfast Health and Social Care Trust, Mater Infirmorum Freestanding Midwifery Led Unit Northern Health and Social Care Trust, Antrim Hospital Northern Health and Social Care Trust, Causeway Hospital Southern Health and Social Care Trust, Craigavon Hospital and Alongside MLU Southern Health and Social Care Trust, Daisy Hill Hospital Western Health and Social Care Trust, Altnagelvin

	Hospital and Alongside MLU Western Health and Social Care Trust, South West Acute Hospital and Alongside MLU South Eastern Health and Social Care Trust, Ulster Hospital and Alongside MLU South Eastern Health and Social Care Trust, Lagan Valley Freestanding MLU South Eastern Health and Social Care Trust, Downe Freestanding MLU Queen’s University Belfast, Midwifery Department
Date of Report Publication	4 July 2014

Introduction to NMC QA Framework

The Nursing and Midwifery Council is the professional regulatory body for nurses and midwives in the UK. Our role is to protect patients and the public through efficient and effective regulation. We aspire to deliver excellent patient and public-focused regulation.

We set midwives rules and standards (2012) that must be met by LSAs, supervisors of midwives and midwives.

Published in June 2013, the NMC's QA framework identified key areas of improvement for our QA work, which included: using a proportionate, risk based approach; a commitment to using lay reviewers; an improved 'responding to concerns' policy; sharing QA intelligence with other regulators and greater transparency of QA reporting.

Our risk-based QA process promotes self-reporting of risks by LSAs and engages those responsible for the supervision of midwives.

Review is the process by which the NMC ensures that LSAs continue to meet our rules and standards. Specifically, Rule 11 outlines our framework and provides a structured means of reviewing a local supervising authority in order to demonstrate the effectiveness of statutory supervision of midwives and good practice, and highlight areas of concern. Reviews take account of LSA self-reporting of risks and factor in intelligence from a range of other sources that can shed light on potential risks associated with LSAs. Our focus for reviews, however, is not solely risk-based. We might select an LSA for review due to thematic or geographical considerations. Every year the NMC will publish a schedule of planned reviews, which includes a sample chosen on a risk basis. We can also incorporate extraordinary reviews or unscheduled visits in response to any emerging public protection concerns.

This annual monitoring report forms a part of this year's review process. In total, six LSAs were assessed by a review team including a managing reviewer, midwife reviewers and a lay reviewer. The review takes account of feedback from midwives, supervisors of midwives, student midwives, representatives from the LSAs, Heads of Midwifery and service users. We report how the LSA under scrutiny has performed against key risks identified at the start of the review cycle. Standards are judged as "met", "not met" or "requires improvement". When a standard is not met an action plan is formally agreed with the LSA directly and is delivered against an agreed timeline.

Summary of Key Findings

Relevant LSA / Midwives Standard	Risk Indicator	Key Risk
Rule 4: Notifications by local supervising authority	1.1 Public protection is placed at risk if midwives do not submit their Intention to Practice (ItP) to the NMC by the required annual submission date	1.1.1 All midwives have a named Supervisor of midwives (SoM) to submit their ItP
	1.2 Midwives risk lapsing or losing their midwifery registration if ItPs are not submitted in time to the NMC	1.2.1 Accurate information and completion of ItPs submitted to the NMC by the date set by Council
Rule 6: (LSA standard)	2.1 LSAs have inadequate data protection policies for the retention of midwifery records	2.1.1 LSAs ensure that there are clear and comprehensive local guidelines for the secure retention of midwifery records that addresses all requirements
Rule 6: (Midwives standards)	3.1 Midwives do not store records securely, this poses a risk to public protection	3.1.1 Midwives comply with systems designed to accurately and securely store records for 25 years
Rule 7: The local supervising authority midwifery officer	4.1 LSAs do not use the core criteria to appoint an appropriately experienced midwife to undertake the role of LSA midwifery officer (LSA MO)	4.1.1 LSAs and the LSA MO complying with the rules, standards and guidance set by the NMC
Rule 8: Supervisors of midwives	5.1 LSAs do not have a clear policy and procedure for the recruitment of SoMs	5.1.1 LSAs ensures that student SoMs are adequately recruited and are only appointed following successful completion of an approved programme of education for the preparation of supervisors of midwives' programme
Rule 9: Local supervising authority's responsibilities for supervision of midwives	6.1 The LSA consistently exceeds the recommended ratio of 1 SoM to 15 midwives (1.1, 1.2, 1.3, 1.4, 1.6)	6.1.1 LSAs have processes in place to ensure that recruitment supports the necessary number of SoMs to maintain the required ratio and that SoMs have adequate resources to undertake their role
	6.2 The annual review identifies that a midwife has failed to meet the requirement to maintain their midwifery registration (1.5)	6.2.1 LSA Guidelines are clear in giving direction to SoMs as to the content of the annual review so that the SoM undertakes this in a consistent manner and she can be assured that a midwife has complied with the requirement to maintain their midwifery registration
Rule 10: Publication of local supervising authority procedures	7.1 LSAs do not complete supervisory investigations in an open, fair and timely manner	7.1.1 LSAs have developed mechanisms to ensure investigations are carried out fairly, effectively, efficiently and to time.
Rule 14: Suspension from practice by a local supervising authority	8.1 Public being placed at risk if a midwife continues to practise when their fitness to practise is alleged to be impaired	8.1.1 LSAs have developed adequate guidelines for the suspension of a midwife from practice

Standard met	***Requires improvement***	***Standard not met***

Introduction to Northern Ireland LSA

The Public Health Agency (PHA) is responsible for ensuring that the Local Supervising Authority (LSA) function is implemented effectively in Northern Ireland. The PHA was established in 2009 under a major reform of health structures and is a multi-professional body with a strong regional and local presence to provide: health and social wellbeing improvement; health protection; public health support to commissioning and policy development; and, research and development. The LSA midwifery officer (LSA MO) post is firmly seated within the PHA and reports directly to the PHA Board on the statutory supervision of midwives in Northern Ireland.

Within Northern Ireland there are five health and social care trusts providing maternity care in 11 units. There are standalone midwifery led units (MLUs) in Lisburn, Downpatrick and the Mater Infirmorum in Belfast.

Maternity services are commissioned by the Regional Health and Social Care Board. Most mothers give birth in their nearest maternity unit and for most local commissioning groups (LCGs) there is a clear primary provider of services.

In 2012/2013, there were 25,375 births in Northern Ireland and at 31 March 2013 there were 117 Supervisors of Midwives (SoM) and 1440 midwives giving a ratio of 1:12.

The LSA review took place over two days. Day one involved meetings and telephone interviews with a range of stakeholders across the LSA. Day two was spent at Ulster Maternity Unit, South Eastern Trust and also Craigavon Area Hospital, Southern Health and Social Care Trust visiting the maternity unit and meeting with key stakeholders.

Summary of public protection context and findings

Our findings demonstrate that robust systems are in place to ensure that all midwives have a named SoM to whom they submit their intention to practise (ItP) annually. Clear and rigorous cross checking procedures ensure that all ItPs are successfully uploaded to the NMC database by the required date. We found that the LSA database supports and evidences that the statutory requirements for ItP fully meet the NMC requirements.

To ensure public protection there is comprehensive guidance for the transfer of midwifery records from self-employed midwives to the LSA. Trusts have robust and effective records, management policies and compliance of secure storage of records which are consistent with the NMC standards.

Appointment of the LSA MO meets NMC requirements. The importance of the LSA function and LSA MO role is recognised and highly valued by the PHA. Midwifery services report that the LSA MO has a high profile at a strategic and operational level which has been invaluable in raising the profile of statutory supervision for the protection of the public.

We found that the nomination, selection and preparation of SoMs is effectively implemented. This ensures that midwives entering and progressing on the preparation of SoMs programme meet NMC standards and requirements, fundamental to protection

of the public. We are also assured that SoMs meet the minimum continuing professional development requirements to maintain their eligibility to continue in the role.

Student midwives have a named SoM during practice placements. They have a good knowledge and understanding of the supervisory role; show awareness of the differences between supervision and management and the important role of the SoM as a mechanism to protect the public.

A robust and effective system is in place to ensure that every practising midwife has an annual review with their named SoM and all reviews have been completed. We are assured that this process contributes to public protection as midwives describe their review as an integral part of their professional development to ensure their knowledge and skills as a midwife remain up to date.

Our findings conclude that the PHA LSA ensures adequate measures are taken to control risks and meet the *Midwives rules and standards* (NMC, 2012) and LSA standards to protect the public in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls.

Summary of areas that require improvement

Our findings conclude that the LSA is meeting the standards set by the NMC for the delivery of the statutory supervision of midwives as set out in the *Midwives rules and standards* (NMC, 2012) in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls.

In rule 7:4.1 the statutory supervision process needs strengthening in relation to service user participation and how midwifery supervision could support women's choices. There were also issues in relation to formalising the annual audit process and providing a more comprehensive report to enable relevant action points to be fully understood.

Rule 7: 4.1

The statutory supervision process needs strengthening in relation to service user participation and how midwifery supervision could support women's choices. A strategic plan should be developed to include how service users' involvement can be enhanced in all areas of the supervision of midwives process including how the supervision process can support women's choices.

The LSA process for the annual audit for the midwifery services should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood.

The LSA MO meets NMC requirements and effectively performs her role and function however; minimal resources inhibit the scope of the role.

The PHA should consider providing additional resources to support the LSA MO role.

Rule 10: 7.1

We concluded that there are stringent clinical governance processes in place which protect the public and robust midwifery supervisory investigations; however the interface with statutory supervision following adverse incidents and trust governance processes

could be improved.

Procedures around investigating adverse incidents, complaints or concerns relating to midwifery practice or allegations of impaired fitness to practise against a midwife need to be strengthened in order to ensure that the public are protected from poor midwifery practice.

Summary of areas for future review

- LSA annual audit process.
- Lay/service user involvement in all areas of supervision particularly in relation to how the supervision process can support women's choices.
- Resources to support the role of the LSA MO.
- The effectiveness and efficiency of supervisory investigations.
- Review protected time is achieved by all SoMs

Summary of notable practice

The annual review toolkit is an excellent resource and is currently being factored into the LSA MO forum UK update of the annual review guidance, process and record which will be made available to all midwives in the UK.

Summary of feedback from groups involved in the review

Supervisors of midwives

We found SoMs are enthusiastic and motivated to ensure high quality service provision and supervision of midwives. We were told that there is no shortage of midwives who want to undertake the preparation for SoMs programme. SoMs state they have considerable opportunity for continuing professional development and these opportunities contribute to meeting their own needs as well as those of their staff.

SoMs feel strongly supported by the LSA MO who is visible and actively involved in raising the profile of statutory supervision for the protection of the public.

In their view the education programme for the preparation of SoMs develops skills and knowledge that exceed what has previously been achieved.

SoMs told us about their concerns regarding the limited protected time available to them to fulfil their statutory functions. SoMs acknowledge the interface between midwifery supervision and service users is underdeveloped and that there is an important role that supervision can play in normalising birth for all women and supporting women's choice.

Clinical commission group / employers

The heads of midwifery (HoMs) and the midwifery advisor to the Department of Health, Social Services and Public Safety (DHSSPS) we interviewed are in agreement that the LSA MO and SoMs are aware of their respective roles and perform them well.

The LSA function has become embedded within the function of the PHA. The PHA values the role of the LSA MO and supports the role. The director of nursing (DoN) meets with the LSA MO monthly to talk through the work plan and undertakes annual appraisals. The LSA MO is held in high esteem in Northern Ireland as a senior midwifery leader who works alongside her colleagues in the PHA and the Northern Ireland Practice and Education Council (NIPEC) to further the care of women and their families. One acting chief executive officer described the LSA as an 'unstoppable force to improve services for women'.

Students

Student midwives described to us how to access a SoM. They demonstrated a good knowledge and understanding of the role of the SoM appropriate with their level of pre-registration midwifery training.

Service users and carers

Services users' representatives were positive about their engagement with the LSA and were able to describe involvement in LSA audits, the recruitment of SoMs, and interactions with student midwives and student SoMs in academic settings, albeit on an ad hoc basis. They had a clear understanding of how the role of the SoM could support women's choice but evidence of this taking place is limited in their experience. Service users explained that they were active in signposting women to SoMs; however most women have little or no knowledge of the role of the SoM and more could be done to explain this and make it more visible to them.

Relevant issues from external quality assurance reports

There are no external quality assurance reports within the last five year period relating to the maternity services or supervision of midwives in the LSA in Northern Ireland.

Evidence / Reference Source

Not applicable

Outcomes of LSA annual and quarterly quality monitoring reports

Specific issues followed up from the LSA annual and quarterly quality monitoring (QQM) reports include:

- The ratio of SoMs to midwives.

Southern Health and Social Care Trust has a high ratio of SoM to midwives 1:18 resulting in a higher caseload for SoMs. An action plan is in place to address this issue.

Issues and challenges for the LSA include:

- Women's choices in maternity care are leading them to cross the border into NI which increases the workload of midwives and SoMs;
- There are difficulties for lapsed midwives being able to access return to practice programmes in NI as the programme has not run in 2012/13;
- The need to improve the quality of supervisory reports.

At the LSA review we found clear evidence that issues raised in the annual and quarterly quality monitoring reports are acted upon and communicated to executive levels of respective organisations and outcomes closely monitored.

Some of the QQM reports were brief and informal and did not appear to provide a sound evidence base. The LSA MO advised that new guidance has been provided by the LSA MO forum UK which will be implemented in next year's reports.

Evidence / Reference Source

1. LSA NI annual report, 2012/13
2. NMC quarterly quality monitoring report (QQM) for LSAs 2013/2014
3. NMC QQM April to June, 2013
4. NMC QQM July to September, 2013

Outcomes of LSA annual audits

Specific issues in the LSA annual report 2012/13 include:

Preparation of SoMs programme:

The LSA has access to one preparation course for SoMs within Northern Ireland at Queen's University Belfast. The programme is available at degree or masters level and it takes approximately one year from nomination to appointment as a SoM. The programme did not run in 2012/13 as the NMC ratio of SoMs to midwives was sufficient following the appointment of SoMs in the summer of 2012.

Return to practice (midwifery) programme:

Queen's University Belfast has responsibility for the midwifery return to practice (RtP) but there was no programme delivered in NI in 2012/2013.

At the LSA review issues that related to the provision of the preparation of SoMs programme and the RtP programme were discussed with the education provider and HoMs. They agreed that the current commissioned numbers of students appeared to meet the service requirements. There are 11 midwives on the current preparation of SoMs programme at Queen's University Belfast due to finish in summer 2014.

The implications for the maternity services following the publication of the strategy for maternity care in Northern Ireland 2012-2018.

The PHA was reviewed by the NMC on 22-24 March 2011. The report was published in June 2011 and an action plan returned to the NMC. There were no public protection issues. The LSA met 53 of the 54 standards with one being partially met in relation to

the variable provision of administrative support for SoMs.

Evidence / Reference Source

1. LSA NI annual report, 2012/13

Findings against key risks

Rule 4: Notifications by local supervising authority

1.1 Public protection is placed at risk if midwives do not submit their Intention to Practice (ItP) to the NMC by the required annual submission date

1.2 Midwives risk lapsing or losing their midwifery registration if ItPs are not submitted in time to the NMC

Risk indicator 1.1.1 - all midwives have a named Supervisor of midwife (SoM) to submit their ItP

What we found before the event

All midwives in the PHA LSA have a named SoM.

The NMC sends intention to practise (ItP) forms to all midwives in December/ January each year. The LSA MO emails all SoMs in NI at the beginning of January giving guidance for the ItP process which includes completed examples of ItPs, power point posters for midwives and SoMs with date reminders for ItP submission.

The SoMs check and sign each midwife's ItP and load the details onto the LSA database. There is an upload to the NMC for each ItP and annual upload at the end of March each yea: this enables the NMC to hold accurate details of every midwife intending to practise midwifery in the following year.

What we found at the event

We found that the LSA database supports and evidences that the statutory requirements for ItP fully meet the NMC requirements.

Our findings are that all midwives have a named SoM to whom they submit their ItP. Midwives new to the LSA are allocated to a SoM on commencement of employment. There is a clear and robust process that midwives and SoMs follow for submission and

uploading of ItPs in accordance with the *Midwives rules and standards (NMC, 2012)*. We found midwives and SoMs had a good knowledge and understanding of the process. HoMs confirmed the process is very efficient. The LSA demonstrated that the process for submission of ItP is articulated to SoMs each year. There is a robust checking mechanism in place to quality assure that this process is completed in a timely and effective manner. From our findings we are confident that this risk is well controlled; all midwives have a SoM to whom they submit their ItP.
Evidence / Reference Source
1. NMC LSA NI Self-assessment report, 2014 2. Regional record for the supervision of midwifery practice, undated 3. LSA MO forum UK: Annual review of practice by a supervisor of midwives, April 2013 4. LSA MO forum UK policies for the statutory supervision of midwives, Confirming a midwife's eligibility to practise, April 2013 5. LSA MO forum UK , Guidelines: Supervising midwives practising in specialist roles, April 2013 6. Scrutiny of database reports, 12-13 March 2014 7. Meetings with LSA MO, SoMs, midwives, 12-13 March 2014
Risk indicator 1.2.1 - accurate information and completion of ItPs submitted to the NMC by the date set by Council
What we found before the event
Any ItPs received by SoMs during the year are checked, for example when new midwives are employed. The ItP information is loaded on to the LSA database and this information is then uploaded to the NMC. New midwives are allocated a SoM initially and may then change a SoM, if they wish. Any issues arising from NMC 'error' reports are dealt with by direct email communication with the named SoM for the particular midwife or the contact SoM.
What we found at the event
We found the LSA MO communicates with all SoMs at the beginning of January each year giving guidance about the ItP process for midwives and SoMs with date reminders for ItP submission. The SoMs confirm eligibility to practise and upload the ItP details onto the LSA database. The information is subsequently uploaded to the NMC by the LSA MO. Our findings confirm the timely submission of ItP for the current practice year Midwives employed by the LSA after the annual submission date to notify ItPs for the

subsequent practice year are required to submit an ItP prior to commencing work as a midwife.

SoMs are required to maintain the accuracy of the database in relation to notification of ItP to the LSA.

The LSA regularly checks the LSA database to ensure its accuracy.

From our findings we conclude that the systems and processes in place confirm and ensure midwives complete their ItPs and risks are controlled to ensure supervision of midwifery meets the *Midwives rules and standards* (NMC, 2012) and LSA standards to protect the public.

Evidence / Reference Source

1. LSA NI Self-assessment report, 2014
2. LSA MO forum UK policies for the statutory supervision of midwives, Confirming a midwife's eligibility to practise, April 2013
3. Access to database reports, 12-13 March 2014
4. Meetings with LSA MO, SoMs, HoMs, 12-13 March 2014

Outcome: Standard met

Comments: no further comments

Areas for future reviews: none

Findings against key risks

Rule 6: (LSA standard)

2.1 LSAs have inadequate data protection policies for the retention of midwifery records

Risk indicator 2.1.1 - LSAs ensure that there are clear and comprehensive local guidelines for the secure retention of midwifery records that addresses all requirements

What we found before the event

There is a national policy for the transfer of midwifery records from self-employed midwives. The records are transferred to the LSA in the midwife's main geographical

area of practice.

Records must be in an electronic format either as scanned or computer generated documents. All paper and electronic records must be securely destroyed/deleted following submission to the LSA, in line with information governance regulations.

Written acknowledgement of safe receipt of midwifery records will be given to the midwife and a copy will be retained by the LSA.

The midwife should inform women of the location of their maternity records.

What we found at the event

The LSA MO forum UK policy provides comprehensive guidance for the transfer of midwifery records from self-employed midwives to the LSA.

We found the PHA LSA does not currently have any self-employed midwives and would use the UK guidance if any independent midwives were in practice.

During our visits to the maternity services HoMs confirmed that the trusts have their own records management policies, which are consistent with the NMC standards for the retention of midwifery records.

There are clear and comprehensive local guidelines for the secure retention of midwifery records that addresses all NMC requirements and protects the public.

Evidence / Reference Source

1. LSA MO forum UK, Policy for the 'Transfer of midwifery records from self-employed midwives' 2013.
2. Meetings with LSA MO, SoMs, midwives, 12-13 March 2014

Outcome: Standard met

Comments: no further comments

Areas for future reviews : none

Findings against key risks

Rule 6: (Midwives standards)

3.1 Midwives do not store records securely, this poses a risk to public protection

Risk indicator 3.1.1- Midwives comply with systems designed to accurately and securely store records for 25 years
What we found before the event
DHSSPS Northern Ireland guidance Good management good records (GMGR) is a guide to the required standards of practice for those who work within or under contract to Health and Social Care (HSC) and Public Safety. GMGR identifies the specific actions, managerial responsibilities and minimum retention periods for the effective management of all types of care records and public safety records, regardless of whether they are paper or electronic, from creation to disposal. Trusts are expected to have in place a process for documenting records management activities.
What we found at the event
We found that each trust has their own policy for storing records which meets NMC requirements. Retention and destruction of maternity records are as per the PHA's policy. Midwives and SoMs informed us they are familiar with the system of retention and storage of documentation. The LSA undertakes an annual review of the secure storage utilised by SoM teams to ensure that they meet with the LSA MO forum UK information governance policy. During the visit to the maternity services in the trusts we were able to view and confirm compliance of secure storage of records. We conclude that safe and secure processes are in place for the storage of records for 25 years, meeting NMC requirements and providing assurance that public protection is controlled.
Evidence / Reference Source
1. LSA NI Self-assessment report, 2014 2. DHSSPS Records management; good records good management, part 1,undated 3. Meetings with LSA MO, HoMs, SoMs, midwives, 12-13 March 2014 4. Meeting with HoM, South Eastern Health and Social Care Trust, 13 March 2014 5. Meeting with midwifery advisor at the DHSSPS, 12 March 2014
Outcome: Standard met
Comments: no further comments

Areas for future reviews: none

Findings against key risks

Rule 7: The local supervising authority midwifery officer

4.1 LSAs do not use the core criteria to appoint an appropriately experienced midwife to undertake the role of LSA midwifery officer (LSA MO)

Risk indicator 4.1.1 - LSAs and the LSA MO complying with the rules, standards and guidance set by the NMC

What we found before the event

The LSA MO job description uses NMC core criteria and there was NMC representation on the interview panel in 2007. The LSA MO in NI resigned as a SoM when this requirement was made explicit by the NMC.

The LSA MO has an annual appraisal, plus regular six-eight weekly 1:1 meetings with the PHA DoN and AHPs throughout the year.

The LSA office and secretarial /administrative support is based in County Hall Ballymena. The LSA MO is a full time appointment supported by 0.3 wte secretarial and administrative support.

There is an LSA annual audit that includes site visits of each maternity unit in the LSA. Audits take place in January-March each year.

There are quarterly quality monitoring reports to the NMC which are followed up by a telephone discussion between the LSA MO and the NMC.

The LSA produces an annual report which is presented to the PHA board.

The development of the LSA database, in particular; the noting of SoMs continuing professional development (CPD), the SoM activity sheet and the review of midwives' annual reviews all facilitate the LSA's monitoring of the practice of SoMs.

All trusts have a maternity services liaison committee (MSLC) that involves service users. A service user is on the interview panels for the preparation of SoMs programme.

Service users drawn from MSLCs, National childbirth trust (NCT) and doulas present the user voice on LSA audits. From 2014/2015 this ad hoc arrangement will be superseded by lay reviewers who have been recruited formally for the LSA audits and will participate following a training programme.

When the LSA MO in NI is on leave, a SoM is first point of contact but LSA cover is arranged with the LSA MO from another area.

What we found at the event

We found the LSA MO reports annually to the PHA Board on the statutory supervision of midwives and presents the annual report. The PHA Director of nursing is the LSA MO's line manager and is responsible for providing management supervision and undertaking the appraisal process which includes setting annual role objectives and agreeing a work plan.

The LSA MO fully meets the NMC requirements and effectively performs her role and function which is highly valued by the PHA and HoMs. However, the LSA MO has only minimal resources to fulfil her responsibilities and this inhibits the scope of the role.

The PHA may wish to provide additional resources to support the role. For example, this might be from a LSA support midwife who could implement training programmes for SoMs around investigation processes and support the engagement of service users into all aspects of the statutory supervision process.

Our findings conclude that the LSA process for the annual audit for midwifery services in the LSA area should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood.

Evidence is available that the LSA MO arranges suitable cover for her absences by other LSA MOs.

The PHA LSA has agreed plans to involve women in assuring the effectiveness of the midwifery supervision process. The plan involves the recruitment of lay reviewers in the audit process and is in the early stages of implementation. As the involvement of women service users is a key priority a strategic plan should be developed to include how service users' involvement can be enhanced in all areas of the supervision of midwives process, in particular, including how the supervision process can support women's choices.

We conclude from our findings that there are various policies and procedures in place which confirm the PHA LSA and the LSA MO comply with the rules, standards and guidance set by the NMC and ensure that protection of the public is addressed.

However, there are two areas which require improvement: firstly the LSA process for the annual audit for the midwifery services which should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood. Secondly, how service users' involvement can be enhanced in all areas of the supervision of midwives process, in particular, including how the supervision process can support women's choices.

Evidence / Reference Source

1. NMC LSA NI Self-assessment report, 2014
2. LSA MO job description and personnel specification.
3. NMC Quarterly quality monitoring (QQM) reports, 2013-14
4. QQM report April-June, 2013
5. QQM report July-September, 2013

6. QQM report October – December, 2013
7. LSA audit visits completed 2012-2013 for the following maternity services:
8. LSA audit Belfast HSCT MATER, 01 March 2013
9. LSA audit RJMH, 27 March 2013
10. LSA audit Northern HSCT Causeway, 25 February 2013
11. LSA audit Antrim, 25 March 2013
12. LSA audit Southern HSCT Craigavon and Daisy Hill, 22 March 2013
13. LSA audit Western HSCT Altnagelvin, 20 February 2013
14. LSA audit SWAH, 21 February 2013
15. LSA audit South Eastern HSCT Ulster, 26 March 2013
16. LSA audit Lagan Valley and Downe, 28 March 2013
17. PHA - Policy for annual leave/ leave of absence cover for the LSA MO, August 2013
18. LSA database
19. Scrutiny of 5 LSA audit reports from 2013-14
20. Meetings with chief executive PHA, DoNs LSA MO, HoMs, SoMs, service user representatives, midwifery advisor at the DHSSPS, 12-13 March 2014

Outcome: Standard requires improvement

Comments:

The LSA process for the annual audit for the midwifery services should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood.

- Annual audit process should be formalised with a more comprehensive report to enable action points to be fully understood.

A strategic plan should be developed to include how service users' involvement can be enhanced in all areas of the supervision of midwives process, in particular, including how the supervision process can support women's choices.

- Enhance lay/service user involvement in all areas of supervision particularly in relation to how the supervision process can support women's choices.

The LSA MO meets NMC requirements and effectively performs her role and function; however minimal resources inhibit the scope of the role.

- The PHA to consider providing additional resources to support the LSA MO role.

Areas for future reviews:

- LSA annual audit process
- Lay/service user involvement in all areas of supervision particularly in relation to how the supervision process can support women's choices.
- Resources to support the role of the LSA MO.

