AGENDA

80th Meeting of the Public Health Agency board to be held on Thursday 17 December 2015, at 1:30pm, Conference Rooms 3+4, 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 previous meeting held on 19 November 2015		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.45	Finance Update • PHA Financial Performance Report	**PHA/01/12/15 (for Noting)**	Mr Cummings
8.	2.00	Governance and Audit Committee Update • Minutes of 14 October 2015 meeting • Verbal briefing from Chair	**PHA/02/12/15 (for Noting)**	Mr Coulter
9.	2.15	Service Framework for Respiratory Health and Wellbeing 2015-2018	**PHA/03/12/15 (for Approval)**	Dr Harper
10.	2.35	Personal and Public Involvement (PPI) Update Report	**PHA/04/12/15 (for Noting)**	Mrs Hinds
11.	2.55	Any Other Business		

12. **Date, Time and Venue of Next Meeting**
Thursday 21 January 2016
1:30pm
Conference Rooms 3+4, 2nd Floor
12/22 Linenhall Street
Belfast
BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 79th Meeting of the Public Health Agency board held on Thursday 19 November at 1:30pm, in Conference Rooms 3+4, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mr Andrew Dougal - Chair
Dr Eddie Rooney - Chief Executive
Dr Carolyn Harper - Director of Public Health/Medical Director
Mrs Mary Hinds - Director of Nursing and Allied Health Professionals
Mr Edmond McClean - Director of Operations
Councillor William Ashe - Non-Executive Director
Mr Brian Coulter - Non-Executive Director
Mr Leslie Drew - Non-Executive Director
Mrs Julie Erskine - Non-Executive Director
Mr Thomas Mahaffy - Non-Executive Director
Alderman Paul Porter - Non-Executive Director

IN ATTENDANCE:

Mr Robert Graham - Secretariat
Mr Paul Cummings - Director of Finance, HSCB
Mrs Joanne McKissick - External Relations Manager, PCC

APOLOGIES:

Mrs Fionnuala McAndrew - Director of Social Care and Children, HSCB

		Action
110/15	**Item 1 – Welcome and Apologies**	
110/15.1	The Chair welcomed everyone to the meeting and apologies were noted from Mrs Fionnuala McAndrew.	
111/15	**Item 2 - Declaration of Interests**	
111/15.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

112/15 Item 3 – Minutes of previous meetings:

- **Meeting of 15 October 2015**

112/15.1 The minutes of the previous meeting, held on 15 October 2015, were approved as an accurate record of the meeting.

113/15 Item 4 – Matters Arising

113/15.1 There were no matters arising.

114/15 Item 5 – Chair's Business

114/15.1 The Chair made reference to the recent Ministerial announcement on the future of health and social care in Northern Ireland. He advised members that PHA staff had had an opportunity to attend a workshop at which the Chief Executive outlined key aspects of the announcement and what this might mean. He said that changes provided an opportunity to do things differently, and for innovation, and advancing new ideas for a changing environment. He added that the PHA should not let slip any opportunities which might be seized at this brief window in time.

114/15.2 The Chair said that he had met with all non-executive members on a 1:1 basis, and altogether, and that this had been useful. He added that he had attended a Safe and Well event in the Down Lisburn area.

114/15.3 The Chair informed members that he had met with Assistant Directors Janet Little, Mary Black and Lorraine Doherty and continued to be impressed by the range of work in which the PHA is involved.

114/15.4 The Chair said that he had attended one of the consultation events on Lifeline and that he was planning to attend the next Board meeting of Public Health England.

115/15 Item 6 – Chief Executive's Business

115/15.1 The Chief Executive also made reference to the Ministerial announcement and said that he was expecting further information from DHSSPS regarding the constitution of the expert panel and the consultation process.

115/15.2 The Chief Executive said that he had attended the AGM of Resurgam in Lisburn at which Mervyn Storey attended. He said that Mr Storey had been complimentary of the work of PHA.

115/15.3 The Chief Executive said that as part of the next phase of the work relating to local government and the implementation of Making Life Better, he had attended a series of meetings with local Councils. He made specific reference to the work undertaken by Belfast City Council on their City plan which maps together their relationships with other regional and statutory bodies.

115/15.4 The Chief Executive said that he had visited three areas in Ballymena with councillors and local community representatives.

115/15.5 Alderman Porter outlined an example of how the work that PHA does in local communities is important. He said that £20k of PHA funding had helped secure £500k of future investment from other bodies.

116/15 Item 7 – Finance Update – PHA Financial Performance Report (PHA/01/11/15)

116/15.1 Mr Cummings presented the Finance Report and advised that the year-to-date position showed a surplus of £21k against a budget of £43.8m, which is made up of a £224k deficit in non-Trust expenditure and a £245k surplus in the management and administration budget. He added that the year-end position is projected to be a break even one.

116/15.2 Mr Cummings highlighted the section in the report looking at non-Trust expenditure and explained that the surplus in the Lifeline budget is being offset by expenditure within both Health Improvement and Health Protection. He clarified that these are not overspends, but issues regarding profiling the budget across the year.

116/15.3 Mr Drew asked if there was a reason for the underspend. Mr Cummings explained that this was due to a change in activity levels. Dr Harper added that the reduction has followed recent meetings with Contact regarding their management of the contract. Mr Drew sought assurance that the needs of callers were continuing to be met. Dr Harper indicated this was at the core of PHA's work with the provider as well as monitoring and review of the contract. Mr McClean explained that the issue was about ensuring that callers were receiving appropriate follow-up therapies consistent with their specific needs.

116/15.4 Dr Harper advised that demand for the follow-on counselling services has decreased. Mr Drew clarified that the previous level of calls being invoiced was unnecessarily high. Dr Harper said that following a clinical audit, this was noted to be the case and that PHA took action in this regard. Mr Cummings added that mediation had been required. Mr Drew asked whether the business case reflected the current volume of activity and whether going forward the contract should cost less. Dr Harper said that this should be case, but she added that any underspend is being reinvested into other mental health and suicide prevention work.

116/15.5 Alderman Porter noted that this has been a major issue for the PHA Board and it was refreshing to see this reduction.

116/15.6 Mr Cummings moved on to the management and administration budget and said that PHA should be pleased that it is achieving savings despite the reduction in this budget for 2015/16.

116/15.7 Mr Cummings drew members' attention to the mid-year balance sheet at the end of the Report.

116/15.8 Members noted the Finance Report.

117/15 Item 8 – Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 30 September 2015 (PHA/02/10/15)

117/15.1 Mr McClean presented the performance management report for the first six months and said that it covered both the Business Plan targets and the Commissioning Plan direction targets. He said that at this stage two of the targets were rated "red" and 18 were rated "amber". He noted that many of these were rated this way due to factors outwith PHA's control.

117/15.2 Alderman Porter asked whether of the targets had been carried over from previous years but Mr McClean advised that these were new targets.

117/15.3 Mr Mahaffy asked whether the "green" rating for Making Life Better was truly reflective of progress to date and what this was being measured against. The Chief Executive began his response by saying that a fuller update on Making Life Better would be presented at a future meeting. He said that the targets to date principally related to the establishment of the different forums and that these had begun to meet. Mr Mahaffy said he hoped that Making Life Better would have a greater impact than the previous Investing for Health strategies. The Chief Executive said that he also hoped that this would be the case, and said that it was critical that there was buy-in to Making Life Better across all sectors. Mr Mahaffy made reference to the Anti-Poverty Strategy. The Chief Executive said that it was important that all of these different strategies, including anti-poverty be fed into the next Programme for Government.

117/15.4 Mr Coulter made reference to the C difficile and MRSA levels and expressed concerns about the Trusts exceeding their targets. He suggested that this action should be rated "red". Dr Harper explained that there are differences between Trusts, and that in any Trust where the target is being exceeded PHA would meet with Trusts and local GPs. She said that with regard to anti-microbial resistance, PHA has limited resources to take forward work in this area, but that this area is seen as a priority over the coming years. She said that with regard to C difficile and MRSA, Trusts have made significant progress in recent years and that Trusts in Northern Ireland are holding their own in comparison to Trusts across the rest of the UK.

117/15.5 Mr Coulter said he understood PHA's role to be an advisory one. Dr Harper agreed that DHSSPS sets the policy and PHA has to monitor this and, in response to a question from the Chair, she advised that there is an Escalation Policy. She pointed out that the number of cases is quite small in relative terms.

117/15.6 Mr Drew said it was pleasing to see so many targets rated as "green". He asked that, given the proposed changes, was there any indication as to which delivery areas would be affected. The Chief Executive said that it would depend on which functions were transferred.

117/15.7 Mr Mahaffy asked about the commissioned report relating to PPI. Mrs Hinds agreed to send Mr Mahaffy a copy of this report.

117/15.8 Mrs Erskine said that she hoped that the new HRPTS system would allow PHA to monitor the registration of nurses and midwives. Mrs Hinds said that PHA is looking at alternative solutions.

117/15.9 Mr Coulter asked about the Diabetic Retinopathy Screening Programme. He noted the absence of a key member of staff and asked about the impact of this on the programme. Dr Harper acknowledged that there are backlog issues, but the programme is getting back on track. The Chair asked if there was any evidence of a lower take-up on this programme from those of lower socio-economic classes. Dr Harper said that there is an extensive action plan, and as part of this there are videos on the PHA website from patients who have previously used the programme and want to encourage others to come forward.

117/15.10 The Chair congratulated staff on their achievements to date. Members noted the performance management report.

118/15 Item 9 – Unscheduled Care

118/15.1 The Chief Executive reminded members that at the last meeting he had announced that new arrangements were being put in place to take forward work in unscheduled care. He said that the Regional Unscheduled Care Group had held its first meeting and that the Strategic Accountability Group, which would be jointly chaired by himself and Valerie Watts, Chief Executive of HSCB, was holding its first meeting on 7 December.

118/15.2 The Chief Executive noted that this is a significant additional workload for both HSCB and PHA with a lot of resources being consumed and no backfill.

118/15.3 The Chair asked if there was a timeline for the completion of this work. The Chief Executive said work is being undertaken every day, but this was a long term project and the meeting of 7 December would be used an opportunity to evaluate progress to date.

118/15.4 Members noted the update on unscheduled care.

119/15 **Item 10 – Lifeline Consultation**

119/15.1 Dr Harper gave members an update on the Lifeline consultation process. She said that there have been a number of consultation events, and that in general the questions raised at these events related to the separation of the telephone from the follow on services, and the skillset of those handing the calls. She said that all of the main themes from the consultation would be collated and fully considered.

119/15.2 Dr Harper outlined the proposed next steps. She said that there would be a workshop for PHA Board members on 17 December to look at a draft of the paper summarising the main issues emerging through the consultation process which would be formally brought to the PHA Board in January 2016. She said that to date 157 responses had been received to the consultation.

119/15.3 Alderman Porter asked whether specific groups were targeted as part of the consultation, and when responses are received, are any major concerns or issues raised dealt with immediately. Dr Harper said that she would check this, and in terms of responses the summary report will show the numbers of responses made by individuals, organisations, staff etc.

119/15.4 Mrs Erskine and Mr Drew both stated that they had attended one of the consultation events and commented on the professionalism of the PHA staff participating.

119/15.5 Mr McClean said that PHA Board members would receive a copy of each of the submissions.

119/15.6 Members noted the update on the Lifeline consultation.

120/15 **Item 11 – Media Monitoring on Suicide**

120/15.1 Mr McClean welcomed Mr Stephen Wilson and Ms Roisin McManus to the meeting and invited them to deliver the presentation on media monitoring on suicide.

120/15.2 Mr Wilson explained that the area of media monitoring on suicide has been well researched and the way that the press pick up and report on suicide has raised major concerns, and this was highlighted in the Protect Life Strategy.

120/15.3 Ms McManus gave an overview of the media monitoring and explained that in her role she would analyse each reference to suicide in the press and if necessary, follow this up with the appropriate organisation if it is deemed that the coverage is inappropriate. She added that PHA had begun to work with the universities, offering courses in communications, and the National Union of Journalists.

120/15.4 Mr Wilson said that PHA has begun to work with the Western Trust as part of its Community Response Plan. He said that there is a need to be more responsive in terms of closing down sites on social media.

120/15.5 Alderman Porter asked whether an article that has been shared on social media can be taken down. Ms McManus explained that if there is a link to an article and the article has been amended then the link will direct people to the updated article.

120/15.6 Mr Drew suggested that PHA could work with other organisations in this e.g. PSNI and Translink.

120/15.7 Mr Coulter welcomed this work but added that with the advent of social media, the scale of the problem is huge and it is important to come up with ways of addressing these issues.

120/15.8 Mrs McKissick asked who was delivering the training. Ms McManus advised that it was herself and a colleague from Samaritans. Mrs McKissick asked what would happen in a situation where an organisation does not comply with the guidelines set. Mr Wilson said that the guidelines developed by Samaritans have a lot of credibility and are generally followed.

120/15.9 The Chair asked if editors are responsive when issues are raised. Ms McManus said that in approximately two-thirds of cases PHA would receive a response. She added that the training is not targeted solely at journalists but also editors.

120/15.10 Members noted the presentation on media monitoring on suicide and thanked Ms McManus and Mr Wilson for an insight into this important area of PHA work.

121/15 **Item 12 – 10,000 Voices Phase 2: Regional Report Relating to Care in Your Own Home (October 2015) (PHA/03/10/15)**

Item 13 – 10,000 Voices: Regional Report on Experience of Nursing and Midwifery Care Key Performance Indicators (KPIs) (PHA/04/10/15)

121/15.1 Mrs Hinds presented the two reports which were compiled following responses to the 10,000 Voices initiative. She said that she and Mr Cummings chair the steering group. To gather the responses for the initiative she said that staff had garnered stories from people in shopping centres as well as in their own home. In general, she said that the stories were positive, but that there is more learning from stories which are negative.

121/15.2 In terms of the first report, "Care in Your Own Home", Mrs Hinds said that the main issues are isolation and loneliness; timing of calls and call allocation; care of clients with dementia; and communication. She said that the issue of isolation and loneliness is a major one and one that the HSC cannot resolve on its own, and that there should be joined-up working with organisations like church groups and voluntary groups. She added that a workshop will be planned as this is part of the Making Life Better strategy.

121/15.3 Mr Cummings said that there are workforce issues for HSC and that the current economic climate and the introduction of a new living wage will see the situation worsen.

121/15.4 Mr Mahaffy asked if there was a breakdown available by provider so that comparisons could be made. He also noted that there was a disproportionate number of responses from Trusts. Mrs Hinds said that people volunteered their stories and that Trust employees would tend to ask people in Trust settings for their stories, but she said that there were efforts to capture as many stories as possible from as many different settings as possible.

121/15.5 Councillor Ashe asked whether it was more productive for agencies to carry out a large number of short visits, or a shorter number of longer visits to patients in their own homes. Mr Cummings said that it was more likely that Trusts would allocate more time to with the more difficult calls. Mr Drew said that there would be issues in terms of the quality of the care provided in short calls.

121/15.6 The Chair asked about the number of providers and if comparisons were possible, but Mr Cummings explained that one Trust has 37 providers.

121/15.7 Mrs Erskine asked about an action plan. Mrs Hinds said that PHA would wish to take time to review what can be done based on the findings in order to have the biggest impact.

121/15.8 Alderman Porter asked if the inputs are confidential. Mrs Hinds confirmed that each story is confidential, but any concerns raised are immediately escalated. Alderman Porter said that every story is vital and Mrs Hinds agreed adding that perhaps in a setting like a shopping centre people may be inclined to say more about their experiences.

121/15.9 Mrs McKissick said that in the main, the report supported findings from work undertaken by PCC, namely that care visits are rushed and that there are feelings of isolation and that there is a need to have a workshop which would involve people and carers. She went on to say that the issue of isolation should be looked at by Councils as part of their remit. Mrs Hinds noted that this is where Making Life Better will become important.

121/15.10 Mrs McKissick said that the recent Domiciliary Care Review is quite technical and asked whether there were other ways of using the information from 10,000 Voices to better inform future direction. Mrs Hinds said that this report will be shared with Trusts and they will be held to account to deliver on the recommendations.

121/15.11 Mr Coulter welcomed the report and said it contributed to the understanding of issues around domiciliary care. He said that one of the biggest concerns for him is about domiciliary care which is delivered by patient’s own families and variances around the quality of this. He expressed concern about the variability across Trusts with regard to sheltered housing. Finally, he asked about the rigour of this exercise and if there would be any external evaluation of the 10,000 Voices project.

121/15.12 Mrs Hinds said that the project is held in high regard and there was a presentation about the programme delivered to the Kings

Fund in London. She said that the Sensemaker tool which is used to collate the stories can show highlight areas that staff can focus on to resolve issues. Mr Coulter said that the tool is not used for evidence-based commissioning. Mr Cummings said that the findings have forced commissioners to look at fresh ideas, but he added that the majority of this type of care is not carried out by the Trusts, where there could be up to 50 providers that we have limited control over. He went on to say that the issue of social isolation is not one that the health service alone can solve. He said that report has highlighted that a situation cannot continue whereby the tendering process leads to procuring the cheapest, and therefore, lowest quality of service.

121/15.13 The Chief Executive said that the use of Sensemaker has allowed PHA to analyse information better, and this added value is allowing concerns to be picked up and dealt with immediately.

121/15.14 Mr Drew said that in terms of procurement, there was a need to be smarter and build in criteria requirements. Dr Harper outlined to members the example of a model being used in Holland.

121/15.15 Mrs Hinds moved onto the second report which related to Nursing and Midwifery Key Performance Indicators. She said that there are good examples of care, but there are issues with regard to staffing levels and that there are efforts being made to increase the number of nurses with discussions taking place with heads of nursing regarding this.

121/15.16 Mrs McKissick said that its findings concur with those of a recent piece of work by PCC. She noted that there are issues of expectant mothers feeling that they are not being listened to and not being taken seriously. Overall, she welcomed the report and its recommendations.

121/15.17 Members approved the two 10,000 Voices Reports.

122/15 Item 14 – Any Other Business

122/15.1 There was no other business.

