HSC Public Health Agency

AGENDA

79th Meeting of the Public Health Agency board to be held on Thursday 19 November 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 15 October 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/01/11/15 (for Noting)**	Mr Cummings
8.	1.55	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 30 September 2015	**PHA/02/11/15 (for Noting)**	Mr McClean
9.	2.20	Unscheduled Care		Chief Executive
10.	2.40	Lifeline Consultation		Dr Harper
11.	2.55	Media Monitoring on Suicide		Mr McClean

12.	3.15	10,000 Voices Phase 2: Regional Report Relating to Care in Your Own Home (October 2015)	**PHA/03/11/15 (for Approval)**	Mrs Hinds
13.	3.30	10,000 Voices: Regional Report on Experience of Nursing and Midwifery Care Key Performance Indicators (KPIs)	**PHA/04/11/15 (for Approval)**	Mrs Hinds
14.	3.45	Any Other Business		

15. **Date, Time and Venue of Next Meeting**
    Thursday 17 December 2015
    1:30pm
    Conference Rooms 3+4, 2nd Floor
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 78th Meeting of the Public Health Agency board held on Thursday 15 October at 1:30pm, in Fifth Floor Meeting Room, 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
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 Simon Christie	-	Assistant Director, Finance, HSCB (*on behalf of Mr Cummings*)
Mr Robert Graham	-	Secretariat
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

APOLOGIES:

Councillor William Ashe	-	Non-Executive Director
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB

		Action
94/15	**Item 1 – Welcome and Apologies**	
94/15.1	The Chair welcomed everyone to the meeting and apologies were noted from Councillor Billy Ashe, Mr Paul Cummings and Mrs Fionnuala McAndrew.	

95/15	**Item 2 - Declaration of Interests**
95/15.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
96/15	**Item 3 – Minutes of previous meetings:** • **Meeting of 20 August 2015**
96/15.1	The minutes of the previous meeting, held on 20 August 2015, were approved as an accurate record of the meeting.
97/15	**Item 4 – Matters Arising**
	86/15 PHA Annual Business Plan 2015/16
97/15.1	The Chief Executive confirmed that, following approval by the PHA Board, the Annual Business Plan had been forwarded to DHSSPS and that DHSSPS had written to PHA confirming their acceptance of the Plan.
	66/15 Commissioning Plan 2015/16
97/15.2	Mr Coulter asked whether there was any update on the Commissioning Plan. The Chief Executive advised that HSCB had been seeking formal clarification of some of the issues that PHA had raised but this had not yet been received. He said that he would raise this at the PHA's next Sponsorship Review Meeting with DHSSPS.
98/15	**Item 5 – Chair's Business**
98/15.1	The Chair informed members that he had met with Assistant Directors Mary Black and Janice Bailie and continued to be impressed by the range of work that the PHA is involved in.
98/15.2	The Chair said that he had attended a meeting of the Irish Cardiac Society, but was disappointed that the focus was not on prevention.
98/15.3	The Chair expressed his thanks to members for their attendance and participation at the recent Board away day on the Corporate Strategy.

99/15	**Item 6 – Chief Executive's Business**
99/15.1	The Chief Executive began his business with an overview of recent developments with regard to unscheduled care. In terms of background, he explained that last July the Minister had set up a taskforce to look at 12-hour breeches, with membership including the Chief Medical Officer, Chief Nursing Officer and representatives of all HSC organisations. He advised that as of today, this work has progressed to a new stage which is being co-chaired by himself and Valerie Watts, Chief Executive, HSCB. He added that this was a significant development and presented a lot of challenges bringing the different organisations into unique partnerships. He explained that he would be co-chairing a Strategic Accountability Group, but that there would also be a Regional Unscheduled Care Group chaired by Pat Cullen (PHA) an Dean Sullivan (HSCB), as well as five locality networks, one in each LCG area.
99/15.2	The Chief Executive advised that the focus of this work was on core areas of public health, with emphasis on prevention as well as effective discharge, with an increased focus on the patient. He said that correspondence is being issued to the HSC today, and this together with terms of reference will be shared with Board members. He added that this work will place additional pressures on HSCB and PHA staff.
99/15.3	The Chief Executive informed members that a new webpage has been launched as part of the NI Direct website whereby the public can access up to date information on waiting times at emergency departments. This, he said, will help the public make better decisions in terms of where to access care. Mrs Hinds explained that the Patient Client Council was central to the development of this new webpage, as they co-ordinated a group to provide feedback on what the page should look like.
99/15.4	Mr Drew asked about the remit and timelines. The Chief Executive explained that the focus work was on emergency departments, but acknowledged that this is inter-related with all other aspects of care. He added that the task group has already been working for 14 months with a clear remit of eliminating 12-hour breeches. Mr Drew underlined that this is a significant piece of work. The Chief Executive agreed but noted that two of the HSC Trusts have almost eradicated their 12-hour