Findings against key risks

Rule 8: Supervisors of midwives

5.1 LSAs do not have a clear policy and procedure for the recruitment of SoMs

Risk indicator 5.1.1- LSAs ensures that student SoMs are adequately recruited and are only appointed following successful completion of an approved programme of education for the preparation of supervisors of midwives programme
What we found before the event
The process for the recruitment of SoMs follows LSA MO forum UK policy. The current list of SoMs in the LSA is held on the LSA database. The LSA provides a range of provision of CPD opportunities for SoMs each year. The preparation of SoMs programme reflects the NMC standards for the preparation and practice of SoMs (2006).
What we found at the event
We found the procedure for the recruitment of SoMs follows the LSA MO forum UK, policy for the nomination, selection and appointment of SoMs which meets the NMC requirements. The LSA MO and SoMs are on the curriculum planning group for the preparation of SoMs programme. The programme leader is a SoM. Other SoMs and the LSA MO give input to the midwives on the programme, attend presentation days and review their portfolios. SoMs describe the current programme as robust, challenging and effective. They told us that the skills and knowledge of SoMs completing the programmes meet the statutory requirements for supervision of midwives. All new SoMs are supported by a "buddy SoM" for a period of six months and are supported when undertaking reviews and investigations. Our findings demonstrate that the LSA facilitates a range of CPD opportunities for supervisors of midwives. These range from meetings for SoMs to LSA conferences; workshops; master classes; consultation sessions and LSA briefings. Themes arise from investigations, learning lessons from significant adverse incidents (SAIs) and clinical governance, maternity care developments, and SoM suggestions. The SoMs told us they undertake the required six hours continuing professional development each year. From our findings we conclude that there is a consistent and appropriate process demonstrated for recruitment of student SoMs to the preparation of SoMs programme, and they are adequately prepared as SoMs on completion of the programme to meet NMC standards.
Evidence / Reference Source

1. NMC LSA NI Self-assessment report, 2014
2. LSA MO forum UK; Nomination, selection and appointment of supervisors of midwives , April 2013
3. LSA MO forum UK: Reviewing the ability of a supervisor of midwives to undertake the role, 2013
4. SoM activity sheet supervision records
5. Meetings with LSA MO, HoMs, DoNs, SoMs, midwives, service users, 12-13 March 2014

Outcome: Standard met

Comments: no further comments

Areas for future reviews: none

Findings against key risks

Rule 9: Local supervising authority's responsibilities for supervision of midwives

6.1 The LSA consistently exceeds the recommended ratio of 1 SoM to 15 midwives (1.1, 1.2, 1.3, 1.4, 1.6)

6.2 The annual review identifies that a midwife has failed to meet the requirement to maintain their midwifery registration (1.5)

Risk indicator 6.1.1 - LSAs have processes in place to ensure that recruitment supports the necessary number of SoMs to maintain the required ratio and that SoMs have adequate resources to undertake their role

What we found before the event

All midwives in the LSA have a named SoM. The SoMs meet with their midwife at least once a year, to reflect, identify any training updates and provide support. There is a 24 hour rota in all trusts for midwives to contact a SoM.

Students are allocated either as a group to a SoM in their area of practice placement or they are given an individual supervisor during their time in practice.

The ratio meets the NMC standard of 1:15. There are some fluctuations in the ratio in trusts as SoMs may retire or have leave of absence, but this is anticipated and midwives are encouraged to be nominated for the preparation of SoMs programme.

What we found at the event

Our findings confirmed that the LSA has an overall SoM to midwife ratio of 1:12.2 which is to be commended. The trust with the most challenged ratio of 1:18 has an ongoing rolling programme of recruitment in place. They will be supported to request the appointment of two more SoMs in the summer 2014 which will bring their ratio within the recommended LSA ratio of 1:15.

The preparation of SoMs programme currently runs bi-annually which meets the requirements for the provision of SoMs in the trusts. HoMs told us that protected time for midwifery supervision is built into the SoM role. However due to other demands, some SoMs report that on occasions they fulfil their SoM duties in their own time as they are not always able to take the protected time.

SoMs also support student midwives studying pre-registration midwifery programmes. We found all student midwives have a named SoM during practice placements. Student midwives have a good knowledge and understanding of the supervisory role; showed awareness of the differences between supervision and management and the important role of the SoM as a mechanism to protect the public.

We conclude from our findings that the PHA LSA has robust processes in place to ensure that the recruitment of student SoMs supports the necessary number of SoMs to maintain the required ratio of SoM to midwives. In addition that SoMs have adequate resources to undertake their role.

Evidence / Reference Source

1. LSA NI Self-assessment report, 2014
2. LSA NI annual report, 2012/13
3. Regional record for the supervision of midwifery practice
4. Guidance: to assist in the use of the regional record
5. Scrutiny of LSA audits
6. Review of the LSA database
7. Meetings with LSA MO, HoMs, SoMs, midwives and student midwives, 12-13 March 2014

Risk indicator 6.2.1 - LSA Guidelines are clear in giving direction to SoMs as to the content of the annual review so that the SoM undertakes this in a consistent manner and she can be assured that a midwife has complied with the requirement to maintain their midwifery registration

What we found before the event

LSA NI has a robust annual review toolkit developed with NIPEC.

The annual review summary can be uploaded onto the LSA database and the number of annual reviews completed checked via the LSA database reports.

There are locked filing cabinets in maternity units if any paper records of midwifery

supervision remain, but the use and subsequent development of the electronic record, that is, the LSA database and templates and internet based guidance for supervision, has superseded hard copies.
What we found at the event
We found that to support the framework of statutory supervision the LSA has implemented an annual review toolkit for use across the LSA with the intention to improve supervisory records, processes and guidelines around the annual review. The LSA MO worked in collaboration with NIPEC and the LSA annual review toolkit is available on the NIPEC website. Plans are in place to link the annual review with the LSA database and currently a summary is available to be uploaded onto the database. Midwives described their annual review as an integral part of their professional development as a midwife. They told us they place value on the opportunity to discuss midwifery practice, raise issues and review and discuss new ideas. The process supports them to identify their personal learning needs to ensure their knowledge and skills as a midwife remain up to date. Our findings confirm that SoMs undertake the annual review in a consistent and effective manner and ensure that the midwife has complied with the requirements to maintain their midwifery practice and NMC registration.
Evidence / Reference Source
1. NI self-assessment report, 2014 2. NMC LSA NI Annual Report 2012/13 3. LSA database reports 4. LSA MO forum UK database: annual review of practice by a SoM 5. Meetings with LSA MO, SoMs, midwives, 12-13 March 2014
Outcome: Standard met
Comments: • Some SoMs report that on occasions they fulfil their SoM duties in their own time as they are not always able to take the protected time.
Areas for future reviews: • Ensure protected time is achieved by all SoMs.

Findings against key risks
Rule 10: Publication of local supervising authority procedures **7.1 LSAs do not complete supervisory investigations in an open, fair and timely manner**
Risk indicator 7.1.1- LSAs have developed mechanisms to ensure investigations are carried out fairly, effectively, efficiently and to time.
What we found before the event
The LSA MO is informed by the PHA of all serious adverse incidents (SAIs), complaints and concerns relating to midwifery practice or a midwife. In addition the LSAMO is contacted by phone by either the SoM on call or a SoM or the HoM where there are concerns.
What we found at the event
We found there is a LSA MO forum UK policy which relates to the supervisory review and investigation process and action should be taken to ensure that this policy is fully implemented across the LSA. Our findings demonstrate that when clinical issues occur in relation to a midwife's practice the supervisory investigation process needs to be strengthened to ensure that the LSA MO's responsibilities in relation to fitness to practise and protection of the public are fully met. The LSA MO should make explicit to SoMs the responsibilities for investigating midwifery practice issues and may wish to consider, given the current political climate, to make more explicit the links between the investigation process as part of midwifery supervision and clinical governance procedures within the trusts. We found there are stringent clinical governance processes in place which protect the public and there are robust midwifery supervisory investigations. However, the interface with statutory supervision following all adverse incidents and trust governance processes are not always clear. Trust risk management midwives were unable to reassure us that there was a strong interface between supervisory investigations and risk management processes at an early stage following all clinical incidents.
Evidence / Reference Source

- LSA NI self-assessment report, 2014
- LSA NI annual report, 2012/13
- LSA MO forum UK policy: LSA review and investigation processes, November 2013
- Templates in relation to the outcome of an investigation
- Scrutiny of 3 files for midwifery supervision investigations.
- PHA LSA reporting and monitoring of serious untoward incidents: guidance for SoMs, January 2011
- PHA LSA maternal death: guidance for SoMs, January 2011
- LSA database reports
- Meetings with LAS MO, SoMs, clinical governance and risk managers and HoMs, 12-13 March 2014

Outcome: Standard requires improvement

Comments:

- Procedures around investigating adverse incidents, complaints or concerns relating to midwifery practice or allegations of impaired fitness to practise against a midwife need to be strengthened in order to ensure that the public are protected from poor midwifery practice.

Areas for future reviews:

- The effectiveness and efficiency of supervisory investigations.

Findings against key risks

Rule 14: Suspension from practice by a local supervising authority

8.1 Public being placed at risk if a midwife continues to practise when their fitness to practise is alleged to be impaired

Risk indicator 8.1.1- LSAs have developed adequate guidelines for the suspension of a midwife from practice

What we found before the event

The LSA MO forum UK policy: LSA review and investigation processes was reviewed and updated in November 2013.

What we found at the event

We found that the LSA follows the LSA MO forum policy for suspension and referral of a midwife. This was verified by discussion with the LSA MO and the review of a folder of evidence. Our findings concluded that referrals and suspensions are undertaken in a timely manner. Evidence on the suspension process follows agreed procedure and fully meets its primary purpose of protecting the public from the risks associated by poor

midwifery practice.

Evidence / Reference Source

1. LSA NI self-assessment report, 2014
2. LSA NI annual report, 2012/13
3. LSA MO forum UK policy: LSA review and investigation processes, November 2013
4. Templates in relation to the outcome of the investigation
5. LSA database reports
6. Scrutiny of suspended midwife's file
7. Meetings with LSA MO, SoMs, HoM, midwifery advisor at the DHSSPS, 12-13 March 2014

Outcome: Standard met

Comments: no further comments

Areas for future reviews: none

Personnel supporting the LSA review
Initial visit on 19 February 2014. Meetings with:
LSA MO Department of Health, midwifery advisor, LSA secretarial and administrative support
During the review visit.
LSA MO Chief executive, Public Health Agency Director of nursing, Public Health Agency Chief executive, Health and Social Care Trust Directors of nursing, Health and Social Care Trusts x 4 Assistant director of acute services, Health and Social Care Trust Supervisors of midwives x 7 Heads of midwifery and midwifery managers x 9 Clinical governance / midwifery risk managers x 3 Lead midwife for education, Programme leader, supervisor of midwives programme Programme leader, pre-registration midwifery programme Lead midwife at clinical education centre

Meetings with:

LSA MO	1
Lead midwife for education	1
Midwives	15
Supervisor of midwives	22

Mentors / sign-off mentors	1
Service users / Carers	3
Practice Education Facilitator	
Director / manager midwifery	9
Clinical commission group representative	
Senior Trust representative	10
Other (please specify)	8 Midwifery advisor DHSSPS; practice development midwife (previous PEF); Teleconference: programme lead for preparation for supervisor of midwives programme; lead midwife with HIE clinical education centre; manager with HIE clinical education centre; 3x midwifery risk managers, consultant midwives.)
Midwife who had undergone LSAPP	

Meeting with students

Midwifery three year	Year 1: 0 Year 2: 4 Year 3: 1
Midwifery 18month	Year 1: 0 Year 2: 3 Year 3: 0

Mott MacDonald

Protecting the public through quality assurance
of education and supervision of midwives

Nursing & Midwifery Council

Supervision, support and safety: Annual report of the quality assurance of the local supervising authorities

1 April 2013- 31 March 2014

<table>
<tr><td>Local Supervising Authority (LSA)</td><td>Public Health Agency</td></tr>
<tr><td>Provider hospitals and/or trusts</td><td>Belfast Health and Social Care Trust
• Mater Infirmorum - freestanding Midwifery Led Unit) (MLU)
• Royal Jubilee Maternity Service

Northern Health and Social Care Trust
• Antrim Hospital
• Causeway Hospital

South Eastern Health and Social Care Trust
• Lagan Valley (freestanding MLU)
• Downe (freestanding MLU)
• Ulster Hospital (with alongside MLU)

Southern Health and Social Care Trust
• Craigavon Maternity Unit (with alongside MLU)
• Daisy Hill Hospital

Western Trust
• Altnagelvin Hospital (with alongside MLU)
• South West Acute Hospital (with alongside MLU)</td></tr>
<tr><td>Date of report</td><td>31 July 2014</td></tr>
</table>

Part 1

Section 1

Total number of midwives practising in your LSA	1433 (as of 31 March 2014)
Total number of Supervisor of Midwives (SoMs) practising in your LSA	110 (as of 31 March 2014)
Ratio of supervisor of midwives to midwives	1:13 (at 31 March 2014)
New SoM appointments	None. The Preparation of Supervisors of Midwives course (PoSoM) course did not run during the academic year finishing in summer 2013. 11 midwives are due to complete the 2013-2014 PoSoM course in June 2014.
SoM resignation(s)	6
SoM removal(s)	1

The LSA was reviewed by Mott MacDonald for the NMC on 11 & 12 March 2014.

From the report. "The LSA review took place over two days. Day one involved meetings and telephone interviews with a range of stakeholders across the LSA. Day two was spent at Ulster Maternity Unit, South Eastern Trust and also Craigavon Area Hospital, Southern Health and Social Care Trust visiting the maternity unit and meeting with key stakeholders.

"Our findings demonstrate that robust systems are in place to ensure that all midwives have a named SoM to whom they submit their intention to practise (ItP) annually. Clear and rigorous cross checking procedures ensure that all ItPs are successfully uploaded to the NMC database by the required date. We found that the LSA database supports and evidences that the statutory requirements for ItP fully meet the NMC requirements."

"To ensure public protection there is comprehensive guidance for the transfer of midwifery records from self-employed midwives to the LSA. Trusts have robust and effective records, management policies and compliance of secure storage of records which are consistent with the NMC standards."

"Appointment of the LSA MO meets NMC requirements. The importance of the LSA function and LSA MO role is recognised and highly valued by the PHA. Midwifery services report that the LSA MO has a high profile at a strategic and operational level which has been invaluable in raising the profile of statutory supervision for the protection of the public."

"We found that the nomination, selection and preparation of SoMs are effectively implemented. This ensures that midwives entering and progressing on the preparation of SoMs programme meet NMC standards and requirements, fundamental to protection of the

public. We are also assured that SoMs meet the minimum continuing professional development requirements to maintain their eligibility to continue in the role."

"Student midwives have a named SoM during practice placements. They have a good knowledge and understanding of the supervisory role; show awareness of the differences between supervision and management and the important role of the SoM as a mechanism to protect the public."

"A robust and effective system is in place to ensure that every practising midwife has an annual review with their named SoM and all reviews have been completed. We are assured that this process contributes to public protection as midwives describe their review as an integral part of their professional development to ensure their knowledge and skills as a midwife remain up to date."

"Our findings conclude that the PHA LSA ensures adequate measures are taken to control risks and meet the Midwives rules and standards (NMC, 2012) and LSA standards to protect the public in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls."

What mechanisms are in place to allow midwives continuous access to a SoM?

Midwives can contact their named SoM via email, land line or mobile telephone. All midwives practising within Northern Ireland have a named Supervisor of Midwives and midwives are able to choose their named Supervisor of Midwives.

Midwives new to organisations are allocated a Supervisor of Midwives (SoM) when they start work. The newly appointed midwives are advised of the names of all the Supervisors of Midwives within that organisation and that they may change their Supervisor when they have had an opportunity to get to familiarise themselves with the new post and the supervisors.

Each individual SoM informs their supervisees of how they can be contacted and how they can contact other Supervisors at any time. Maternity units keep a copy of the SoMs on call rota or other method of continuous access to a SoM, on the delivery suite and in the midwives' office or staff room at the antenatal clinic, ward and community office level.

The Maternity Hand Held Record (used throughout NI) has a section for the SoM contact number and notices about Supervision of Midwives are available in public areas of Trusts giving information.

At least once a year a meeting takes place between Supervisor and supervisee for an annual review to provide an opportunity for discussion on professional issues and to identify any learning needs. In the LSA the web based annual review toolkit is available on the LSA website and via the NIPEC website

Supervision of Midwives Or: Midwifery Practice Reviews

Contacting a Supervisor of Midwives in an Emergency

Each Trust provides a 24 hour access to a Supervisor of Midwives. There are local arrangements as to how this may be achieved. Most SoMs choose to do seven nights on call in a row. One unit always has a senior midwife who is a SoM in the unit on both day and night duty so 24 hour access to a SoM is provided through the senior midwife mechanism rather than through a separate SoM on call rota.

In 2013/2014 the LSA Midwifery Officer has not been advised that any woman or midwife has been unable to contact a Supervisor of Midwives.

The feedback from midwives during the LSA audit visits is that local arrangements are working well. Midwives know how to contact a SoM 24/7 and there are on call rotas with numbers displayed in maternity areas about the on call 24. Contact details for SoMs and the LSAMO are also available on information noticeboards in Trusts and on Trust and the LSA websites.

Contingencies if a SoM is not contactable

The contingency plan if the on-call supervisor cannot be contacted would be for another Supervisor to be contacted by the midwife. Switchboard operators at Trusts will put through requests for a Supervisor of Midwives to delivery suite if they are unsure. Delivery suites can then contact a SoM if required.

The LSAMO is also available to be contacted by midwives by telephone or email.

Section 2

Provide an evaluative overview of how the LSA involved maternity service users and/or lay auditors in monitoring supervision of midwives and assisting the LSA Midwifery Officer with annual LSA audits and the impact this had on the LSA function. (Include information on outcomes of recruitment, training and future initiatives to improve participation.)

Lay auditors have been involved in the panel for the interviews of midwives prior to doing the Preparation of Supervisor of Midwives course at QUB. At the audits in 2013/2014 there were lay auditors and they took part in the Mott MacDonald review of the LSA in March 2014.

Following the Mott MacDonald review, where LSA draft information, including a training pack and job descriptions had been prepared and was seen by the review team, a recommendation is to proceed with formal recruitment of Lay Reviewers to help with LSA function. From the report:

Rule 7: 4.1

“The statutory supervision process needs strengthening in relation to service user participation and how midwifery supervision could support women's choices. A strategic plan should be developed to include how service users’ involvement can be enhanced in all areas of the supervision of midwives process including how the supervision process can support women’s choices.”

“The LSA process for the annual audit for the midwifery services should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood.”

“The LSA MO meets NMC requirements and effectively performs her role and function however; minimal resources inhibit the scope of the role. The PHA should consider providing additional resources to support the LSA MO role.”

Rule 10: 7.1

“We concluded that there are stringent clinical governance processes in place which protect the public and robust midwifery supervisory investigations; however the interface with

statutory supervision following adverse incidents and trust governance processes could be improved."

Procedures around investigating adverse incidents, complaints or concerns relating to midwifery practice or allegations of impaired fitness to practise against a midwife need to be strengthened in order to ensure that the public are protected from poor midwifery practice.

In March 2014, Mott Macdonald found that, "Services users' representatives were positive about their engagement with the LSA and were able to describe involvement in LSA audits, the recruitment of SoMs, and interactions with student midwives and student SoMs in academic settings, albeit on an ad hoc basis. They had a clear understanding of how the role of the SoM could support women's choice but evidence of this taking place is limited in their experience. Service users explained that they were active in signposting women to SoMs; however most women have little or no knowledge of the role of the SoM and more could be done to explain this and make it more visible to them.

Following the review, the LSA will implement formal recruitment, training and involvement of lay service users in LSA supervision processes to replace the current informal arrangements for the inclusion of lay reviewers in LSA processes. Information from another LSA's lay reviewer has been helpful in identifying best practice around recruitment, training and idea for future initiatives for lay reviewers.

Provide an evaluative overview of the outcomes of the year's LSA audit activity highlighting the LSA's appraisal of both risks that require actions and benefit realisation.

From the review of the LSA of the audit reports from 2012-2013:

"The LSA process for the annual audit for the midwifery services should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood."

At the Mott MacDonald review of the LSA which took place in March 2014, the review team visited the maternity units at the Ulster Hospital, South Eastern Health and Social Care Trust and Craigavon Area Hospital, Southern Health and Social Care Trust and met with key stakeholders.

The LSA Audits for 2013-2014 were carried out during January-March 2014. The audit tool and the more detailed audit reports had been updated and prepared based on the London LSA audit documentation. The four domains covered by the audit were:

1. The interface of statutory supervision with midwives and clinical governance
2. The profile and effectiveness of statutory supervision of mdiwives
3. Team working, leadership and development
4. Supervision of midwives and the interface with users

All the Trusts prepared documentation for the review team in advance of the visit. This move towards paperless (email) preparatory work allows documentation to be read and considered in advance of the visit. Examples include:

- SoM meeting agenda and minutes
- Governance meeting agenda
- ALERT newsletter (local initiative involving SoMs in improving practice)

- Record keeping audit results
- New guidelines and polices developed with SoMs involvement
- PROMPT programme with SoM involvement
- SoM initiatives to improve Medicines Management at both local and regional level
- SoM involvement in achievements such as RCM Midwifery Awards
- SoM involvement in achievements such as Chairman's Awards
- SoM development of recruitment for local MSLCs
- Initiatives to support student midwives within the supervisory framework

The LSAMO reviewed in advance information available from the LSA database such as:

- LSA database information on percentage of completed annual reviews
- LSA database information on caseload of midwives per supervisor of midwives
- LSA database information on Intentions to Practice
- LSA database information on Trust midwife and SoM demographics
- LSA database information on SoM PREP/CPD activity

The LSA risks that require action have been highlighted in the Mott MacDonald review and the effectiveness and efficiency of supervisory investigations and protected time for SoMs was reflected at Trust level.

Improvement needed	Action
LSA annual audit process.	Review the documentation used in the annual audit; update as required. Formalise the process, visit and reports. *Report on action in quarterly monitoring return to the NMC*
Lay/service user involvement in all areas of supervision particularly in relation to how the supervision process can support women's choices.	Implement formal recruitment, training and involvement of lay service users in LSA supervision processes. *Report on action in quarterly monitoring return to the NMC*
The effectiveness and efficiency of supervisory investigations.	Update supervisors of midwives on the revised polices and templates for supervisory investigation. Monitor the effectiveness and efficiency of supervisory investigation through the use of the LSA database facilities for noting

	investigations and follow up of recommendations from supervisory investigation reports. Strengthen the interface with statutory supervision following adverse incidents and trust governance processes *Report on action in quarterly monitoring return to the NMC*
Review protected time is achieved by all SoMs	Monitor though the collation and analysis of the SoM activity sheets, the LSA audit visits and meetings with SoMs. *Report on action in quarterly monitoring return to the NMC*
Resources to support the role of the LSA MO.	PHA senior management consideration of a LSA Midwife to support the role of the LSAMO. *Report on action in quarterly monitoring return to the NMC*

Notable Practice

The Mott MacDonald review team considered that the LSA & NIPEC annual review toolkit is an excellent resource. It is currently being factored into the LSA MO Forum UK update of the annual review guidance, process and record which will be made available to all midwives in the UK. The application of this annual review toolkit may be useful for revalidation of midwives in the future.

Within Trusts, SoMs are involved in leading, developing and supporting practice in many initiatives. Examples are:

- Leaflets for women on 'Home birth or Hospital birth' in Portuguese, Polish and Lithuanian
- Caspe Healthcare Knowledge Systems (CHKS) award – one of the top three maternity unit in the UK
- Annual report to the LSA
- Promoting normality and MLU on a float at the Lord Mayor's show
- Meet with GPs annually
- Birth Afterthoughts – service and booklet
- Facilitating medicines update for midwives
- Facilitating PROMPT training
- Producing a short video of a 'virtual' tour of the unit and one of the MLU rooms
- Developing work with asylum seekers and specific BME groups

- Promoting supervision at local Health Fairs
- Hosting an Open Day at the MLU
- Birth planning
- SBAR training
- Developing ALERT newsletter (interface with clinical governance)

The multidisciplinary regional working group on 'Midwives and Medicines', co-chaired by NIPEC and the LSA will improve knowledge and practice around medicines management. This work will be complete in the autumn of 2014 and the aim is to explore and develop evidence based guidance, communication and education support arrangements that will be of benefit and provide clarity to the midwifery workforce in relation to medicines legislation and safe, best practice. One of the reasons leading to this initiative was a NMC case (conduct and competence committee substantive hearing in 2013/2014) where issues for the midwife included medicines management.

Supervisors of Midwives are involved in the multidisciplinary workgroups on maternity care that are part of the HSC Safety Forum and the on-going work around the implementation of the Maternity Strategy for NI (a Strategy for Maternity Care 2013-2018 (DHSSPS (2012)). This important work on the Maternity Strategy leads on improving and developing practice in maternity care and the Northern Ireland Maternity Information System (NIMATS). SoMs both lead and are involved in the multidisciplinary NIMATS regional steering group, the operational group and the business objects group.

Benefits realisation

The PHA Benefits Realisation plan is contained within the Performance management and performance monitoring report. The LSA informs the development of the annual business plan that is in place for delivering on the long term objectives of reducing health inequalities and improving long term health and wellbeing. Robust processes are in place for monitoring the impact actions being taken by the PHA are having in delivering on the targets that have been agreed.

Appraise the engagement between the LSA and the approved education institutions in relation to supervisory input into midwifery education. (Include information on what has worked well and where challenges remain)

The LSA and SoMs contribute to curriculum development for both pre-registration midwifery courses and also to the preparation of supervisors of midwives module. The LSAMO presents on supervision of midwives and the roles of the LSA and LSAMO to students during their 18 month course and during the direct entry, 3 year midwifery course. The LSAMO is also involved in the development of the PoSoM module.

The LSAMO meets six monthly with the midwifery educators to discuss and update on supervision of midwives and midwifery lecturers contribute to LSA practice programmes as required.

The involvement of the LSAMO and supervisors works well as it has informed student midwives about the supervisory framework. From the Mott MacDonald review, "Student midwives described to us how to access a SoM. They demonstrated a good knowledge and understanding of the role of the SoM appropriate with their level of pre-registration midwifery training.

Challenges remain in the continuous recruitment lay reviewers, but as noted in the LSA review, service users had been able to describe their interactions with student midwives and student SoMs in academic settings, albeit on an ad hoc basis.

Section 3

Please identify any issues or trends that are currently impacting, or may impact in the future, the practice of midwives in the LSA. For example this may be increasing birth rates, increasing LSCS, changes to service delivery. Please rate the risk of these issues or trends on effective supervision of midwives using a RAG rating (Red, amber, green)

The key findings about births in NI in 2013 (NISRA 2014) are:

• In 2013, there were 24,279 births registered in Northern Ireland, almost 1,000 fewer than in 2012 (25,269 births).

• The Total Period Fertility Rate – the hypothetical average number of children per woman – fell to 1.95 children per woman in 2013.

• The number of births to teenage mothers reached a record low for Northern Ireland at 937 births.

• Continuing recent trends towards later childbearing, last year over half (53%) of all babies born were to mothers aged 30 or over.

• In 2013, 10% of births were to mothers born outside the UK and Ireland, the highest percentage on record. In comparison, in 2005, this figure was 5% and in 1997 it was less than 3%.