123/15 **Item 15 – Date and Time of Next Meeting**

Date: Thursday 17 December 2015
Time: 1:30pm
Venue: Conference Rooms 3+4
2nd Floor
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: ________________

Date: ________________

Public Health Agency

Finance Report

2015-16

Month 7 - October 2015

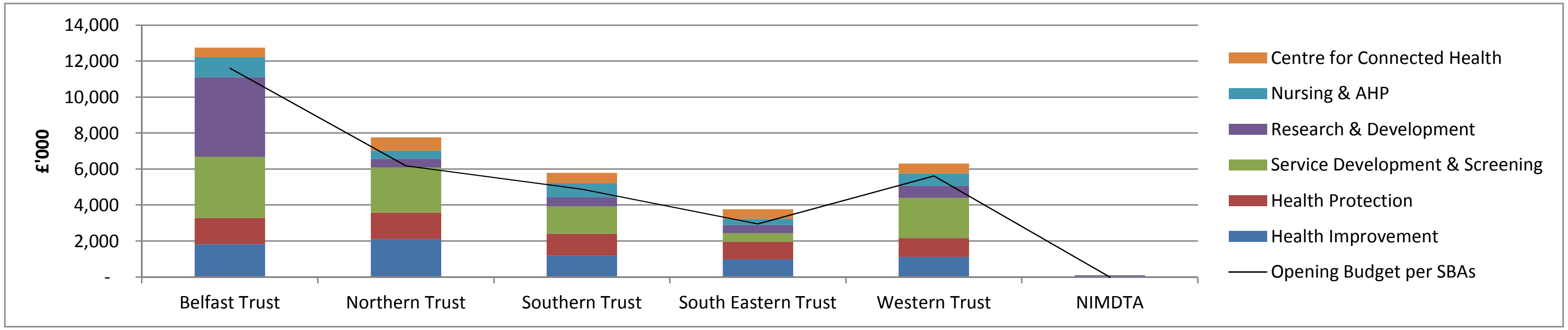
Public Health Agency

2015-16 Summary Position - October 2015

	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust	Non-Trust			Trust	Non-Trust		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Adjusted Departmental Allocation	36,526	48,562	21,832	**106,920**	21,331	19,735	11,150	**52,216**
Income from Other Sources	-	663	570	**1,233**	-	637	314	**951**
Total Available Resources	36,526	49,225	22,402	**108,153**	21,331	20,372	11,464	**53,167**
Expenditure								
Trusts	36,526	-	-	**36,526**	21,331	-	-	**21,331**
Non-Trust Programme	-	49,225	-	**49,225**	-	21,944	-	**21,944**
PHA Administration	-	-	22,402	**22,402**	-	-	11,174	**11,174**
Total Proposed Budgets	36,526	49,225	22,402	**108,153**	21,331	21,944	11,174	**54,449**
Surplus/(Deficit)	-	-	-	**-**	-	(1,572)	290	**(1,282)**

The year to date financial position for the PHA shows an overspend against profiled budget of £1.3m. This is the result of non-trust expenditure ahead of profile by £1.6m, offset by a year-to-date underspend on Management & Administration of £0.3m. The detail behind these variances is set out on pages 3 and 4 of this report. It is currently anticipated that the PHA will breakeven on its full year budget.

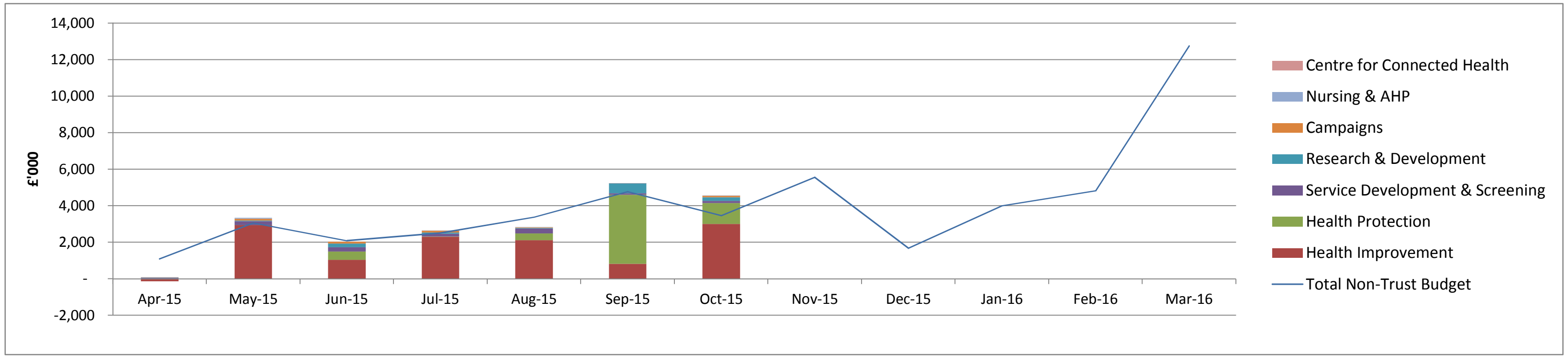
Programme Expenditure with Trusts



Current Trust RRLs	**Belfast Trust £'000**	**Northern Trust £'000**	**Southern Trust £'000**	**South Eastern Trust £'000**	**Western Trust £'000**	**NIMDTA £'000**	**Total Current Budget £'000**
Health Improvement	1,821	2,104	1,187	974	1,115	-	**7,200**
Health Protection	1,469	1,474	1,214	999	1,057	-	**6,213**
Service Development & Screening	3,404	2,520	1,520	460	2,227	-	**10,130**
Research & Development	4,411	475	506	465	675	107	**6,638**
Nursing & AHP	1,119	465	785	347	697	-	**3,412**
Centre for Connected Health	536	732	590	525	549	-	**2,932**
Total current RRLs	**12,758**	**7,770**	**5,802**	**3,770**	**6,318**	**107**	**36,526**
Opening Budget per SBAs	**11,604**	**6,183**	**4,887**	**2,950**	**5,626**	**-**	**31,250**

As part of a service improvement project the Finance Directorate has coded the Trust Revenue Resource Limits to their budget area, as shown by the summary above. During October additional commitments of £2.2m were made to HSC Trusts, primarily in respect of Pertussis and Meningococcal vaccination programmes.

Non-Trust Programme Expenditure



	Apr-15 £'000	May-15 £'000	Jun-15 £'000	Jul-15 £'000	Aug-15 £'000	Sep-15 £'000	Oct-15 £'000	Nov-15 £'000	Dec-15 £'000	Jan-16 £'000	Feb-16 £'000	Mar-16 £'000	Total £'000	Budget (YTD) £'000	Expenditure (YTD) £'000	Variance (YTD) £'000
Budget																
Health Improvement	719	2,378	919	2,006	2,190	627	1,190	3,250	670	2,374	1,588	5,423	**23,334**	10,029	12,117	(2,087)
Lifeline	292	292	292	292	292	292	292	292	292	292	292	292	**3,500**	2,042	1,377	665
Health Protection	-	15	418	12	460	3,026	1,494	431	385	787	1,148	911	**9,087**	5,425	5,774	(350)
Service Development & Screening	83	368	85	83	368	93	127	380	123	106	395	303	**2,514**	1,206	1,144	62
Research & Development	-	-	237	60	45	501	185	1,120	113	112	1,181	4,486	**8,039**	1,028	1,051	(23)
Campaigns	-	1	131	58	32	230	180	95	85	290	230	414	**1,746**	632	442	190
Nursing & AHP	-	3	3	-	3	-	-	3	23	39	- 12	896	**960**	10	92	(82)
Centre for Connected Health	-	-	-	-	-	-	-	0	-	-	0	0	**0**	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	9	36	**44**	-	(53)	53
Total Non-Trust Budget	**1,094**	**3,056**	**2,085**	**2,511**	**3,390**	**4,768**	**3,468**	**5,571**	**1,691**	**4,000**	**4,830**	**12,760**	**49,225**	**20,373**	**21,944**	**(1,572)**
Actual Expenditure	**233**	**3,506**	**2,306**	**2,681**	**3,109**	**5,292**	**4,815**	**-**	**-**	**-**	**-**	**-**	**21,944**			

The Non-Trust Programme budget decreased by £1.3m since the last report due to the transfer to Trusts of allocations from DHSSPS primarily for Pertussis and Meningococcal Vaccination Programmes.

The financial position to date shows expenditure is £1.6m ahead of the budget profile. This is primarily due to a number of Health Improvement payments being made earlier than anticipated due to faster processing by Shared Services, with the expenditure expected to come back into line with profile over the next few months. An underspend against the Lifeline contract is expected to continue. The Programme position is being closely managed and a plan has been developed to manage the variances and ensure a breakeven position for the financial year.

A significant portion of the budget is currently profiled in the last quarter which Budget managers have confirmed will be utilised in 2015-16. Budget managers have been asked to review these figures closely and liaise with the Financial Management team if amendments to profiles are required.

PHA Administration

2015-16 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	2,868	3,480	10,160	287	318	475	**17,587**
Goods & Services	227	1,421	556	(120)	82	442	**2,608**
VER Scheme				2,207			**2,207**
Total Budget	**3,095**	**4,901**	**10,716**	**2,374**	**400**	**917**	**22,402**
Budget profiled to date							
Salaries	1,641	2,029	5,869	156	182	302	**10,179**
Goods & Services	123	788	300	(70)	49	96	**1,285**
Total	**1,763**	**2,817**	**6,169**	**86**	**231**	**398**	**11,464**
Actual expenditure to date							
Salaries	1,658	2,026	5,824	141	188	302	**10,139**
Goods & Services	68	701	181	(29)	12	102	**1,035**
Total	**1,727**	**2,726**	**6,005**	**112**	**200**	**403**	**11,174**
Surplus/(Deficit) to date							
Salaries	(18)	3	45	15	(6)	(0)	**39**
Goods & Services	54	87	119	(41)	36	(6)	**250**
Surplus/(Deficit)	**37**	**90**	**164**	**(26)**	**30**	**(6)**	**290**

The Management & Administration (M&A) budget for the PHA was reduced by the DHSSPS in 2015-16 by 15%, or £2.8m. However, after discussion and liaison with the DHSSPS, it was agreed that, for the current year only, a total of £1.3m will be generated from within M&A budgets and the balance of £1.5m will be managed across the total PHA budget. This process will allow a more strategic review to be completed in order to deliver a recurrent 15% reduction in future years.

Total recurrent budgets allocated to Directorates have been reduced by the actual 2014-15 surplus and a 20% travel saving, totalling £1.149m. This leaves a balance of £0.151m against the £1.3m savings target, and this is currently held in the PHA Board cost centre being managed centrally through Scrutiny and other measures. The overall M&A budget has increased by £0.2m from month 6 as a result of additional allocations for Dementia Strategy (£28k), EITP (£16k), Vaccines (£60k) and the SBNI e-Safety strategy (£60k).

While cumulatively to date a surplus of £0.290m is shown, (including a £6k overspend in SBNI which is expected to breakeven for the year), this has largely been generated from Goods & Services budgets within Operations, which may be required later in the year. PHA must therefore continue to manage discretionary expenditure and savings plans to ensure a breakeven position at the end of the financial year.

During September the PHA received a ringfenced allocation of £2.2m to fund a Voluntary Exit Scheme in 2015-16. This funding is currently held in the PHA Board cost centre, profiled at the end of the year so as not to impact year to date figures. These funds will be monitored and reported on separately, with greater detail provided in this report as the year progresses.

PHA Prompt Payment

Prompt Payment Statistics

	October 2015 Value	October 2015 Volume	Cumulative position as at 31 October 2015 Value	Cumulative position as at 31 October 2015 Volume
Total bills paid (relating to Prompt Payment target)	£6,273,139	463	£29,392,174	3,358
Total bills paid on time (within 30 days or under other agreed terms)	£6,234,812	432	£28,222,760	3,054
Percentage of bills paid on time	**99.4%**	**93.3%**	**96.0%**	**90.9%**

Prompt Payment performance to the period ending October 2015-16 shows that on value paid (96%) the PHA is exceeding the 30 day target of 95%, while the volume of invoices is below the target at 91%. Generally PHA is making excellent progress on ensuring that high value invoices are processed promptly, supported by the October value performance of 99.4%.

In addition, 10 day prompt payment performance was 84.4% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2015-16 of 60%.

HSC Public Health Agency

MINUTES

Minutes of the 31st Meeting of the Governance and Audit Committee
held on 14 October 2015, at 9.30am
PHA Conference Room, 18 Ormeau Avenue
Belfast, BT2 8HS

Present:

Mr Brian Coulter - Chair
Alderman Paul Porter - Non-Executive Director
Mr Thomas Mahaffy - Non-Executive Director

In Attendance:

Mr Edmond McClean - Director of Operations,PHA
Mr Paul Cummings - Director of Finance, HSCB
Miss Rosemary Taylor - AD Planning & Operational Services
Mrs Catherine McKeown - Internal Audit, BSO
Ms Christine Hagan - ASM
Mr Tomas Wilkinson - NIAO
Mr Mark Anderson - Sponsor Branch, DHSSPSNI
Mrs Una Turbitt - AD Nursing for Children & Young People (*for Item 12*)
Mrs Cathy McAuley - Secretariat

Apologies:

Mrs Mary Hinds - Director of Nursing

63/15 Item 1 - Welcome and Apologies

Action

The Chair welcomed everyone to the meeting and noted apologies.

64/15 Item 2 - Declaration of Interests

The Chair asked if anyone had any interests to declare relevant to any items on the agenda. No interests were declared.

65/15 Item 3 - Chair's Business

2016 Meeting Dates

The Chair confirmed that meeting dates for 2016 would be confirmed as soon as possible.

NIAO Events Company

The Chair asked members to read and consider the recent NIAO report on the Northern Ireland Events Company.

66/15 **Item 4 - Notes of previous Meeting – 10 June 2015**

The minutes of the previous meeting, held on 10 June 2015, were approved as an accurate record of the meeting.

67/15 **Item 5 - Matters Arising**

NIAO Events Company

Members agreed that the learning from this Report is valuable and it should be made widely available including the PHA Board. A PAC view on the Report is likely in due course.

68/15 **Item 6 - PHA 2014/15 Report to those Charged with Governance**

Mr Morrow presented the RTTCWG 2014/15 final report advising that there were no changes from the draft report presented to the GAC in June 2015.

Members **noted** the report.

69/15 **Item 7 - Report to those Charged with Governance Progress Report on Implementation of Recommendations**

Mr Cummings presented the RTTCWG progress report in respect of the two priority 3 findings for noting.

Prompt Payment Disclosure

Alderman Porter expressed his concern in respect of the priority 3 rating and the challenging target required by the Department regarding the prompt payment policy of 30 days following receipt of Invoices. Mr Cummings acknowledged that the target was challenging. He assured the committee that significant progress had already been made during 2014/15 and with continued monitoring the rating would continue to improve in 2015/16.

The Chair advised that the audit findings in relation to the leases of accommodation in Belfast were regrettably outside the control of the PHA. He added that the Strategic Outline Business Case for the extension of the leases for Alexander House and Anderson House had been submitted but have not been approved by the Department. He added that this issue had been highlighted within the 2015/16 Mid-Year Assurance Statement.

Members **noted** the report.

70/15 **Item 8 - IA Progress Report**

Risk Management

Mrs McKeown advised that Internal audit had provided a satisfactory level of assurance with no priority 1 findings, and 2 priority 2 findings identified. All recommendations had been accepted by management.

Health and Social Wellbeing Improvement Contracts (including visits to a sample of funded voluntary organisations.

Mrs McKeown advised Internal audit had provided a satisfactory assurance level with 1 priority 1 finding and three priority 2 findings in respect of the PHA management of voluntary and community contracts. Two of the organisations visited received limited assurance and 5 received satisfactory assurances. All recommendations had been accepted by management.

Procurement & Contract Management 2015/16

Mrs McKeown advised that Internal Audit has provided satisfactory assurance with no priority 1 findings and three priority 2 findings. All recommendations had been accepted by management.

Members **noted** the report.

71/15 **Item 8.1 - IA Mid-Year Follow up on previous recommendations**

Mrs McKeown advised that 76% of the recommendations had been implemented. Members expressed their concern on the low percentage implemented for some individuals. However it was noted that some of the actions were outside the control of the PHA.

Members **noted** the report.

72/15 **Item 8.2 - IA Shared Services Update**

Mrs McKeown advised Payments Shared Services had been awarded a satisfactory level of assurance with 1 priority 1 finding. She added that Business Services had been awarded a satisfactory level of assurance with 2 priority 2 findings.

Mrs McKeown tabled an updated BSO Internal Audit Payroll Shared Services report and advised it had received limited assurance. She added that there were 5 priority 1 findings; overpayment policy, volume of manual activity (not applicable to PHA), maternity calculations, HRTPS monitoring, review of access controls established.

Mr Cummings advised the report was for information and BSO is responsible for implementing recommendations.

Members **noted** the report.

73/15 **Item 8.3 - IA Mid-Year Assurance Statement**

Mrs McKeown presented the Internal Audit Mid-Year Assurance Statement for noting and summarised the report to members. Members **noted** the Mid-Year Assurance Statement.

74/15 **Item 9.0 - Corporate Risk Register (30 June 2015)**

Mr McClean presented the Corporate Risk Register as at June 2015 for noting and summarised the report. He said that 1 new risk had been added: CR 35: Property Asset Management and that 1 risk had been removed from the register CR33: VOIP Telephone System.

Mr McClean acknowledged that there been a significant amount of activity in seeking out accommodation options for PHA, but with no resolved outcome as yet. He advised the committee that the leases for Alex House and Anderson House had expired and the lease for Ormeau Baths would expire in February 2017. He added that while PHA is working with the DHSSPS, there is a lack of clarity regarding departmental strategic direction and requirements and DFP role. Members agreed that is an unsatisfactory position.

Members expressed concern at the continuing adverse impact of highly unsatisfactory accommodation upon PHA staff and performance. It was agreed that this situation be reported to PHA Board.

The Chair said the recent Internal Audit report on PHA's risk management processes noted that there is not an annual Board workshop to consider the Corporate Risk Register, but that he was content that members were engaged in the risk management process under the current arrangements.

Members **approved** the Corporate Risk Register as at 30 June 2015.

77/15 **Item 9.1 - PHA Assurance Framework 2015/16**

Mr McClean presented the assurance framework review as at September 2015 for approval.

Members **approved** the report.

76/15 **Item 9.2 - PHA Controls Assurance Standards Process**

Miss Taylor presented the Controls Assurance Standard

Assessment Process for 2015/16 for noting and added 15 of the 22 Controls Assurance Standards apply to PHA, four of which will be audited by Internal Audit in 2015/16.

Members **noted** the report.

77/15 Item 9.3 - ICT Security Policies

Miss Taylor explained that a review of the full suite of ICT policies and procedures had been undertaken by BSO ITS.

Members **approved** the updated ICT policies.

78/15 Item 9.4 - Information Governance Action Plan

Miss Taylor updated members on the progress made taking forward the information governance action plan. The action plan was also reviewed by the Information Governance Steering group in September.

Members **noted** the action plan.

79/15 Item 10 - SBNI Declaration of Assurance

Mr McClean said the PHA is corporate host to the SBNI. He added the SBNI Declaration of Assurance was being brought to this committee for noting and related to those areas directly related to PHA to confirm that SBNI was adhering to set governance requirements.

Members **noted** the SBNI Declaration of Assurance.

80/15 Item 11 - PHA Mid-Year Assurance Statement

Mr McClean presented the PHA Mid-Year Assurance Statement for approval and recommendation for PHA Board approval subject to further discussion at next PHA Board meeting.

Members recommended the Mid-Year Assurance Statement for PHA Board approval. **Mr McClean**

81/15 Item 12 - SBNI Section 12 Audit Tool 2015

The Chair welcomed Mrs Turbitt. Mrs Turbitt gave an overview advising that all members of the SBNI including the PHA are required to participate in an annual generic standards audit. The final audit report for the PHA demonstrates a high level of compliance.

The Chair congratulated Mrs Turbitt on achieving this level of compliance and said that GAC was grateful for the sharing of the report.

Members **noted** the report.

82/15 **Item 13 - PHA/BSO/HSCB Emergency Preparedness & Response Annual Report**

The Chair advised that there would be no representation for this item due to a recent bereavement. He advised he would raise recent re-emergence of an Ebola case in Scotland at the next PHA board meeting.

Members **noted** the report.

83/15 **Item 14 - Any other business**

83/16 **Item 15 - Date of next meeting**

Date	9 December 2015
Time	9.30am
Venue	Conference Rooms 3 & 4, 2nd floor, Linenhall Street, Belfast

Signed: Brian Coulter

Date: 9 December 2015

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	17 December 2015
Title of Paper	Service Framework for Respiratory Health and Wellbeing
Agenda Item	9
Reference	PHA/03/12/15
Summary	
Attached is the final draft of the detailed Implementation Plan with regard to the above. This is in response to a letter from the Permanent Secretary to both the HSCB and PHA Chief Executives (attached). Once approved, this paper will be submitted to DHSSPS.	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This framework was approved by AMT on 17 November.
Recommendation / Resolution	For Approval
Director's Signature	CHarper
Title	Director of Public Health
Date	17 November 2015

SERVICE FRAMEWORK FOR RESPIRATORY HEALTH AND WELLBEING 2015-2018

DETAILED IMPLEMENTATION PLAN – FINAL DRAFT

NOVEMBER 2015

TABLE OF CONTENTS

1. Abbreviations…………………………………………………………………………………………….3

2. Overview ………………………………………………………………………………………………4

3. Implementation Structure …………………………………………………………………………7

4. Reporting Arrangements …………………………………………………………………………10

5. Commissioning ……………………………………………………………………………………11

6. Stakeholder Involvement …………………………………………………………………… 11

7. Resources and Funding……………………………………………………………………………12

8. Progress to Date ……………………………………………………………………………………12

9. Key priorities for the next 6 months…………………………………………………………..13

Appendix A Membership of Regional Respiratory Forum

Appendix B Reporting Structure for the Respiratory Framework

The following are in a separate Excel document

Appendix C RSF Reporting Schedule

Appendix D RSF Annual Reporting Template

Appendix E Colour Key Definitions – Detailed Definitions for Progress Report

1 ABBREVIATIONS

CAP	Community Acquired Pneumonia
CF	Cystic Fibrosis
COPD	Chronic Obstructive Pulmonary Disease
DHSSPS	Department of Health, Social Services and Public Safety
GAIN	Guidelines and Audit Implementation Network
HRSCG	Hospital and Related Services Commissioning Group
HSC	Health and Social Care
HSCB	Health and Social Care Board
ILD	Interstitial Lung Disease
KPIs	Key Performance Indicators
LTOT	Long Term Oxygen Therapy
LTV	Long Term Ventilation
NICE	National Institute for Health and Care Excellence
OSAHS	Obstructive Sleep Apnoea
PHA	Public Health Agency
PMSI	Performance Management and Service Improvement
PPI	Personal and Public Involvement
R&D	Research and Development
RQIA	Regulation and Quality Improvement Authority
RSFW	Service Framework for Respiratory Health and Wellbeing

2 OVERVIEW

2.1 BACKGROUND

Service Frameworks are an important element in a standards driven system for improving the way that health and social care is planned, commissioned and delivered in Northern Ireland.

A service framework is a document which contains explicit standards, underpinned by evidence and legislative requirements. Service frameworks set targets, timeframes and expected outcomes for specific services, and are designed to:

- improve the health and social wellbeing of the population of Northern Ireland,
- reduce inequalities and promote social inclusion,
- improve the quality and safety of care,
- safeguard vulnerable individuals and groups,
- improve partnership working with other agencies and sectors.

Each Service Framework follows an individual's journey from prevention through to end-of-life care taking into account the different health and social care needs of children and adults.

Service frameworks links the key policies and strategies already developed, and draw on evidence from established sources, including the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

The revised Respiratory Service Framework was launched by the Health Minster on 10th September for implementation across Northern Ireland. On 8th October 2015, DHSSPS wrote to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) requesting an Implementation Plan to be submitted by 18th December 2015. This document set out the phased implementation plan for all three years of the framework (2015-2018).

2.2 SERVICE FRAMEWORK FOR RESPIRATORY HEALTH AND WELLBEING

The RSFW sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of the individuals and communities who currently have or are at greater risk of developing respiratory diseases.

2.2.1 Initial Service Framework

The initial Service Framework for Respiratory Health and Wellbeing was formally launched by the Minister for Health Social Services and Public Safety in 2009, recognising that it was, and continues to be, one of the most significant causes of ill health and disability in Northern Ireland.

2.2.2 The Regulation and Quality Improvement Authority (RQIA) Review

The initial Respiratory Service Framework finished its three years implementation cycle in 2012. The RQIA then completed an independent review of the implementation of the original Framework in 2013 and gave a positive report on progress achieved. The Review

Report is available using the following link:
http://www.rqia.org.uk/publications/rqia_reviews/rqia_reviews_2013.cfm

RQIA found widespread support among stakeholders for the service framework approach. There was a clear consensus that the framework had established a vehicle to realise the goals and objectives of the Northern Ireland Strategic Framework for Respiratory Conditions (‘A Healthier Future’: March 2006). The RQIA was complementary regarding the partnership approach adopted during development of the framework that created a positive platform and a strong foundation for the implementation process.

The review team also found that collaboration with service users, stakeholders and the public was well planned, and to the forefront of both the development and the implementation of the Respiratory Service Framework. The stakeholders’ feedback was that the implementation process has been a success that shaped the way services are being taken forward, and the framework contributed significantly to improvements in respiratory services.

2.2.3 Revision of initial RSFW

The Original Framework, upon reaching the end of its 3-year cycle, underwent a fundamental review in 2014, conducted by the Regional Respiratory Forum. Following this process, the revised version of the Framework was issued for public consultation. The final version of the revised *‘Service Framework for Respiratory Health and Wellbeing’* , was published by DHSSPS on 10th September 2015. Both documents may be accessed on the Department’s website:
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks/sqsd-service_frameworks_respiratory.htm

2.2.4 The Service Framework for Respiratory Health and Wellbeing 2015-2018

The revised RSFW recognises that several diseases can co-exist, share common risk factors and can adversely impact on prognosis; therefore the revised service framework included both standards for specific respiratory conditions, as well as standards relating to all respiratory conditions, and also generic standards relating to a range of conditions.

The revised framework sets out standards for the whole care pathway for respiratory diseases from prevention through diagnosis, treatment, ongoing care, rehabilitation to palliative and end of life care. Each standard is supported by key performance indicators, which set levels of performance to be achieved over the three-year period 2015/16 – 2017/18.

The revised RSFW includes 46 standards, each of which is supported by Key Performance Indicators (KPIs) with target levels of performance to be achieved over 3 years. The revised Framework will continue to be subject to regular review and refinement, to ensure it provides a sound basis for continued improvement in the quality of health and social services.

Standards for specific respiratory conditions:

- Chronic Obstructive Pulmonary Disease (COPD)
- Adult Oxygen
- Asthma in Adults
- Asthma in Children and Young People
- Community Acquired Pneumonia (CAP) in Adults
- Community Acquired Pneumonia (CAP) in Children and Young People
- Obstructive Sleep Apnoea / Hypopnoea Syndrome in Adults (OSAHS)
- Obstructive Sleep Apnoea / Hypopnoea Syndrome in Children and Young People (OSAHS)
- Long Term Ventilation in Adults (LTV)
- Long Term Ventilation in Children and Young People (LTV)
- Cystic Fibrosis (CF)
- Bronchiectasis
- Interstitial Lung Disease (ILD)

Standards relating to all respiratory conditions:

- Pulmonary Rehabilitation
- Transitional Care for Adolescents with Chronic Respiratory Disease
- Acute Oxygen Therapy
- Social and Emotional Support
- Information
- Training
- Medicines Management
- Palliative Care

2.2.5 Generic Standards

Generic standards on Communication and Involvement, Health Improvement and Protection and Palliative and End of Life Care are also included in the RSFW. These standards are common to all Service Frameworks and are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping. Implementation of the generic standards is not dealt with in this document as these standards will be monitored separately.

3 IMPLEMENTATION STRUCTURE & PROCESS

3.1 IMPLEMENTATION REQUIREMENTS

The development of a detailed implementation plan is the DHSSPS requirement for the implementation process. The HSCB and PHA will adopt a phased approach to the implementation process over the three years of Framework (2015-2018).as outlined below:

1. Identify a lead professional to take forward the implementation of the revised Respiratory Service Framework.
2. Establish a Respiratory Health and Wellbeing Service Framework Stakeholder Group, with the role of monitoring implementation progress.
3. Submit an implementation plan to the department by 18th December 2015.
4. All standards for which there was already a data source in place to be fully implemented by March 2016.
5. By March 2016, for the remaining standards, appropriate steps to be taken to establish data sources and baselines. Performance levels for these standards to be determined once baselines had been established.

3.2 REGIONAL RESPIRATORY FORUM

Implementation of the revised RSFW will be overseen by the Regional Respiratory Forum. This group will work jointly with the HSCB and the PHA, in relation to the development of strategies and plans to improve the respiratory health of the population. The membership of the Regional Respiratory Forum and the terms of reference have both been revised to meet the need of the implementation of the revised Respiratory Framework (Appendix A):

This group will:

- Act as champions and advocates for continuous respiratory health and wellbeing service quality improvements.
- Consider all aspects of respiratory health and wellbeing: ranging from primary prevention through secondary and tertiary care, to rehabilitation and end of life care.
- In conjunction with subgroup leads, identify commissioning priorities and develop plans in relation to respiratory services and health improvement for the HSCB, PHA and other stakeholders.
- Develop and maintain close links and partnership working with other parts of the HSC commissioning structure.
- Establish systems to routinely collect, collate, analyse and report data to monitor implementation of the RSFW progress on performance targets.
- Continually review and monitor Respiratory Framework quality indicators to ensure compliance with emerging evidence based best practice.
- Via subgroup leads, engage with and represent views of all stakeholders including service users, carers, the public and voluntary organisations.
- Facilitate collaborative working between the various subgroups in the RSFW.

- Link into the HSCB / PHA Performance Management arrangements.

The group will be chaired by Dr. Muhammad Sartaj (PHA) and will be multi-disciplinary and multi-agency, with representation from PHA, HSCB, HSC Trusts, General Practice, Queen's University Belfast, together with relevant Voluntary Organisations, service users, patients, clients and careers.

3.3 SUB-GROUP LEADS

The Subgroup Leads are fundamental in taking forward the work involved in implementing the RSFW, both via their links with clinical Networks and groups, and as members of the Regional Respiratory Forum. There are 13 subgroup leads within the Framework, each with oversight of their own section. Each Trust has a local respiratory forum, which will have a key role at Trust level to ensure that plans are made to meet standards and performance indicators.

Sub-Groups for the Respiratory Service Framework

Subgroup	Subgroup lead	Role
BHSCT Respiratory Forum	Anne-Marie Marley	Respiratory Nurse consultant, BHSCT
SHSCT Respiratory Forum	Catriona Kavanagh	Head of service for respiratory, SHSCT
WHSCT Respiratory Forum	Mary McMenamin	Respiratory coordinator, WHSCT
NHSCT Respiratory Forum	Linda Patton	Assistant director, NHSCT
SET Respiratory Forum	Janet Sinnerton	Respiratory Nurse specialist, NHSCT
Paeds Asthma, Allergy & Anaphylaxis Network	Prof. Mike Shields	Paediatric Respiratory Consultant, BHSCT
Spirometry subgroup	Rose McHugh	Nurse consultant, PHA
Obstructive Sleep Apnoea	Dr Martin Kelly	Respiratory Consultant, BHSCT
Cystic Fibrosis	Dr Muhammad Sartaj	Public Health consultant, PHA
Medicines Management	Deirdre Quinn	Pharmaceutical Services lead, HSCB
Regional Respiratory Commissioning	Sophie Lusby	Assistant director, Commissioning
Information	Dr Muhammad Sartaj	Public Health consultant, PHA
Adult and Paediatric Asthma *(to be established)*	To be agreed	

**** Other subgroups / task and finish groups will be established as and when required as part of the implementation process.***

Subgroup leads will work through existing and as necessary, bespoke structures: Implementation of the RSFW will be the responsibility of these structures, linking with HSC staff in Primary and Secondary care, as appropriate. The overall reporting structures for implementation of the Framework are outlined in Appendix B.

3.3.1 Sub-Group Lead Updates

Each subgroup lead will provide an update report on all relevant KPIs annually to the Regional Respiratory Forum, with exception reporting at other meetings as required. It is planned that this group will meet four times per year.

Subgroup lead updates to the Regional Respiratory Forum will incorporate the following, as appropriate:

- An overview of the current status of each standard and associated KPIs,
- Details of how KPIs are measured, any issues which have arisen and any proposed changes to KPIs,
- Details on target performance levels progress and timeframe for establishing any outstanding baseline performance levels,
- Progress against KPIs and in particular, details of any KPIs where target performance levels are not being met,
- Timeframes for reporting and processes to inform and feedback to clinical groups,
- Overview of Personal and Public Involvement (PPI), including reflections on how effective PPI has been and any challenges encountered,
- Any other pertinent section-specific information.

3.4 CORE-SUPPORT

The Director of Public Health is the nominated Lead Professional for implementation of the RSFW on behalf of PHA and HSCB. A Public Health Consultant, a HSCB Regional Respiratory Commissioning lead, a PHA nurse and AHP consultant and a Project Manager support the work of the subgroup leads and the Regional Respiratory Forum.

3.4.1 Information Officer

An Information Officer from the Performance Management Service Improvement (PMSI) Directorate, HSCB, has been identified to provide support. The Information Officer will liaise with subgroup leads and Trusts with regards to information requirements and data sources. Whilst much of the information can be collected from existing data sources, in some instances new data sources must be established, and clinical audit may be required. Arrangements for data collection will be agreed and confirmed with subgroup leads and with Trusts, where appropriate, in advance of commencement of data collection.

As with many other services, information is not available in a suitable format. Work is currently undertaken to allow information to be standardized and collected from existing systems across the region and to establish new information systems where needed.

Further work will be undertaken to standardised coding for existing systems. The development and implementation of new information systems will be required to report on the new KPIs in the revised framework. As the development of new information systems will require time and resources, it is therefore likely that dates for reporting on some KPIs may need to be moved or reported through alternate data sources e.g. audits. The potential for any delay will be continually assessed and reported as required.

Within PMSI, individual staff members have responsibility for assimilating data for each section of the Framework. The Information Officer will play a key role in facilitating and co-ordinating data collection and analysis for the overall RSFW, and in providing returns for progress/annual reports.

4 REPORTING ARRANGEMENTS

4.1 MONITORING ARRANGEMENTS

It is recognised that measuring health outcomes directly related to the service framework is difficult in chronic respiratory diseases. These can relate to a wide range of interconnected processes, assessments and treatments. However, Trusts will be asked to complete self-assessment proformas which will be used in conjunction with benchmarking information on service provision, standardized usage data and audit to ensure that standards are being met. To facilitate monitoring of progress of implementation of the framework, a reporting template, colour-key template has been developed (see appendix C). This is completed at least annually and is supported by a service specification breakdown.

4.2 REPORTING ARRANGEMENTS

Data collection will commence for some of the KPIs in 2016. A Reporting Schedule has been developed to monitor commencement of data collection and timeframes for reporting for each KPI (Appendix C). Because of the nature of some of the data sources, data will not be available for reporting until three to four months following the end of each data collection timeframe. For example, for the period up to and including March 2016, a report will be available in July 2016. A progress report will then follow for the period April 2016-September 2016, which will be available in January 2017. Progress reporting will continue on a six-monthly basis for the duration of the Framework.

Standardised Reporting Templates will be used to ensure consistency across the sections for progress and annual reports (Appendix D). A standardised Colour Key System will be used to denote achievement/status (Appendix E). Completion of these templates will be overseen by the Information Officer, as above. Completed reports will be shared with Section Leads, before being forwarded to the Steering Group.

Twice per year, the Regional Respiratory Forum will provide a progress report to the Senior Management Team of the HSCB and the Agency Management Team of the PHA for approval. An annual report will be submitted to the DHSSPS Service Framework Programme Board.

To allow clinicians to monitor performance against KPIs, subgroup leads will share section specific reports on progress with clinical groups / Networks. This regular feedback will allow action to be taken in a timely manner, to address any issues which may be impeding performance, or which should be brought to the attention of the Regional Respiratory Forum.

5 COMMISSIONING

It is anticipated that the respiratory commissioning lead, with the support of the nominated public health consultant and the project manager, will take forward all commissioning issues, channeling these through the relevant commissioning structures, i.e. Respiratory Commissioning Subgroup, Local Commissioning Groups, Specialist Services Commissioning Team, or any other relevant Commissioning Teams.

The Regional Respiratory Forum will have the capacity to identify priorities and make recommendations to the relevant commissioning group.

These arrangements will need to be reconsidered in light of the Minister's announcement on the outcome of the DHSSPS Review of Commissioning and the Donaldson Report.

6 STAKEHOLDER INVOLVEMENT

Stakeholder involvement, particularly service users, carers and public involvement, was a key principle underpinning development of the revised RSFW, and will continue to be of key importance in its implementation.