The key findings represent continuing trends in NI. There has been a slight decrease in 2013 births from the plateau of around 25,000 births that occurred 2008-2012.

In 2013 the Royal Group of Hospitals in Belfast and the Ulster Hospital Dundonald delivered 41% of all babies born in Northern Ireland. The Erne Hospital ceased maternity services in June 2012 with the hospital moving to the South West Acute Hospital (SWAH) outside Enniskillen which saw 1,213 births in 2013. The Mater Hospital changed to a new freestanding Midwifery Led Unit in April 2013, with most of the births being absorbed by the other maternity unit (Royal Jubilee Maternity Service) within the Belfast Health and Social Care Trust (BHSCT).

This means there are now three freestanding MLUs in NI - the Downe and Lagan Valley in the SEHSCT and the Mater in BHSCT, plus alongside MLUs in Altnagelvin and SWAH (WHSCT), the Ulster (SEHSCT) and Craigavon (SHSCT) with anticipated MLU rooms in Daisy Hill (SHSCT) later in 2014. The NHSCT is reviewing its service delivery as it currently has no MLU in either of its consultant led maternity units.

The main themes of the Maternity Strategy are:

- Prevention – healthier lifestyle, preconception care
- Antenatal education & postnatal support
- Shift from hospital to community
- Shift from medical to midwifery care
- Normalising birth and reducing inappropriate interventions
- Review profile of maternity units

Some examples of how the maternity strategy is being implemented so far include many areas of work to improve maternal health and maternity services such as:

- Development of a regional parenting education programme led by Health Improvement
- Scoping exercise for community maternity care led by the PHA in conjunction with the Northern Ireland Practice Education Council.
- Maternity collaborative on promoting normality and reducing interventions led by the Safety Forum
- Review of inclusion and exclusion criteria for smaller obstetric units who do not currently have the appropriate 24 hour medical cover.
- Scoping exercise to assess the needs of Black and Minority Ethnic women, and migrant women who use maternity services
- Upgrade of NIMATs to ensure better data collection

In particular the work of the multidisciplinary Safety Forum, the work around 'maternity dashboards' and a range of quality and safety initiatives has had an impact on practice. One example is that BHSCT has been able to demonstrate a steady and maintained decrease in caesarean section rates. Supervisors of Midwives are an integral part of these practice developments, initiatives, improvements and key to their implementation.

LSA issue or trend and RAG rating for the risk on effective supervision

	Issue or Trend	**Comment**	**Impact**	**LSA action**	**Mitigation**	**RAG rating**
1	SoM ratios	LSA meets the standard	None yet - new SoMs being appointed will balance retirements	Appointment of PoSoM course midwives 2013/14. Further recruitment to 2014/2015 module	Trust with ratios slightly above1:15 has action in place (midwives on the PoSoM course); Trust was visited by the review team	
2	Supervisory investigation s	Identified in review	Delay in process	Action in 2014/15	Work done in 2013/2014. Needs rolling programme and updating on processes	

3	Service user involvement in LSA	Identified in review	Already take part in LSA processes on an informal basis	Action in 2014/15. Prepare a strategic plan to include how service users can enhance all areas of the Supervision of midwives process	Formal recruitment pack training and information for service users prepared	
4	LSA annual audits	Identified in review	To enable relevant action points to be fully understood	Action in 2014/15	Documentation updated for next year; online approach	
5	Improve interface with clinical governance and supervision	Identified in review	Avoid duplication	Action in 2014/15	There are stringent clinical governance processes in place which protect the public	
6	Resources for LSAMO	Identified in review	Delivery of assurance and succession	Action in 2014/15	Case in preparation	
7	Midwife demographics	Reviewed regularly; workforce, RCM, DHSSPS, AEIs and Trusts all aware	None yet - new midwives balance retirements	Review regularly with other stakeholders	Midwife demographics known	
8	New roles for midwives	(Private) Independent Midwives intend to provide care in NI	Unknown in NI	Meet with IMs; contact RQIA re registration	New to NI	
9	Birth rate	Stable	SoMs and multidisciplinary work	Review	Review	
10	Complex pregnancies	On-going work with multidisciplinary team and SoMs	Increase in normal birth rate	Work with key stakeholders	Lots of good work already in place and more developments.	
11	BME women	Increase in numbers; developing work	Improve communication	SoMs involved	Continue improvements	
12	Teenage Mothers	Decreasing	None on supervision	SoMs involved	Multidisciplinary approach	

Detail any new policies, national or local, related to the supervision of midwives and how the LSA has applied them and what success measures or challenges have emerged

Following publication of the updated Midwives rules and standards 2012, the LSAMO Forum UK updated all the LSA policies and guidelines. This updating took place during 2013-2014 and the updated policies and guidelines are listed below.

SoMs are advised to download guidance as needed from the LSAMO Forum UK website (http://www.lsamoforumuk.scot.nhs.uk/), so that they use the most up to date guidance. Any comments or suggestions for improvement are used as feedback to the author of the policy or guideline to inform the next update.

The investigation guidance will be updated in 2014/2015, taking into account the Parliamentary and Health Service Ombudsman's report into Midwifery supervision and regulation: recommendations for change (PHSO 2013), as well as feedback from SoMs of their experience of using the guidance and templates.

Feedback from Mott MacDonald and the NMC following the LSA reviews of 2013/2014, mean that the 'Transfer of midwifery records for self-employed midwives' policy will be reviewed and updated first, followed by all the other guidance to ensure that any changes to NMC standards or guidance or new reports affecting supervision of midwives are incorporated. SoMs will be asked for their comments and suggestions on the policies and guidelines as part of this updating process.

Policies

Annual review of practice by a supervisor of midwives

Complaints against a supervisor of midwives or LSA Midwifery Officer

Confirming a midwife's eligibility to practise

Contacting a supervisor of midwives: 24 hour access

Guideline development

Local Supervising Authority Supervisory Investigation Decision Tool

Local Supervising Authority Review and Investigation Processes

Template letters in relation to the steps of the investigation process

- step 3 letter to Head of Midwifery informing her of the investigation
- step 7 letter to midwife informing her of the investigation including a request for a statement and the date of interview
- step 9 letter requesting statements from health professionals involved
- step 10 letter asking midwife to 2nd interview
- step 13 letter to midwife for agreement of meeting notes
- step 17 letter to midwife informing her of the recommendations
- step 20 letter to employer re the outcome of the investigation
- Report Template

Templates in relation to the outcome of the investigation

- Local Action Plan
- LSA Practice Programme

Proficiencies - April 2014

- Accountability
- Communication
- Medicines Management
- Professional Practice - monitoring maternal & fetal wellbeing
- Record Keeping

Nomination, selection and appointment of supervisors of midwives

Policy Development

Reviewing the ability of a supervisor of midwives to undertake the role

Suspension of midwives from practice by a LSA

Transfer of midwifery records for self-employed midwives

Guidelines

Guidance for clinical mentors and academic assessors supporting a midwife undertaking a LSA Practice Programme

Guidance for: Programme Lead Supervisors and Supporting Supervisors of Midwives leading a LSA Practice Programme

Information governance

Maternal Death

Providing midwifery care to a relative, friend or colleague

Provision of Supervisory Support in Challenging Situations

Role of the contact supervisor of midwives

Social Networking

Supervising self-employed/ independent midwives

Supervising midwives practising in specialist roles

Unassisted/ free birthing

Voluntary resignation from the role of supervisor of midwives

Working collaboratively with women and their birth supporters

Working with doulas

Available: http://www.lsamoforumuk.scot.nhs.uk/policies-guidelines.aspx

Section 4

Detail the number of complaints regarding the discharge of the supervisory function and, if so, how the LSA ensured that the complaints were responded to in a fair and impartial manner.

There were no complaints to the LSA regarding supervisory function during 2013/2014

Report the year's numerical figure in each of the following tables.

(1 April 2013 – 31 March 2014)

Total number of investigations	5
Total number of investigations completed within the best practice guidelines of 45 working days	1
Total number of midwives placed on local action under the supervision of a named SoM	7
Total number of midwives placed on a local supervising authority practice programme	3
Total number of midwives referred to the NMC	0 None by the LSA, but one midwife referred following dismissal from employment and one following referral by the police.
Total number of suspensions	0 There were no suspensions from practice of a midwife by the LSA during 2013/2014

Describe how the LSA has monitored supervisory investigations and ensured that they act fairly and equitably and comply with the standards and guidance set by the NMC, as well as the local guidelines set by the LSA

There is a LSA database group, led by an LSAMO that suggests improvements and developments to the LSA database. During the reporting year, the LSA database has been improved and the noting of LSA investigations adjusted.

During 2013/2014, SoMs used the revised national guidance for supervisory investigation (updated following the new Midwives Rules and standards 2012). There was update training at Trust level on the investigation guidance. This is part of on-going CPD of Supervisors of Midwives, along with LSA conferences on the theme of 'Lessons Learned). SoMs and midwives have given feedback on the investigation, the decision toolkit and the process and this is part of the feedback into the planned update of the national investigation guidance in 2014/2015.

Following the Mott Macdonald reviews of the LSA, workshops and conferences in the following year will update all SoMs on the LSA database improvements as well as the updated supervisory investigation guidance, templates and reports.

The LSA regularly reviews all supervisory investigations to check compliance with the NMC and LSA standards and guidance. The follow up of recommendations from supervisory reports will be highlighted in the revised LSA audit template for 2014/2015.

There is an opportunity in 2014/2015 for sharing best practice and learning with other LSAs and the LSAMO will pursue this option during 2014/2015.

On-going training on the new templates and supervisory investigations will involve supervisors using the full potential of the LSA database and improve the fairness and equity of the process as well as the compliance with the standards set down by the NMC and LSAs.

Section 5

Has a system regulator reviewed or directly commented on an area within this LSA?

The system regulator (RQIA) has not reviewed maternity services during 2013-2014.

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Professional regulator

Mott MacDonald reviewed the PHA LSA in March 2014. The report noted, "Our findings demonstrate that robust systems are in place to ensure that all midwives have a named SoM to whom they submit their intention to practise (ItP) annually. Clear and rigorous cross checking procedures ensure that all ItPs are successfully uploaded to the NMC database by the required date. We found that the LSA database supports and evidences that the statutory requirements for ItP fully meet the NMC requirements.

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in raising the profile of statutory supervision for the protection of the public."

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"A robust and effective system is in place to ensure that every practising midwife has an annual review with their named SoM and all reviews have been completed. We are assured that this process contributes to public protection as midwives describe their review as an integral part of their professional development to ensure their knowledge and skills as a midwife remain up to date".

"Our findings conclude that the PHA LSA ensures adequate measures are taken to control risks and meet the Midwives rules and standards (NMC, 2012) and LSA standards to protect the public in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls."

Summary of notable practice

"The annual review toolkit is an excellent resource and is currently being factored into the LSA MO Forum UK update of the annual review guidance, process and record which will be made available to all midwives in the UK."

If yes, detail the number of system regulator reviews this year and how it has impacted on maternity care, midwifery care and supervision, actions taken and outcomes following those actions.

System regulator

There are some midwives working in neonatal units in NI. The infection protection and hygiene inspections reports contain areas for improvements and areas of good practice and any recommendations are shared with the maternity units.

"Staff worked well as a team and were eager to learn from findings on the first day of the inspection. This was evidenced by changes noted on the second day of the inspection." (www.rqia.org.uk)

Professional regulator

Summary of areas that require improvement

"Our findings conclude that the LSA is meeting the standards set by the NMC for the delivery of the statutory supervision of midwives as set out in the Midwives rules and standards (NMC, 2012) in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls."

"In rule 7:4.1 the statutory supervision process needs strengthening in relation to service user participation and how midwifery supervision could support women's choices. There

were also issues in relation to formalising the annual audit process and providing a more comprehensive report to enable relevant action points to be fully understood."

Rule 7: 4.1

"The statutory supervision process needs strengthening in relation to service user participation and how midwifery supervision could support women's choices. A strategic plan should be developed to include how service users' involvement can be enhanced in all areas of the supervision of midwives process including how the supervision process can support women's choices."

"The LSA process for the annual audit for the midwifery services should be formalised and a more comprehensive report provided to enable relevant action points to be fully understood."

"The LSA MO meets NMC requirements and effectively performs her role and function however; minimal resources inhibit the scope of the role. The PHA should consider providing additional resources to support the LSA MO role."

Rule 10: 7.1

"We concluded that there are stringent clinical governance processes in place which protect the public and robust midwifery supervisory investigations; however the interface with statutory supervision following adverse incidents and trust governance processes could be improved."

"Procedures around investigating adverse incidents, complaints or concerns relating to midwifery practice or allegations of impaired fitness to practise against a midwife need to be strengthened in order to ensure that the public are protected from poor midwifery practice."

Summary of areas for future review

- LSA annual audit process.
- Lay/service user involvement in all areas of supervision particularly in relation to how the supervision process can support women's choices.
- Resources to support the role of the LSA MO.
- The effectiveness and efficiency of supervisory investigations.
- Review protected time is achieved by all SoMs

If originally the answer was no however after the event the LSA became aware that a system regulator had reviewed or directly commented on an area within this LSA please indicate how this review has impacted on maternity care and supervision, actions taken and outcomes following those actions.

There has been no system regulator (RQIA) review of maternity services in 2013/2014.

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During 2013/2014, there have been actions by the Health Minister and RQIA relating to Emergency Department work, but these have not had a detrimental effect on maternity care or supervision.

In June 2013, the Health Minister welcomed the opening of the new Antrim Hospital
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Emergency Department. He also appointed two senior executives to the Northern Health and Social Care Trust to lead on the next stages of turnaround in order to improve performance in critical areas of service delivery, particularly in Emergency Department waiting times (http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-june-2013)

During 2014/2014, RQIA was asked by the Health Minister to review arrangements for management and coordination of unscheduled care in the Belfast HSC Trust and related regional considerations. This review has been published (July 2014): http://www.rqia.org.uk/publications/rqia_reviews.cfm

Identify key issues for the LSA in 2013-2014 not highlighted elsewhere

The following healthcare events occurred during 2013/2014. One event highlights the MLU facilities in Lagan Valley, others represent learning opportunities for SoMs at national and international level plus the opportunity for feedback from users of the service at a regional level.

In September 2013 prior to the 8th International Neonatal Nursing Conference in Belfast, the Health Minister confirmed the development of a managed clinical network (The Neonatal Network NI), "which along with recommendations from the paediatric review, will provide a platform for and be a key driving force in the operational development of the best structure for safe, high quality neonatal services in Northern Ireland." (http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-september-2013/)

In November 2013, the Health Minister Edwin Poots welcomed HRH The Princess Royal to the Lagan Valley Hospital where she officially opened the Midwifery Unit (MLU). The Minister concluded: "Since its opening the MLU at the Lagan Valley Hospital has seen 600 births. It is an excellent facility that offers new choices for women with low risk pregnancies where they can give birth in a 'home from home' environment led by skilled midwives who they have come to know (http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-november-2013).

On 11 March 2014, the LSAMO Forum UK organised the 8th Biennial LSA Conference in East Midlands Conference Centre (http://www.jmdevents.co.uk/lsamo-forum-uk/7th-biennial-conference/).

Also in March 2014, the Public Health Agency in partnership with the Health Service Executive & Royal College of Physicians in Ireland held the first Quality Improvement and Safety Conference specifically aimed at staff from Northern Ireland and the Republic of Ireland (http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum/news).

'10,000 Voices' is a Public Health Agency initiative that aims to involve the public in improving patient experience, highlight the things that were important to them and influence commissioning of services. Maternity services and the LSA look forward to the results of the analysis of the responses in 2014/2015.

Examples of notable or innovative practice.

Please include occasions when you have worked with other LSAs.

An example of notable practice at LSA level is the Annual review toolkit (joint work with NIPEC). LSA resources for SoMs include monthly LSA briefings, conference presentations, maternity 'drivers', audit tools for maternity records, controlled drugs, a professional mandatory training template and leaflet about Supervisors of Midwives. These are available on: http://www.nipec.hscni.net/supervisionofmidwives/resources.html

The Midwives and Medicines work with NIPEC will result in a toolkit including a maternity medicines kardex, monographs for midwives for midwives exemptions, online updating on medication management and legislation with scenarios, questions and answers with knowledge assessment 'before and after'.

The LSA worked with all the other LSAs through the LSAMO Forum UK, particularly to update the national policies and guidelines, respond to consultations and liaise with key stakeholders in the UK such as the NMC, NHS England and the RCM.

Examples of proactive models of supervision.

Please include the impact of the proactive model on enhancing supervision of midwives and enhancing the protection of women and their families.

Within the LSA, SoMs have developed proactive models involving supervisors of midwives that enhance the protection of women and their families.

In one Trust a SoM lead an organisation excellence initiative using strategy, leadership and culture to enhance supervision and care. The key strategy issue was that 'a culture of normalisation of birth has the potential to reduce unnecessary interventions and improve the birthing experience for the parents, baby and family'. The work involved considering normalisation culture, modes of delivery in the unit, normality workshops with midwives and 'Proud of Our Practice multidisciplinary workshops for midwives and obstetricians. Other factors were record keeping audits, better use of the MHHSR intrapartum risk assessment, a 'familiarisation plan' and use of intervention 'bundles, all delivered with SoM input. The use of maternity 'dashboards' illustrated that over a year the normal birth has increased by 10% and the caesarean section has decreased by 8%.

Another initiative improves the interface between statutory supervision and clinical governance. The SoMs are involved in Acute Life-Threatening Events; Recognition and Treatment (ALERT) training. This multi-professional course trains staff in recognising patient deterioration and acting appropriately in treating the acutely unwell. The ALERT newsletter, developed with SoMs involvement, succinctly raises awareness of important practice issues such as fundal height measurements and personalised growth charts as well as giving feedback from clinical governance findings.

A MLU in the LSA received the RCM Mothercare Award for Maternity Service of the Year. SoMs lead and are part of the clinical team. The basis of the award was because the midwives ensure continuity of choice and local care for women in this isolated area. They led a high-profile campaign for a change in health service policy, which resulted in Northern

Ireland's first freestanding community midwifery-led unit. The whole midwifery team has worked tirelessly to promote the unit and, throughout the development process, has been willing to adapt to ensure a safe, high-quality service for women and families.

Another Trust in 2013/2014 encouraged SoMs to be involved in the preparation and work leading to the prestigious CHKS ward as one of the top three maternity units in the UK.

All these examples show SoMs leadership and involvement in the provision of services and care that enhance care for women and their babies.

The review of the LSA summarised their findings by noting, "A robust and effective system is in place to ensure that every practising midwife has an annual review with their named SoM and all reviews have been completed. We are assured that this process contributes to public protection as midwives describe their review as an integral part of their professional development to ensure their knowledge and skills as a midwife remain up to date."

"Our findings conclude that the PHA LSA ensures adequate measures are taken to control risks and meet the Midwives rules and standards (NMC, 2012) and LSA standards to protect the public in all areas other than in rule 7 and rule 10 which require improvement to strengthen the risk controls."

The LSAMO has had the opportunity to review LSA in other parts of the UK during 2013/2014.

Themes selected for 2013-14:

Annual theme one: Impact on supervision of midwives working outside of maternity services	No impact. So far, this is not an issue in Northern Ireland. Some midwives work outside the health service (for example in Universities), but the numbers are small and to date, there has not been a noticeable impact on supervision of midwives. During 2013/2014, there were no independent midwives practising in NI. This may change in 2014/2015 as there are independent midwives based in the Republic of Ireland who have shown an interest in practising in Northern Ireland.
Annual theme two: overview of impact of supervisory investigations that were not completed within best practice time of 45 working days and how this was reported at Trust/Health Board level	This has been reported as an issue in quarterly returns and has been highlighted in the review of the LSA during 2013/2014. The main reason behind delays is sick leave of midwives and in implementation of the process particularly if the SoM is clinically based and the investigation takes place around their work role. The impact is delayed implementation of local action plans or practice programmes. During the year, the LSA has moved towards ensuring that SoMs do not carry out investigations in the unit where they work. This is to address the possibility of a conflict of interest identified as possible with a supervisory investigation in the Parliamentary and Health Service Ombudsman's report. (Midwifery supervision and regulation: recommendations for change; PHSO 2013)

	The LSAMO presents this report to the PHA Board. The LSAMO adds issues to the risk register under Supervision of Midwives. Issues are discussed and ideas and support to address them sought from the LSA. As part of the action plan and to improve the links with clinical governance, the risks identified around investigations will be addressed by the LSAMO and SoMs during 2014/2015. The intention is to use investigatory 'best practice' in other LSAs in the UK and incorporate it into a rolling programme of learning, updating and training for supervisors.

Part 2

Annual report declaration form

I confirm that:

- the LSA continues to meet the NMC's Midwives rules and standards (2012);
- all key risks identified in the NMC annual report 2013-2014 are controlled

Key risk	Confirm risks are controlled
Resources	LSA midwife; request to senior management team at PHA for recruitment to the post in 2014/2015
Service user/lay auditor involvement	Formal recruitment and training of LSA lay auditors 2014/2015
Ratio of midwives to SoM	1:13 in the LSA. 11 midwives on the PoSoM course and due to be appointed in summer of 2014. They will replace SoM retirements.
Investigations	Ongoing training, development, strengthening and enhancing during 2014-2015. Regular monitoring by the LSAMO to demonstrate improvement.

I confirm the information given on this annual report form is correct and failure to disclose relevant information could result in further action by the NMC.

LSA Midwifery Officer Name: Verena Wallace Signature: Verena Wallace
Date: 31 July 2014
Telephone number: (028) 9536 2888
Email address: verena.wallace@hscni.net

Chief Executive of PHA: Dr Eddie Rooney Director of Nursing & AHPs: Mrs Pat Cullen Signatures:
Date: 2014
Telephone number: (028) 9536 3424 (028) 9536 3505
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Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	Serious Adverse Incidents Learning Report
Agenda Item	15
Reference	PHA/08/08/14

Summary

Introduction
From May 2010 the responsibility for the management and follow up of SAIs transferred from DHSSPSNI to the HSCB working jointly with the PHA and collaboratively with RQIA.

During 2012/13 the HSCB, working with the PHA, undertook a review of the 2010 Procedure and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation by 1 April 2014.

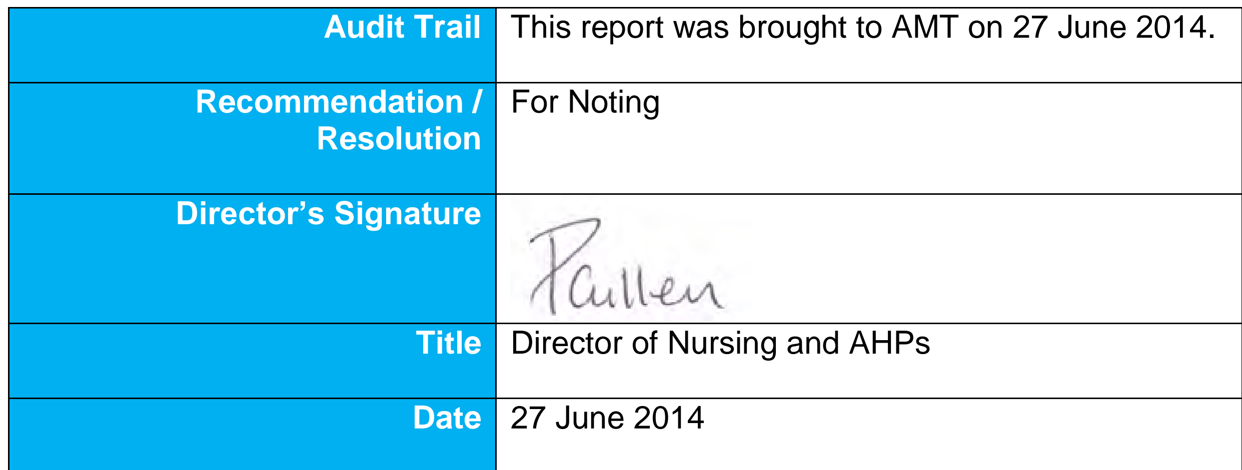
SAI Process
The aim of the procedure is to provide a system whereby the wider HSC not only report SAIs, but that learning from these incidents can be shared both locally and regionally. This provides the mechanism to improve the care and treatment of patients and clients, to improve safety and ensure respectful management of the incident.

The attached bi-annual report provides details of the key regional learning identified, action taken and proposed from SAIs reported to the HSCB during the period October 2013 – March 2014. Some of these initiatives may relate to learning identified and reported in previous learning reports as part of on-going work.

This is the sixth bi-annual SAI Learning Report and following approval will be shared with the wider HSC.

The report contains:
Section one: Information in relation to the new SAI Procedure (October 2013),
Section two: Learning from SAIs,
Dissemination of learning initiatives (including synopsis of incidents)
Section three: Next Steps (including synopsis of thematic reviews)
Appendix B: SAI statistics

Equality Screening / Equality Impact Assessment	N/A



Audit Trail	This report was brought to AMT on 27 June 2014.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Nursing and AHPs
Date	27 June 2014

HSC Health and Social Care Board

HSC Public Health Agency

Learning Report

Serious Adverse Incidents

October 2013 – March 2014

June 2014

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SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

During 2012/3 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation on 1 April 2014.

2.0 REVISED PROCEDURE FOR THE REPORTING AND FOLLOW UP OF SAIS (October 2013)

During 2012/13 the HSCB, working with the PHA, undertook a review of the procedure issued in 2010. This involved meetings with colleagues from across the HSC to identify ways in which the current arrangements could be further strengthened. As a result of these discussions, a revised draft procedure was issued for consultation during August. Further amendments were made to reflect comments received during this exercise, with a final version being issued to all Departmental Arm's Length Bodies in September 2013

2.1 NOTABLE CHANGES TO PROCEDURE

The notable changes to the procedure are:

- **SAI criteria**
  - An additional criterion has been included - "*any death of a child in receipt of HSC Services (up to eighteenth birthday).*
  - SAIs involving a service user known to/referred to mental health services has been revised from 24 months to 12 months

- **Investigation levels**
  - The single investigation process for all SAIs has been replaced by three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning.

- **Timescales**
  - Timescales for conducting investigations have been revised in line with the level of investigation to be undertaken. However to date, there have been a number of investigation reports that are outstanding beyond their

submission date. This issue has been raised during 2013/14 and further steps are being taken to improve the timeliness of these reports

2.2 AIM OF THE REVISED PROCEDURE

The main aim of the revised procedure is to:

- Provide a mechanism to effectively share learning in a meaningful way, with a focus on safety and quality, ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI, to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs;

- Ensure the process works simultaneously with all other statutory and regulatory organisations;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- provide a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

2.3 SERVICE USER / FAMILY INVOLVEMENT IN SAIS

The revised SAI Procedure makes clear the need for and importance of, appropriate communication and involvement of service users, relatives and carers. However, in light of recent communications with DHSSPS, and in order to further assist Trusts, the HSCB and PHA have reviewed the SAI Notification Form and developed a SAI Investigation Report Checklist which should accompany all SAI Investigation Reports regardless of the investigation level. This will ensure a consistent approach is afforded to the level of service user / family engagement across the region. The checklist also contains a section in relation to those SAIs that have been notified to the Coroner (*where there is a requirement to do so*).