As has been acknowledged in the structures, implementation of the Framework will require working closely in partnership with a number of established projects, networks, groups and organisations. In addition, existing arrangements to secure PPI and to gather and reflect on patient, client and carer experience will be used to support implementation of the Framework. Collaboration with these stakeholders, and others, will also be particularly important in addressing those performance indicators relating to quality improvement in the relevant sections of the Framework and this will be facilitated by the subgroup leads.

It is essential that HSC works in partnership with other government departments, both statutory and non-statutory to seek to influence and improve health and social wellbeing. Accordingly, representatives from Asthma UK, NI Chest, Heart & Stroke and the British Lung Foundation are members of the Regional Respiratory Forum.

The Framework covers many disease areas which may have linked risk factors but are very different in terms of patient or client experience. In addition, many of the established Networks and groups have existing service user involvement, or are developing PPI Processes. Considering the wide range of diseases covered by the Framework and the existing PPI / Service User systems, Service User involvement will also be embedded at subgroup level with wider stakeholder events as required.

7 RESOURCES AND FUNDING

The experience to date indicates, while there have been many service improvements with the original Respiratory Service Framework, to achieve full implementation and compliance with standards in the revised Respiratory Service Framework will require additional funding.

Any resource implications associated with RSFW implementation will be handled through normal commissioning processes with bids made for service developments through the relevant commissioning team to the HSCB Senior Management Team or the PHA Management Team as appropriate. They will be considered against available funds along with service development bids from other services. Key investments will be reflected, as appropriate, in the relevant annual Commissioning Plan.

It is anticipated that some additional infrastructure is required to support monitoring of RSFW implementation. That infrastructure will provide and/or support collation of information from existing data sources, establishment and running of new data sources, data analysis and reporting. Some KPIs cannot be reported through existing information systems and, subject to stakeholder views, may require new clinical audits to be designed, tested, and then established across Northern Ireland. The scale and nature of the resources required to support these audits will depend on the methodologies agreed through subgroup leads with stakeholders. Bids for funding to develop that infrastructure will be made through usual processes in due course.

8 PROGRESS TO DATE

- A public health consultant has been nominated as the lead for the implementation of the Respiratory Service Framework.

- An Information Officer has been nominated and will be essential in co-ordinating data collection for all sections within the RSFW.

- HSCB have identified a regional commissioning lead, along with dedicated commissioning support for the respiratory framework implementation process.

- A series of meetings are being planned with subgroup leads and the Information Officer to discuss the stakeholder engagement process to define data sources, the methodology of data collection and reporting, anticipated performance levels and timescales for data collection and reporting. In certain instances, baseline performance levels and timeframes for clinical audit or other bespoke data collection methods are yet to be determined. This will occur during on-going engagement with stakeholders, subgroup leads and the Regional Respiratory Forum.

- A standardised Reporting Schedule has been developed, identifying the action associated with each KPI and the associated timeframe. Initiation of data collection and frequency of progress reports will also be captured in the Reporting Schedule.

- A standardised Colour Key System and standardised Reporting Templates have also been developed and will form the basis of all future progress reports, capturing data on progress against targets.

- The terms of reference for the Regional Respiratory Forum have been revised to reflect the needs of the RSFW.

- Commissioning issues in relation to wider respiratory services have recently been discussed with relevant commissioning leads and significant progress has been made.
- An information subgroup has been established to support the respiratory framework implementation process.

- Discussions have ben progressed with GAIN in relation to the audit requirements of the respiratory framework.

9 KEY PRIORITIES FOR THE NEXT SIX MONTHS

- To complete a baseline assessment exercise to identify gaps in current services and information systems.
- Progress the Respiratory Service Framework Implementation Plan and submit specific service development proposals through the 2016-17 Commissioning Plan process.
- To develop information systems including audits for KPIs where there are no established information systems.
- Continue to work with the Information Officer and Section Leads to commence data collection for KPIs which are due to start data collection in Year 1

LIST OF APPENDICES

Appendix A	Membership of Regional Respiratory Forum
Appendix B	Reporting Structure for the Respiratory Framework

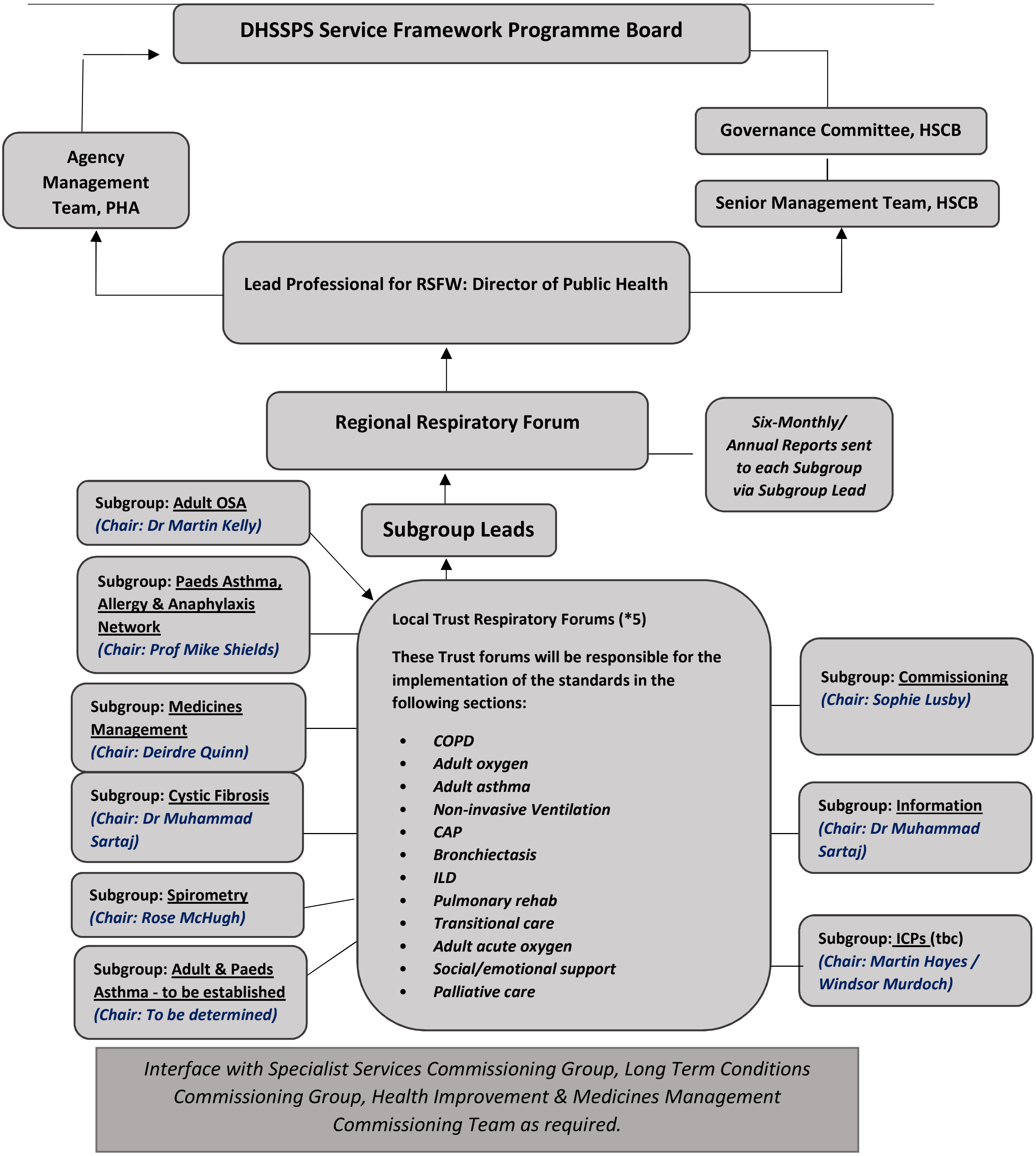
The following are in a separate Excel document

Appendix C	RSF Reporting Schedule
Appendix D	RSF Annual Reporting Template
Appendix E	Colour Key Definitions – Detailed Definitions for Progress Report

APPENDIX A - MEMBERSHIP OF REGIONAL RESPIRATORY FORUM

Organisation	Name	Role
PHA	Dr Muhammad Sartaj	Consultant, Public Health
PHA	Wendy Thornton	Project manager
PHA	Rose McHugh	Nurse consultant
PHA	David Tumilty	Health & social wellbeing improvement senior officer
PHA	Gerry Bleakney	Head of health and social wellbeing and improvement
PHA	Shane Breen	AHP consultant
HSCB	Sophie Lusby	Assistant Director, commissioning
HSCB	Deirdre Quinn	Pharmaceutical services lead
HSCB	Dr Edward O'Neill	Consultant medical advisor
HSCB	Veranne Lynch	Medicines management advisor
HSCB	Martin Hayes	Project Director, Integrated Care Partnerships
HSCB	Dr Windsor Murdoch	ICP Regional Lead
HSCB	Rachel Leonard	Business support manager, SE LCG
HSCB	Deborah McCord	Senior commissioning manager (N)
HSCB	Paul Dolan	Senior commissioning manager (W)
HSCB	Conor Curran	TYC Senior Change and Engagement manager
HSCB	Cathy Gillen	Information
DHSSPS	Linda Greenlees	Standards & Guidelines Quality Unit
RQIA	Nicola Porter	Guidelines and audit manager, GAIN
BHSCT	Dr Tim Warke	Consultant respiratory physician
BHSCT	Dr Stewart Elbron	Consultant respiratory physician
BHSCT	Prof Mike Shields	Respiratory paediatric consultant
BHSCT	Anne Marie Marley	Respiratory nurse consultant
BHSCT	Deirdre Wasson	Respiratory physiologist
BHSCT	Jacqui Megarry	Respiratory physiologist
BHSCT	Dr Majella Tuohy	Consultant respiratory physician
NHSCT	Dr Wendy Anderson	Consultant respiratory physician
NHSCT	Linda Patton	Assistant Director
NHSCT	Siobhan Bradley	Respiratory nurse specialist
SHSCT	Dr Alexander John	Consultant respiratory physician
SHSCT	Catriona Kavanagh	Head of Service (Acute)
SHSCT	Martina Thompson	Head of service (Community COPD)
SHSCT	Cathie McIlroy	Physiotherapy specialist
SET	Dr Ian Gledhill	Consultant respiratory physician
SET	Laura Elias	Clinical manager
SET	Janet Sinnerton	Respiratory nurse specialist
SET	Jennifer Howard	Respiratory specialist physiotherapist
SET	Lisa Elder	Respiratory nurse specialist
WHSCT	Dr Margaret McCloskey	Consultant respiratory physician
WHSCT	Mary McMenamin	Respiratory co-ordinator
WHSCT	Dr Rose Sharkey	Consultant respiratory physician
WHSCT	Dr Martin Kelly	Consultant respiratory physician
WHSCT	Brendan McGrath	Manager
Vols - Asthma UK	Joseph Clift	Senior policy officer
Vols - B.L.F	Nessie Blair	Service development manager
Vols - CH&S	Fiona Greene	Acting director of care
U.U.J	Brenda O'Neill	Senior lecturer
Primary Care	Cait Hannity	Practice nurse
Primary Care	Carole McGrath	Practice nurse
Primary Care	Dr Geoffery Allen	GP with special interest
Marie Curie	Lesley Rutherford	Palliative care specialist
NIMDTA	Maeve Lambe	GP training NIMDTA
Marie Curie	Dr Yvonne Duff	Palliative care consultant
Marie Curie	Dr Pauline Wilkinson	Palliative care consultant

APPENDIX B - RSFW REPORTING STRUCTURE



These Trust forums will be responsible for the implementation of the standards in the following sections:

- *COPD*
- *Adult oxygen*
- *Adult asthma*
- *Non-invasive Ventilation*
- *CAP*
- *Bronchiectasis*
- *ILD*
- *Pulmonary rehab*
- *Transitional care*
- *Adult acute oxygen*
- *Social/emotional support*
- *Palliative care*

Interface with Specialist Services Commissioning Group, Long Term Conditions Commissioning Group, Health Improvement & Medicines Management Commissioning Team as required.

Colour Key for Reporting Schedule	
One-Off Action	⬛
Commence data collection	🟦
Identify datasource and baseline	🟥
Establish baseline & agree anticipated performance levels	🟪
six monthly report	🟩

Respiratory Services Framework - Reporting Schedule 2015/16 to 2018/19

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
ADULT COPD	10a	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**		All practices to have developed registers																				🟦						🟩						🟩						🟩
ADULT COPD	10b	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**	60%	80%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	10c	Percentage (%) of patients with COPD with a record of FEV1 in the preceding 15 months.	QOF	**QOF**		75%																				🟦						🟩						🟩						🟩
ADULT COPD	10d	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**	70%	90%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	10e	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**		70%																				🟦						🟩						🟩						🟩
ADULT COPD	10f	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**	70%	90%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	10g	Percentage (%) of people with COPD with Sp02 levels <92% , **when condition stable**, who are referred to the local Home Oxygen Assessment and Review (HOS-AR) service.	Regional LES	**Regional LES**		90%																				🟦						🟩						🟩						🟩
ADULT COPD	10h	Percentage (%) of people with COPD who smoke, who have had appropriate smoking advice.	Regional LES	**Regional LES**	90%	95%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	10i	Percentage (%) of people with COPD who have had influenza immunisation in the preceding 1 September to 31 March.	QOF	**QOF**	95%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	11	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT COPD	12a	Percentage (%) of people with COPD given individualised, face to face information and a written self-management action plan.	Regional LES	**Regional LES**	90%		95%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	12b	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**	70%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	12c	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**	70%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	13a	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT COPD	13b	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT COPD	13c	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**	70%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	13d	Managed in a respiratory ward or formally designated respiratory area within a ward.	Regional Discharge Audit / PAS	**AUDIT**	50%		70%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	13e	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**	70%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	14a	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**	90%		95%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	14b	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**	90%		95%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	14c	Percentage (%) of people who receive non-invasive ventilation who have a clear management plan which includes ceiling of care.	BTS NIV audit	**AUDIT**	90%		95%							🟦						🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) (preparing for Year 1 report)									Year 2 (2016/17) (Full report on year 1 progress & mid-year report on Year 2)												Year 3 (2017/18) (Full report on year 2 progress & mid-year report on Year 3)												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
ADULT COPD	**15a**	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**	70%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT COPD	**15b**	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**	40%	60%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**16a**	Percentage (%) of Trusts that have HOS-AR assessment processes in place for LTOT.	HSC Trust report	**Trust Report**	All Trusts									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**16b**	Percentage (%) of people started on LTOT who have been appropriately assessed via the assessment process.	HSC Trust report & HOOF database	**Multiple sources**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**17a**	Percentage (%) of Trusts that have HOS-AR assessment processes in place for ambulatory oxygen.	HSC Trust report	**Trust Report**	All Trusts									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**17b**	Percentage (%) of people prescribed ambulatory oxygen in addition to LTOT via a concentrator following specialist assessment.	HOOF database	**Existing information system**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**18**	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**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Oxygen	**19**	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**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**20**	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**21a**	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**21b**	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**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**21c**	% of people aged 14 and above with a diagnosis of asthma that attended and have been asked to demonstrate their inhaler technique at asthma review.	Regional LES	**Regional LES**	80%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**22a**	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**	70%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**22b**	Percentage (%) of people on step 5 treatment currently under the care of secondary care asthma services.	Regional LES	**Regional LES**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23a**	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**	40% 70%	50% 80%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23b**	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**	60% 80%	60% 80%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23c**	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT Asthma	**23d**	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT Asthma	**23e**	Percentage (%) of practices with a register of patients at risk of near fatal asthma.	Regional LES	**Regional LES**		70%																				🟦		🟪				🟩						🟩						🟩
ADULT Asthma	**23f**	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**	80%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23g**	Percentage (%) of people with acute severe asthma admitted to hospital with an exacerbation who received care from a respiratory team.	BTS audit	**AUDIT**	60%		80%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23h**	Percentage (%) of people admitted with acute severe asthma on beta-2-agonist therapy only who are commenced on inhaled corticosteroids.	BTS audit	**AUDIT**	80%		90%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23i**	Percentage (%) of people admitted with acute severe asthma who receive a written discharge care plan.	BTS audit	**AUDIT**	60%		80%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**23j**	Percentage (%) of people with asthma who smoke, who have had appropriate smoking advice.	Regional LES	**Regional LES**	90%	95%								🟦						🟩						🟩						🟩						🟩						🟩
ADULT Asthma	**24a**	Percentage (%) of people assessed to benefit from appropriate monoclonal antibody therapy who are offered a therapeutic trial.	Regional difficult asthma database	**Existing information system**		100%																				🟦						🟩						🟩						🟩
ADULT Asthma	**24b**	Percentage (%) of people attending outpatients who have had appropriate management as per BTS guidelines.	To be agreed		Establish Baseline									🟦		🟪				🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
ADULT Asthma	**24c**	Percentage (%) of people who are admitted who have appropriate inpatient and discharge planning as per BTS guidelines.	To be agreed		Establish Baseline									🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**25A**	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**26a**	Percentage (%) of children and young people with asthma who have had individualised face to face information and self-management action planning.	Regional LES	**Regional LES**	80%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**26b**	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**26c**	Percentage (%) of schools supported with policies and training for asthma.	HSC Trust Report	**Trust Report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**26d**	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**27a**	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).	OoH audit ED audit care bundle methodology every 6 months	**AUDIT**	60% 60%	80% 80%								🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**27b**	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
PAEDS Asthma	**27c**	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
PAEDS Asthma	**27d**	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28a**	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**	100%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28b**	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**	100%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28c**	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28d**	Percentage (%) of schools attending an annual update on the recognition and treatment of acute anaphylaxis .	HSC Trust report	**Trust Report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28e**	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**	50%	90%								🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**28f**	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**		All Trusts																				🟦						🟩						🟩						🟩
PAEDS Asthma	**29a**	Percentage (%) of children and young people on beclometasone dipropionate or budesonide 800 mcg/day (or fluticasone propionate 400 mcg/day) who have been given a steroid alert card.	Outpatient audit (via Paeds Resp & Allergy network)	**AUDIT**	90%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**29b**	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**	90% for each criterion									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**29c**	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**	50%	60%	80% for each criterion							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**29d**	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**	50%	60%	80%							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	**29e**	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**	50%	60%	80%							🟦						🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level		
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**
PAEDS Asthma	29f	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**	50%	90%	
PAEDS Asthma	29g	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**		All Trusts	
ADULT C.A.P	30a	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**	80%		90%
ADULT C.A.P	30b	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**	80%		90%
ADULT C.A.P	30c	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**	80%		90%
ADULT C.A.P	30d	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**	90%		95%
PAEDS C.A.P	31a	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**	75%		90%
PAEDS C.A.P	31b	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**	20%	10%	
PAEDS C.A.P	31c	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**	80%	90%	
ADULT O.S.A	32a	Percentage of Trusts that have specialist OSAHS services which can provide overnight oximetry; limited polysomnography and CPAP provision.	HSC Trust report	**Trust Report**		All Trusts	
ADULT O.S.A	32b	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**		50%	80%
ADULT O.S.A	32c	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**		50%	80%
ADULT O.S.A	33a	Regional respiratory centre (at BCH) should establish a regional OSAHS service for people requiring full polysomnography.	HSC Trust report	**Trust Report**	service established		
ADULT O.S.A	33b	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**		60%	80%
ADULT O.S.A	34a	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**	All Trusts		
ADULT O.S.A	34b	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**	80%	90%	
ADULT O.S.A	35a	Percentage (%) of people meeting urgent referral criteria who have commenced CPAP within 4 weeks.	CPAP database (local trusts)	**Existing information system**	95%		
ADULT O.S.A	35b	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**		80%	
ADULT O.S.A	35c	Percentage (%) of people who were reviewed on an annual basis with CPAP adherence checked.	CPAP database (local trusts)	**Existing information system**		40%	60%
PAEDS O.S.A	36a	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**	100%		

		Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
PAEDS Asthma	29f							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS Asthma	29g																			🟦						🟩						🟩						🟩
ADULT C.A.P	30a							🟦						🟩						🟩						🟩						🟩						🟩
ADULT C.A.P	30b							🟦						🟩						🟩						🟩						🟩						🟩
ADULT C.A.P	30c							🟦						🟩						🟩						🟩						🟩						🟩
ADULT C.A.P	30d							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS C.A.P	31a							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS C.A.P	31b							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS C.A.P	31c							🟦						🟩						🟩						🟩						🟩						🟩
ADULT O.S.A	32a																			🟦						🟩						🟩						🟩
ADULT O.S.A	32b																			🟦						🟩						🟩						🟩
ADULT O.S.A	32c																			🟦						🟩						🟩						🟩
ADULT O.S.A	33a							🟦		⬛				🟩												🟩						🟩						🟩
ADULT O.S.A	33b																			🟦						🟩						🟩						🟩
ADULT O.S.A	34a							🟦						🟩						🟩						🟩						🟩						🟩
ADULT O.S.A	34b							🟦						🟩						🟩						🟩						🟩						🟩
ADULT O.S.A	35a							🟦						🟩						🟩						🟩						🟩						🟩
ADULT O.S.A	35b																			🟦						🟩						🟩						🟩
ADULT O.S.A	35c																			🟦						🟩						🟩						🟩
PAEDS O.S.A	36a							🟦						🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) (preparing for Year 1 report)									Year 2 (2016/17) (Full report on year 1 progress & mid-year report on Year 2)												Year 3 (2017/18) (Full report on year 2 progress & mid-year report on Year 3)												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
PAEDS O.S.A	36b	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**	95%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS O.S.A	36c	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**	95%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37a	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37b	Percentage (%) of people with motor neurone disease, who have 3-month assessment of forced vital capacity (FVC) or equivalent (mouth or nasal pressures) SpO2 measurement and symptom check for neuromuscular respiratory failure and Sp02 measurement within the first 36 months of diagnosis (unless already on NIV or deemed to be progressing very slowly and not requiring frequent monitoring).	Regional MND register	**Existing information system**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37c	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37d	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37e	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37f	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**	All Trusts									🟦						🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37g	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**	All Trusts									🟦						🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37h	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37i	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**		50%	50%																			🟦						🟩						🟩						🟩
ADULT L.T.V (long term ventilation)	37j	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**		establish baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
PAEDS L.T.V	38a	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38b	Percentage (%) of children and young people requiring inpatient sleep studies who are admitted within 13 weeks.	RBHSC report	**Tertiary Trust Report**	60%	90%	100%							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38c	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**	70%	80%	90%							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38d	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38e	Percentage (%) of children who require cough augmentation equipment, who access it within 4 months of decision to provide.	RBHSC report	**Tertiary Trust Report**	50%		100%							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38f	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**	20%	40%	60%							🟦						🟩						🟩						🟩						🟩						🟩
PAEDS L.T.V	38g	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Cystic Fibrosis	39	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**	UK Standard from April 2014		TBC							🟦						🟩						🟩						🟩						🟩						🟩
Cystic Fibrosis	40a	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	**Existing information system**	95% acceptable, 100% achievable	95% acceptable, 100% achievable	95% acceptable, 100% achievable							🟦						🟩						🟩						🟩						🟩						🟩
Cystic Fibrosis	40b	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	**Existing information system**	80% acceptable, 100% achievable	80% acceptable, 100% achievable	80% acceptable, 100% achievable							🟦						🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Cystic Fibrosis	41a	Percentage (%) of adults who have the following data recorded annually:· * FEV1 % predicted· * BMI * Sputum microbiology	CF registry	**Existing information system**		90%																				🟦						🟩						🟩						🟩
Cystic Fibrosis	41b	(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**		90%																				🟦						🟩						🟩						🟩
Cystic Fibrosis	41c	Percentage (%) of people reporting satisfaction with communication / information received from the specialist team.	Adults: Patient questionnaire Children: Peer review due Feb 2014	**AUDIT**	90%									🟦						🟩						🟩						🟩						🟩						🟩
Cystic Fibrosis	42a	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**		85%																				🟦						🟩						🟩						🟩
Cystic Fibrosis	42b	Percentage (%) of inpatients in single room accommodation.	CF centres report	**Trust Report**	100%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	43a	ADULTS - Percentage (%) of people with clinical diagnosis of bronchiectasis who have had diagnosis confirmed by high resolution CT chest.	BTS audit	**AUDIT**	90%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	43b	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**	40%	60%								🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	43c	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**	80% of children meet the diagnostic target		100%							🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44a	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**	All Trusts									🟦		⬛				🟩												🟩						🟩						🟩
Bronchiectasis	44b	ADULT STABLE - Percentage (%) of individuals diagnosed with bronchiectasis who have been reviewed by a respiratory physiotherapist.	BTS audit	**AUDIT**	90%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44c	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44d	ADULT STABLE - Percentage (%) of patients with breathlessness affecting activities of daily living referred to pulmonary rehabilitation.	BTS audit	**AUDIT**	60%		80%							🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44e	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44f	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**	80%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44g	ADULT EXACERBATIONS - Percentage (%) of individuals with an exacerbation of bronchiectasis who are offered home IV therapy where appropriate.	BTS audit	**AUDIT**	60%		80%							🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44h	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**	100%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44i	CHILDREN STABLE - Percentage (%) of children and young people who have a comprehensive annual review to include spirometery, BMI centile and sputum microbiology where appropriate.	BTS paediatric audit	**Tertiary Trust Report**	90%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44j	CHILDREN STABLE - Percentage (%) of children and young people who have regular microbiological surveillance every 3 months.	BTS paediatric audit	**Tertiary Trust Report**	60%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44k	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**	100%	100%								🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	44l	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**	100%									🟦						🟩						🟩						🟩						🟩						🟩
Bronchiectasis	45	Percentage (%) of adults attending secondary care who have been given individualised, face-to-face information and a written action plan.	HSC Trusts	**Trust Report**	60%	70%	80%							🟦						🟩						🟩						🟩						🟩						🟩
ADULT I.L.D	46a	Percentage (%) of trusts who have local access to a radiologist with expertise in thoracic imaging.	HSC Trust report	**Trust Report**		100%																				🟦						🟩						🟩						🟩
ADULT I.L.D	46b	Percentage (%) of Trusts who have regional access to a pathology service with appropriate expertise in ILD.	HSC Trust report	**Trust Report**		100%																				🟦						🟩						🟩						🟩
ADULT I.L.D	46c	Percentage (%) of Trusts with a named lead consultant respiratory physician with an interest in ILD.	HSC Trust report	**Trust Report**	100%									🟦						🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
ADULT I.L.D	**46d**	Percentage (%) of Trusts with a named specialist respiratory nurse with an interest in ILD.	HSC Trust report	**Trust Report**		100%																				🟦						🟩						🟩						🟩
ADULT I.L.D	**46e**	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**			50%																									🟩						🟩						🟩
ADULT I.L.D	**46f**	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**			Baseline to be determined																									🟩						🟩						🟩
ADULT Pulmonary Rehab	**47a**	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**		50%																				🟦						🟩						🟩						🟩
ADULT Pulmonary Rehab	**47b**	Percentage (%) of pulmonary rehabilitation programmes which are geographically accessible i.e. within 30 minutes of travel.	HSC Trust report	**Trust Report**	100%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Pulmonary Rehab	**47c**	Percentage (%) of pulmonary rehabilitation programmes which include all required elements as per BTS guidelines.	HSC Trust report	**Trust Report**	100%									🟦						🟩						🟩						🟩						🟩						🟩
ADULT Pulmonary Rehab	**47d**	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**	100%									🟦						🟩						🟩						🟩						🟩						🟩
Transitional Care	**48**	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**		should be able to meet service specifications																				🟦						🟩						🟩						🟩
ADULT Acute Oxygen	**49**	Emergency oxygen therapy should be prescribed using a target saturation range for patients admitted to hospital requiring oxygen therapy.	BTS Emergency Oxygen Audit	**AUDIT**	60%	80%								🟦						🟩						🟩						🟩						🟩						🟩
Social & Emotional Support	**50a**	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**			100%																									🟩						🟩						🟩
Social & Emotional Support	**50b**	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**			100%																									🟩						🟩						🟩
Social & Emotional Support	**50c**	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**	40%		80%							🟦						🟩						🟩						🟩						🟩						🟩
Social & Emotional Support	**50d**	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**			100%																									🟩						🟩						🟩
Social & Emotional Support	**50e**	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**			80%																									🟩						🟩						🟩
Social & Emotional Support	**50f**	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**	30%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Information	**51a**	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**		All areas																				🟦						🟩						🟩						🟩
Information	**51b**	Information available (including links to above) on HSCB and NI Direct websites.	PHA HSCB	**PHA HSCB report**		All websites																				🟦						🟩						🟩						🟩
Information	**51c**	Percentage (%) of people with respiratory disease accessing on-line support groups via HSC web and portal.	HSCB report	**HSCB report**	establish baseline	10% increase on baseline	20% increase on baseline							🟦		🟪				🟩						🟩						🟩						🟩						🟩
Information	**51d**	Percentage (%) of carers of people with respiratory disease accessing on-line support groups via HSC web and protal.	HSCB report	**HSCB report**	establish baseline	10% increase on baseline	20% increase on baseline							🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	**52a**	Percentage (%) of GP employed nurses who have completed self-assessment as per NIPEC R-CAT.	ICPs (to be agreed)	**ICP report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	**52b**	Percentage (%) of Trust employed specialist paediatric respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	**Trust Report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩

Disease Area & Key Performance Indicator			Data Source		Anticipated Performance Level			Year 1 (2015/16) *(preparing for Year 1 report)*									Year 2 (2016/17) *(Full report on year 1 progress & mid-year report on Year 2)*												Year 3 (2017/18) *(Full report on year 2 progress & mid-year report on Year 3)*												(2018/19) FINAL REPORT			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**Mar-16**	**Mar-17**	**Mar-18**	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Training	52c	Percentage (%) of Trust employed specialist adult respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	**Trust Report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52d	Percentage (%) of Trust-employed specialist respiratory physiotherapists, carrying out pulmonary rehabilitation, who have been trained to the standards agreed by the regional respiratory forum.	Trusts	**Trust Report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52e	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52f	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52g	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52h	Percentage (%) of GP practices where a primary care HSC professional has completed brief intervention training for smoking cessation.	ICPs (to be agreed)	**ICP report**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Training	52i	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**	establish baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Medicines Mg't	53a	Percentage (%) of respiratory prescribing in accordance with local medicines formulary	HSC Trusts BSO Perscribing Database	**Integrated Care report**	70%	tandem with developme								🟦						🟩						🟩						🟩						🟩						🟩
Medicines Mg't	53b	Percentage (%) of people with respiratory conditions accessing a medicines management support service	HSCB (Community Pharmacy Contract) Trusts (Self administration of medicines)	**Integrated Care report**	Establish Baseline	Performance levels agreed								🟦		🟪				🟩						🟩						🟩						🟩						🟩
Medicines Mg't	54	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**		Establish Baseline	Performance levels agreed																			🟦		🟪				🟩						🟩						🟩
Palliative Care	55a	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**	50%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55b	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**	50%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55c	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	**information system**	50%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55d	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**	50%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55e	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**	10%		30%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55f	Percentage (%) of the specialist respiratory team members who have had training in appropriate palliative care competencies.	HSC Trust report	**Trust Report**	80%		90%							🟦						🟩						🟩						🟩						🟩						🟩
Palliative Care	55g	Percentage (%) of specialist respiratory team members trained in appropriate communication skills .	HSC Trust report	**Trust Report**	95%									🟦						🟩						🟩						🟩						🟩						🟩

Colour Key for Reporting Schedule	
Standard achieved	Green
Standard partially or almost achieved	Amber
Standard not achieved	Red
Unable to make assessment or issues with data collection	Black
Awaiting data	Purple

Respiratory Services Framework - Annual Reporting Template for Year 1 *(2015/16)*

Disease Area & Key Performance Indicator			**Data Source**		**Year 1 (2015/16)**			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
ADULT COPD	**10b**	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**	60%			
ADULT COPD	**10d**	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**	70%			
ADULT COPD	**10f**	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**	70%			
ADULT COPD	**10h**	Percentage (%) of people with COPD who smoke, who have had appropriate smoking advice.	Regional LES	**Regional LES**	90%			
ADULT COPD	**10i**	Percentage (%) of people with COPD who have had influenza immunisation in the preceding 1 September to 31 March.	QOF	**QOF**	95%			
ADULT COPD	**12a**	Percentage (%) of people with COPD given individualised, face to face information and a written self-management action plan.	Regional LES	**Regional LES**	90%			
ADULT COPD	**12b**	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**	70%			
ADULT COPD	**12c**	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**	70%			
ADULT COPD	**13c**	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**	70%			
ADULT COPD	**13d**	Managed in a respiratory ward or formally designated respiratory area within a ward.	Regional Discharge Audit / PAS	**AUDIT**	50%			
ADULT COPD	**13e**	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**	70%			
ADULT COPD	**14a**	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**	90%			
ADULT COPD	**14b**	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**	90%			
ADULT COPD	**14c**	Percentage (%) of people who receive non-invasive ventilation who have a clear management plan which includes ceiling of care.	BTS NIV audit	**AUDIT**	90%			
ADULT COPD	**15a**	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**	70%			
ADULT COPD	**15b**	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**	40%			
ADULT Oxygen	**16a**	Percentage (%) of Trusts that have HOS-AR assessment processes in place for LTOT.	HSC Trust report	**Trust Report**	All Trusts			
ADULT Oxygen	**16b**	Percentage (%) of people started on LTOT who have been appropriately assessed via the assessment process.	HSC Trust report & HOOF database	**Multiple sources**	Establish Baseline			
ADULT Oxygen	**17a**	Percentage (%) of Trusts that have HOS-AR assessment processes in place for ambulatory oxygen.	HSC Trust report	**Trust Report**	All Trusts			
ADULT Oxygen	**17b**	Percentage (%) of people prescribed ambulatory oxygen in addition to LTOT via a concentrator following specialist assessment.	HOOF database	**Existing information system**	Establish Baseline			

Disease Area & Key Performance Indicator			**Data Source**		**Year 1 (2015/16)**			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
ADULT Oxygen	18	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	Establish Baseline			
ADULT Oxygen	19	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	Establish Baseline			
ADULT Asthma	20	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	80%			
ADULT Asthma	21a	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	80%			
ADULT Asthma	21b	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	Establish Baseline			
ADULT Asthma	21c	% of people aged 14 and above with a diagnosis of asthma that attended and have been asked to demonstrate their inhaler technique at asthma review.	Regional LES	Regional LES	80%			
ADULT Asthma	22a	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	70%			
ADULT Asthma	22b	Percentage (%) of people on step 5 treatment currently under the care of secondary care asthma services.	Regional LES	Regional LES	Establish Baseline			
ADULT Asthma	23a	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	40% 70%			
ADULT Asthma	23b	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	60% 80%			
ADULT Asthma	23f	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	80%			
ADULT Asthma	23g	Percentage (%) of people with acute severe asthma admitted to hospital with an exacerbation who received care from a respiratory team.	BTS audit	AUDIT	60%			
ADULT Asthma	23h	Percentage (%) of people admitted with acute severe asthma on beta-2-agonist therapy only who are commenced on inhaled corticosteroids.	BTS audit	AUDIT	80%			
ADULT Asthma	23i	Percentage (%) of people admitted with acute severe asthma who receive a written discharge care plan.	BTS audit	AUDIT	60%			
ADULT Asthma	23j	Percentage (%) of people with asthma who smoke, who have had appropriate smoking advice.	Regional LES	Regional LES	90%			
ADULT Asthma	23b	Percentage (%) of people attending outpatients who have had appropriate management as per BTS guidelines.	To be agreed		Establish Baseline			
ADULT Asthma	23c	Percentage (%) of people who are admitted who have appropriate inpatient and discharge planning as per BTS guidelines.	To be agreed		Establish Baseline			
PAEDS Asthma	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	80%			
PAEDS Asthma	26a	Percentage (%) of children and young people with asthma who have had individualised face to face information and self-management action planning.	Regional LES	Regional LES	80%			
PAEDS Asthma	26b	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	80%			
PAEDS Asthma	26c	Percentage (%) of schools supported with policies and training for asthma.	HSC Trust Report	Trust Report	establish baseline			
PAEDS Asthma	26d	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	80%			

Disease Area & Key Performance Indicator			Data Source		Year 1 (2015/16)			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
PAEDS Asthma	27a	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).	OoH audit ED audit care bundle methodology every 6 months	AUDIT	60% 60%			
PAEDS Asthma	27d	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	establish baseline			
PAEDS Asthma	28a	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	100%			
PAEDS Asthma	28b	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	100%			
PAEDS Asthma	28c	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	establish baseline			
PAEDS Asthma	28d	Percentage (%) of schools attending an annual update on the recognition and treatment of acute anaphylaxis .	HSC Trust report	Trust Report	establish baseline			
PAEDS Asthma	28e	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	50%			
PAEDS Asthma	29a	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	90%			
PAEDS Asthma	29b	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	90% for each criterion			
PAEDS Asthma	29c	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	50%			
PAEDS Asthma	29d	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	50%			
PAEDS Asthma	29e	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	50%			
PAEDS Asthma	29f	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	50%			
ADULT C.A.P	30a	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	80%			
ADULT C.A.P	30b	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	80%			
ADULT C.A.P	30c	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	80%			
ADULT C.A.P	30d	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	90%			
PAEDS C.A.P	31a	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	75%			
PAEDS C.A.P	31b	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	20%			

Disease Area & Key Performance Indicator			**Data Source**		**Year 1 (2015/16)**			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
PAEDS C.A.P	**31c**	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**	80%			
ADULT O.S.A	**33a**	Regional respiratory centre (at BCH) should establish a regional OSAHS service for people requiring full polysomnography.	HSC Trust report	**Trust Report**	service established			
ADULT O.S.A	**34a**	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**	All Trusts			
ADULT O.S.A	**34b**	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**	80%			
ADULT O.S.A	**35a**	Percentage (%) of people meeting urgent referral criteria who have commenced CPAP within 4 weeks.	CPAP database (local trusts)	**Existing information system**	95%			
PAEDS O.S.A	**36a**	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**	100%			
PAEDS O.S.A	**36b**	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**	95%			
PAEDS O.S.A	**36c**	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**	95%			
ADULT L.T.V (long term ventilation)	**37a**	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**	establish baseline			
ADULT L.T.V (long term ventilation)	**37b**	Percentage (%) of people with motor neurone disease, who have 3 month assessment of forced vital capacity (FVC) or equivalent (mouth or nasal pressures) SpO2 measurement and symptom check for neuromuscular respiratory failure and Sp02 measurement within the first 36 months of diagnosis (unless already on NIV or deemed to be progressing very slowly and not requiring frequent monitoring).	Regional MND register	**Existing information system**	establish baseline			
ADULT L.T.V (long term ventilation)	**37f**	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**	All Trusts			
ADULT L.T.V (long term ventilation)	**37g**	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**	All Trusts			
ADULT L.T.V (long term ventilation)	**37h**	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**	establish baseline			
PAEDS L.T.V	**38a**	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**	80%			
PAEDS L.T.V	**38b**	Percentage (%) of children and young people requiring inpatient sleep studies who are admitted within 13 weeks.	RBHSC report	**Tertiary Trust Report**	60%			
PAEDS L.T.V	**38c**	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**	70%			
PAEDS L.T.V	**38d**	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**	establish baseline			
PAEDS L.T.V	**38e**	Percentage (%) of children who require cough augmentation equipment, who access it within 4 months of decision to provide.	RBHSC report	**Tertiary Trust Report**	50%			
PAEDS L.T.V	**38f**	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**	20%			
PAEDS L.T.V	**38g**	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**	establish baseline			
Cystic Fibrosis	**39**	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**	UK Standard from April 2014			

Disease Area & Key Performance Indicator			Data Source		Year 1 (2015/16)			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
Cystic Fibrosis	40a	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	**Existing information system**	95% acceptable, 100% achievable			
Cystic Fibrosis	40b	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	**Existing information system**	80% acceptable, 100% achievable			
Cystic Fibrosis	41c	Percentage (%) of people reporting satisfaction with communication / information received from the specialist team.	Adults: Patient questionnaire Children: Peer review due Feb 2014	**AUDIT**	90%			
Cystic Fibrosis	42b	Percentage (%) of inpatients in single room accommodation.	CF centres report	**Trust Report**	100%			
Bronchiectasis	43a	ADULTS - Percentage (%) of people with clinical diagnosis of bronchiectasis who have had diagnosis confirmed by high resolution CT chest.	BTS audit	**AUDIT**	90%			
Bronchiectasis	43b	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**	40%			
Bronchiectasis	43c	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**	80% of children meet the diagnostic target			
Bronchiectasis	44a	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**	All Trusts			
Bronchiectasis	44b	ADULT STABLE - Percentage (%) of individuals diagnosed with bronchiectasis who have been reviewed by a respiratory physiotherapist.	BTS audit	**AUDIT**	90%			
Bronchiectasis	44c	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**	80%			
Bronchiectasis	44d	ADULT STABLE - Percentage (%) of patients with breathlessness affecting activities of daily living referred to pulmonary rehabilitation.	BTS audit	**AUDIT**	60%			
Bronchiectasis	44e	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**	80%			
Bronchiectasis	44f	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**	80%			
Bronchiectasis	44g	ADULT EXACERBATIONS - Percentage (%) of individuals with an exacerbation of bronchiectasis who are offered home IV therapy where appropriate.	BTS audit	**AUDIT**	60%			
Bronchiectasis	44h	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**	100%			
Bronchiectasis	44i	CHILDREN STABLE - Percentage (%) of children and young people who have a comprehensive annual review to include spirometery, BMI centile and sputum microbiology where appropriate.	BTS paediatric audit	**Tertiary Trust Report**	90%			
Bronchiectasis	44j	CHILDREN STABLE - Percentage (%) of children and young people who have regular microbiological surveillance every 3 months.	BTS paediatric audit	**Tertiary Trust Report**	60%			
Bronchiectasis	44k	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**	100%			
Bronchiectasis	44l	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**	100%			
Bronchiectasis	45	Percentage (%) of adults attending secondary care who have been given individualised, face-to-face information and a written action plan.	HSC Trusts	**Trust Report**	60%			
ADULT I.L.D	46c	Percentage (%) of Trusts with a named lead consultant respiratory physician with an interest in ILD.	HSC Trust report	**Trust Report**	100%			
ADULT Pulmonary Rehab	47b	Percentage (%) of pulmonary rehabilitation programmes which are geographically accessible i.e. within 30 minutes of travel.	HSC Trust report	**Trust Report**	100%			
ADULT Pulmonary Rehab	47c	Percentage (%) of pulmonary rehabilitation programmes which include all required elements as per BTS guidelines.	HSC Trust report	**Trust Report**	100%			

Disease Area & Key Performance Indicator			Data Source		Year 1 (2015/16)			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
ADULT Pulmonary Rehab	**47d**	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**	100%			
ADULT Acute Oxygen	**49**	Emergency oxygen therapy should be prescribed using a target saturation range for patients admitted to hospital requiring oxygen therapy.	BTS Emergency Oxygen Audit	**AUDIT**	60%			
Social & Emotional Support	**50c**	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**	40%			
Social & Emotional Support	**50f**	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**	30%			
Information	**51c**	Percentage (%) of people with respiratory disease accessing on-line support groups via HSC web and portal.	HSCB report	**HSCB report**	establish baseline			
Information	**51d**	Percentage (%) of carers of people with respiratory disease accessing on-line support groups via HSC web and protal.	HSCB report	**HSCB report**	establish baseline			
Training	**52a**	Percentage (%) of GP employed nurses who have completed self-assessment as per NIPEC R-CAT.	ICPs (to be agreed)	**ICP report**	establish baseline			
Training	**52b**	Percentage (%) of Trust employed specialist paediatric respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	**Trust Report**	establish baseline			
Training	**52c**	Percentage (%) of Trust employed specialist adult respiratory nurses who have completed self-assessment as per NIPEC R-CAT.	Trusts	**Trust Report**	establish baseline			
Training	**52d**	Percentage (%) of Trust-employed specialist respiratory physiotherapists, carrying out pulmonary rehabilitation, who have been trained to the standards agreed by the regional respiratory forum.	Trusts	**Trust Report**	establish baseline			
Training	**52e**	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**	establish baseline			
Training	**52f**	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**	establish baseline			
Training	**52g**	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**	establish baseline			
Training	**52h**	Percentage (%) of GP practices where a primary care HSC professional has completed brief intervention training for smoking cessation.	ICPs (to be agreed)	**ICP report**	establish baseline			
Training	**52i**	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**	establish baseline			
Medicines Mg't	**53a**	Percentage (%) of respiratory prescribing in accordance with local medicines formulary	HSC Trusts BSO Perscribing Database	**Integrated Care report**	70%			
Medicines Mg't	**53b**	Percentage (%) of people with respiratory conditions accessing a medicines management support service	HSCB (Community Pharmacy Contract) Trusts (Self administration of medicines)	**Integrated Care report**	Establish Baseline			
Palliative Care	**55a**	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**	50%			
Palliative Care	**55b**	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**	50%			
Palliative Care	**55c**	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	**information system**	50%			

Disease Area & Key Performance Indicator			Data Source		Year 1 (2015/16)			
Section	**KPI No.**	**Key Performance Indicator**	**Data Source**	**Category**	**KPI *Target***	**KPI *Result***	**Rag Status**	**Comments**
Palliative Care	55d	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**	50%			
Palliative Care	55e	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**	10%			
Palliative Care	55f	Percentage (%) of the specialist respiratory team members who have had training in appropriate palliative care competencies.	HSC Trust report	**Trust Report**	80%			
Palliative Care	55g	Percentage (%) of specialist respiratory team members trained in appropriate communication skills .	HSC Trust report	**Trust Report**	95%			

Appendix D (i) Service Frameworks Progress & Annual Reports - Status Colour Key

Colour	*Key*	*Definition / Perameters*	*Example(s)*
Green	**Standard achieved**	The anticipated performance level was **fully achieved**, i.e. the target was fully met or exceeded. ** Use of the term 'surrogate data’ in this category will mean that an alternative data source has been used as an interim proxy measure and that the result is <u>fully achieved</u> as per the definition.* *** Use of the word 'self assessment' in this category will mean that the performance level has been self-assessed by Trusts against a service specification and that the result is <u>fully achieved</u> as per the definition*	e.g. the anticipated performance level was 80% and the actual result was 80% or greater.
Amber	**Standard partially achieved**	The anticipated performance level was **partially achieved**, i.e. the result was within between 50% and 99% of the anticipated performance level. ** Use of the term 'surrogate data’ in this category will mean that an alternative data source has been used as an interim proxy measure and that the result is <u>partially achieved</u> as per the definition* *** Use of the word 'self assessment' in this category will mean that the performance level has been self-assessed by Trusts against a service specification and that the result is <u>partially achieved</u> as per the definition*	e.g. the anticipated performance level was 80% but the actual result was only between 40% and 79%.

Red	**Standard not achieved**	The anticipated performance level was **not achieved**, i.e. the result was less than 50% of the anticipated performance level. ** Use of the term 'surrogate data' in this category will mean that an alternative data source has been used as an interim proxy measure and that the result is not achieved as per the definition* *** Use of the word 'self assessment' in this category will mean that the performance level has been self-assessed by Trusts against a service specification and that the result is not achieved as per the definition*	e.g. the anticipated performance level was 80% but the actual result was only 40% or less.
Black	**Unable to make an assessment or issues with data collection**	Unable to determine KPI result for various reasons, i.e. no available data source, or changes to data source meaning KPI is now unmeasurable, or problems with carrying out audits.	
Purple	**Awaiting data**	Not yet able to determine KPI result as waiting on data,	e.g QOF reuslts are only published in September, so any KPI which has QOF as the data source would be listed as purple until the data is available.
White	**No target for this year**	The KPI did not have a target for this year.	

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	17 December 2015
Title of Paper	Personal and Public Involvement (PPI) Update Report
Agenda Item	10
Reference	PHA/04/12/15

Summary

As part of our Governance & Reporting arrangements, an update Report on PPI is produced and tabled for the PHA Board to consider, on a twice yearly basis.

Attached is the PPI Update Report for the period from June 2015 to November 2015.

Also attached for consideration is a Research paper on PPI (Executive Summary), jointly commissioned by the PHA and PCC from a team led by Queens University and the Ulster University.

In keeping with the previously agreed format, it is proposed that the Board will be updated on the formal report and also on this occasion, research paper, by way of delivery of a short presentation. The focus of the presentation will be the PPI Training programme and the research findings.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This update was approved by AMT on 8 December.
Recommendation / Resolution	For Noting
Director's Signature	Mary Hinds
Title	Director of Nursing, Midwifery and Allied Health Professions
Date	9 December 2015

DRAFT

Personal and Public Involvement (PPI)

PHA Board Update December 2015

Personal and Public Involvement (PPI)
Involving you, improving care

Personal & Public Involvement (PPI)

Personal and Public Involvement – What is it?

PPI is the active and effective involvement of services users, carers and the public in health and social care services. Involvement can range from one to one clinical or social care interactions with service users and carers, through to larger engagements to assess needs, partnership working to co-design services and influence commissioning priorities and policy development.

The rationale for PPI – Why do it?

People have a right to be involved in and consulted with on decisions that affect their health and social care. There is an increasing body of evidence which demonstrates that meaningful Involvement also helps to:

- Effectively identify need
- Increases efficiency through tailoring services and setting agreed priorities
- Improve quality, safety and patient experience
- Reduce complaints and SAIs
- Encourage self-responsibility for health and social well being

Statutory duty

Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement. The PHA and other HSC organisations now have a Statutory Duty to Involve & Consult service users, carers and the public on:

1. The planning and provision of care;
2. The development and consideration of proposals for change in the way that care is provided;
3. Decisions that affect the provision of care.

The PHA's role

In the 2012 PPI Policy Circular, the DHSSPS confirmed and assigned to the PHA, responsibility for the leadership of the implementation of this key policy area across the HSC system. It requires the PHA to provide the DHSSPS with assurances that HSC bodies and in particular Trusts, meet their PPI Statutory and policy responsibilities. Additional responsibilities confirmed / assigned also included:

- Ensuring consistency and co-ordination in approach to PPI;
- The identification and sharing of best PPI practice across HSC;
- Communication and awareness raising about PPI;
- Capacity building and training;
- Development of the Engage website;
- Monitoring of and reporting on PPI.

PPI up-date

The following table outlines areas of work undertaken and agreed future action required. The actions set out in this report have emerged from a variety of sources including:

- The legislative duty of Involvement,
- The PHA's leadership responsibilities as set out in the last PPI Circular,
- The PPI Standards that the PHA led on and which were launched in March 2015,
- The work plan of the Regional HSC PPI Forum and
- The internal PHA PPI Monitoring report, conducted earlier this year.

Standard	What have we achieved?	What do we need to do?
1. Leadership	**PPI Standards** The PHA led the development of a set of PPI Standards for HSC, which were co-designed with service users and carers. The Standards set out what is expected of HSC organisations and staff in terms of PPI. They will help standardise PPI practice and support the drive towards a truly person centred service. The PHA has put a programme in place to raise awareness of the Standards, which has included the distribution of some 12,000 leaflets across HSC, promoting them through twitter, Facebook, Connect etc. **Advice and Guidance** The PHA PPI Team provides professional leadership advice, guidance and support within the PHA and across the HSC system on PPI. In the last year, circa 50 such requests were received, which have involved input to significant HSC areas of work including Lifeline, Unscheduled Care, Podiatric Surgery, Cancer, Community Pharmacy, Nursing for Older People, TYC Care Pathways etc.	1. The PHA should appoint a Non-Executive PPI Lead at Board level. 2. In line with the internal audit report findings the PHA should consider how it can resource the implementation of the PPI Strategy / Action Plan moving forward. 3. The PHA needs to ensure that there are clear, accessible and transparent arrangements for involvement across each Directorate and Division.

Standard	What have we achieved?	What do we need to do?
	Leadership Structures / Arrangements At the Executive/Board level the PHA has a named executive Director who carries responsibility for PPI. An internal PPI Leads Forum was established to help embed Involvement into the culture and practice of the organisation. Each Division of the PHA is represented by a named delegate and deputy at this Forum. **Staffing** The PHA invested in a second PPI band 7 post utilising Stakeholder Involvement funding allocated from the DHSSPS. This was due in part to a recommendation from an internal audit report on PPI. It was also because of the expansion in demand for leadership, advice and guidance on Involvement within the PHA and across the HSC system as awareness and understanding of our responsibilities in respect of the Statutory Duty of Involvement increase. **Regional HSC PPI Forum** The PHA in its strategic leadership role, continues to Chair and	

Standard	What have we achieved?	What do we need to do?
	facilitate the work of the Regional HSC PPI Forum. The Forum recently established a strategic tier to give oversight and direction to PPI in HSC, involving the Directors / Assistant Directors with PPI responsibility from all HSC organisations. The Forum itself comprises representatives from all HSC organisations and of service users, carers and advocates. The Forum is the primary vehicle through which the PHA exercises its leadership function in PPI. It does this through: • The sharing of Best Practice. • Joint working on areas of common interest through established sub groups. • Active participation of and partnership with service users and carers.	
2. Governance	**Strategies and plans** The Corporate Plan has committed to PPI as a key approach to how the PHA does its business and this is reflected in our Annual Business Plan. The PHA's PPI Strategy, "Valuing People, Valuing Participation"	1. The PHA needs to ensure through its commissioning/planning arrangements and investments, that PPI is an active consideration in the decision making process.

Standard	What have we achieved?	What do we need to do?
	guides and directs the work of the organisation and its staff to embed PPI. An annual Action Plan is also developed for the Regional Forum and this alongside the PPI Strategy, covers all the strategic roles and responsibilities that the PHA carries in this area across HSC. Specific PPI Action Plans have been developed by some PHA Divisions including, Research & Development, the Safety Forum and Health Protection. Other work areas, AHPs for example, have PPI actions built in as an integral element of their strategy/work plan. **Reporting** A range of corporate governance reporting is undertaken against the PPI Strategy and Action Plan including quarterly Directorate Update Reports, bi-annual Board & Departmental update reports. An external facing Annual PPI Report is submitted to the DHSSPS reflecting on the work undertaken to progress PPI across the HSC on a partnership basis.	2. The PHA needs to update its PPI Strategy/ Action Plan for the period up to 2018. This should be undertaken in partnership with internal PPI Leads, service users, carers, voluntary / advocacy organisations and the public. 3. The PHA needs to review and update its Consultation Scheme, to provide clarity to staff and the public alike, (a requirement under the legislation on PPI) and ensure that it is meaningful and effective.