The revised forms were issued to all DHSSPS Arm's Length Bodies and Special Agencies to be implemented with immediate effect (April 2014) for all newly reported SAIs and for on-going SAIs for which investigations have not yet been completed. In addition, and in line with DHSSPS communication, the HSCB and PHA are working with the Patient Client Council and RQIA to develop guidance

for HSC organisations when involving service users/families throughout the relevant stages of the SAI process.

The HSCB/PHA are currently developing the HSCB DATIX risk management system to record the additional level of detail in relation to service user/family involvement, and reporting to the Coroner. This will enable analysis of this information to be reported on in future learning reports.

2.4 TRAINING TO SUPPORT PROCEDURE

In order to ensure organisations are equipped to commence the full operational implementation of the procedure, a number of regional training programmes were arranged. This training provided staff with the necessary information and guidance to enable them to carry out significant event audits (SEA) and route cause analysis (RCA) investigations.

A number of regional training programmes were delivered during 2013/14:

- SEA Training (December 2013)
- Designated Review Officer (DRO) Workshop (December 2013)
- RCA Training (January – March 2014)

This RCA training was delivered by the Royal College of Nursing (RCN) and the evaluation from these training sessions was very positive. A further two sessions have been arranged for DROs new to the SAI process or for those who were unable to attend the other sessions.

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs;
- The nomination of a DRO to review and scrutinise reports;
- SAI Review Sub Group meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAI Review Sub Group and agree actions and assurance arrangements;
- Escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports
  - assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis.

4.0 SAIs REPORTED DURING PERIOD OCT 2013 – MAR 2014

During the period 1 October 2013 to 31 March 2014, the HSCB received 300 SAI notifications. This represents an increase on the previous six months (April 2013 - September 2013) when 183 SAIs notifications were reported to HSCB.

It should be noted that that this is the first reporting period since the revision of the Procedure and the revised SAI reporting criteria (refer to Appendix A), heightened awareness of the revised procedure (following the consultation and implementation), the HSC training programmes for SEA and RCA along with recent Thematic Reviews undertaken will account for some of the increases in reporting.

A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate the SAI, however, the decision to approve the de-escalation will be made by the HSCB/PHA Designated Review Officer.

During the reporting period eight (8) SAI notifications received were de-escalated.

6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIS

It is important that when a serious event or incident occurs, that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

- **Quality Safety and Experience (QSE) Group**

  The HSCB and PHA recently established a jointly chaired QSE Group to provide an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

  A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alert Team (SQAT)**

  The work of the QSE group is closely aligned to SQAT, which is responsible for overseeing the implementation and assurance of Regional Learning Letters/Guidance issued by HSCB/PHA in respect of SAIs

SAI LEARNING MECHANISMS

Learning opportunities from SAIs can be identified by the reporting organisation, DROs the Regional SAI Sub Review and QSE Sub Groups and learning can take the form of:

- Local organisation actions;

- Formal learning letter;

- Thematic Reviews: Commissioned by the Regional SAI Sub Review Group and the QSE Group, to review trends, patterns and provide an in-depth analysis. Key learning points are disseminated across the HSC;

- Learning Matters Newsletter: HSCB-PHA have developed a newsletter to ensure that local incidents are shared regionally to drive improvements for patients and

services across the HSC. The first edition was issued across the HSC in December 2013 with the second due to be issued in May 2014.

- The SAI Bi-annual Learning Report provides an overview on all learning letters / thematic reviews carried out and/or reported on during the period of reporting.

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed this is not intended to diminish the personal impact that these incidents have.

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of on-going work.

2.1. PATIENT SELECTION AND INTRAPARTUM CARE IN MATERNITY UNITS - (update from previous report)

In two SAIs where one baby died and another suffered harm, there were some underlying issues which were common to both incidents. Escalation and appropriate action was delayed due to:

- not taking account of the entire clinical picture of the woman and her baby. CTG tracings and risk factors for pregnancy and labour were not considered together;
- failure to recognise pathological CTG tracings and escalate appropriately;
- lack of clarity in communication between members of the multidisciplinary team.

A Safety and Quality Learning Letter LL/SAI/2012/013 was issued on 3 January 2013 which identified the following actions for HSC Trusts:

- immediate dissemination of learning letter to all relevant staff including students;
- if a Consultant obstetric unit in trusts does not meet the minimum medical staffing standard of at least ST3-level resident cover in obstetrics, paediatrics and anaesthetics, the trust must immediately review the inclusion/exclusion criteria for the unit and adjust those to ensure that only low risk women are booked for delivery.

In addition, Trusts were asked to confirm:

- that staff are trained at least annually in interpreting CTGs;
- that staff competence in CTG interpretation is checked annually;
- that maternity teams conduct regular audits of their adherence to local protocols/policies for induction of labour, and in case reviews of intrapartum care;
- the date of the last audit of induction of labour, or the date of the next planned audit;
- the date of the last case review of intrapartum care, or the date of the next planned review.

Responses have been received by all Trusts identifying further actions before compliance is achieved. Designated Leads in the PHA and HSCB are continuing to work in collaboration with AD commissioners and individual Trusts to secure agreement on revisions to the patient selection criteria that further reduces risk. Longer term changes will be addressed through the Maternity Strategy implementation process. A further update will be available in the next SAI Learning Report.

2.2. KNOW THE MASSIVE HAEMORRHAGE PROTOCOL *(update from previous report)*

A SAI occurred during a diagnostic laparoscopic procedure in a standalone surgical day procedure unit, which was remote from the main hospital site. The patient's common iliac vein was accidentally perforated during trocar introduction, creating the potential for massive blood loss. The patient underwent successful surgery, but this was considered a 'near miss' as the response was slower than would have been expected as the protocol was not followed correctly.

A Learning Letter LL/SAI/2013/019(AS) was issued to all Trusts and RQIA on 9 July 2013, setting out the following learning:

Trusts were required to:

- disseminated the learning letter to the staff groups named in the Transferable Learning Section, and other relevant staff;
- ensure staff in areas where major blood loss is a possible event, participate annually in drills of their Trust's protocol(s) for massive blood transfusion;

All HSC Trusts have confirmed compliance has been achieved in meeting these requirements.

2.3. COMMUNICATION OF PATIENTS RISK STATUS FOR CJD *(update from previous report)*

During 2012, there were two incidents where a patient's CJD risk status was not adequately flagged to staff performing surgery/a procedure on the patient.

In the first, a patient had a surgical procedure and was subsequently discovered to be CJD 'at-risk' several hours post- surgery. However, when the patient returned to theatre for further surgery some days later, the theatre set was not discarded because the CJD 'at-risk' status had not been flagged adequately in the patient's notes. The error was detected a few days later, but it meant that the theatre set could have been used in the interim on other patients.

In the second incident, the 'at-risk' status was known, but was not recorded in the patient's notes.

A Safety and Quality Learning Letter LL/SAI/2013/021 (AS) was issued to HSC Trusts on 19 August 2013 and reissued on 2 September 2013 identifying the learning and requested confirmation of the following:

HSC Trusts were required to confirm the following:

- the learning letter has been disseminated to the staff groups named in the Transferable Learning Section, and other relevant staff;
- that they are following the latest suite of guidance on minimising the transmission of CJD and vCJD;
- that they have a protocol for risk assessing patients preoperatively for CJD and notifying other staff of a patient's CJD 'at-risk' status;
- the date(s) of the last audit(s) of compliance with CJD risk-assessments, or the date(s) of the next audit(s), in relevant specialties.

HSC Trusts have confirmed that all actions are now complete or have confirmed a date for actions to be completed.

2.4. SAFE USE OF INTRAVENOUS (IV) MAGNESIUM SULPHATE (update from previous report)

Following a SAI involving IV magnesium sulphate the Regional Secondary Care Medicines Governance Team were approached, by the Trust involved, to identify measures to minimise risks with prescribing, preparation and administration of IV magnesium sulphate. To do this, the Medicines Governance Team facilitated a multi-disciplinary Failure Modes and Effect Analysis (FMEA).

A Safety and Quality Learning Letter LL/SAI/2013/023 was issued on 9 September 2013 and HSC Trusts were asked to:

- review the complete FMEA report and risk assess current practice its recommendations. Three of these recommendations were highlighted in the learning letter. These included:

  - Any existing electronic prescribing and dispensing systems should be amended to express magnesium sulphate injections and pre-prepared infusion strength, in both mmol and grams to reduce the potential for confusion in dosing.

  - Clinical guidelines should be in place to support the safe prescribing of IV magnesium sulphate in all relevant settings (for example, but not limited to, hypomagnesaemia, asthma, arrhythmias, severe pre-eclampsia, eclampsia, neuroprotection of the fetus in the management of preterm labour). The guidelines should express the dose required in both gram and mmols and the required rate of infusion.

  - The NI Secondary Care Medicines Governance Team is leading regional work to make pre-prepared IV magnesium sulphate infusions available and this work should be supported by other Trust staff. When pre-prepared infusions become available, all other magnesium sulphate injections should be removed from ward stock and replaced with the pre-prepared products.

- Share the content of the learning letter and the FMEA report with medical, nursing, midwifery and pharmacy staff and specific direction was provided to them stating that they should:

    - Never administer a bolus dose(s) of IV magnesium sulphate from an infusion preparation where both bolus and infusion are to be given.

    - Read the FMEA report so that you are aware of the risks associated with prescribing, dispensing, administration and monitoring of IV magnesium sulphate. The FMEA report provides a complete list of recommendations and you should consider their application to your own practice.

- Trusts were requested to provide confirmation of the following:

    - that this letter has been disseminated to the staff groups named in the Transferrable Learning Section and other relevant staff;
    - that the FMEA report has been reviewed by each HSC Trust and current practice risk assessed against its recommendations.

HSC Trust have confirmed that all actions are now complete or have confirmed a date for actions to be completed.

In addition:

- The NI Medicines Governance Team is progressing with the purchase of pre-prepared IV magnesium sulphate infusions.

THE ITEMS BELOW ARE NEW LEARNING ISSUED SINCE LAST REPORT

2.5. SAFE MANAGEMENT OF LOWER BOWEL DYSFUNCTION INCLUDING DIGITAL RECTAL EXAMINATION AND DIGITAL REMOVAL OF FAECES

Two SAIs were reported where an inappropriate method to manually remove faeces from patients occurred. These incidents involved members of staff who were employed within the Independent Sector across two Trust areas.

A Safety and Quality Learning Letter LL/SAI/2013/024 was issued to all HSC Trusts and RQIA on the 16 December 2013, setting out the following actions:

For Frontline Nursing Staff:

- Do not use implements to remove faeces from patients.

- It is your responsibility to make sure you follow your organisation's policy/procedure when performing digital removal of faeces from patients.

- If your organisation does not yet have a policy/procedure for digital removal of faeces from patients, you should follow the Royal College of Nursing guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) published 15 November 2012 and available at www.rcn.org.uk/publications.

Directors of Nursing and Managers of Nursing and Residential Homes *were asked* to ensure that:

- Their organisation has a policy/procedure for the assessment, treatment and management of patients/clients who require digital removal of faeces. The Royal College of Nursing has produced guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) (published 15 November 2012 and available at www.rcn.org.uk/publications). These guidelines should be used as a reference for your own policy/procedure;

- All relevant staff are aware of their organisation's policy/procedure;

- Staff who require additional training in the policy/procedure, receive training.

HSC Trusts were asked to confirm by the 14 February 2014:

- That the learning letter had been disseminated to the Trust staff groups named in the Transferable Learning Section, and other relevant Trust staff – timescale – immediate;

- That their Trust has a policy/procedure that covers digital removal of faeces and that it reflects Royal College of Nursing guidelines on "Management of lower bowel dysfunction, including DRE and DRF" (digital rectal examination/digital removal of faeces) (published 15 November 2012 and available at www.rcn.org.uk/publications

Confirmation of all requirements from all HSC Trusts was received by 14 February 2014.

2.6. HEAD INJURY IN PATIENTS ON WARFARIN – TREAT AS A MEDICAL EMERGENCY

Two recent SAIs related to patients who had presented at the Emergency Department (ED) with head injury, who were also on warfarin. In the first case the patient confirmed that they were taking warfarin. The patient was triaged as Category 3, which meant they should have had a medical assessment with 1 hour; however the waiting time for Category 3 patients at the time was over 3 hours. Following a CT scan the patient was diagnosed with a subdural haemorrhage. Prothrombin Complex Concentrate (PCC) was ordered (by then 5 hours after the patient arrived in ED), but this was not administered until almost 2 hours later i.e. almost 7 hours after the patient arrived in ED. The frequency of neurological observations was not increased to the recommended 'every 15 minutes'. A repeat CT scan showed a dramatic increase in the subdural haemorrhage and midline shift; palliative care was given and the patient subsequently died.

The second case had similar circumstances. An elderly patient was brought by Ambulance to ED following a fall and with a visible head injury. Triage staff did not use the Trust's head injury proforma and therefore did not identify that the patient was on warfarin. The patient was triaged as Category 4; they had a medical

assessment almost 4 hours later and at that point, noted to be on warfarin. A CT scan was ordered but not performed until 1.5 hours later. PCC was ordered when the CT scan showed a subdural haematoma but not administered for a further 45 minutes and therefore almost 8 hours after the patient first presented to ED. The patient subsequently deteriorated and died.

Head injury in patients on warfarin has a significant mortality rate, but patient outcomes are improved when warfarin is reversed quickly. In these cases there were a number of factors which contributed to the delays in administration of Prothrombin Complex Concentrate (PCC):

- There was no advance warning to ED staff that a patient with a head injury and on warfarin was being brought to ED. ED staff therefore did not have an opportunity to prepare for immediate medical assessment of the patient;

- The NI Electronic Care Record (NIECR) was not used to check the patient's medications and staff were therefore unaware that the patient was on warfarin;

- Head injury in patients on warfarin was not recognised as a medical emergency and patients were therefore not fast-tracked for assessment and treatment;

- In both cases, PCC was given after the CT scan rather than in advance on a precautionary basis despite signs of possible intracranial bleeding;

- PCC was not stored in the ED so immediate administration of PCC was not possible;

- ED escalation plans did not maintain the ED waiting time for Category 3 & 4 patients within the College of Emergency standards, so the patients' assessment by a doctor was delayed by 3-4 hours. This suggests that the ED Escalation Plan was not adequate or was not activated sufficiently.

A Safety and Quality Learning Letter LL/SAI/2014/025 was issued to all Trusts, NIMDTA, Directorate of Integrated care and RQIA on the 8 January 2014, setting out transferable learning for various personnel:

Trusts were asked to provide a response by the 30 April 2014 that the identified learning was actioned. They were asked to confirm the following:

a. That the learning letter has been disseminated to the Trust staff groups named in the Transferable Learning Section, and other relevant Trust staff;

b. That their Trust ED protocol(s) for managing head injury has been amended as necessary to reflect the content of the Transferable Learning section of this letter;

c. That their Trust protocol(s) for managing head injury in-patients in hospital or Trust nursing/residential settings has been amended to reflect the content of the Transferable Learning section;

d. That the protocols in b) and c) above have been disseminated to relevant staff;

e. That their Trust ED Escalation Plan has been amended to reflect the content of the Transferable Learning section;

f. That key ED staff know the procedure to increase staffing levels in response to increased numbers of patients registering at ED and/ or other escalation triggers.

HSC Trust responses will be reviewed by the Safety and Quality Alerts team on 23 June 2014 and an update will be provided in the next SAI Learning Report.

2.7. DISPENSING BETA BLOCKERS – SELCTION ERRORS

Over the past year, a small number of adverse incidents have been reported to the HSCB where beta blockers have been inadvertently supplied to patients as a result of a selection error at the point of dispensing in a community pharmacy. Some of these resulted in patients coming to serious harm. The three most common beta blockers that have been supplied in error were atenolol, bisoprolol and propranolol. Contributory factors to these errors included:

- Similar names
- Similar drug strengths
- Similar packaging
- Close proximity of a beta blocker to the intended drug on the shelf.

It should be noted that inadvertent administration of beta blockers can have potentially serious side effects, especially in vulnerable patients such as the elderly or those with other serious co-morbidities. Side effects include:

- Bradycardia
- Hypotension
- Acute cardiac insufficiency
- Bronchospasm.

A Safety and Quality Learning Letter LL/SAI/2014/026 was issued on 9 April 2014 which identified the following transferable learning for HSC Trusts:

There are a range of practical steps that can be taken to reduce the risk of this type of error occurring. These include:

- For all prescriptions, ensure that there is a double-check built into your dispensing process where possible. This may be by another pharmacist or member of dispensary staff and should be included in your Standard Operating Procedures (SOPs). All staff who dispense should be trained in and signed up to the SOPs.

- The Royal Pharmaceutical Society of Great Britain suggested some principles to be followed when carrying out the final accuracy check on a dispensed medicine. The mnemonic 'HELP' may be useful:

H How much has been dispensed
E Expiry date check
L Label checks for the correct patient's name, drug name, dose, and warnings
P Product check, i.e. the correct medication and strength have been supplied.

Consider:

- Moving beta blockers to a separate storage area

- Marking stock or shelf edges clearly to highlight beta blockers

- Adding an alert to the computer to highlight drugs which have the potential to be mis-selected

- When procuring medicines, look for packaging designs that assist accurate product selection, e.g. consider different generic manufacturers for different generic products, or generic manufacturers whose packaging is sufficiently different between preparations to allow them to be distinguished easily.

In secondary care, robotic dispensing should help prevent this type of selection error. However, where 'broken bulk' of medicines is used, measures such as those listed above should be put in place to avoid selection of a beta blocker when another medicine is intended.

Extra care should *be taken to check prescriptions for high risk drugs.*

Extra care should be taken where three or more tablets or capsules of the same medication are either prescribed or required to make up the prescribed dose.

As outlined in the Pharmaceutical Society of Northern Ireland's Professional Standards and Guidance for the Sale and Supply of Medicines[1], the pharmacist must ensure that the patient receives sufficient information and advice to enable the safe and effective use of the prescribed medicine. It is therefore good practice that when pharmacists or dispensary staff are handing out medication to patients, they should check the patient's or carer's understanding of the medicine they are expecting to receive, where possible. This will help verify the accuracy of the prescription and dispensed medication. The name and appearance of the dispensed item should also be verified where possible.

For further suggestions, please see please see Medicines Safety Matters, Prescribers & Community Pharmacists Vol 2 Issue[2]

Incorrect selection may also occur at ward level and nursing staff should be aware of the potential to select a beta blocker and the possibility of harmful effects should it be administered in error.

[1]http://www.psni.org.uk/documents/313/Standards+on+Sale+and+Supply+of+Medicines.pdf
[2]http://www.medicinesgovernance.hscni.net/primary-care/newsletters/medicines-safety-matters-prescribers-community-pharmacists/

Community Pharmacies and HSC Trusts were asked to confirm by the 30 May 2014 that the following actions had been taken:

- This Learning Letter was shared with all staff involved in either dispensing or the administration of medicines to patients;

- Review and as necessary, update your SOPs and arrangements for managing beta blockers, taking account of the suggestions in the Transferable Learning section of this letter.

An update will be provided in the next SAI Learning Report.

SECTION 3

NEXT STEPS

1.0 REVIEW OF COMPLAINTS AND SAIs REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following a thematic review of SAIs and complaints relating to the care and treatment of older people, a workshop was held on 17 May 2013 to agree actions in response to regional learning identified. *(An Older Person is defined as someone 65 years and over).*

The workshop was attended by lead clinicians and managers of older people services across Northern Ireland. Expert speakers from across health and social care N.I., as well as other agencies interfacing with older peoples services, led the discussions and action planning.

The following themes were discussed at the learning event:

- Advocacy (*recognising that most complaints are not made by older people themselves*)
- Falls
- Privacy and Dignity
- Misdiagnosis and delay in commencement of treatment
- Staff attitude and behaviour and staff communication with patients, service users and families.

An action plan was developed, to ensure that learning from this review and the workshop is used to inform the improvement of services for older people by identifying existing streams of work or establishing where a new focus of work is required. A report giving an overview of both pieces of work is currently being finalised and will be issued in the near future.

2.0 THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA Quality Safety and Experience (QSE) Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

- ***PATIENT FALLS IN HOSPITALS***

The Regional In-Patient Falls Group was established to provide multidisciplinary advice and support in preventing harm to patients who fall whilst in hospital. To support the work of this group a review of all SAIs reported to the HSCB was commissioned by the Regional Serious Adverse Incident Review Group.

This information will inform the established regional quality improvement work that is being undertaken. The 'Fallsafe' bundle, which is being implemented regionally, recommends multiple interventions for those people vulnerable to falls, and a phased approach to its introduction is required. Information from this review will also assist the Regional In-patient Falls Prevention Group to prioritise those elements which provide the greatest opportunity for improvement. In particular, the management of delirium and confusion.

There has been an increase in reported SAI incidents relating to falls, since 1st October 2013. The introduction of the new SAI procedure in October 2013, which includes SEA's, the report on the Regional Review of Patient Falls in Hospital and the improvement work by the Regional falls group and the Regional Governance leads group, have all contributed to the increase in awareness of reporting of serious harm from falls.

A further piece of work has been recommended by the SAI Review Sub Group, to commence at the end of May 2014. This was requested following significant increase in incidents relating to falls resulting in fractured femurs and an update will be provided in the next learning report.

The Thematic Review of In-Patient Falls has been completed and has been shared with HSC Trusts and other relevant HSC organisations.

- ***PATIENT MIS-IDENTIFICATION IN HOSPITALS***

'Misidentification of Patients/ Clients' in HSC services was identified as a theme through SAI analysis, following several reported incidents. The aim of this thematic review was to identify recurrent themes found within reported SAIs and to consider any regional actions that could be implemented to reduce the incidence of "Misidentification of Patients and Clients".

This review is currently being finalised and a number of recommended actions in relation to the findings have already commenced these include:

- Visual aids, such as posters will be designed and displayed throughout Trust wards and departments to raise awareness across all HSC staff of the importance of patient verification processes at every stage of care.

- A newsletter article "Right Patient Right Care" has been published in the PHA newsletter "Learning Matters" (no1, December 2013).This newsletter is disseminated Trust wide and its purpose is to provide service users and health service staff access to important learning.

- The Patient Safety Forum and the Royal College of Nursing (RCN) who are currently responsible for the delivery of Leadership Training to nursing staff are exploring the possibility of including a topic based on Quality improvement in Leadership for Safety with theatres and procedural areas.

The review will be issued to HSC Trusts and relevant organisations in the coming weeks.

- ***FAILURE IN REFERRAL OR FOLLOW UP PROCESS***

The Regional SAI Review Group commissioned this review following reported incidents of patients/clients not being referred or not receiving follow-up of care. The purpose of this review was to analyse SAI reports, identify regional learning and consider implementation of actions to improve systems.

This review provides a detailed analysis of SAIs relating to where a Failure in the Referral or Follow-up Process has occurred across all programmes of care, for the period 1 May 2010 to 19 July 2013. The majority of these SAIs were identified within the Acute Services Programme of Care.

From the conclusions of this review it is clear that there are multi- faceted reasons for failure in the referral or follow-up process and this learning will inform future quality improvement work. The main themes identified related to: communication, ownership and handover of documentation. Work is progressing to address the main issues from the themes identified within this report and these will be addressed through the Regional Electronic Care Record (ECR), the HSCB review of Red Flag guidelines, NICaN workplan and the Regional Hospital at Night Group.

The Thematic Review of SAIs relating to where a Failure in the Referral or Follow-up Process has been completed and shared with HSC Trusts and other relevant HSC organisations.

- ***VENOUS THROMBOEMBOLISM (VTE)***

In December 2013 a review of reported SAIs in which patients suffered venous thromboembolism (VTE) was requested by the HSCB/PHA QSE Group.

A review of all SAIs reported to the HSCB for the Acute Services Programme of Care from 1 May 2010 to 22 November, 2013 was conducted. This review identified three reported SAIs relating to VTE. In conclusion all three reports show that either risk assessment was not undertaken, or appropriate prophylactic treatment was not prescribed in line with NICE Guidelines.

PHA monitors HSC Trusts compliance with VTE risk assessment quarterly, through Quality Improvement Plan (QIP) reporting. The issues and learning from this review will be considered within a number of work streams as the PHA continues to provide support and leadership to quality improvement in prevention of VTE in hospital patients.

The Thematic Review of SAIs relating to where patients suffered VTE has been completed shared with HSC Trusts and other relevant HSC organisations;

3.0 NEWSLETTER – "LEARNING MATTERS"

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

The title of this newsletter is ‘Learning Matters’ and the first edition was issued in December 2013.

www.publichealth.hscni.net/publications

www.hscboard.hscni.net/publications/index.html

The second edition will be issued in May 2014.

SECTION 4

CONCLUSION

The HSCB/PHA are committed to learning from SAIs, improving services and reducing the risks of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following SAIs ensures that quality improvements are embedded into practice.

The NIAO Report (October 2012)[1] recognised that a regional process for reporting, managing, analysing and learning from SAIs is in place within Northern Ireland and alluded to the benefits in highlighting risks and identifying good practice through the regular reporting of SAIs..

The SAI procedure was revised in October 2013 following engagement with staff across the HSC. Since the last report three learning letters, and three thematic reviews have been disseminated to the relevant HSC organisations. Additionally the "Learning Matters" newsletter was published in December 2013, to compliment the other methods of learning and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

HSCB/PHA have recognised a need to enhance service users/families involvement in the SAI process. As a result, the HSCB and PHA have revised the SAI documentation to include a checklist to identify service users / family and, the statutory reporting to the HM Coroner (where there is a requirement to do so). The revised forms have been issued to HSC organisations for immediate use.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

1 The Safety of services provided by Health and Social Care Trusts (23 October 2012) Northern Ireland Audit Office

APPENDIX A

REVISED CRITERIA FROM 1 OCTOBER 2013

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[2] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI criteria

- serious injury to, or the unexpected/unexplained death of:
  - a service user (including those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS,*

[2] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2013 – MARCH 2014

The HSCB has **received 300 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[3] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 Oct to 31 Mar**.

Total Activity	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	49	70
HSCB	1	0
NHSCT	48	98
NIAS	4	1
NIBTS	2	1
PCARE	15	14
SEHSCT	34	38
SHSCT	25	47
WHSCT	26	31
Totals:	**204**	**300**

This is the first reporting period since the revised SAI reporting criteria was introduced in October 2013 (refer to Appendix A). Heightened awareness of the revised procedure (following the consultation and implementation), the HSC training programmes for SEA and RCA along with recent Thematic Reviews undertaken will account for some of the increases in reporting.

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **ten (10) SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	3	4
NHSCT	3	3
PCARE	2	0
SEHSCT	1	2
SHSCT	0	1
WHSCT	2	0
Totals:	**11**	**10**

[3] Source- HSCB DATIX Information System

DUPLICATE SAI NOTIFICATIONS

A notification may be received from one or more organisation but relating to the same incident. During the reporting period there were no duplicate notifications received.

TOTAL DUPLICATE	Oct 12 - Mar 13	Oct 13 - Mar 14
NHSCT	2	0
WHSCT	1	0
Totals:	**3**	0

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	16	17
NHSCT	8	36
NIAS	3	1
NIBTS	0	1
SEHSCT	8	7
SHSCT	5	7
WHSCT	2	8
Totals:	**42**	**77**

Current period: Seventy seven (77) SAIs were reported. The top five groups related to the following classifications/categories. Eighteen (18) incidents being the most reported in any one category.