Standard	What have we achieved?	What do we need to do?
	Inclusion as part of business processes PPI is now an integral element of business cases, procurement / tendering processes and contract monitoring arrangements.	
3. Opportunities and support for involvement	**Established variety of opportunities for involvement** There are a range of opportunities and ways in which service users, carers, voluntary / advocacy organisations and the public can become involved with the work of the PHA, helping to inform, shape and develop plans and priorities. **Employed diversity in Involvement methodologies** Each Division has evidenced the involvement of service users, carers, voluntary sector partners and the public, using a variety of approaches including: • Use of Social media such as Facebook and Twitter • One off responses to surveys / questionnaires • Public consultations • Attendance at and contributions to Public meetings • Attendance at and contribution to Workshops & Focus Groups	1. The PHA should develop a central register of opportunities for involvement which is updated across all Divisions (where appropriate) and readily accessible by the public. 2. The PHA needs to consider the development of a PR / Marketing campaign, utilising social media etc. to evidence that the PHA is a listening organisation which effectively encourages involvement, debate and discussion and which brings the commitment to Involvement to the fore. 3. The PHA should finalise its set of guidance materials on essential support

Standard	What have we achieved?	What do we need to do?
	• Development of case studies • Membership of task & finish groups • Membership of Steering Groups • Reference Groups **Support materials** The PHA has developed support materials to facilitate the involvement of service users/carers including: • Use of the Out of Pocket Re-imbursement Guide for Service Users & Carers. • Practical Guides to different aspects of involvement. **Research** The PPI team working with Research & Development colleagues and the Patient Client Council commissioned a team led by Queen's University and Ulster University to examine various aspects of involvement including how it currently operates, how to assess progress and the barriers to involvement including looking at ways in which these might be addressed. The report has been completed	that should be made available for the involvement of service users and carers. 4. Feedback must be embedded as standard practice at all levels across the organisation and compliance with this, needs to be monitored. 5. The findings from the Research Report need to be disseminated and utilised to ensure further progress is made in the field of involvement in the HSC system.

Standard	What have we achieved?	What do we need to do?
	and the latest draft accompanies this report.	
4. Knowledge and Skills	**<u>Awareness raising training</u>** The PHA has led the development of a generic regional PPI training programme for HSC. This has been co-designed with service users/carers alongside HSC partners and will be formally launched in February 2016. The programme includes: • Taught modules • PPI Coaching • PPI Team Briefing • PPI e-learning programme 100+ staff across HSC participated in piloting a number of aspects of the programme during its development. PHA staff continue to deliver awareness raising and training sessions on PPI across the HSC. Examples of formal tailored PPI training sessions undertaken in the last reporting period include: • MSc in Public Health QUB • MSc Social Sciences, QUB	To inform and equip staff with the understanding, knowledge and skills to effectively involve and engage with service users, carers and the public, it is recommended that the PHA takes steps to: **Internal** 1. Build PPI into all future Job Descriptions and any review of existing Job Descriptions. 2. Ensure PPI is a part of individual job induction processes 3. Ensure PPI is factored into staff development plans and appraisals. **External** 1. Guide and support the roll out of the

Standard	What have we achieved?	What do we need to do?
	- Involving People, HSCB - BSc in Pharmacy, UU	PPI training programme across the HSC system. 2. Deliver the proposed 'Engage' website (within NI Direct / Knowledge Exchange) as a one stop resource for Involvement.
3. Measuring Outcomes	**<u>Monitoring arrangements</u>** The PHA working with service users, carers and HSC partners, designed and implemented the regionally agreed and Department endorsed PPI Monitoring process and arrangements within HSC. Monitoring was undertaken with five HSC Trusts, the RQIA and internally within the PHA with the findings and corresponding recommendations set out against the five PPI Standards. PHA reports were shared with the DHSSPS as part of agreed arrangements for accountability and are now on our website.	**Internal** **1.** There is a need to devise and operationalise effective and efficient mechanisms to record and capture evidence of PPI in practice at Divisional level across the PHA on an **on-going basis.** 2. Senior Management need to ensure that PPI (where appropriate) has been factored into plans, proposals etc which are presented for consideration.

Standard	What have we achieved?	What do we need to do?
	Impact through influencing/informing policy, investments and decisions The PPI team undertook monitoring across PHA to evidence and identify the action being taken to meet the PPI statutory duty which is evidenced below**:** **Research and Development** Decisions around Research and Development investment allocations for various funding / research programmes were directly affected / influenced by input from the R&D PPI panel. **AHP** The shaping of the Review of AHP Support for Children with Special Educational Needs as a result of the intensive PPI engagement with children, parents, schools and other direct stakeholders was highlighted. **Nursing** Nursing provided a range of examples of direct impact as a	**External** 1. The PHA need to utilise the recommendations from the last round of PPI monitoring with the Trusts to assess progress in this key policy area when conducting future monitoring. 2. The PHA should review with service users, carers and HSC partners the monitoring processes for PPI moving forward, with a particular focus on how impact is recognised and reported.

Standard	What have we achieved?	What do we need to do?
	consequence of PPI including work in Nursing Homes; IMROC which used co-production to bring about a number of service improvements and helped co-design and deliver educational courses for people affected by mental health issues. Nursing colleagues working with the Communications Dep't referred to work in the area of Cancer services, whereby service users and carers were instrumental in the development of plans to take forward a regional cancer awareness raising campaign. **Service Development and Screening** PPI approaches were instrumental in informing and shaping the development of the AAA screening programme and also in areas such as the modernisation of Diabetic Retinopathy Screening and helping to examine issues such as poor uptake of cancer screening amongst ethnic minorities. **Health Protection** The value of PPI in work on hand Hygiene in schools and Immunisation and Vaccination work in respect of TB, Measles etc was identified as having ensured messages were effectively tailored	

Standard	What have we achieved?	What do we need to do?
	to the target audience, helping to increase awareness of the issues and compliance with good practice. **Health & Social Wellbeing Improvement** Good practice examples of PPI in Transgender issues, work with Drug users and Suicide and Self-Harm were cited. Evidence of co-production in the development of educational materials to be used in EDs & the joint development of Care Pathways were also detailed. **Planning & Operations** PPI brought about changes to PHA practice which are now impacting right across the organisation, with all publicly tendered services now needing to evidence how PPI has been accounted for in determining the shape and scale of the services being commissioned. **Safety Forum** Pro-active support for the development of members of their PPI	

Standard	What have we achieved?	What do we need to do?
	Panel through attendance at a training programme on Quality Improvement and Patient Safety had resulted in the introduction of a “Teach Back” initiative, whereby the knowledge and insights gained are brought back and formally shared with the wider group.	

Summary Report

Personal and Public Involvement (PPI) and its impact - Monitoring, measuring and evaluating the impact of Personal and Public Involvement (PPI) in Health and Social Care in Northern Ireland.

This research has been commissioned by the Public Health Agency and the Patient Client Council. The report authors and researchers are grateful to both the PHA and PCC for their financial support and guidance throughout the time of this project.

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Summary

This report details the findings from research conducted across Northern Ireland's five Health and Social Care Trusts during 2015 which examines the current state of Personal and Public Involvement (PPI). This is about how service users, carers and patients engage with staff, management and directors of statutory health and social care organisations. Most statutory health and social care organisations must, under legislation, meet the requirements of PPI. PPI has been part of health and social care policy in Northern Ireland since 2007 and became law two years later with the introduction of the Health and Social Care Reform Act (2009). It is, therefore, timely that PPI is now assessed in this systematic way in order to both examine the aspects which are working well and to highlight those areas where improvements need to be made. As far as possible, this Summary Report is written in an accessible way, avoiding jargon and explaining key research terms, so as to ensure it is widely understood. This is in keeping with established good practice in service user involvement research. This summary, therefore, gives a picture of PPI in Northern Ireland currently. There is also a fuller report which gives a lot more details about the research and findings. Information on this is available from the Public Health Agency and/or the Patient Client Council.

Background

The Public Health Agency (PHA) promotes and aims to improve health and wellbeing and has a lead responsibility for PPI. The PHA is also responsible for health protection and provides professional input to the commissioning process (how funding is used to provide services). The Patient Client Council is often seen as the voice of the service user, carer and patient and, as a result, also has a very keen interest in PPI and related issues.

Aims and Objectives

The research commissioners (the Public Health Agency and the Patient Client Council) stipulated the following key aims and objectives for this study:

1. To identify best practice in PPI

2. To identify any barriers to effective involvement

3. To identify possible ways to overcome these barriers within the context of an integrated health and social care system

4. To identify valid and reliable ways of measuring and evaluating the impact of PPI activity.

5. To ensure that service users and carers are at the heart of this project in a significant and meaningful way.

Methodology (How we did the Research)

A group made up of academic staff from Queens University and Ulster University, Health Trust staff who have a particular interest in PPI and a number of service users and carers came together to carry out this research. This has been seen as an unusual approach to research involving people from different backgrounds, but it was hoped that this would lead to better engagement and involvement, using a wide range of skills and not just pure academic tools.

Central to all of this work was a strong service user and carer spirit, with service users and carers at the heart of all this work. It was agreed initially that the research would involve four key stages: Literature Review (using a Rapid Evidence Assessment (REA) approach)[1], On-line Survey, Focus Groups and, if required, follow-up telephone interviews. As sufficient information was gathered from the first three stages, the research team decided not to have the fourth stage.[2]

In addressing the previously stated research objectives, the team applied a *mixed methods* approach (different ways of gathering research information) using both *quantitative* (information expressed through statistics) and *qualitative* (information expressed as thoughts, opinions and ideas) methods to gather *data* (information) from key participants across Northern Ireland's health and social care sector alongside service users and carers.

The specific stages of the Methodology are as follows:

1. Stage one – Rapid Evidence Assessment

As the first stage of the project, the research team conducted a Rapid Evidence Assessment (REA) to search the international, national, regional and local literature on the following four key aspects of this project:

- Best practice in PPI internationally, nationally and in NI
- Barriers to effective involvement
- Possible ways to overcome these barriers

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[1] The literature review for the fuller report was undertaken using an approach described as a Rapid Evidence Assessment (REA). This process uses technical terms which must be used in the report to demonstrate the rigour with which this part of the research was undertaken.

[2] The research team decided not to conduct telephone interviews as sufficient depth was provided in the focus groups and on-line survey

- Valid and reliable ways of measuring and evaluating the impact of PPI activity

Rapid Evidence Assessments (REAs) provide an established methodology for using *systematic review methods* (structured ways of finding out what is already written on a topic) to identify and critically analyse the available literature and research evidence on legal, policy and practice issues. They are a rigorous, open and effective means of evaluating what is known and facilitating consideration of future developments and are particularly suited to projects which have a limited timescale such as in this instance.

2. Stage two – On-line Survey with Service Providers

Information on PPI activities and the impact of these was collected through an on-line questionnaire administered to statutory/public sector, third sector (organisations that are neither public sector nor private sector such as voluntary and community based) and private organisations (see Appendix Item 3 in Main Report). The on-line questionnaire was piloted (tested out) in one Health and Social Care Trust area and the sample (those who would be taking part) for this stage of the study was guided by advice from the Personal and Public Involvement lead staff in each of the Health and Social Care Trusts. In total, one hundred and thirty eight (***n*[3]=138**) respondents completed the on-line survey.

3. Stage three - Focus groups (number = 10)

The research team conducted ten focus groups across Northern Ireland aimed at establishing current experiences in PPI from the health and social care service user/carer and service provider perspectives in each of the five Health and Social Care Trust areas. Two focus groups were therefore conducted in each Trust area, incorporating these 'user' and 'provider' perspectives on PPI in separate focus groups. Each focus group took place in areas and community settings which we felt were geographically central and accessible to as many people as possible. The focus group questions were designed to reflect the research Objectives and were also shaped by the findings from both the literature review and on-line survey. Purposive sampling [4] was used to ensure that the focus group in each Trust area contained representation from service providers across statutory, private, third sectors and service users with experience of PPI in health and social care contexts. We also developed a Screening Tool to assist us in ensuring we had as broad a cross-section of the service user perspective as possible. Trust lead staff had a key role in publicising the

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[3] n = number

[4] Purposive sampling is where the decisions about who is to be involved in the focus groups is taken by the researcher because of the person’s experience or knowledge in a particular area to do with the research

research through Trust and other relevant networks. In total eighty nine (***n* = 89**) people participated in the focus groups (36 staff and 53 service users).

4. Stage four– follow-up telephone interviews

If the focus groups identified specific issues that were not explored in sufficient depth in the group, we agreed that these issues would be further investigated through follow-up interviews, with permission from the individual focus group participants who identified the issue. It was however not necessary to conduct any interviews such was the depth and quality of data the team was able to obtain through the focus groups.

Project Management

A Research Advisory Group was established to advise the research team on key aspects of the project. This was made up of staff representatives from across Trusts, Service User and Carer Organisations and individual service users/carers with research interests and experience in PPI. Membership of this Advisory Group was informed by key contacts recommended by and already known to members of the Research Team. This Group met on two occasions over the six month duration of the research and was updated appropriately at key stages of the research process.

Ethical Review

This research was ethically reviewed by the following organisations:

1. The School of Sociology, Social Policy and Social Work Research Ethics Committee, Queen’s University.

2. The Office of Research Ethics Committee, Northern Ireland.

3. The Research Governance Committees in Northern Ireland’s five Health and Social Care (HSC) Trusts.

The research project was also registered in the Queen’s University Human Subjects Research Database.

Meeting the Research Objectives

As mentioned already, the research was based around five Objectives. Each of these objectives is now summarised with reference to the main findings from this research.

Objective 1: To identify best practice in PPI

The focus groups for service users and staff included a specific question aimed at highlighting examples of positive practice and indeed best practice in regard to PPI in Northern Ireland. This was also addressed in the on-line survey. Importantly, the range of responses to this particular question leads the research team to conclude that there is much to be proud of in regard to what has been achieved to date in Northern Ireland. The picture is therefore quite encouraging with a host of examples provided which evidence meaningful change and impact across a range of service user and carer groups. This report also has a section dedicated to highlighting examples of best practice in PPI from across Northern Ireland's HSC Trusts. From the perspective of service users and carers, what contributed to positive PPI were factors such as: Information, staff attitudes, training and preparation, good communication skills, getting feedback, a sense of trust, enthusiasm and genuineness on the part of staff, being listened to and attention to detail in regard to practicalities. From the perspective of staff, the things that were important in achieving good PPI were: Being skilled, having the right attitude, having a commitment to PPI 'from the top', the values of the organisation and having resources in place, (particularly around administration, practical support and training).

The following is one example of good practice in PPI from our research.

Resettlement from Learning Disability Hospitals in Northern Ireland: Ensuring Betterment, Parity and Learning

Following a decision by the Department of Health, Social Services and Public Safety to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to accommodation offering a better life for the patient, the Trusts involved in partnership with the Health and Social Care Board and Disability Action developed a "Betterment Document" to ensure that a person-centred approach was used throughout the process, there was accessible and appropriate information available, discussions were informal and that sufficient time was provided for people to consider their options and articulate their views.

Resettlement was to offer "betterment" for the patient by being clinically appropriate, meeting the patient's needs, and offering the potential to better the life of the patient. A range of engagement methods were used depending on the needs or preference of the individuals *involved. The nature of the engagement often developed from an individual's or family's desire for privacy around what they identified as very sensitiveand emotional issues. While this required a great deal of 1-1 work it allowed for individualised information to be imparted in a safe, non-judgemental environment. As a result of this transparent and inclusive, person-centered process Resettlement was completed ahead of schedule and almost 2 years on everyone remains in placement.*

An evaluation of the project from an Independent Advocacy perspective concluded that the Betterment Documentation: helped prioritise individual and family views and increased ownership of services, increased levels of accountability, helped to reduce the perceived power imbalance between the service user / families and 'the bosses', helped to reduce complaints and deal more effectively with concerns at a local level and in a way that empowers rather than dis-empowers the service user and keeps the clear human rights of the individual to the forefront.

Objective 2: To identify any barriers to effective involvement

The on-line survey, focus groups and literature review specifically addressed the question of barriers in the context of the types of things which could prevent PPI from being effective and meaningful. The findings from the staff on-line survey clearly indicate that inadequate funding is one of the most significant barriers to PPI. Not having sufficient resources was evident in staff not having enough time to give to PPI work as well as not having sufficient staff in place to also do this type of work. Further barriers noted related to staff not feeling knowledgeable and skilled in PPI work. The latter point also links with the finding that only half of the staff surveyed knew who was responsible for PPI in their organisations and that half of those surveyed regarded PPI as part of everyday work. There was also a perception that PPI was not the responsibility of senior managers. Training on PPI was identified as being patchy and uneven, but it was recognised that attempts were being made to address this by the PHA.

Service users and carers in the focus groups observed ongoing problems with the language of PPI, staff not giving sufficient attention to the practicalities that go along with PPI, staff having poor communication skills, the absence of respect and empathy, instances of tokenistic involvement, procedural barriers in getting expenses paid and not being told about the impact of their involvement. Staff in their focus groups noted barriers such as: The working culture not being committed to PPI, staff not realising they were doing PPI work, not enough support from senior staff, the fact that good PPI takes time but without sufficient resource is very challenging, geographical unevenness in terms of PPI leading to a perception that some Trusts were better supported than others and the need for staff to be skilled in person centred working. These barriers are also consistent with the findings from the literature review.

Objective 3: To identify possible ways to overcome these barriers within the context of an integrated health and social care system

The following are key points identified from the review of the literature in addressing barriers that can prevent effective PPI:

- The need for training for everybody involved
- The need to have a commitment to achieving change on the part of those seeking involvement and for the public
- The need to recognise and promote diversity so as to involve a breadth of people's lived experiences
- The importance of relationship building skills
- The need for careful planning of involvement activities and to see these as integral to care planning and service development
- The need to have an *ethic of care* approach governing involvement which openly recognises power differences and the various roles and responsibilities of all parties involved in PPI work
- The need to have a staff member employed to have lead responsibility for involvement work and a dedicated team to provide practical support and develop resources to embed PPI as a way of working across the organisation, and finally,
- The need to provide feedback and evidence of impact following involvement.

The on-line survey highlighted the importance of PPI work needing to be better funded to deal with the feeling that staff expressed about being overburdened. The importance of training was also recognised as having a key contribution to make in ensuring that barriers to effective PPI can be minimised. Findings from the staff focus groups also echoed these sentiments, especially around the need to have PPI better resourced given this was a statutory duty, as distinct from Patient Client Experience, and also the need for improved training with a focus on skills. The resource issue was also related to needing to have service user and carer time remunerated for involvement work and the need to have staff time recognised as an important part of resource that good PPI demanded. Staff also expressed the view that PPI needed to be better supported and championed at senior management level in organisations.

The service user focus groups also made the following types of suggestions in regard to overcoming these types of barriers:

- The need to recognise and respect the service user and carer experience
- The need to make the language of PPI more accessible
- The need to be involved at a level that is chosen by the service user/carer (the on-line survey noted limited examples of involvement at strategic level)
- Being made aware that a difference has been made
- Staff needing to be consistent in showing respect and having a positive attitude, attending to the practicalities of Involvement
- The need for service users to be offered training
- The need to avoid tokenism in PPI work.