Classification/category

- Treatment, procedure
- Accident that may result in personal injury
- Diagnosis failed or delayed
- Medication
- Access, Appointment, Admission, Transfer, Discharge

Since the revised criteria (see Appendix A) were introduced, there has been an increase in the number of reported incidents relating to falls; within the above classification/ catergory: accident that may result in personal injury, 16 SAIs related to slip, trips, falls and collisions.

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	4	37
NHSCT	1	8
NIAS	1	0
NIBTS	1	0
SEHSCT	0	8
SHSCT	2	12
WHSCT	0	7
Totals:	**9**	**72**

Current period: Seventy-two (72) SAIs relating to maternity and child health were reported. The revised criteria (Appendix A) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 85% of the reported SAIs (n=61) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	2	3
NHSCT	10	4
SEHSCT	1	5
SHSCT	3	1
WHSCT	1	0
Totals:	**17**	**13**

Current period: Thirteen (13) SAIs relating to family and childcare were reported. The largest classification/category group (n=10) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	3	22
SEHSCT	4	3
SHSCT	3	12
WHSCT	2	2
Totals:	**13**	**39**

Current period: Thirty-nine (39) SAIs reported related to older people services. The largest classification/category group (n=30) was 'Accident that may result in personal injury' of which 87% (n=26) related to slips, trips and falls.

MENTAL HEALTH

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	21	8
NHSCT	19	17
SEHSCT	17	10
SHSCT	12	13
WHSCT	15	10
Totals:	**84**	**58**

Current period: Fifty-eight (58) SAIs relating to adult mental health services were reported. 79% (n=46) related to suspected/attempted suicides* or unexpected deaths.

The remaining reported incidents related to the following classifications:

- Abuse
- Attempted suicide, whether proven or suspected
- Accident that may result in a personal injury

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	1	4
SEHSCT	2	2
SHSCT	0	0
WHSCT	0	1
Totals:	**4**	**7**

Current period: Seven (7) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

POC7	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	1	0
NHSCT	0	1
SEHSCT	1	0
Totals:	**2**	**1**

Current period: One SAI relating to physical disability and sensory impairment services was reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
HSCB	1	
PCARE	13	14
Totals:	**14**	**14**

Current period: Fourteen (14) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=9) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Oct 12 - Mar 13	Oct 13 - Mar 14
BHSCT	0	1
NHSCT	1	3
NIBTS	1	0
SEHSCT	0	1
SHSCT	0	1
WHSCT	3	3
Totals:	**5**	**9**

Current period: Nine (9) SAIs were reported relating to corporate business. The largest classification/category group (n=3) was 'Patient information (records, documents, test results, scans)'

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	Quality Improvement Annual Report
Agenda Item	16
Reference	PHA/09/08/14
Summary	

Introduction

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.

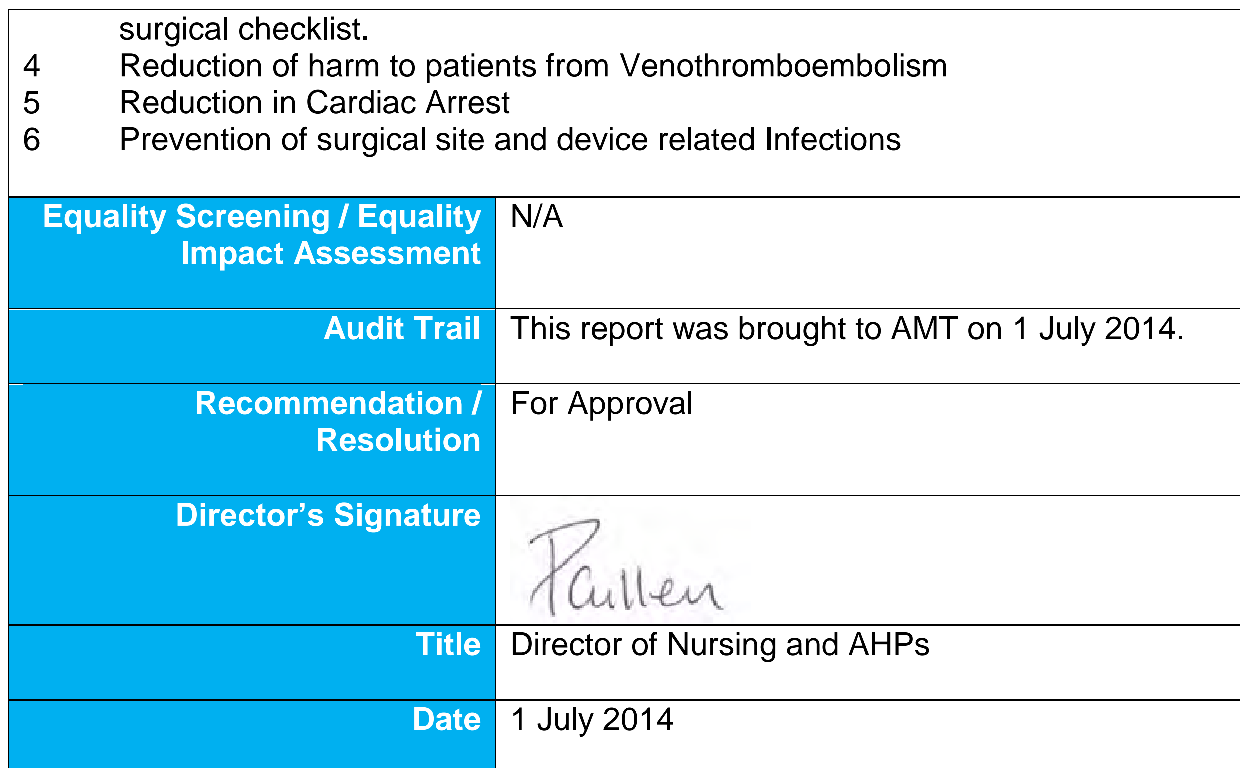
The HSC framework (DHSSPS, 2011) requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan (PHA and HSCB, 2013/14) is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety, 2013/2014 and identifies the key strategic priorities. These consider the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

Process

HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan and locally identified quality improvement initiatives. Data of agreed measures relating to the commissioning plan indicators are required to be submitted via an electronic SharePoint within six weeks of each quarter end. An escalation protocol has been agreed in the event timely submissions are not received. This data is reviewed and analysed by the Quality, Safety and Experience Team, PHA and used to inform this report. The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

The key areas covered in this report are:

1 Prevention of Pressure Ulcers
2 Reduction of Harm from Falls
3 Prevention of harm to patients undergoing surgery and procedures- WHO



surgical checklist. 4 Reduction of harm to patients from Venothromboembolism 5 Reduction in Cardiac Arrest 6 Prevention of surgical site and device related Infections	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 1 July 2014.
Recommendation / Resolution	For Approval
Director's Signature	P Cullen
Title	Director of Nursing and AHPs
Date	1 July 2014

Quality Improvement Annual Report

2013-14

June 2014

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1.0 INTRODUCTION

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.

The HSC framework (DHSSPS, 2011) requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan (PHA and HSCB, 2013/14) is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety, 2013/2014 and identifies the key strategic priorities. These consider the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

The purpose of this report is to provide an annual report which demonstrates the progress in relation to quality improvement in key areas identified in The HSCB / PHA Commissioning Plan and Trusts QIPS. The information will provide assurance to commissioners that patient and client healthcare services are being provided to the required standard in these priority areas. The report is intended to compliment key information available from other sources, for example Patient Client Experience monitoring, Complaints and Serious Adverse Incident (SAI) reporting.

HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB PHA Commissioning Plan and locally identified quality improvement initiatives. The framework for reporting and review including definitions of each quality indicator and measures of improvement have been developed by the PHA in collaboration with HSC Trusts, this can be found in Appendix 1.

Data of agreed measures relating to the commissioning plan indicators are required to be submitted via an electronic SharePoint within six weeks of each quarter end. An escalation protocol has been agreed in the event timely submissions are not received. This data is reviewed and analysed by the Quality, Safety and Experience Team, PHA and used to inform this report.

The key areas covered in this report are:

1 Prevention of Pressure Ulcers

2 Reduction of Harm from Falls

3 Prevention of harm to patients undergoing surgery and procedures- WHO surgical checklist.

4 Reduction of harm to patients from Venothromboembolism

5 Reduction in Cardiac Arrest

6 Prevention of surgical site and device related Infections

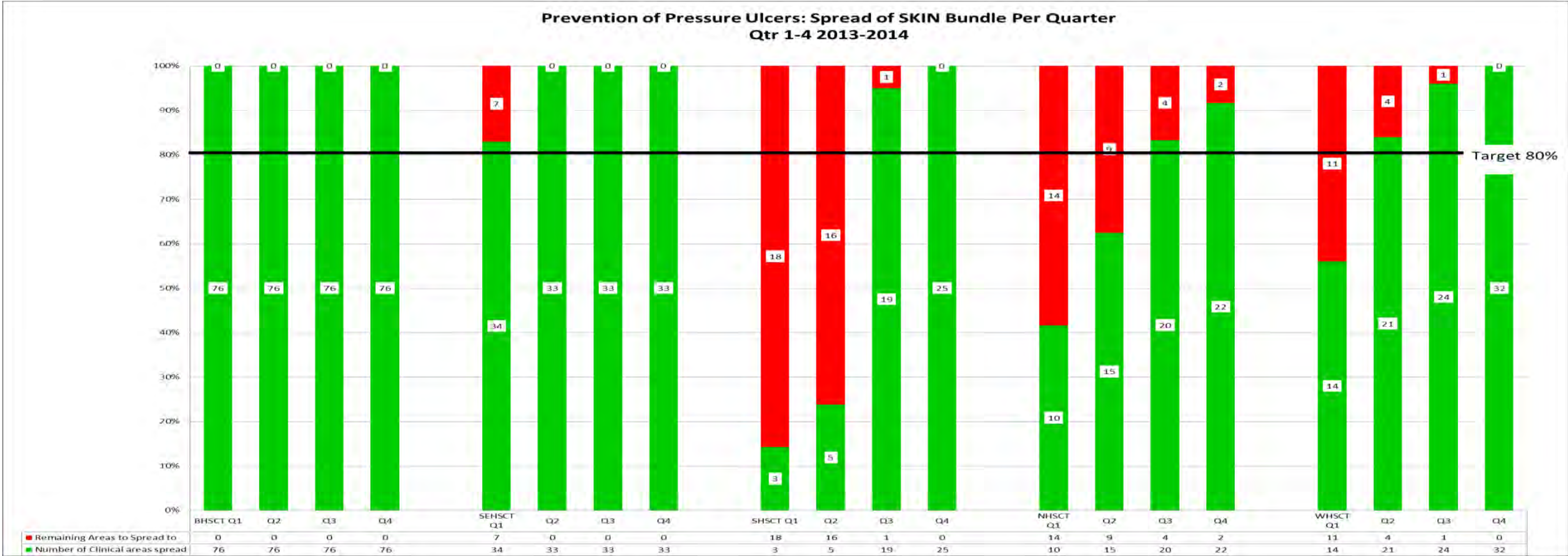
The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives.

Update on QIP Indicators

Prevention of Pressure Ulcers

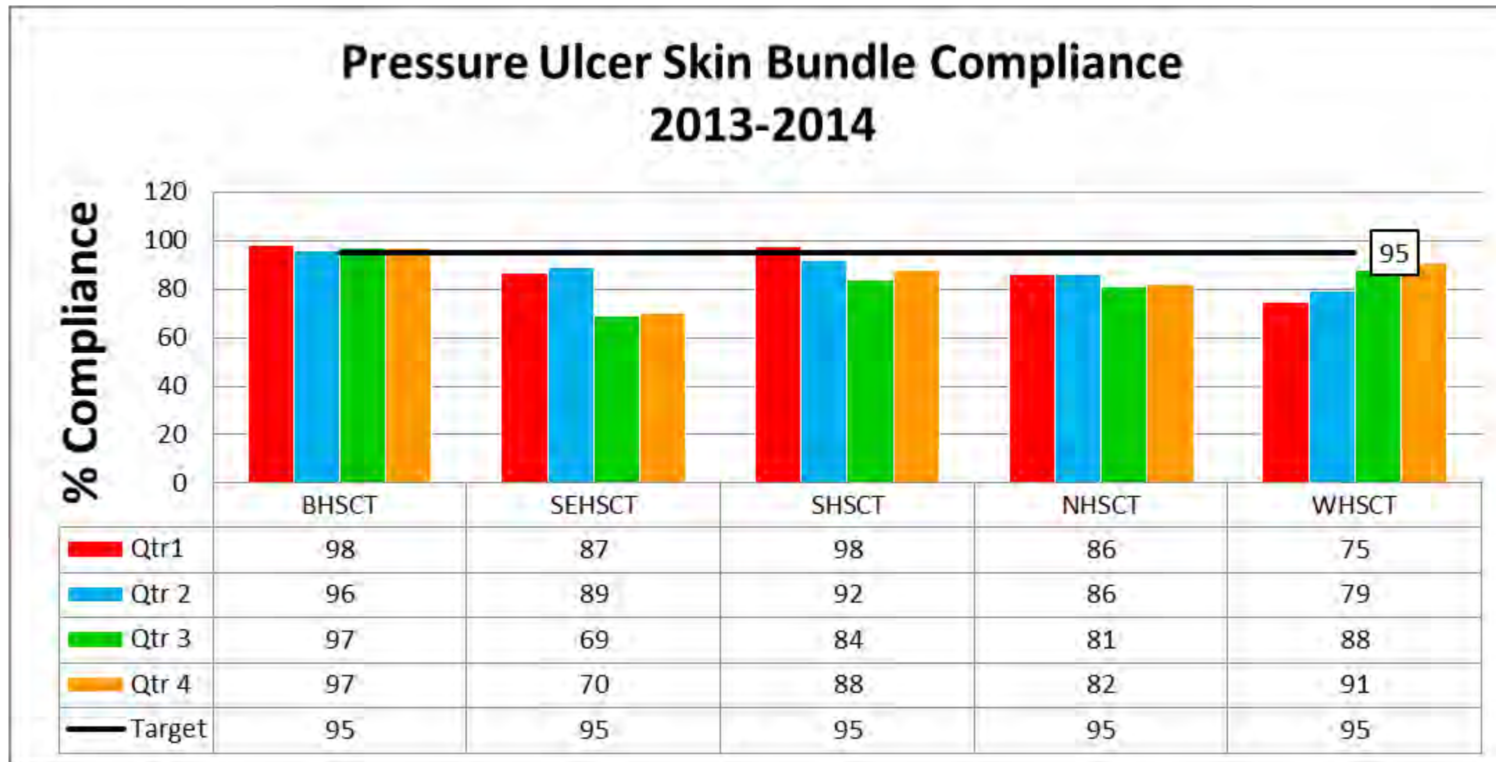
2013-2014 Commissioning Plan requirement; – Trust will spread the SKIN Bundle to 80% of all adult inpatient areas / Wards ensuring 95% compliance by March 2014.Trusts will monitor and provide reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days.

Diagram 1



	BHSCT Q1	Q2	Q3	Q4	SEHSCT Q1	Q2	Q3	Q4	SHSCT Q1	Q2	Q3	Q4	NHSCT Q1	Q2	Q3	Q4	WHSCT Q1	Q2	Q3	Q4
Remaining Areas to Spread to	0	0	0	0	7	0	0	0	18	16	1	0	14	9	4	2	11	4	1	0
Number of Clinical areas spread	76	76	76	76	34	33	33	33	3	5	19	25	10	15	20	22	14	21	24	32

Diagram 2



	BHSCT	SEHSCT	SHSCT	NHSCT	WHSCT
Qtr1	98	87	98	86	75
Qtr 2	96	89	92	86	79
Qtr 3	97	69	84	81	88
Qtr 4	97	70	88	82	91
Target	95	95	95	95	95

Analysis of Results from Prevention of Pressure Ulcer Feedback

Whilst some pressures ulcers are unavoidable, many are preventable. The SKIN Bundle is an evidence based collection of interventions proven to prevent pressure ulcers. PHA supports HSC Trusts through The Regional Prevention of Pressure Ulcer Quality Improvement Collaborative to Implement SKIN in all Hospitals in Northern Ireland

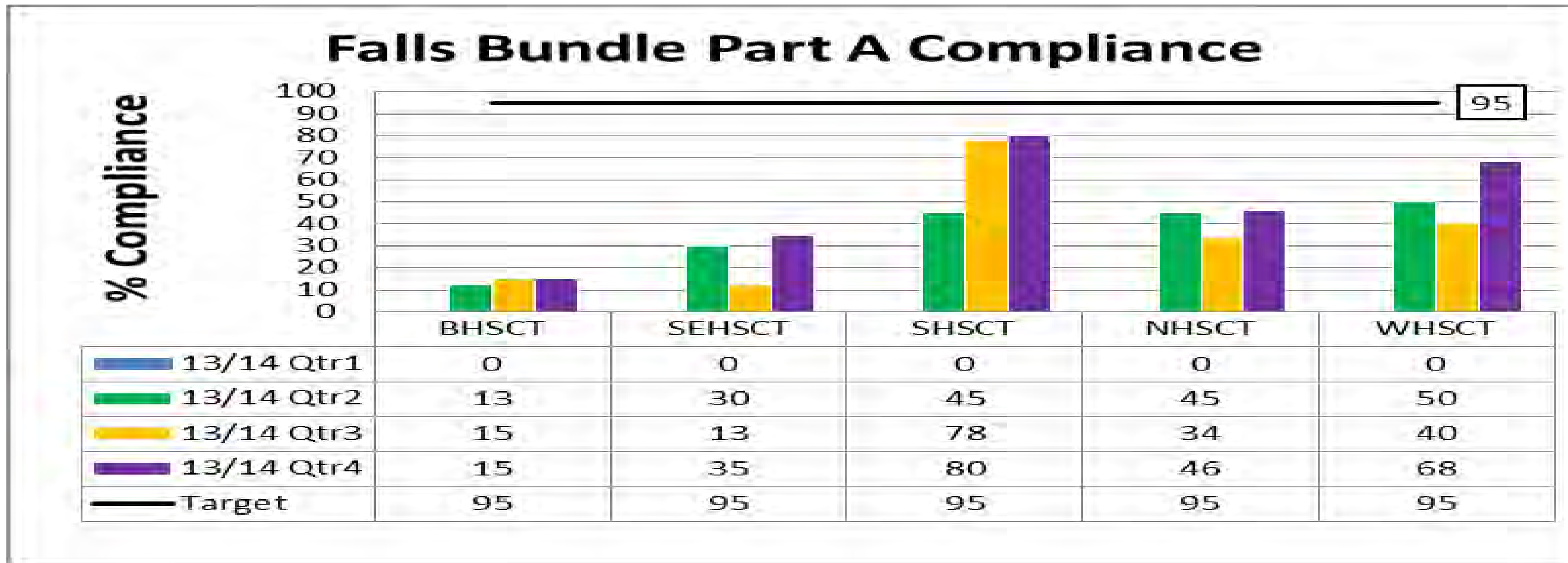
Whilst the indicator required the Trusts to have spread the SKIN Bundle to over 80% of all adult inpatient areas, four of the five Trusts spread to 100% of all adult inpatient areas, the NHSCT spread to 92% of the required areas. The SKIN Care Bundle is a powerful tool as it defines and ties best practices together. The bundle also makes the actual process of preventing pressure ulcers visible to all. This minimises variation in care practices. A process is a series of actions which are required in order to achieve a desired outcome (such as a reduction in the number of pressure ulcers). Reliably delivering all elements of the care bundle at every care opportunity, will improve the pressure area care that a person receives. This will have impact on improving care outcomes. This has provided a challenge for achieving the pressure ulcer compliance due to staff enthusiasm and belief in the value of the SKIN Bundle in the pilot areas where 95% compliance was being achieved, BHSCT and SET has an extra year to spread and achieve compliance as they had initially been in the national project for the ‘1000 lives campaign’. BHSCT have reported 96-98% compliance consistently throughout the year with all elements of the bundle. SET introduced a new reporting system in the 3rd quarter of the year, which combined all their full KPI for prevention of pressure ulcers which exceeded the reporting requirements of the bundle, they were not able to report in only on the four elements of the bundle, hence the reduction in compliance with quarter 3 & 4. They have been able however to change this for the incoming year and will be able to report on individual elements. The Tissue Viability Team have confirmed that from their independent audits for the last two quarters, the four SKIN bundle elements compliance rates are between 90-95%.

Within the NHSCT, SHSCT & the WHSCT the SKIN Bundle was spread quickly across adult inpatient areas, throughout 2013/14.there has been challenge in relation to compliance for these Trust due to the bundle being spread into new areas each quarter and thus compliance with the new areas reduced overall percentage compliance until that area achieved reliability with the process. At the end of quarter 4 these Trusts are reporting over 80% compliance with the bundle, which should improve over the next year and lead to achieving the target for next year ‘by March 2015 trust will secure a 10% reduction in pressure ulcers.’

Prevention of Harm from Falls in Hospitals

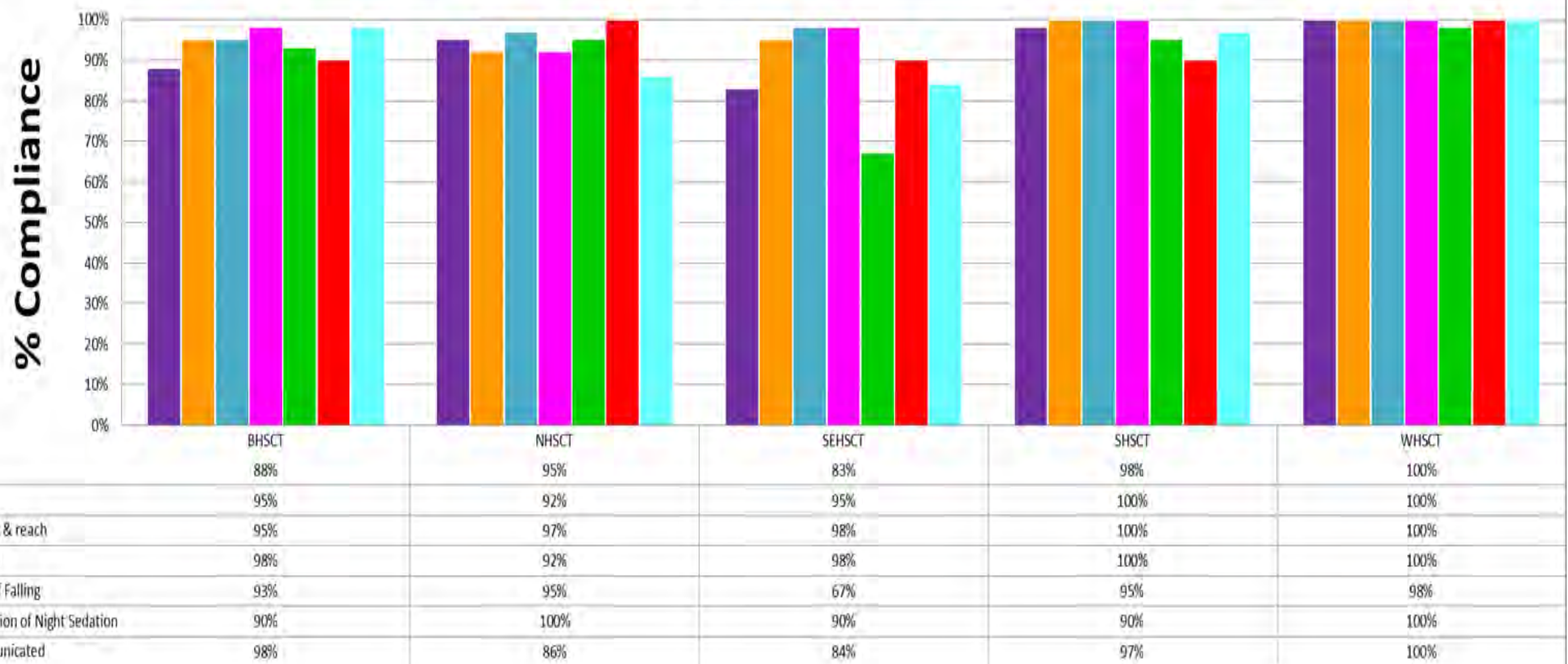
2013-2014 Commissioning Plan requirement; – Trusts will put in place a test and spread plan to ensure 95% compliance with a Falls Bundle in identified pilot clinical areas by March 2014. Trusts will monitor and provide reports on bundle compliance and the incidents of falls per 1,000 bed days.

Diagram 3



	BHSCT	SEHSCT	SHSCT	NHSCT	WHSCT
13/14 Qtr1	0	0	0	0	0
13/14 Qtr2	13	30	45	45	50
13/14 Qtr3	15	13	78	34	40
13/14 Qtr4	15	35	80	46	68
Target	95	95	95	95	95

Diagram 4



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
A: Call Bell	88%	95%	83%	98%	100%
A: Safe Footwear	95%	92%	95%	100%	100%
A: Personal Items in sight & reach	95%	97%	98%	100%	100%
A: No Trip or Slip Hazard	98%	92%	98%	100%	100%
A: Asked about History of Falling	93%	95%	67%	95%	98%
A: Avoidance of perscription of Night Sedation	90%	100%	90%	90%	100%
A: Mobility Status communicated	98%	86%	84%	97%	100%

Analysis of Results from Prevention of Falls

There is evidence that falls are a significant cause of harm to patients in receipt of health and social care in Northern Ireland. Falls are among the top five (5) most frequent adverse incidents reported within Health and Social Care (HSC) Trusts All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy. Research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions.

The PHA leads a project to implement The Royal College of Physicians 'Fallsafe' bundle in hospitals in Northern Ireland. This is an evidence based bundle of interventions for falls reduction.

In quarter 1 a regional Falls in Hospital steering group established the evidence based interventions available and agreed to pilot the Royal College of Physicians 'Fallsafe' Bundle. A Pilot commenced in 2 wards in each trust in June 2013, baseline data on bundle A compliance was first reported in Quarter 2. Some Trusts have made progress with implementing the 'Fallsafe' bundle. All pilot areas are facing considerable challenges in achieving 95% with the multiple elements of the bundle. Part A - 7 elements. Diagram 3 shows overall compliance with all elements of the bundle was low, ranging from 15% to 80%.