Objective 4: To Identify valid and reliable ways of measuring and evaluating the impact of PPI activity.

The literature review includes examples of ways in which the impact of PPI activity has been measured and evaluated. One of the important findings in the literature is that the impact of PPI is under researched. It is also noted that there is a need to measure and evaluate PPI across the broad spectrum of health and social care. The literature does refer to more examples of where PPI has been evaluated in regard to its impact on research, but less so in the domain of health and social care. The challenges in this area are also recognised, particularly in regard to introducing more quantitative based approaches where statistical evidence can be used to evaluate impact. Whilst the literature recognises that this type of approach is complex, it is also noted that there has tended to be an overreliance on using descriptive and retrospective accounts of involvement which are more qualitative based. The literature review concludes with a very relevant article for this project in reference to the work of Staniszewska et al. (2011a).[5] These authors argue in favour of thinking towards measurement approaches to involvement being co-designed with service users which can build on the more established methods of doing so using qualitative methods such as focus groups.

The on-line survey also included questions to address this objective. Highlighting the scale of the challenge in developing evaluation methods, only 17% of respondents (n=7) said their organisation always evaluated PPI activity with a further 41% (n=22) stating evaluation is

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[5] Staniszewska, S., Adebajo, A., Barber, R., Beresford, P., Brady, L., Brett, J., et al. (2011a). Developing the evidence base of patient and public involvement in health and social care research: The case for measuring impact. *International Journal of Consumer Studies*, 35(6), 628-632.

undertaken sometimes. Thirty-seven per cent of participants were unsure if evaluation was undertaken and 6% (n=3) of respondents said PPI activities are not evaluated. Reported methods for collecting PPI evaluation data were wide and varied with the most common being surveys of PPI participants. Focus groups were the next most frequently used evaluation method. A wide range of organisational outcomes and impacts from PPI activities are included in evaluations with the most commonly cited being the effect of PPI involvement on services (56%) and the least common being a change in the budget allocation process (4%).

Evaluation of PPI activity is therefore an area for further development given the on-line survey's conclusion that thirty nine per cent of respondents noted the production of an evaluation report and twenty-nine per cent stating that no such report is produced. The cited perceived reasons for not producing an evaluation report related to a lack of resources particularly in regard to: lack of staff time (52%), lack of staffing resources (45%) and lack of funding (34%).

The focus groups also included specific questions in this area. From the perspective of staff, it was recognised that progress in the right direction was starting in regard to monitoring and evaluating PPI with the initiatives led on by the Public Health Agency. There were also examples of how methods such as Survey Monkey were being used to evaluate particular projects. What was absent however was a sense of consistency and coherency in regard to how monitoring and evaluating were being approached.

Staff also expressed the view that senior managers needed to accept and own responsibility for PPI, including accountability for monitoring its effectiveness and overall implementation. The need for service users and carers to be made aware of the outcomes and impact of their involvement activities was also recognised as being central to monitoring and evaluation processes. The point was also made that sometimes it was only the highly publicised PPI projects which were monitored and evaluated to the exclusion of other on-going ‘part of the job’ PPI activity. Having one overall action plan was also recognised by staff as being potentially helpful as a tool in coordinating the monitoring and evaluation of PPI at Trust level. The staff focus group analysis concluded with the view that monitoring and evaluation needed to be systematically captured.

From the service user and carer perspective, the focus groups underscored the importance of PPI being evaluated so as impact following service user involvement in PPI work could be evidenced. Generally, the service users and carers in these focus groups evidenced limited awareness of evaluation and monitoring of PPI. However, there were some examples of where it had gone well and also room for improvement as evaluation and monitoring was considered to be ad hoc. Some PPI members pushed hard to get effective evaluation and monitoring in place.

In concluding this objective it is also worth highlighting the impact of an existing challenging and demanding environment within which PPI occurs. In the development and refinement of monitoring and evaluation tools, these would need clearly defined parameters and agreed priorities for recording, monitoring and evaluation. As noted in one of the service user focus groups, this does not have to be overly complex but having a standard template across Health and Social Care (HSC) or standard columns to add to mainstream action plans and progress reports would ensure the process is not time consuming for recording, collection and analysis.

Objective 5: To ensure that service users and carers are at the heart of this project in a significant and meaningful way.

The research team was committed to collaboration and participation in regard to all aspects of design. The team involved two peer researchers from a service user background who have been fully involved in all aspects of the research from writing the original application for funding to contributing to this final report. In addition, the research was supported by a Research Advisory Group (RAG) with representation from a diverse range of service user and carer groups and individuals from across Northern Ireland. All of the research tools (on-line survey questions and focus group questions) were designed in close collaboration with the full research team and the members of the RAG. An accessible version of the research report has also been written by a research team member from a user background. Service user organisations in the community also helped accommodate the focus groups and assisted with the design and dissemination of the focus group flyers for service users.

Recommendations

Below are the ten key recommendations coming from this research. Each of the three methods of enquiry that we have used has been given a symbol and these are explained below. Many of the recommendations came from more than one of the methods used. Also we have highlighted what we feel is the key agency, or agencies that could address each recommendation.

Key to Methods of Enquiry

Focus Groups	**Focus Groups are symbolized by:**	
On Line Survey	**On Line Survey is symbolized by:**	
Literature Review	**Literature Review is symbolized by:**	

Research Recommendations

The Recommendations below are based collectively on the findings from the different but interlocking strands of our research: Focus groups, on-line survey and the systematic overview of the literature. Delivery responsibility for each recommendation has implications at a number of levels across HSC.

The Department of Health Social Services and Public Safety (through its Safety, Quality and Standards Directorate) has responsibility for policy on PPI, including reviewing, developing and refining the policy. It is responsible for reviewing and issuing appropriate guidance as necessary, and for setting regional priorities and standards in this area. The Department is also be responsible for providing assurance to the Minister that HSC organisations are meeting the requirements placed upon them by the statutory duty of involvement as laid down in the Health and Social Care Reform Act (2009), including the requirement to develop consultation schemes.

The Public Health Agency (PHA) has responsibility for leading the implementation of policy on PPI across the HSC. This responsibility is taken forward through the Regional PPI Forum, which is chaired and serviced by the PHA. It includes representation from all HSC organisations as well as community and voluntary sector representatives, service users and carers. The Forum is a key vehicle by which the PHA, working with other organisations, ensures the effective implementation of PPI policy across the HSC.

The Patient Client Council (PCC) responsibilities in respect of PPI, include representing the public interest, promoting/supporting the involvement of the public, and undertaking research into best methods/practices for involving and consulting the public in regard to HSC matters.

HSC Trusts are responsible for establishing appropriate organisational governance arrangements to meet their statutory duty of involvement, and for maintaining and building on progress already made in relation to embedding in line with the requirements contained in the 2007 PPI guidance circular [6].

If the HSC can begin to address these recommendations, this will go a long way to overcome the identified barriers to involvement and help the HSC, move forward to fully realise the benefits to embed PPI into its culture and practice at all levels bringing a wide range of benefits.

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[6] Department of Health, Social Services and Public Safety. (2007). *Guidance on strengthening personal and public involvement in health and social care*. Belfast: DHSSPS.

Recommendation 1.

For the development of effective PPI, adequate and dedicated resources are essential.

Context: This recommendation is even more pertinent in times of austerity when there are increasing demands on existing resources. It is critical to properly fund PPI with structured and ring-fenced funding. Time, as well as finance, is an important resource and this is as relevant to staff and their time as to service users and carers. Paying service users and carers for their time in structured involvement with the HSC should also be considered.

Implementation Guidance: This recommendation is directed at the DHSSPS. Our research clearly shows that the delivery of PPI activity at ground level is in need of additional resources to fully realise the benefits of involvement to deliver effective person centred care. The availability of ring-fenced funding for each Trust will therefore build on the positive achievements that have been possible to date and assist in overcoming the barriers identified through the research.

Recommendation 2.

There should be an ongoing process of raising awareness of what PPI is and what it means for staff, service users and carers.

Context: This recommendation will help promote the wider benefits of PPI for the organisations and staff and will also help to embed PPI in the culture of HSC organisations. Innovative ways should be explored of making such awareness more meaningful and effective. Raising the profile of PPI should also address the need to get a better balance of professionals and service users/carers at meetings, particularly seldom heard groups and individuals in addition to service user and carer involvement in the development and implementation of individual care and treatment plans.

Implementation Guidance: The PHA, working closely with the Trusts, should more proactively showcase examples of PPI which have been beneficial to key aspects of the service and also to the service users, carers and other stakeholders with whom effective engagement has taken place. The PCC also has a specific role in raising awareness of PPI with service users, carers and the public and providing wraparound support and training to encourage and enable service users, carers and the public to become meaningfully and effectively involved at all levels of PPI across HSC organisations.

Recommendation 3.

PPI needs to be defined in a way that is explicit and meaningful to service users, carers, providers and the wider public.

Context: The language of PPI needs to be re-visited so it is distinct from other terms in current usage which may be confusingly similar to both staff and service users. If there is a way of coming up with a different term to PPI, then this should be explored (the term PPI is part of DHSSPS policy language but is not used in the legislation). Other terms such as: citizen involvement/user/client involvement could be considered.

Implementation Guidance: Consideration should therefore be given to replacing this term or explaining this better so as everybody involved is clear on meaning. This is the responsibility of the DHSSPS, the PHA and the PCC to coordinate and for Trusts and other HSC organisations to implement.

Recommendation 4.

Each Trust should develop a PPI Champion staff role with a small team whose jobs will be entirely and specifically related to PPI at Trust level.

Context: Currently all Trusts have Director and operational PPI Leads, however none of these staff focus exclusively on PPI. As awareness of PPI is raised and staff understand their obligations and those of the Trust, there is an increasing demand for practical support which is both time consuming and resource intensive. In addition to this support, there is also a Departmental requirement to collate, analyse and report on the impact of PPI activity. For PPI to have a common purpose and the capacity to meet support and reporting needs will, therefore, require the designation of PPI Champions with a small team whose jobs will be entirely and specifically related to PPI at Trust level.

Implementation Guidance: This recommendation is for the DHSSPS to consider allocating additional resources to enable relevant HSC organisations to have a designated PPI Champion supported by full time dedicated professional PPI staff with knowledge, expertise and skills to enable the organisation to deliver on its statutory duty in regards to involvement. HSC Trusts will have responsibility to implement and PHA should monitor this.

Recommendation 5.

Social Media and Technology should be effectively utilized to promote PPI across HSC. This should include a one-stop website for information, guidance, support, resources, templates and good practice examples.

Context: In considering the impact of this recommendation, each Trust should review and monitor how currently their websites are promoting examples of PPI activity. The use of social media platforms such as Facebook and Twitter should continue to be maximised to further embed and raise awareness of PPI activity. The development of a mobile application on PPI could also be considered as part of this. There is also a need for a one-stop-shop website where all PPI information (links to local PPI leads, etc.) could be housed. This needs to be resourced so that the information remains current and relevant.

Implementation Guidance: The PHA should lead on this recommendation in partnership with the HSC Trusts and the PCC.

Recommendation 6.

Structured evaluation must be built into PPI as a way to measure its effectiveness.

Context: The review of literature for this research indicated there is a gap in evaluation using quantitative approaches. Person-centered evaluation methods should be piloted, which become part of the job and non-onerous on staff time. In regard to the measurement of PPI impact, standardised quantitative measures should also be piloted with service users to evaluate their experiences of involvement and engagement following the service (for example, exit surveys, questionnaires, use of technology, etc.).

Implementation Guidance: Lead responsibility for progressing this recommendation rests with the PHA.

Recommendation 7.

Feedback on the impact of involvement should be standard practice.

Context: Providing feedback in regard to the outcomes of involvement was quite sporadic and inconsistent in our research findings. This must be mainstreamed into all PPI practice as standard activity so as participants feel they are valued and are made aware of the impact of their PPI activities.

Implementation Guidance: The PHA should develop guidance on this.

Recommendation 8.

Appropriate and dedicated PPI training should be made available for HSC staff.

Context: PPI awareness training should be a standard aspect of induction for all new employees. This could be made available as an on-line activity but all staff would have to show that they had completed this as a necessary feature of their introduction to the HSC organisation or for existing staff as part of their PDP (Personal Development Plan). All staff should then have to complete appropriate PPI training at a designated point in the early stages of their employment and refresher courses should also be made available and mandatory.

Implementation Guidance: The PHA should have lead responsibility for developing a consistent PPI training programme resourced by DHSSPS. HSC organisations have also individual responsibility for ensuring that staff undertake relevant PPI training. The PCC also has a specific role in raising awareness of PPI with service users, carers and the public and providing wraparound support and training to enable service users, carers and the public to become meaningfully and effectively involved at all levels of PPI across HSC organisations.

Recommendation 9.

PPI should be a core feature of all Trust recruitment and performance/appraisal processes.

Context: This recommendation is aimed at embedding PPI into the mindset of those applying for HSC Trust positions and at also ensuring that this is kept very much to the forefront for staff at all levels in their ongoing work. Therefore, questions about reviewing PPI activity in appraisal and supervision meetings would concretely elevate its importance for staff at all levels. Having a basic range of questions around involvement, engagement and partnership working at interviews and having the perspective of service users and carers in staff selection would also be a firm way of assessing prospective employees' understanding of issues related to involvement.

Implementation Guidance: The PHA should lead on developing guidance on this matter. Trusts and other HSC organisations should implement this guidance.

Recommendation 10.

PPI needs to be built into accountability structures and decision making processes at senior manager/director level.

Context: Our research consistently highlighted the importance of PPI being hinged on support from the top of the organisation. When this is in place, the likelihood of having meaningful PPI is increased. Senior managers should therefore be reporting to Trust Board level in regard to PPI oversight issues at a strategic level.

Implementation Guidance: The PHA should offer guidance to Trusts in regard to the format of such reporting which will include monitoring PPI in decision making such as investment and service development plans. HSC organisations will be responsible for implementation of this approach.

Implementing the Recommendations

Recommendation	Responsible Organisation	Role/Action
Recommendation 1 For the development of effective Personal and Public Involvement (PPI), adequate and dedicated resources are essential.	DHSSPS	Make available ring-fenced, annual resources dedicated specifically to PPI.
Recommendation 2 There should be an ongoing process of raising awareness of what PPI is and what it means for staff, service users and carers.	PHA and HSC Trusts PCC	PHA and Trusts to showcase examples of PPI Raise awareness, promote PPI with public.
Recommendation 3 Personal and Public Involvement (PPI) needs to be defined in a way that is explicit and meaningful to service users, carers, providers and the wider public.	DHSSPS PHA PCC HSC Trusts	The DHSSPS has a policy leadership role in reviewing the language of PPI in partnership with the PHA and PCC. HSC Trusts then have an implementation role in this regard.
Recommendation 4 Each Trust should develop a PPI Champion staff role with a small team whose jobs will be entirely and specifically related to PPI at Trust level.	DHSSPS HSC Trusts PHA	Resourcing PPI Champion role. Implementation role Monitoring role
Recommendation 5. Social Media and Technology should be effectively utilized and include a one-stop website for information, guidance, support, resources, templates and good practice examples of PPI.	PHA	PHA to lead on this recommendation in partnership with the HSC Trusts and the PCC.

Recommendation	Responsible Organisation	Role/Action
Recommendation 6. **Structured evaluation must be built into PPI as a way to measure its effectiveness.**	**PHA**	**Develop guidance**
Recommendation 7. **Feedback on the impact of involvement should be standard practice.**	**PHA**	**Develop guidance**
Recommendation 8. **Appropriate PPI training should be made available for HSC staff.**	**PHA** **HSC Trusts** **PCC**	**Development and coordination** **Implementation with staff** **Support public interaction in training**
Recommendation 9. **PPI should be a core feature of all Trust recruitment and performance/appraisal processes.**	**PHA**	**Develop guidance**
Recommendation 10. **PPI needs to be built into accountability structures and decision making processes at senior manager/director level.**	**PHA** **HSC Trusts**	**Guidance development** **Implementation**

Conclusion

Although PPI in Northern Ireland still faces a number of challenges, this research has evidenced that there has been a great deal of work undertaken and a marked improvement, particularly in coordination, over the years since its first introduction as policy in 2007. The leadership role of the Public Health Agency in providing a positive basis for PPI developments should therefore be recognised.

The research recommendations are designed to build upon the progress that has been achieved and are focused on the leadership and implementation aspects of PPI and service development in this particular area. This research has found that progress has been slower than anyone would have liked but the picture is still overall quite positive. Much of this has been achieved within existing resources and it is evident that there is a passion from within Health and Social Care and from those who use the services to further embed effective PPI and develop the structures and mechanisms required to do this and to monitor the impact. PPI in Northern Ireland is still, therefore, very much a developing process which can be improved upon further in light of the recommendations from this research.

To continue embedding PPI and making it a reality for more service users and carers will, however, require strong leadership, coordination, partnership working and resources. These elements will help ensure that PPI becomes more of an integral part of the way the Health and Social Care system does its business, not because it is a statutory requirement, but because it is the right thing to do in terms of targeting services to need, increasing efficiency, improving quality, safety and cost effectiveness. To build on the progress and achievements to date, and to recognise the efforts of everyone involved, the DHSSPS should identify ring-fenced funding to support HSC organisations to further develop their PPI structures and enable them to employ a small dedicated team to provide support to staff so that they can incorporate PPI in their day-to-day work. This will contribute significantly to the development of PPI by positively impacting on the service user and carer experience and ensuring the continued delivery of high quality, safe and effective HSC services that meet the needs of the people who use them. The leadership provided by the PHA remains essential in progressing PPI across the HSC system.

There is also room for improvement in other key aspects of PPI, such as ensuring the public is clear about its meaning as well as having a structured way to evaluate the outcome and impact of PPI activity. The in-depth nature of this research project has provided the opportunity to explore meaningful ways in which PPI can become further improved, embedded and more part of the mainstream in Northern Ireland. The Recommendations in this Report therefore present an opportunity to assist in a process of continuing improvement in regard to PPI in order to achieve truly person-centred services. Linked to this last point, it is therefore apt to conclude with the following quote from a carer in one of the focus groups remarking on the profoundly positive impact PPI had on one service user's life:

".. It just changed his life and even his quality of health and everything increased and he just feels people are listening. I suppose it is kind of ironic because he actually feels he has a voice in every sense now."