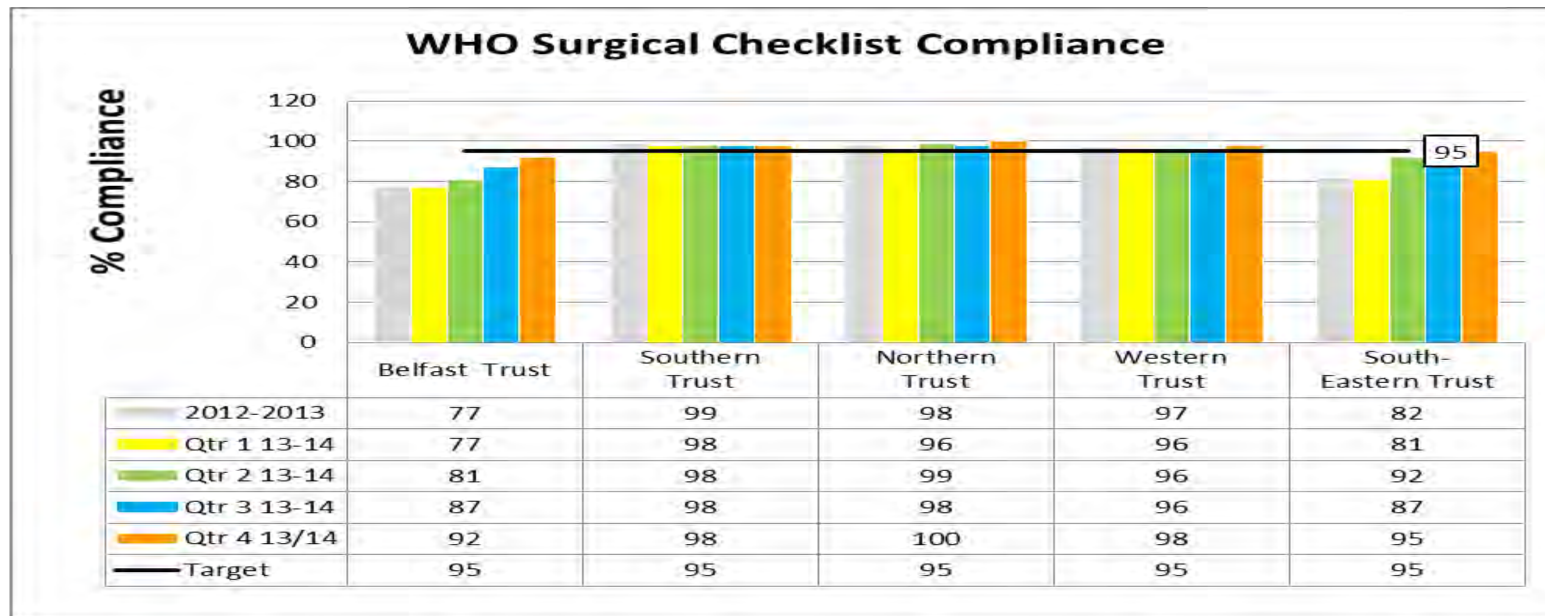
The Trusts have worked very hard towards achieving compliance with all elements of Part A in the bundle, but following analysis of the data, the two elements providing the main challenge were that the current recording documentation does not take into account anywhere that patients are asked about a fear of falling nor currently is urinalysis routinely carried out, therefore these were the two areas which were non complaint. The new regional nursing documentation will include routine urinalysis and a question asking patients about a fear of falling, which should significantly improve compliance once this is introduced. Diagram 2 shows compliance with all other elements of Part A of the bundle (without the elements - asked about a fear of falling and routine urinalysis).

Four elements of Part B of the Bundle have been introduced in quarter four to the pilot areas; these will be reported on in the next year 2014/15 in addition to Part A of the bundle.

WHO Surgical Checklist

2013-2014 Commissioning Plan requirement; – Trusts will achieve at least 95% compliance with completion of the WHO Surgical Safety Checklist across all theatre and procedural areas by March 2014.

Diagram 5



	Belfast Trust	Southern Trust	Northern Trust	Western Trust	South-Eastern Trust
2012-2013	77	99	98	97	82
Qtr 1 13-14	77	98	96	96	81
Qtr 2 13-14	81	98	99	96	92
Qtr 3 13-14	87	98	98	96	87
Qtr 4 13/14	92	98	100	98	95
Target	95	95	95	95	95

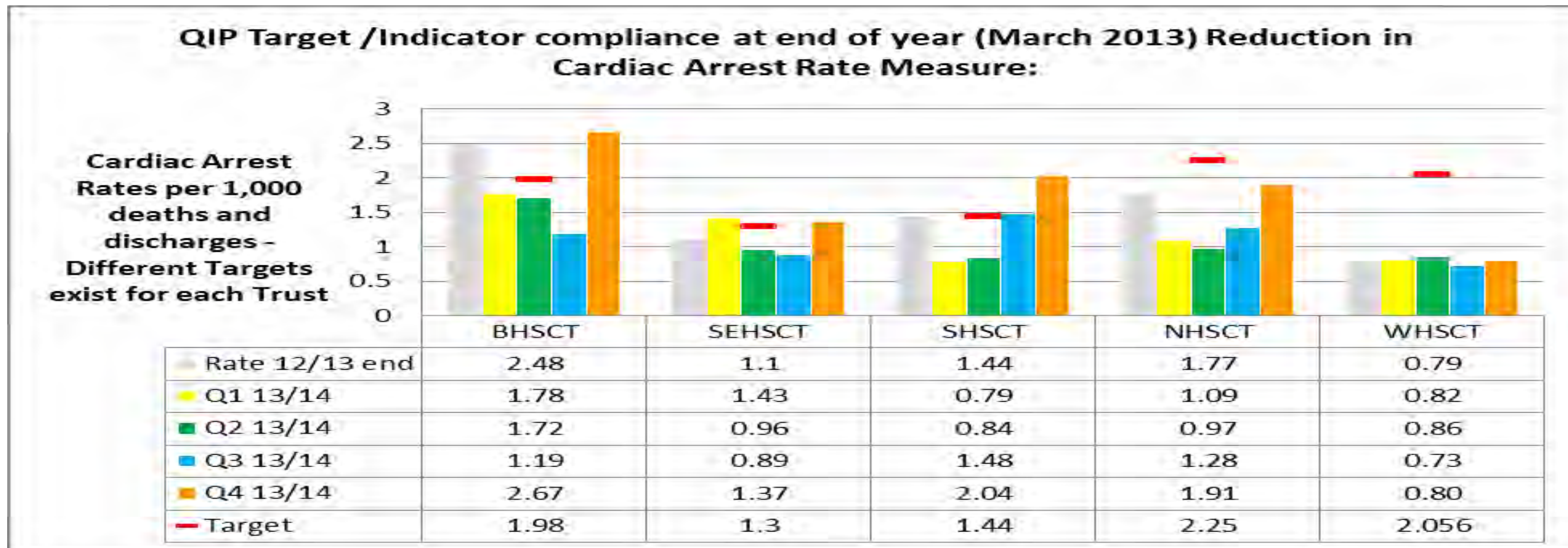
Analysis of WHO Surgical Checklist Compliance

WHO surgical checklist identifies critical steps, which if followed by health care professionals, minimize the most common and avoidable risks endangering the lives and well-being of patients undergoing surgical procedures. All Trusts have shown steady compliance in relation to compliance with the WHO surgical checklist, four of the five Trusts have achieved 95% or more. BHSCT has achieved 92% and have a plan in plan to ensure it is introduced to the remaining areas in the next quarter, these include all procedural areas.

Reduction in Cardiac Arrest Rates

2013-2014 Commissioning Plan requirement; - Crash Call Rates –Trusts will achieve agreed 20% from baseline reduction or maintain if achieved.

Diagram 6



	BHSCT	SEHSCT	SHSCT	NHSCT	WHSCT
Rate 12/13 end	2.48	1.1	1.44	1.77	0.79
Q1 13/14	1.78	1.43	0.79	1.09	0.82
Q2 13/14	1.72	0.96	0.84	0.97	0.86
Q3 13/14	1.19	0.89	1.48	1.28	0.73
Q4 13/14	2.67	1.37	2.04	1.91	0.80
Target	1.98	1.3	1.44	2.25	2.056

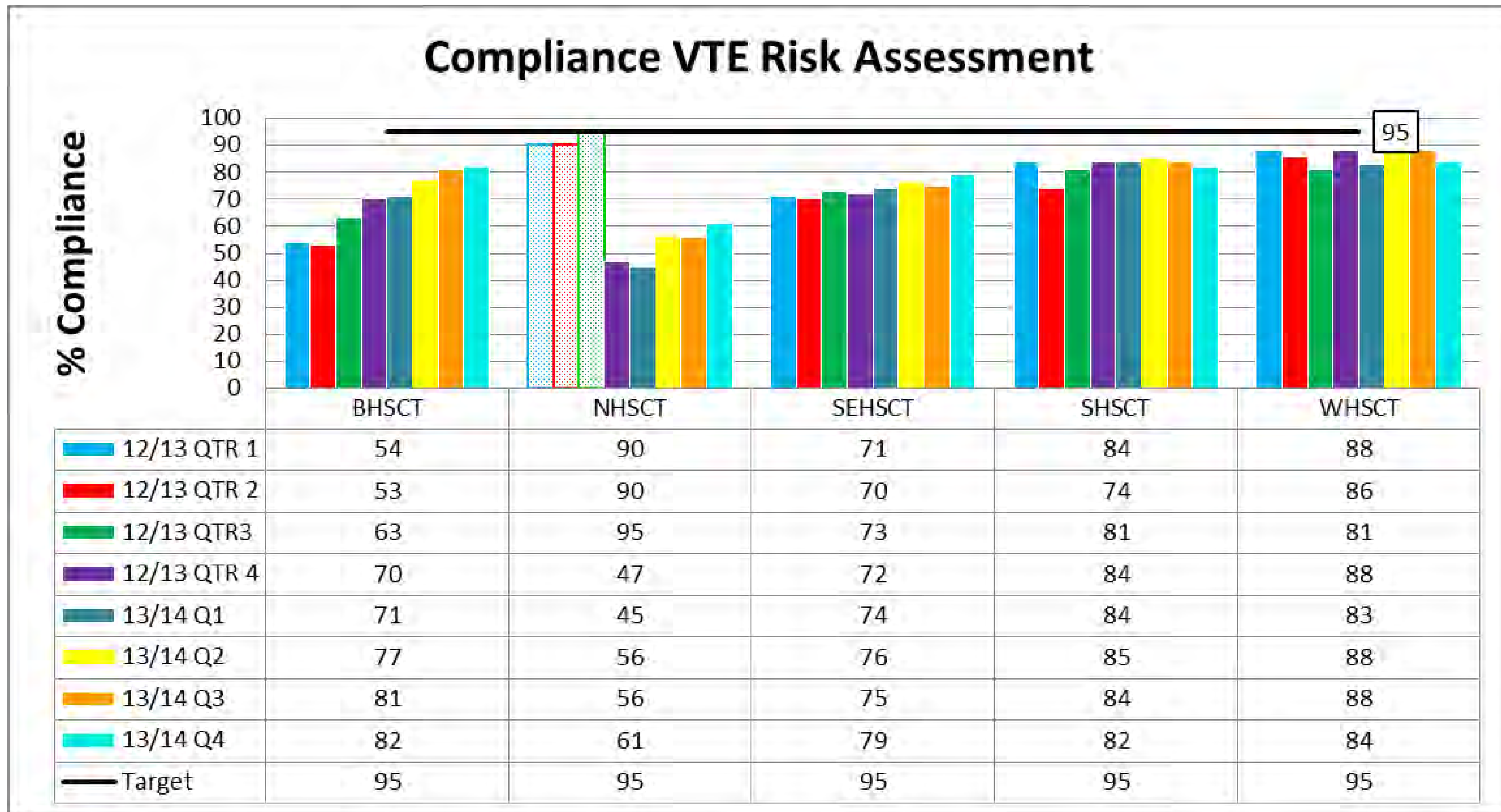
Analysis of Reduction in Cardiac Arrest Rates

All Trusts have achieved compliance with their targets for this reduction over the year. The SHSCT and BHSCT had been within their target rate until the last quarter, but had an increase due to seasonal demands, for example the cardiac arrest target in the SHSCT was 2.04 over for the last quarter but cumulatively for the whole year April 2013 to March 2014 they meet the annual target – they achieved 1.32 (74 Crash Calls) per 1,000 Deaths/Discharges, which was below goal of 1.44 (82 Crash Calls). However all the Trusts' cumulate Crash Call Rates for 13/14 were within their target for the year.

Preventing Harm from VTE

2013-2014 Commissioning Plan requirement; - Trusts will improve compliance with VTE risk assessment across all inpatient units/wards to achieve 95% compliance with appropriate VTE prophylaxis prescribing in all clinical areas by March 2014.

Diagram 7



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
12/13 QTR 1	54	90	71	84	88
12/13 QTR 2	53	90	70	74	86
12/13 QTR3	63	95	73	81	81
12/13 QTR 4	70	47	72	84	88
13/14 Q1	71	45	74	84	83
13/14 Q2	77	56	76	85	88
13/14 Q3	81	56	75	84	88
13/14 Q4	82	61	79	82	84
Target	95	95	95	95	95

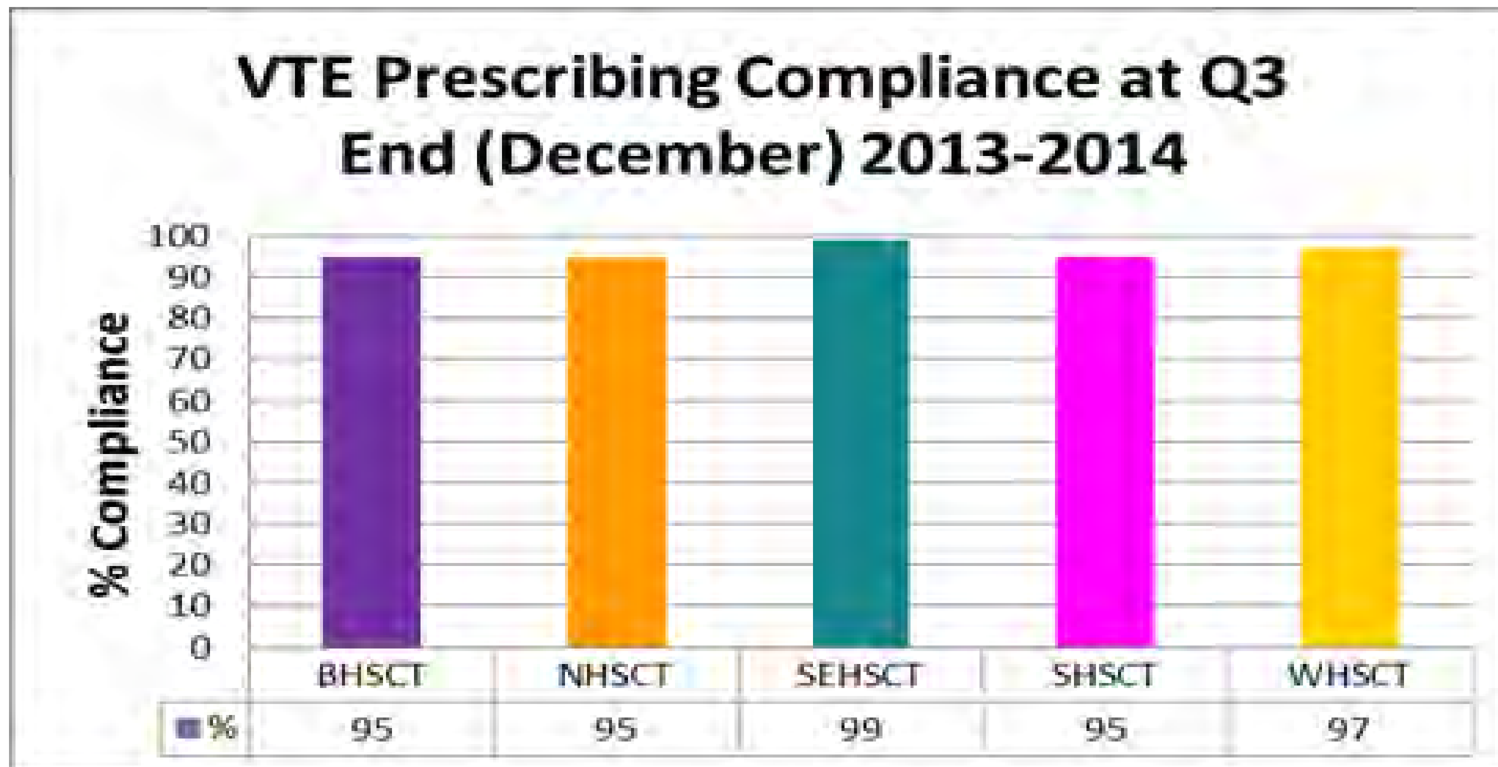
Analysis of Preventing Harm from VTE

VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DHSSPS and implemented in Northern Ireland. Assessing the risks of VTE and bleeding is a key priority for implementation of the guidelines.
Whilst not completely achieving the goal of 95% compliance, within all Trusts, across the region, the results do demonstrate a closing of the gap between minimum and maximum results. Trusts reported they found it a significant challenge in achieving compliance with the risk assessment for VTE but all are committed towards achieving improvement.
This graph demonstrates that all Trusts have increased the number of risk assessments which have been conducted FROM April 2012 to March 2014. Within the **NHSCT:** Quarter's 1 – 3 2012/2013 for the NHSCT were Maternity only – This issue was addressed at NHSCT accountability meeting and they have now a plan in place to improve compliance with risk assessment across all inpatient units/wards and have shown steady improvement . All other Trusts have indicated that whilst they did not achieve the spread plan to all adult inpatient areas by the end of March 2014, plans are in place to progress this work.

VTE Prophylaxis Prescribing

In relation to VTE prophylaxis prescribing in all clinical areas, it was agreed regionally that HSC Trusts would report compliance with this once during the year. This was submitted at the end of quarter 3 (December 2013), all Trusts have reported compliance as 95% or above in relation to this measure.

Diagram 8



Surgical Site and Device associated Infection surveillance programme

2013-2014 Commissioning Plan requirement; - Trusts will improve Surgical Site Infection surveillance; Trusts will achieve 100% compliance with device associated surveillance in I.C.U. (VAP, CLABSI and CAUTI) and at least 95% compliance with Neurosurgery, C-Section and Orthopaedic SSI Surveillance. These are analysis separately as part of the Health Protection Teams work.

Diagram 9

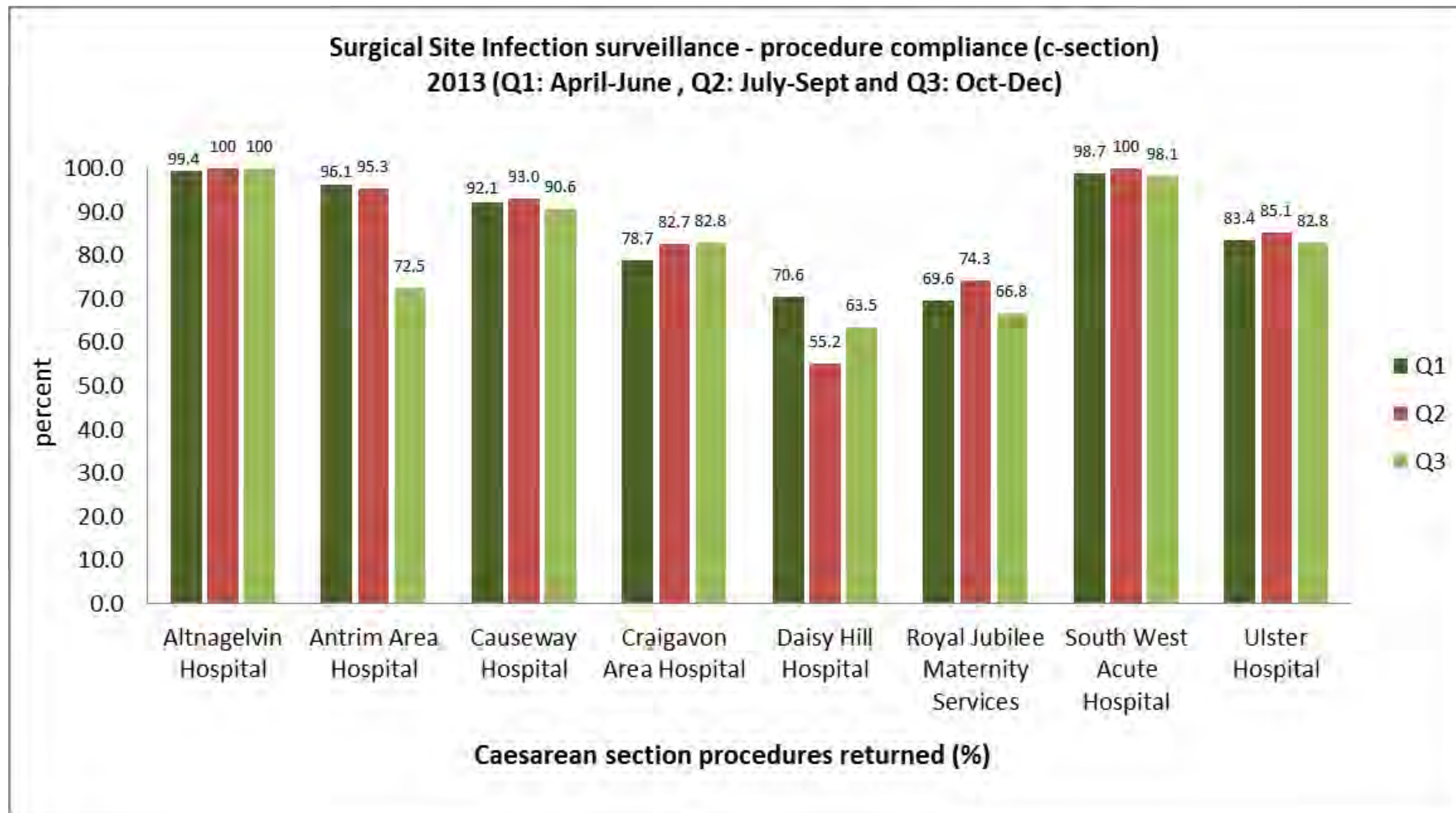
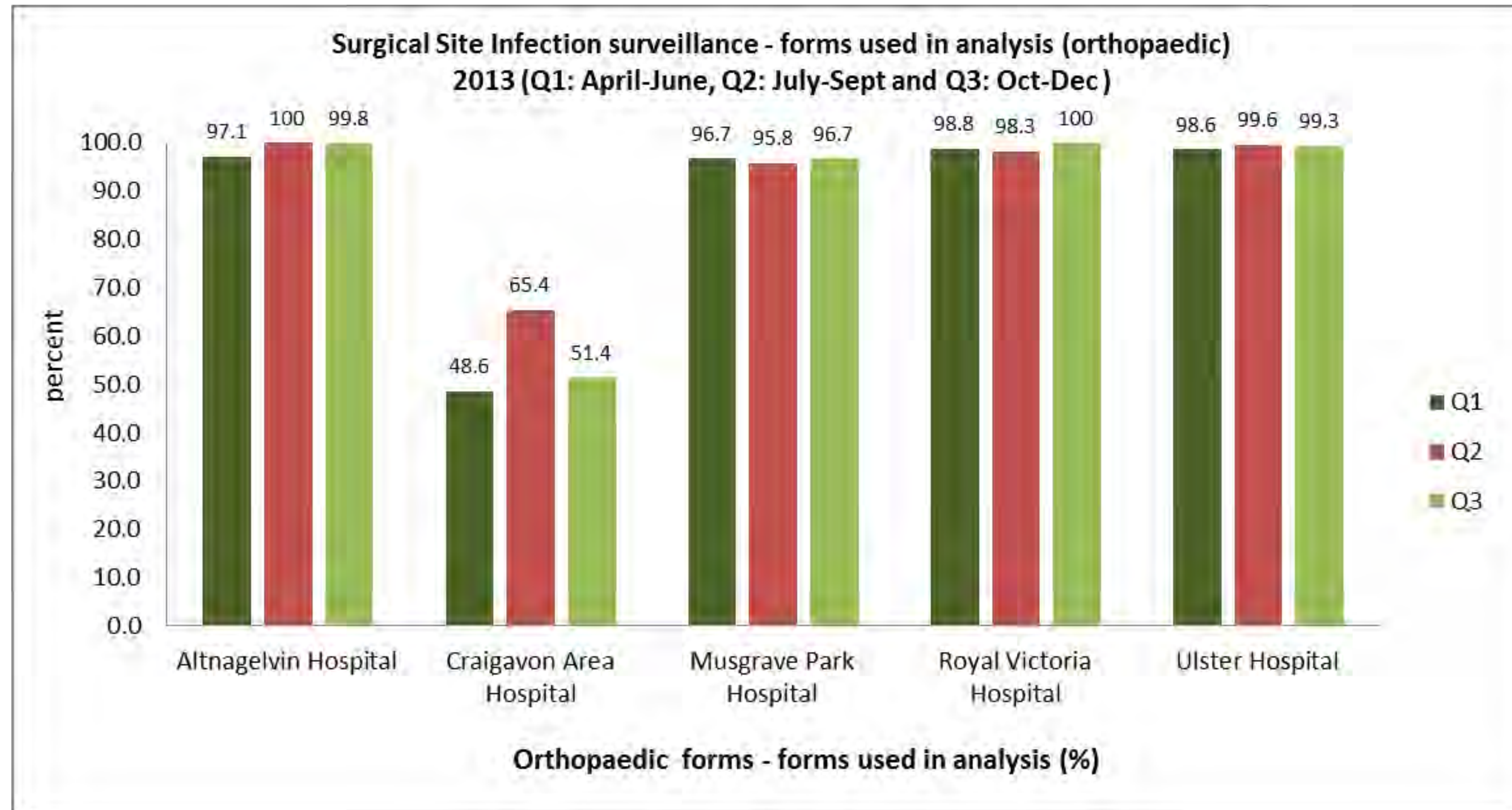


Diagram 10



NB: each of the two graphs shown above are used to measure slightly different things:

- Caesarean section procedures returned by each hospital
- Orthopaedic forms used in analysis (as a percentage of all those returned)
- Some figures may have changed for earlier quarters as additional forms have come in since the last figures were extracted.

Future Plans

An annual cycle of work to develop future indicators and definitions has been established. The PHA have worked collaboratively with Trusts from October 2013 to identify key quality indicators for Health and Social care which will influence core commissioning indicators. Attention has been given to aligning the QIP Indicators with the work of Quality 2020 Annual quality Report.

HSC Trusts will continue to submit to PHA, an annual Quality Improvement Plan which will include the indicators identified in the HSCB PHA Commissioning Plan and locally identified quality improvement initiatives. The framework for reporting and review including definitions of each quality indicator and measures of improvement has been developed by the PHA in collaboration with HSC Trusts, for 2014/15.

Data of agreed measures relating to the commissioning plan indicators will be submitted to the HSCB/PHA via an electronic SharePoint within six weeks of each quarter end. An escalation protocol is in place in the event timely submissions are not received.

PHA is committed to developing a suite of quality indicators which encompass the totality of Health and Social in Northern Ireland and plans to explore indicators for care in the community, mental Health, child and maternal health and social care.

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Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 August 2014
Title of Paper	Review of Respiratory Services Framework
Agenda Item	17
Reference	PHA/10/08/14

Summary

Updated Respiratory Services Framework

This paper seeks formal HSCB and PHA Board approval of the attached updated Respiratory Service Framework for onward transmission to the DHSSPS and public consultation.

1. Introduction

The DHSSPS commenced development of the Service Frameworks Programme in January 2007. The aim of the frameworks is to set specific standards for health and care that are capable of being measured and which will improve the way that health and social care is planned, commissioned and delivered in Northern Ireland. The standards are based on the best available evidence of the treatments and services that work most effectively for patients and will promote and secure better integration of service delivery along the whole pathway of care from prevention of disease/ill health to diagnosis/treatment and rehabilitation, and on to end of life care. One of the main strengths of each framework is that it is inclusive, having been developed in partnership with health professionals, patients, carers, health service managers, voluntary agencies and others with a particular expertise in each field of care.

At present there are Service Frameworks for six service areas, namely, Cardiovascular, Cancer, Respiratory, Mental Health, Learning Disability and Older People. A Service Framework for Children and Young People is currently in development.

An internal group, made up of HSCB and PHA Directors has been established in order to ensure effective oversight arrangements are in place for the development, implementation and monitoring of service frameworks. Leads have also been appointed to coordinate the implementation of each framework. Overall responsibility for the Service Framework Programme sits with the Department – a regional steering group chaired by the CMO and comprises senior officers from the Department, HSCB and PHA meets six-monthly.

Respiratory Framework

The first Respiratory Service Framework ran from 2010/11 to 2012/13. It comprised a total of 56 standards and a large number of key performance indicators relating to

a range of respiratory diseases both for adults and children and across primary, community, secondary and tertiary care services. The framework was developed on a chronic disease management model, especially for common conditions such as asthma and COPD.

In March 2014, the RQIA published a review of the implementation of the framework. The review was overall very positive and supportive. There was a general consensus that the framework had facilitated service improvement and development during the implementation period. There was a strongly held view that the momentum generated by the framework needed to be maintained through the development of a revised framework which would build on the successes of the original framework document.

The Respiratory Service Framework has recently been reviewed using the collaborative approach on which framework developments are based. A wide range of stakeholders have been actively involved and engaged throughout the review, including:

- GPs and practice nurses
- Voluntary organisations
- Patients and carers
- HSCB / PHA representation, including integrated care, nursing, AHPs, commissioning teams and ICPs

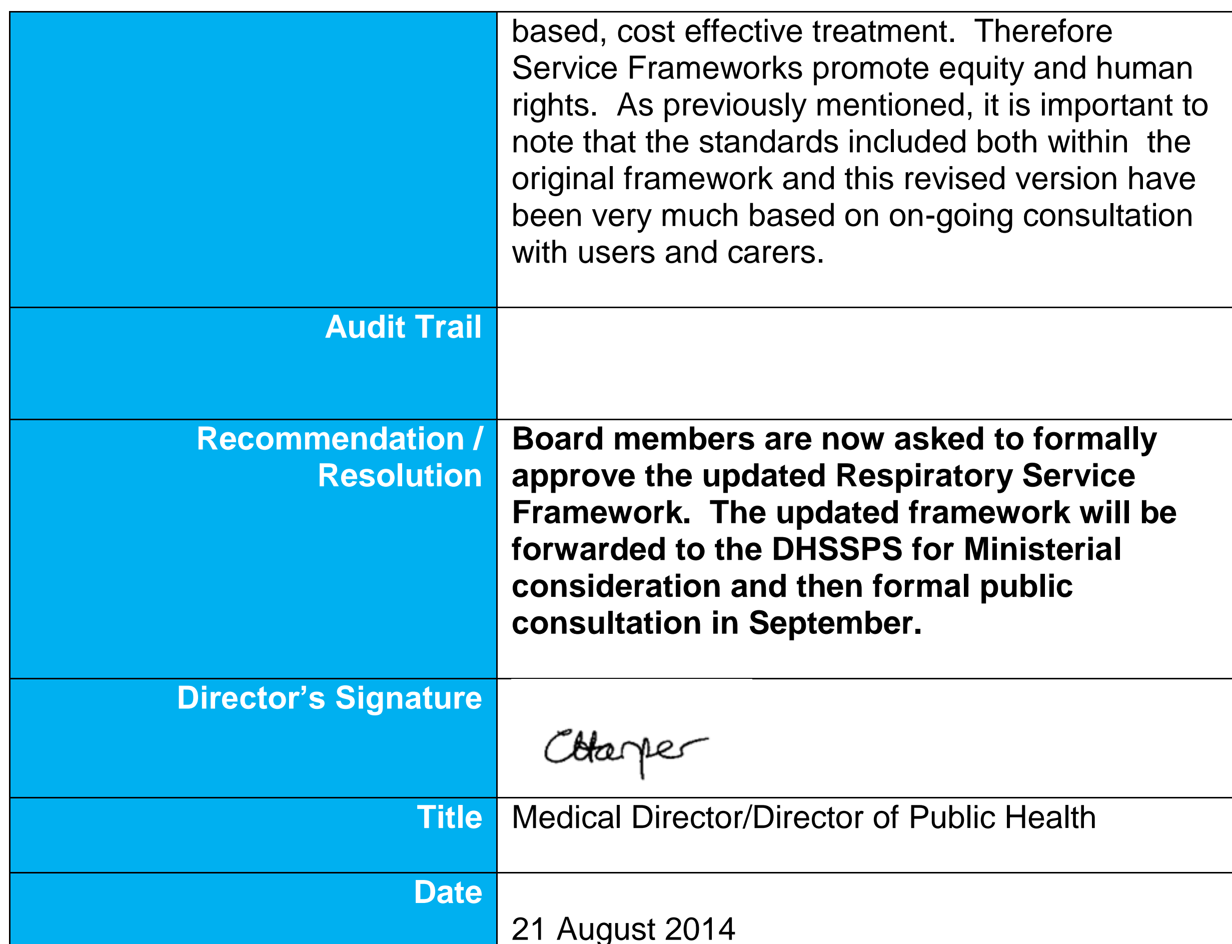
The revised framework document has already undergone wide consultation within the HSCB, PHA, Trusts and relevant Voluntary Organisations. It comprises 21 sections, 46 standards and 166 individual key performance indicators covering an extended range of respiratory conditions and illnesses. The performance indicators within the revised framework are more specific and targeted, based on the detailed baseline information available from the previous framework. As in the previous framework, performance indicators will be measured using a variety of methods including self-assessment against service specifications, methods which were particularly recognised by the RQIA review and recommended for all Service Frameworks.

The provisional timeline is that the revised framework will be issued by the Department for public consultation in the early Autumn with a view to it being formally launched for implementation from April 2015 for a period of three years (i.e. up to 2017/18).

2. Financial implications

Many of the standards contained in the Framework do not require additional resources as they are focussed on quality improvement and should be capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, these will be sought through existing financial planning, service development and commissioning processes; performance levels will be set in the light of competing priorities and available resources in any one year.

Equality Screening / Equality Impact Assessment	One of the key functions of Service Frameworks is to reduce inequality in service provision, and to ensure that everyone has access to evidence



	based, cost effective treatment. Therefore Service Frameworks promote equity and human rights. As previously mentioned, it is important to note that the standards included both within the original framework and this revised version have been very much based on on-going consultation with users and carers.
Audit Trail	
Recommendation / Resolution	**Board members are now asked to formally approve the updated Respiratory Service Framework. The updated framework will be forwarded to the DHSSPS for Ministerial consideration and then formal public consultation in September.**
Director's Signature	
Title	Medical Director/Director of Public Health
Date	21 August 2014

Respiratory Services Framework - 2014/15 to 2016/17 (21 sections, 46 Standards, 166 KPI's) - Primary Care

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
ADULT COPD	10	All people suspected of having COPD should have accurate early diagnosis, assessment and management in primary care.	A	Percentage (%) of GP practices that develop a register of patients who are smokers and/or ex-smokers, over 35 and on short acting beta agonists to facilitate case finding for COPD.	Regional LES	**Regional LES**	PRIMARY CARE			All practices to have developed registers	
ADULT COPD			B	Percentage (%) of people with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 15 months after entering on to the register.	QOF	**QOF**	PRIMARY CARE		60%	80%	
ADULT COPD			C	Percentage (%) of patients with COPD with a record of FEV1 in the preceding 15 months.	QOF	**QOF**	PRIMARY CARE			75%	
ADULT COPD			D	Percentage (%) of people with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months.	QOF	**QOF**	PRIMARY CARE		70%	90%	
ADULT COPD			E	Percentage (%) of people with a diagnosis of COPD and an MRC breathlessness score of >3 and/or functional breathlessness who have been referred for pulmonary rehabilitation.	Regional LES	**Regional LES**	PRIMARY CARE			70%	
ADULT COPD			F	Percentage (%) of people with COPD and Medical Research Council dyspnoea grade greater/equal to 3 at any time in the preceding 12 months, with a record of oxygen saturations value within the preceding 15 months.	QOF	**QOF**	PRIMARY CARE		70%	90%	
ADULT COPD			G	Percentage (%) of people with COPD with Sp02 levels <92% who are referred to the local Home Oxygen Assessment and Review (HOS-AR) service.	Regional LES	**Regional LES**	PRIMARY CARE			90%	
ADULT COPD			H	Percentage (%) of people with COPD who smoke, who have had appropriate smoking advice.	Regional LES	**Regional LES**	PRIMARY CARE		90%	95%	
ADULT COPD			I	Percentage (%) of people with COPD who have had influenza immunisation in the preceding 1 September to 31 March.	QOF	**QOF**	PRIMARY CARE		95%		

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level		
									Mar-16	Mar-17	Mar-18
ADULT COPD	11	**Specialist community team care** - All people with COPD who meet the referral criteria should have access to the services provided by specialist respiratory teams in the community.	A	Percentage (%) of people with severe/very severe COPD who are under the care of the Specialist Community Respiratory Team .	Regional LES (to be agreed)	**Regional LES**	PRIMARY CARE			Establish Baseline	Performance levels agreed
ADULT COPD	12	**Self-management** - All people with COPD and their carers should be given the opportunity to learn about their disease. Those meeting the criteria for pulmonary rehabilitation and case management should receive supported self management as part of their care.	A	Percentage (%) of people with COPD given individualised, face to face information and a written self-management action plan.	Regional LES	**Regional LES**	PRIMARY CARE		90%		95%
ADULT COPD			B	Percentage (%) of people attending pulmonary rehabilitation programmes who have received individualised, face-to-face information and an updated written self-management action plan.	HSC Trust report	**Trust Report**	SECONDARY CARE		70%		90%
ADULT COPD			C	Percentage (%) of people with COPD receiving case management from specialist community respiratory teams who have received individualised, face-to-face information and an updated written self-management action plan.	HSC Trust report	**Trust Report**	SECONDARY CARE		70%		90%
ADULT COPD	13	**Management of acute exacerbations** - All patients with an acute exacerbation of COPD should be managed to an optimal standard in an appropriate setting.	A	Percentage (%) of GP practices with a red flag system to identify people presenting with an acute exacerbation of COPD in GP practices, OoH, emergency departments or ambulatory care settings.	Regional LES (to be agreed)	**Regional LES**	PRIMARY CARE	**ICP**		Establish Baseline	Performance levels agreed
ADULT COPD			B	Percentage (%) of people with an acute exacerbation of COPD presenting in GP practices, OoH, emergency departments or ambulatory care settings with a record of follow-up (telephone or face-to-face) within 14 days of the episode by the GP, practice nurse, community or secondary care.	Regional LES (to be agreed)	**Regional LES**	PRIMARY CARE	**ICP**		Establish Baseline	Performance levels agreed
ADULT COPD			C	Percentage (%) of people with COPD admitted to hospital for more than 24 hours, with an exacerbation who receive care from a respiratory team.	Regional Discharge Audit / PAS	**AUDIT**	SECONDARY CARE	**ICP**	50%		70%
ADULT COPD			D	Managed in a respiratory ward or formally designated respiratory area within a ward.	Regional Discharge Audit / PAS	**AUDIT**	SECONDARY CARE	**ICP**	50%		70%

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
ADULT COPD			E	Smoking status should be documented on all people admitted with an exacerbation of COPD and advice on smoking cessation offered and documented.	Regional Discharge Audit	AUDIT	SECONDARY CARE	ICP	70%		90%
ADULT COPD	14	**Non-invasive ventilation** - All patients with COPD with acute and/or chronic type 2 respiratory failure should have timely access to ventilatory support, if required, in a unit supervised by a respiratory physician or intensive care physician.	A	Percentage (%) of people admitted with an exacerbation of COPD who have had an arterial blood gas (ABG) assessment on admission to identify ventilatory failure.	BTS NIV audit	AUDIT	SECONDARY CARE		90%		95%
ADULT COPD			B	Percentage (%) of people who receive non-invasive ventilation in a respiratory ward or dedicated formally designated respiratory area within a ward.	BTS NIV audit / PAS	AUDIT	SECONDARY CARE		90%		95%
ADULT COPD			C	Percentage (%) of people who receive non-invasive ventilation who have a clear management plan which includes ceiling of care.	BTS NIV audit	AUDIT	SECONDARY CARE		90%		95%
ADULT COPD	15	**Supported discharge** - All patients admitted to hospital with acute exacerbations of COPD should receive appropriate discharge planning and follow-up.	A	Percentage (%) of people discharged from hospital following admission for an exacerbation of COPD who are contacted within 48-72 hours of discharge for telephone review.	Regional discharge Audit	AUDIT	SECONDARY CARE	ICP	Establish Baseline		Performance levels agreed
ADULT COPD			B	Percentage (%) of people discharged from hospital following admission for an exacerbation of COPD who have the following aspects of the COPD discharge bundle completed: * smoking cessation advice * individualised self-management plan * inhaler technique checked * referral to pulmonary rehabilitation * referral to community team for assessment & review for more complex needs	Regional Discharge Audit	AUDIT	SECONDARY CARE	ICP	70%		90%
ADULT COPD			C	Percentage (%) of people discharged from hospital following admission for an exacerbation of COPD who have been offered access to rapid pulmonary rehabilitation within 4 weeks of discharge. (providing they fulfil the inclusion criteria).	Regional Discharge Audit	AUDIT	SECONDARY CARE	ICP	40%	60%	
ADULT Oxygen	16	All people requiring long term oxygen therapy (LTOT) are appropriately assessed prior to commencement of therapy.	A	Percentage (%) of Trusts that have HOS-AR assessment processes in place for LTOT.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	All Trusts		
ADULT Oxygen			B	Percentage (%) of people started on LTOT who have been appropriately assessed via the assessment process.	HSC Trust report & HOOF database	Multiple sources	SECONDARY CARE	ICP	Establish Baseline	Performance levels agreed	

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
ADULT Oxygen	17	Ambulatory oxygen therapy should be prescribed for all people already on LTOT who wish to continue with oxygen therapy outside the home, and who are prepared to use it, but only after an appropriate assessment has been performed by a specialist.	A	Percentage (%) of Trusts that have HOS-AR assessment processes in place for ambulatory oxygen.	HSC Trust report	**Trust Report**	SECONDARY CARE	ICP	All Trusts		
ADULT Oxygen			B	Percentage (%) of people prescribed ambulatory oxygen in addition to LTOT via a concentrator following specialist assessment.	HOOF database	**Existing information system**	SECONDARY CARE	ICP	Establish Baseline	Performance levels agreed	
ADULT Oxygen	18	All people commenced on long term oxygen therapy have their condition reviewed at least annually by a specialist oxygen service (HOS-AR).	A	Percentage (%) of people on LTOT who have had their condition reviewed by a specialist HOS-AR service in the last 12 months.	HOS-AR database	**NEW information system**	SECONDARY CARE	ICP	Establish Baseline	Performance levels agreed	
ADULT Oxygen	19	All people with COPD should be treated with appropriate controlled oxygen therapy during transportation in ambulances.	A	Percentage (%) of people with a history of hypercapnic respiratory failure issued with an Oxygen Alert Card and a 24% or 28% Venturi mask and Ambulance Control informed.	HOS-AR database	**NEW information system**	SECONDARY CARE	ICP	Establish Baseline	Performance levels agreed	
ADULT Asthma	20	**Diagnosis of Asthma** - All people with suspected asthma should have assessment and investigations to confirm the diagnosis.	A	Percentage (%) of people aged 8 or over with asthma (diagnosed on or after 1 April 2006) on the register with measures of variability or reversibility recorded between 3 months before or any time after diagnosis.	QOF	**QOF**	PRIMARY CARE		80%		
ADULT Asthma	21	**Self-management** - All people with asthma and their carers should be given the opportunity to learn about their condition and receive receive a written	A	Percentage (%) of people with asthma step 2 and above who have had individualised face to face information and self-management action planning.	Regional LES	**Regional LES**	PRIMARY CARE		80%		

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
ADULT Asthma		and receive receive a written individualised self-management asthma action plan.	B	Number of people aged over 15 with newly diagnosed asthma step 2 or above, who have attended and completed an asthma specific structured education programme (Long term conditions programme).	Programme providers	Self Mg't Programme Providers	PRIMARY CARE		Establish Baseline	Performance levels agreed	
ADULT Asthma	22	**Ongoing management** - All patients with asthma should be on appropriate pharmacological therapy according to the nature and severity of their disease.	A	Percentage (%) of people with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions.	QOF	QOF	PRIMARY CARE		70%		
ADULT Asthma			B	Percentage (%) of people on step 5 treatment currently under the care of secondary care asthma services.	Regional LES	Regional LES	PRIMARY CARE		Establish Baseline	Performance levels agreed	
ADULT Asthma	23	**Management of acute severe asthma** - All people with acute severe asthma should be accurately assessed and managed appropriately according to the severity of their presentation.	A	Percentage (%) of people with acute severe asthma presenting to ED or OoH* who have a post bronchodilator PFR carried out. *only those people requiring to be nebulised in OoH.	OoH Audit ED Audit	AUDIT	PRIMARY & SECONDARY		40% 70%	50% 80%	
ADULT Asthma			B	Percentage (%) of people presenting with acute severe asthma to ED or OoH* who have an oxygen saturation of less than 94% who have a post bronchodilator oxygen saturation carried out and result recorded. *only those people requiring to be nebulised in OoH.	OoH Audit ED Audit	AUDIT	PRIMARY & SECONDARY		60% 80%	60% 80%	
ADULT Asthma			C	Percentage (%) of GP practices with a red flag system to identify people presenting with acute severe asthma in GP practices, OoH, emergency departments or ambulatory care settings.	Regional LES (to be agreed)	Regional LES	PRIMARY CARE			Establish Baseline	Performance levels agreed
ADULT Asthma			D	Percentage (%) of people with acute severe asthma presenting in GP practices, OoH, emergency departments or ambulatory care settings with a record of follow-up (telephone or face-to-face) within 14 days of the episode by the GP, practice nurse, community or secondary care.	Regional LES (to be agreed)	Regional LES	PRIMARY CARE			Establish Baseline	Performance levels agreed
ADULT Asthma			E	Percentage (%) of practices with a register of patients at risk of near fatal asthma.	Regional LES	Regional LES	PRIMARY CARE			70%	
ADULT Asthma			F	Percentage (%) of people with acute severe asthma who are managed in a respiratory ward or formally designated respiratory area within a ward.	PAS	Existing information system	SECONDARY CARE		60%		80%
ADULT Asthma			G	Percentage (%) of people with acute severe asthma admitted to hospital with an exacerbation who received care from a respiratory team.	BTS audit	AUDIT	SECONDARY CARE		60%		80%

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ADULT Asthma			H	Percentage (%) of people admitted with acute severe asthma on beta-2-agonist therapy only who are commenced on inhaled corticosteroids.	BTS audit	**AUDIT**	SECONDARY CARE		80%		90%
ADULT Asthma			I	Percentage (%) of people admitted with acute severe asthma who receive a written discharge care plan.	BTS audit	**AUDIT**	SECONDARY CARE		60%		80%
ADULT Asthma	24	**Management of difficult asthma at secondary and tertiary level** - All patients with 'difficult asthma'* should be assessed and managed by a team with the appropriate skills and experience.	A	Percentage (%) of people assessed to benefit from appropriate monoclonal antibody therapy who are offered a therapeutic trial.	Regional difficult asthma database	**Existing information system**	TERTIARY CARE			100%	
PAEDS Asthma	25	**Diagnosis of asthma**: All children and young people with suspected asthma should have assessment and investigations to confirm the diagnosis.	A	Percentage (%) of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006) on the register with measures of variability or reversibility recorded between 3 months before or any time after diagnosis. (QOF AST indicator 002)	QOF	**QOF**	PRIMARY CARE		80%		
PAEDS Asthma	26	**Self-management** - All people with asthma and their carers should be given the opportunity to learn about their condition and receive individualised self-management plans.	A	Percentage (%) of children and young people with asthma step 2 and above who have had individualised face to face information and self-management action planning.	Regional LES	**Regional LES**	PRIMARY CARE		80%		
PAEDS Asthma			B	Percentage (%) of children and young people (under 14) with a diagnosis of asthma that attended and have been asked to demonstrate their inhaler technique at asthma review.	Regional LES	**Regional LES**	PRIMARY CARE		80%		
PAEDS Asthma			C	Percentage (%) of schools supported with policies and training for asthma.	HSC Trust Report	**Trust Report**	SECONDARY CARE		establish baseline	Performance levels agreed	
PAEDS Asthma			D	Percentage (%) of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months.	QOF	**QOF**	PRIMARY CARE		80%		
PAEDS Asthma	27	**Management of acute severe asthma** - All people with acute severe asthma should be accurately assessed and managed appropriately according to the severity of their presentation.	A	Percentage (%) of children / young people presenting with acute severe asthma to ED or OoH* who have an oxygen saturation 94% or less, who have a post bronchodilator oxygen saturation carried out and result recorded (if remains less than 92%, person should be admitted). *only those people requiring to be nebulised in OoH.	OoH audit ED audit care bundle methodology every 6 months	**AUDIT**	PRIMARY & SECONDARY		60% 60%	80% 80%	

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
PAEDS Asthma		presentation.	B	Percentage (%) of GP practices with a red flag system to identify children / young people presenting with acute severe asthma within the previous 12 months in GP practices, OoH, emergency departments or ambulatory care settings.	Regional LES (to be agreed)	Regional LES	PRIMARY CARE			establish baseline	Performance levels agreed
PAEDS Asthma			C	Percentage (%) of children / young people with acute severe asthma presenting in GP practices, OoH, emergency departments or ambulatory care settings with a record of follow-up (telephone or face-to-face) within 14 days of the episode by the GP, practice nurse, community or secondary care.	Regional LES (to be agreed)	Regional LES	PRIMARY CARE			establish baseline	Performance levels agreed
PAEDS Asthma			D	Percentage (%) of children and young people with acute severe asthma who attend emergency departments, ambulatory departments or are admitted, who are reviewed (by telephone or face-to-face) by an asthma specialist paediatric nurse within 14 days.	HSC Trust report	Trust Report	SECONDARY CARE		establish baseline	Performance levels agreed	
PAEDS Asthma	28	**Management of acute anaphylaxis** - No child or young person should have a second unmanaged anaphylactic event.	A	Percentage (%) of children younger than 16 years who have had emergency treatment for suspected anaphylaxis who are admitted to hospital under the care of a paediatric medical team.	HSC Trust audit	AUDIT	SECONDARY CARE		100%		
PAEDS Asthma			B	Percentage (%) of children /young people who are referred to a specialist allergy service within 2 weeks of the primary episode (age-appropriate where possible) after emergency treatment for suspected anaphylaxis.	HSC Trust audit	AUDIT	SECONDARY CARE		100%		
PAEDS Asthma			C	Percentage (%) of children / young people who are routinely prescribed an adrenalin auto-injector device who have not had the diagnosis confirmed at a specialist allergy service.	GP audit	AUDIT	SECONDARY CARE		establish baseline	Performance levels agreed	
PAEDS Asthma			D	Percentage (%) of schools attending an annual update on the recognition and treatment of acute anaphylaxis .	HSC Trust report	Trust Report	SECONDARY CARE		establish baseline	Performance levels agreed	
PAEDS Asthma			E	Percentage (%) of specialist staff within the asthma and allergy service that have had training in the management of emotional, social and psychological issues of children and young people with severe generalised allergic and anaphylactic reaction.	HSC Trust report	Trust Report	SECONDARY CARE		50%	90%	
PAEDS Asthma			F	Percentage (%) of Trusts who have developed pathways for emotional, social and psychological support for children with severe generalised allergic reactions and anaphylaxis, as set out in the emotional, social and psychological support section of this service framework.	HSC Trust report	Trust Report	SECONDARY CARE			All Trusts	

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PAEDS Asthma	29	**Management of difficult asthma at secondary and tertiary level** - All patients with 'difficult asthma'* should be assessed and managed by a team with the appropriate skills and experience.	A	Percentage (%) of children and young people on beclometasone dipropionate or budesonide 800 mg/day (or fluticasone propionate 400 mcg/day) who have been given a steroid alert card.	Outpatient audit (via Paeds Resp & Allergy network)	AUDIT	SECONDARY CARE		90%		
PAEDS Asthma			B	Percentage (%) of children and young people attending outpatients who have had appropriate management as per BTS guidelines .	Outpatient audit (via Paeds Resp & Allergy network)	AUDIT	SECONDARY CARE		90% for each criterion		
PAEDS Asthma			C	Percentage (%) of children and young people who are admitted, who have appropriate inpatient and discharge planning as per BTS guidelines.	BTS Paediatric Asthma audit (via Paeds Resp & Allergy network)	AUDIT	SECONDARY CARE		40%	60%	80% for each criterion
PAEDS Asthma			D	Percentage (%) of children and young people with difficult to treat asthma who do not respond to treatment attending a secondary care service, who have a home visit from a specialist respiratory nurse.	HSC Trust report	Trust Report	SECONDARY CARE		40%	60%	80%
PAEDS Asthma			E	Percentage (%) of children and young people with difficult to treat asthma who do not respond to treatment attending the tertiary care service, who have a home visit from a specialist respiratory nurse.	RBHSC Tertiary care service report	Trust Report	TERTIARY CARE		40%	60%	80%
PAEDS Asthma			F	Percentage (%) of specialist staff within the asthma and allergy service that have had training in the management of emotional, social and psychological issues of children and young people with difficult asthma.	HSC Trust report and RBHSC Tertiary care service report	Trust Report	SECONDARY & TERTIARY		50%	90%	
PAEDS Asthma			G	Percentage (%) of Trusts who have developed pathways for emotional, social and psychological support for children with difficult asthma, as set out in the emotional, social and psychological support section of this service framework.	HSC Trust report and RBHSC Tertiary care service report	Trust Report	SECONDARY & TERTIARY			All Trusts	
ADULT C.A.P	30	All people with suspected community acquired pneumonia (CAP) should be assessed, diagnosed and treated according to BTS pneumonia guidelines.	A	Percentage (%) of people admitted to hospital with suspected CAP who have a chest x-ray performed and reviewed before being commenced on antibiotic therapy for CAP.	BTS CAP Audit	AUDIT	SECONDARY CARE		80%		90%
ADULT C.A.P			B	Percentage (%) of people with CAP in whom diagnosis is confirmed by chest radiograph and first antibiotic dose administered within 4 hours from admission*.	BTS CAP Audit	AUDIT	SECONDARY CARE		80%		90%

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ADULT C.A.P			C	Percentage (%) of people diagnosed with CAP who receive antibiotics in line with trust guidance. (appropriateness should be verified by antimicrobial pharmacist and microbiologist)	BTS CAP Audit	AUDIT	SECONDARY CARE		80%		90%
ADULT C.A.P			D	Percentage (%) of people diagnosed with CAP who are reviewed by a consultant within 24 hours of admission* *time of admission refers to the presentation time at the hospital (ambulance transfer sheet/time recorded in notes) if this is available.	BTS CAP Audit	AUDIT	SECONDARY CARE		90%		95%
PAEDS C.A.P	31	All children and young people with suspected community acquired pneumonia (CAP) should be assessed, diagnosed and treated according to the BTS Guidelines.	A	Percentage (%) of children and young adults diagnosed with CAP who are appropriately investigated and managed as per BTS guidelines in the following key areas:· * Chest x-ray (assessment and post discharge)· * Routine blood tests · * Antibiotic therapy· * Oral versus IV antibiotics * Post-discharge follow-up in secondary care	A&E records Assessment centre records Hospital In-patient data Care bundle audit repeated 6-monthly	AUDIT	SECONDARY CARE		75%		90%
PAEDS C.A.P			B	The percentage of children and young people with CAP transferred from another hospital to a ward in RBHSC who are admitted to PICU within 24 hours of arrival in RBHSC.	Audit of ICU records & telephone records	Tertiary Trust Report	TERTIARY CARE		20%	10%	
PAEDS C.A.P			C	Percentage (%) of children and young people requiring admission to PICU with CAP who are admitted within 6 hours of decision to admit.	Audit of ICU records & telephone records	Tertiary Trust Report	TERTIARY CARE		80%	90%	
ADULT O.S.A	32	All adults with a clinical suspicion of having obstructive sleep apnoea / hypopnoea syndrome (OSAHS), should have investigation (ie. overnight oximetry and/or limited polysomnography) at a specialist OSAHS service in their local Health and Social Care Trust led by a respiratory physician.	A	Percentage of Trusts that have specialist OSAHS services which can provide overnight oximetry; limited polysomnography and CPAP provision.	HSC Trust report	Trust Report	SECONDARY CARE	ICP		All Trusts	
ADULT O.S.A			B	Percentage (%) of people with suspected severe OSAHS, or those working in safety critical occupations, who have been assessed and investigated within 6 weeks.	HSC Trust report	Trust Report	SECONDARY CARE	ICP		50%	80%
ADULT O.S.A			C	Percentage (%) of people with lower risk OSAHS who are assessed (9 weeks) and treated (13 weeks) as per DHSSPS waiting time targets).	HSC Trust report	Trust Report	SECONDARY CARE	ICP		50%	80%

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ADULT O.S.A	33	Full Polysomnography (PSG) - All people with suspected OSAHS and where a limited sleep study is negative or inconclusive in the setting of high clinical suspicion, should have timely and appropriate access to inpatient full polysomnography (PSG) in the regional respiratory centre.	A	Regional respiratory centre (at BCH) should establish a regional OSAHS service for people requiring full polysomnography.	HSC Trust report	Trust Report	TERTIARY CARE		service established		
ADULT O.S.A			B	Percentage (%) of people with normal limited sleep studies in whom OSAHS is still suspected, who have had an overnight inpatient full PSG.	Regional PSG Database	NEW information system	TERTIARY CARE			60%	80%
ADULT O.S.A	34	Treatment - Lifestyle factors - All people with OSAHS should be provided with information on lifestyle modification and referred to services as appropriate.	A	Percentage of Trusts that have stablished a system to ensure that all people have the lifestyle assessment proforma completed, appropriate advice given and appropriate referral offered	Trust report against service spec.	Trust Report	SECONDARY CARE	ICP	All Trusts		
ADULT O.S.A			B	Percentage of Trusts with processes to ensure all members of MDT (medical, nursing and respiratory physiologists) have had training in brief intervention in smoking and alcohol, and weight management and behavior modification techniques.	Trust report against service spec.	Trust Report	SECONDARY CARE	ICP	80%	90%	
ADULT O.S.A	35	Treatment CPAP - All people should have timely and equitable access to CPAP treatment, regular review and follow up at Trust level by dedicated CPAP respiratory physiologists / respiratory nurse specialists.	A	Percentage (%) of people meeting urgent referral criteria who have commenced CPAP within 4 weeks.	CPAP database (local trusts)	Existing information system	SECONDARY CARE	ICP	95%		
ADULT O.S.A			B	Percentage (%) of people on CPAP who were treated as per the regionally agreed pathway (confirmed with sleep study 4-6wks post initiation and clinical review).	CPAP database (local trusts)	Existing information system	SECONDARY CARE	ICP		80%	
ADULT O.S.A			C	Percentage (%) of people who were reviewed on an annual basis with CPAP adherence checked.	CPAP database (local trusts)	Existing information system	SECONDARY CARE	ICP		40%	60%
PAEDS O.S.A	36	All children and young people with obstructive sleep apnoea syndrome should have the condition accurately assessed for	A	All trusts should have a nominated clinician(s) who is be able to initiate and interpret investigation (e.g. oximetry) for suspected OSAS and make appropriate referrals (e.g. to ENT) of children with abnormal studies.	HSC Trust report	Trust Report	SECONDARY CARE		100%		

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PAEDS O.S.A		severity and treated in a timely fashion.	B	Percentage (%) of children and young people with OSASH failing first line treatments who are deemed suitable for CPAP, who obtain access to appropriate equipment (with backup technical and equipment support) and training in its use within 2 weeks and 9 weeks depending on level of urgency.	Regional OSA database	Existing information system	TERTIARY CARE		95%		
PAEDS O.S.A			C	Percentage (%) of children and young people with a diagnosis of OSAHS who have a named link respiratory nurse to access the multidisciplinary team at RBHSC.	Regional OSA database	Existing information system	TERTIARY CARE		95%		
ADULT L.T.V (long term ventilation)	37	All adults requiring, or potentially requiring long term ventilation, should have access to services that improve survival, enhance quality of life, avoid unplanned admissions to hospital and support their choice of end of life care.	A	Percentage (%) of people who are at risk of neuromuscular respiratory failure, who have an annual assessment of forced vital capacity (FVC) or equivalent (mouth or nasal pressures) and symptom check for neuromuscular respiratory failure and Sp02 measurement.	Neuromuscular clinics (prospective survey)	AUDIT	SECONDARY CARE		establish baseline	Performance levels agreed	
ADULT L.T.V (long term ventilation)			B	Percentage (%) of people with motor neurone disease, who have 3-month assessment of forced vital capacity (FVC) or equivalent (mouth or nasal pressures) and symptom check for neuromuscular respiratory failure and Sp02 measurement.	Regional MND register	Existing information system	SECONDARY CARE		establish baseline	Performance levels agreed	
ADULT L.T.V (long term ventilation)			C	Percentage (%) of people with symptoms of neuromuscular respiratory failure or with FVC <50% (or inspiratory pressure < 40 cm water) sitting or lying, who are assessed and reviewed by a regional specialist multidisciplinary team (neurological and respiratory: medical, nursing & physiotherapy) every 6 months.	Regional respiratory and neuromuscular clinics - prospective survey	AUDIT	TERTIARY CARE			establish baseline	Performance levels agreed
ADULT L.T.V (long term ventilation)			D	Percentage (%) of people with complex needs on community long term ventilation who have access to support from a tertiary centre specialist respiratory nurse with expertise.	Regional database	NEW information system	TERTIARY CARE			establish baseline	Performance levels agreed
ADULT L.T.V (long term ventilation)			E	Percentage (%) of people with complex needs on community long term ventilation who have access to support from a tertiary centre specialist respiratory physiotherapist with expertise.	Regional database	NEW information system	TERTIARY CARE			establish baseline	Performance levels agreed

Section	St'd No.	Standard	KPI No.	Key Performance Indicator	Data Source	Data Category	Responsibility:	ICP?	Anticipated Performance Level Mar-16	Mar-17	Mar-18
ADULT L.T.V (long term ventilation)			F	Percentage (%) of Trusts with named leads (respiratory physician, specialist respiratory nurse and specialist respiratory physiotherapist) to provide shared care support to people during acute admissions and for those who are unable to travel to regional services.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	All Trusts		
			G	Percentage of Trusts with named leads (respiratory physician, specialist respiratory nurse and specialist respiratory physiotherapist) to provide support across acute and community for people with COPD and OSAHS and obesity hypoventilation syndrome.	HSC Trust report	Trust Report	SECONDARY CARE		All Trusts		
ADULT L.T.V (long term ventilation)			H	Percentage of people who require cough augmentation equipment, who access it at time of discharge from hospital or within 4 months of decision to provide when being managed in the community.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	establish baseline	Performance levels agreed	
ADULT L.T.V (long term ventilation)			I	Percentage (%) of people with motor neurone disease who require cough augmentation equipment, who access it within 2 weeks of decision of clinical need.	Regional MND register	Existing information system	SECONDARY CARE			50%	50%
ADULT L.T.V (long term ventilation)			J	Percentage (%) of people with symptomatic neuromuscular respiratory failure who have had the following (according to stage of illness): * communication on prognosis * shared decision making on issues of ceilings of care * advance care planning * discussion on preferred place of care	HSC Trust report	Trust Report	SECONDARY CARE	ICP		establish baseline	Performance levels agreed
PAEDS L.T.V	38	**Assessment and support** - All children and young people requiring or potentially requiring long term ventilation (LTV) or nocturnal non-invasive ventilatory (NNIV) support at home should have access to a specialist multidisciplinary team at tertiary level.	A	Percentage (%) of children and young people requiring NNIV/LTV who receive an initial assessment / management (within 4 weeks) and regular follow up (at least twice yearly) by the specialist regional multidisciplinary team.	RBHSC report Regional Database Audit	AUDIT	TERTIARY CARE		80%		
PAEDS L.T.V			B	Percentage (%) of children and young people requiring inpatient sleep studies who are admitted within 13 weeks.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		60%	90%	100%
PAEDS L.T.V			C	Percentage (%) of children and young people requiring long term ventilation where the decision has been made to discharge to home or step-down care who are discharged within 6 months.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		70%	80%	90%

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PAEDS L.T.V			D	Percentage (%) of children and young people starting ventilatory support and at critical periods who have specific play therapy input to support and optimise compliance.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		establish baseline	Performance levels agreed	
PAEDS L.T.V			E	Percentage (%) of children who require cough augmentation equipment, who access it within 4 months of decision to provide.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		50%		100%
PAEDS L.T.V			F	Percentage (%) of children and young people whose initial and essential investigations and treatment, as part of evidence based pathways, are coordinated in clinically appropriate times.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		20%	40%	60%
PAEDS L.T.V			G	Percentage (%) of children and young people who require psychology support who receive it from a nominated psychologist with an interest in respiratory disease within 15 weeks.	RBHSC report	Tertiary Trust Report	TERTIARY CARE		establish baseline	Performance levels agreed	
Cystic Fibrosis	39	All newborn babies in Northern Ireland should be offered screening for cystic fibrosis.	A	Percentage (%) of babies born in Northern Ireland (and still resident) with conclusive blood spot screening result recorded on Child Health System by 17 days of age.	Child Health system	Existing information system	SECONDARY CARE		UK Standard from April 2014		TBC
Cystic Fibrosis	40	All people suspected of having cystic fibrosis should have appropriate diagnostic testing at a specialist centre.	A	Percentage (%) of babies suspected of having cystic fibrosis (2 mutations identified) should have their first clinical appointment with the cystic fibrosis team by 28 days of age.	CF registry & Adult and Paediatric CF centres (UK standard from April 2014)	Existing information system	TERTIARY CARE		95% acceptable, 100% achievable	95% acceptable, 100% achievable	95% acceptable, 100% achievable
Cystic Fibrosis			B	Percentage (%) of babies suspected of having cystic fibrosis (1 mutation identified + second IRT positive OR no mutations identified + second IRT positive) should have their first clinical appointment with the cystic fibrosis team by 35 days of age.	CF registry & Adult and Paediatric CF centres (UK standard from April 2014)	Existing information system	TERTIARY CARE		80% acceptable, 100% achievable	80% acceptable, 100% achievable	80% acceptable, 100% achievable
Cystic Fibrosis	41	All people with cystic fibrosis should receive care from a specialist centre delivered by a specialist multidisciplinary team. Care should be in line with best	A	Percentage (%) of adults who have the following data recorded annually:· * FEV1 % predicted· * BMI * Sputum microbiology	CF registry	Existing information system	TERTIARY CARE			90%	

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Cystic Fibrosis		practice guidelines.	B	(a) Percentage (%) of children who have the following data recorded annually: · * BMI centile or weight centile for those <2 · * Sputum microbiology (b) Percentage (%) of children >5 years old who can perform spirometry who have FEV1 % predicted recorded annually.	CF registry	Existing information system	TERTIARY CARE			90%	
Cystic Fibrosis			C	Percentage (%) of people reporting satisfaction with communication / information received from the specialist team.	Adults: Patient questionnaire (to be developed in conjunction with patient advocate) Children: Peer review due Feb 2014	AUDIT	TERTIARY CARE		90%		
Cystic Fibrosis	42	All people with cystic fibrosis should have their care provided in a safe environment consistent with infection control policies.	A	Percentage (%) of people receiving microbiological surveillance of at least 4 samples (sputum or cough swab) per year.	Cystic Fibrosis centres (adult & children) & CF clinical microbiologist report	Existing information system	TERTIARY CARE			85%	
Cystic Fibrosis			B	Percentage (%) of inpatients in single room accommodation.	CF centres report	Trust Report	TERTIARY CARE		100%		
Bronchiectasis	43	All people with suspected bronchiectasis should be investigated in line with BTS guidance.	A	ADULTS - Percentage (%) of people with clinical diagnosis of bronchiectasis who have had diagnosis confirmed by high resolution CT chest.	BTS audit	AUDIT	SECONDARY CARE		90%		
Bronchiectasis			B	Percentage (%) of people with a clinical diagnosis of bronchiectasis who have been investigated for: * Allergic bronchopulmonary aspergillosis * Common variable immunodeficiency * Cystic fibrosis in up to all individuals <40 years old (and considered in >40 for those indicated by BTS guidance)	BTS audit	AUDIT	SECONDARY CARE		40%	60%	

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Bronchiectasis			C	CHILDREN - Percentage (%) of children and young people with suspected bronchiectasis who have the appropriate investigations completed as per the BTS guidelines in tertiary care.	BTS Paediatric Bronchiectasis Audit & RBHSC report	AUDIT	TERTIARY CARE		80% of children meet the diagnostic target		100%
Bronchiectasis	44	All people with clinically significant bronchiectasis should be accurately assessed and managed by a multidisciplinary respiratory team including a consultant, physiotherapist and nurse with a special interest in bronchiectasis.	A	ADULT STABLE - Number of trusts with access to a specialist respiratory team comprising at least a respiratory clinician, respiratory specialist nurse and a physiotherapist with a special interest in bronchiectasis.	HSC Trusts	Trust Report	SECONDARY CARE	ICP	All Trusts		
Bronchiectasis			B	ADULT STABLE - Percentage (%) of individuals diagnosed with bronchiectasis who have been reviewed by a respiratory physiotherapist.	BTS audit	AUDIT	SECONDARY CARE	ICP	90%		
Bronchiectasis			C	ADULT STABLE - Percentage (%) of individuals with a diagnosis of bronchiectasis who had sputum bacteriology culture when clinically stable sent and recorded within the last 12 months.	BTS audit	AUDIT	SECONDARY CARE		80%		
Bronchiectasis			D	ADULT STABLE - Percentage (%) of patients with breathlessness affecting activities of daily living referred to pulmonary rehabilitation.	BTS audit	AUDIT	SECONDARY CARE	ICP	60%		80%
Bronchiectasis			E	ADULT EXACERBATIONS - Percentage (%) of individuals with an exacerbation of bronchiectasis who have a sputum sample sent for microbiological culture prior to empirical treatment.	BTS audit	AUDIT	SECONDARY CARE		80%		
Bronchiectasis			F	ADULT EXACERBATIONS - Percentage (%) of individuals with an exacerbation of bronchiectasis with an objective evaluation of efficacy (at least one of bacteriology, inflammatory markers or spirometry).	BTS audit	AUDIT	SECONDARY CARE		80%		
Bronchiectasis			G	ADULT EXACERBATIONS - Percentage (%) of individuals with an exacerbation of bronchiectasis who are offered home IV therapy where appropriate.	BTS audit	AUDIT	SECONDARY CARE	ICP	60%		80%
Bronchiectasis			H	CHILDREN STABLE - Percentage (%) of children and young people with symptomatic disease who attend a one-stop-shop multidisciplinary service.	HSC Trust report	Tertiary Trust Report	TERTIARY CARE		100%		

									Anticipated Performance Level		
Section	**St'd No.**	**Standard**	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Data Category**	**Responsibility:**	**ICP?**	**Mar-16**	**Mar-17**	**Mar-18**
Bronchiectasis			I	CHILDREN STABLE - Percentage (%) of children and young people who have a comprehensive annual review to include spirometry, BMI centile and sputum microbiology where appropriate.	BTS paediatric audit	**Tertiary Trust Report**	**TERTIARY CARE**		90%		
Bronchiectasis			J	CHILDREN STABLE - Percentage (%) of children and young people who have regular microbiological surveillance every 3 months	BTS paediatric audit	**Tertiary Trust Report**	**TERTIARY CARE**		60%		90%
Bronchiectasis			K	CHILDREN EXACERBATIONS - Percentage (%) of children and young people with poorly controlled symptoms or exacerbations who are admitted within 72 hours of the decision to admit.	RBHSC report	**Tertiary Trust Report**	**TERTIARY CARE**		100%	100%	
Bronchiectasis			L	CHILDREN EXACERBATIONS - Percentage (%) of children and young people admitted with bronchiectasis for IV antibiotics who have therapy started within 24 hours of admission.	RBHSC report	**Tertiary Trust Report**	**TERTIARY CARE**		100%		
Bronchiectasis	45	Education and self-management - All individuals with symptomatic bronchiectasis and their carers should be given the opportunity to learn about their disease and receive individualised self-management information.	A	Percentage (%) of adults attending secondary care who have been given individualised, face-to-face information and a written action plan.	HSC Trusts	**Trust Report**	**SECONDARY CARE**		60%		
ADULT I.L.D	46	**Diagnostic Processes for Interstitial Lung Disease** - People with known or suspected ILD should be under the care of a respiratory multidisciplinary team for interstitial lung disease.	A	Percentage (%) of trusts who have local access to a radiologist with expertise in thoracic imaging.	HSC Trust report	**Trust Report**	**SECONDARY CARE**			100%	
ADULT I.L.D			B	Percentage (%) of Trusts who have regional access to a pathology service with appropriate expertise in ILD.	HSC Trust report	**Trust Report**	**TERTIARY CARE**			100%	
ADULT I.L.D			C	Percentage (%) of Trusts with a named lead consultant respiratory physician with an interest in ILD.	HSC Trust report	**Trust Report**	**SECONDARY CARE**	**ICP**	100%		

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ADULT I.L.D			D	Percentage (%) of Trusts with a named specialist respiratory nurse with an interest in ILD.	HSC Trust report	Trust Report	SECONDARY CARE	ICP		100%	
ADULT I.L.D			E	Percentage (%) of people with suspected ILD / IPF who have had case discussion at a local multidisciplinary team meeting for ILD.	ILD database (to be developed)	NEW information system	SECONDARY CARE	ICP			50%
ADULT I.L.D			F	Percentage (%) of people with ILD / IPF who have been assessed as per the evidence based pathway, at a regional centre for Pirfenidone and other novel therapies.	ILD database (to be developed)	NEW information system	TERTIARY CARE				Baseline to be determined
ADULT Pulmonary Rehab	47	All people with respiratory conditions who can benefit from pulmonary rehabilitation should be offered this by their GP or specialist respiratory team.	A	Percentage (%) of people with COPD who meet the criteria for pulmonary rehabilitation and have been offered referral for pulmonary rehabilitation.	Regional LES HSC Trust report	Multiple sources	PRIMARY & SECONDARY	ICP		50%	
ADULT Pulmonary Rehab			B	Percentage (%) of pulmonary rehabilitation programmes which are geographically accessible i.e. within 30 minutes of travel.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	100%		
ADULT Pulmonary Rehab			C	Percentage (%) of pulmonary rehabilitation programmes which include all required elements as per BTS guidelines.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	100%		
ADULT Pulmonary Rehab			D	Percentage (%) of pulmonary rehabilitation programmes which have a mechanism to provide support to patients for on-going exercise and social support for those who need this.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	100%		
Transitional Care	48	All young people with chronic respiratory disease (asthma / OSAS / LTV / cystic fibrosis / bronchiectasis) should have appropriate arrangements in place for transition to transfer to adult services.	A	Trust self-assessment against service specifications for transitional care arrangements for each of the following:- 1) asthma (secondary & tertiary care) 2) cystic fibrosis (tertiary care) 3) bronchiectasis (tertiary care) 4) LTV (tertiary care) 5) OSAS (tertiary care)	Trusts reports and RBHSC report	Trust Report	SECONDARY & TERTIARY			All trusts should be able to meet service specifications	

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ADULT Acute Oxygen	49	All acutely ill patients, apart from those at risk from hypercapnic respiratory failure, should have oxygen prescribed to achieve a normal or near normal oxygen saturation.	A	Emergency oxygen therapy should be prescribed using a target saturation range for patients admitted to hospital requiring oxygen therapy.	BTS Emergency Oxygen Audit	AUDIT	SECONDARY CARE		60%	80%	
Social & Emotional Support	50	All patients with severe respiratory disease and their carers should be offered an holistic assessment of their needs and be facilitated and supported to maintain their connections with social networks and community life, in order to promote wellbeing and mitigate the potentially isolating effects of long term disability.	A	Percentage (%) of local areas with patient self-help support groups supported and facilitated by HSC Trusts. (approximately 80,000 population).	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP			100%
Social & Emotional Support			B	Percentage (%) of local areas with generic expert patient programmes available for patients with respiratory disease (approximately 80,000 population).	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP			100%
Social & Emotional Support			C	Percentage (%) of people on specialist community respiratory team caseloads who have had an holistic assessment and action planning of their social and emotional support needs.	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP	40%		80%
Social & Emotional Support			D	Percentage (%) of local LCG areas with timely access to respiratory psychology services for those with severe anxiety and depression secondary to respiratory disease when other interventions are not sufficient, as per the emotional social and psychological support model.	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP			100%
Social & Emotional Support			E	Percentage (%) of people who have been offered to move on from pulmonary rehabilitation to local exercise/support groups.	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP			80%
Social & Emotional Support			F	Percentage (%) of carers (of people with respiratory disease who are on community team caseloads) who have been offered a formal carers assessment, where appropriate.	HSC Trust / ICP report	Trust ICP Report	PRIMARY & SECONDARY	ICP	30%		90%

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Information	51	All patients, clients and carers should receive information which will allow them to know about general management options for their condition as well as the range of services available locally, including health promotion and appropriate community support services.	A	Percentage (%) of local* areas where directories of services are available in a variety of formats written(*Approximately 150,000 population).	HSC Trust report	Trust ICP Report	SECONDARY CARE	ICP		All areas	
Information			B	Information available (including links to above) on HSCB and NI Direct websites.	PHA HSCB	PHA HSCB report	PHA HSCB			All websites	
Training	52	All HSC staff, as relevant, should be appropriately trained to meet modern authoritative standards, and have the necessary knowledge, skills and competencies to provide respiratory services and manage respiratory conditions.	A	Percentage (%) of GP employed nurses who have completed self-assessment as per NIPEC R-CAT.	ICPs (to be agreed)	ICP report	PRIMARY CARE	ICP	establish baseline	Performance levels agreed	
Training			B	Percentage (%) of Trust employed specialist paediatric respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	Trust Report	SECONDARY CARE		establish baseline	Performance levels agreed	
Training			C	Percentage (%) of Trust employed specialist adult respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	Trust Report	SECONDARY CARE		establish baseline	Performance levels agreed	
Training			D	Percentage (%) of GP practices who have a minimum of 1 registered nurse who has successfully completed a recognised post-graduate respiratory course in COPD.	ICPs (to be agreed)	ICP report	PRIMARY CARE	ICP	establish baseline	Performance levels agreed	
Training			E	Percentage (%) of GP practices who have a minimum of 1 registered nurse who has successfully completed an approved post-graduate respiratory course in asthma.	ICPs (to be agreed)	ICP report	PRIMARY CARE	ICP	establish baseline	Performance levels agreed	
Training			F	Percentage (%) of GP practices who have a minimum of 1 registered nurse who has completed an approved spirometry training course*. *An approved spirometry course should cover theoretical aspects as well as practical aspects, and individuals should be trained to both conduct the test as well as interpreting the result.	ICPs (to be agreed)	ICP report	PRIMARY CARE	ICP	establish baseline	Performance levels agreed	
Training			G	Percentage (%) of GP practices where a primary care HSC professional has completed brief intervention training for smoking cessation.	ICPs (to be agreed)	ICP report	PRIMARY CARE	ICP	establish baseline	Performance levels agreed	

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Training			H	Percentage (%) of Trust HSC professionals providing a respiratory service who have completed brief intervention training for smoking cessation.	Trust's monitoring returns to PHA	Trust Report	SECONDARY CARE		establish baseline	Performance levels agreed	
Medicines Mg't	53	In partnership with healthcare professionals, all people with respiratory disease should be provided with appropriate, safe and effective medicines and medicines information to enable them to gain maximum benefits from medicines to maintain or increase their quality and duration of life.	A	Percentage (%) of respiratory prescribing in accordance with local medicines formulary	HSC Trusts BSO Perscribing Database	Integrated Care report	PRIMARY CARE		70%	Ongoing in tandem with development of NI Formulary	
Medicines Mg't			B	Percentage (%) of people with respiratory conditions accessing a medicines management support service	HSCB (Community Pharmacy Contract) Trusts (Self administration of medicines)	Integrated Care report	PRIMARY CARE		Establish Baseline	Performance levels agreed	
Medicines Mg't	54	**Medicines Review** - People with respiratory disease should have a systematic review of all their medicines at appropriate intervals along the care pathway to ensure that their medicines continue to be appropriate, and that they participate in the treatment as prescribed.	A	Percentage (%) of people with respiratory disease in secondary care who have had their medicines list checked and verified as accurate on admission	HSC Trust audit	AUDIT	SECONDARY CARE			Establish Baseline	Performance levels agreed
Palliative Care	55	**Palliative and End of Life Care** - All people with advanced progressive incurable respiratory conditions should have their end of life care needs identified; co-ordinated care provided to meet these needs; and supported to die in their preferred place of care, in close collaboration with family and carers at all stages.	A	Percentage (%) of people on community specialist team caseloads who have been assessed as to whether they have palliative care needs using Northern Ireland palliative care guidance (for COPD) or appropriate indicators of possible last year of life in Idiopathic Pulmonary Fibrosis	Community team audit	AUDIT	SECONDARY CARE	ICP	50%		90%
Palliative Care			B	Percentage (%) of people identified as being possibly in last year of life on community team caseloads where there is a record that the community team attended and discussed the patient at a practice multidisciplinary meeting.	HSC Trust report	Trust Report	PRIMARY & SECONDARY	ICP	50%		90%

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Palliative Care			C	Percentage (%) of people with a respiratory diagnosis on the Trust palliative care database who have had an holistic assessment and a care plan developed (including carer needs).	Trust Palliative Care Database	Existing information system	SECONDARY CARE	ICP	50%		90%
Palliative Care			D	Percentage (%) of people with a respiratory diagnosis on the Trust palliative care database with an identified named key worker (usually specialist respiratory team member coordinating with district nursing who then takes on key worker role in last few weeks) responsible for ensuring the 24 hour plan of care is communicated to relevant professionals	Trust Palliative Care Database	Trust Report	SECONDARY CARE	ICP	50%		90%
Palliative Care			E	Percentage (%) of people with respiratory disease who are enabled to die in their appropriate preferred place of care (identified as part of regularly reviewed assessments).	Trust Palliative Care Database	Trust Report	SECONDARY CARE	ICP	10%		30%
Palliative Care			F	Percentage (%) of the specialist respiratory team members who have had training in appropriate palliative care competencies.	HSC Trust report	Trust Report	SECONDARY CARE	ICP	80%		90%
Palliative Care			G	Percentage (%) of specialist respiratory team members trained in appropriate communication skills .	HSC Trust report	Trust Report	SECONDARY CARE	ICP	95%		