	breeches. He added that in terms of financial resources, this work has been identified as a priority area.
99/15.5	Mrs McKissick thanked Mrs Hinds for acknowledging the work of PCC in the development of the information webpage and said that this showed a good example of co-design.
99/15.6	The Chair asked about the out of hours service and if the general public is aware of it, and if it has been successful. The Chief Executive said that PHA's concern initially was to reduce the 12-hour waiting times. Dr Harper said that there are increasing numbers of out of hours sessions, but these cannot be staffed with medical staff, and that there have been lengthy discussions about workforce planning in this area as population trends show that the population is growing, and getting older, therefore demand will increase.
99/15.7	The Chair asked whether there is a link between the use of these services and socio-economic groups. Dr Harper said that the issue is more to do with legacy and cultural behaviours and added that there is work to terms in terms of managing the flow of patients. She added that the Belfast Trust has been making good progress in this area, particularly with the new emergency department that has recently opened.
99/15.8	Members noted the Chief Executive's business.
100/15	**Item 7 – Finance Update – PHA Financial Performance Report (PHA/01/10/15)**
100/15.1	Mr Christie presented the Finance Report and advised that the year-to-date position showed a surplus of £450k against a budget of £34.5m, which is made up of a £300k surplus in non-Trust expenditure and a £149k surplus in management and administration. He added that the year-end position is projected to be a break even one.
100/15.2	Mr Christie highlighted the section in the report looking at non-Trust expenditure and explained that the majority of the surplus comes from within the Lifeline budget, where activity had reduced. He moved onto the management and administration budget and noted that £1.3m had been removed from this budget at the start of the year, but the fact that there was a surplus of

	£149k was credit to the work of the Directors for their close scrutiny of this area. However, he said that PHA could not rest on its laurels at this point. He finished his overview of the report by saying that although the prompt payment statistics were below the DHSSPS target, it was close.
100/15.3	Mr Coulter said that at the Governance and Audit Committee meeting, the issue of Contact's financial viability had been raised and had been advised that this issue was being kept under review.
100/15.4	Mr Christie responded by explaining that PHA has a budget for the Lifeline contract, and that payments to Contact (who provide the service) are made when PHA receives invoices based on activity. He noted that the number of calls has been lower, in keeping with revised protocols to ensure compliance with the contract. He indicated that from PHA's perspective, there is little financial risk, but PHA would be mindful of Contact's sustainability. Mr Coulter asked what would happen if Contact decided not to run the contracts and the risks to the service. Mr Christie explained that PHA had undertaken its own due diligence checks and he did not see any reason why the service would not continue over the duration of the contract. He added that this is a contract that PHA has with a third party, and that the third party is required to adhere to the terms of the contract. Dr Harper advised that there are contingency arrangements in place and there are regular performance reviews.
100/15.5	Mr Drew said that continuity is important, as well as the consultation process and procurement of the new service. He suggested that it may not be in Contact's interest to maintain it, but the Chief Executive said that as long as Contact is receiving the funding, it is in their interest to maintain the service.
100/15.6	Mr Drew asked the £34m that is allocated to Trusts and whether there are mechanisms in place for monitoring how effectively this money is being used. Mr McClean explained that there are Service Level Agreements with Trusts with regular reporting arrangements and nominated identified officers for each contract, as well as clear escalation arrangements where issues of non-performance arise.
100/15.7	Mr Coulter asked about the strategic review referenced in the

	section on management and administration expenditure. The Chief Executive explained that PHA is currently processing application for the Voluntary Exit Scheme (VES), but that there remained issues for PHA in terms of how it would absorb the required 15% savings outlined by DHSSPS, and whether there will be any flexibility as there was for 2015/16, or indeed a requirement to make further savings. He said that there are huge implications for PHA in terms of how it will conduct its business. Mr Coulter said that from a governance point of view, this represented an unsatisfactory position for the Board.
100/15.8	The Chair sought clarity on the impact of £2.8m of savings. The Chief Executive explained that if these savings were to be made fully from management and administration costs, it equated to possibly 45-55 posts being lost. The Chair commended the work of Directors for maintaining this financial position, given the current difficulties.
100/15.9	Members noted the Finance Report.
101/15	**Item 8 – Investment Plan Update (PHA/02/10/15)**
101/15.1	Mr McClean explained that this update gave members an overview of programme expenditure as at the end of September. He said that an additional £2m of funding had been provided to PHA on top of the £82.65m, but there were areas where PHA was awaiting additional funding.
101/15.2	Mr McClean drew members' attention to the proposal for the use of £400k of slippage and explained that these non-recurrent initiatives had been identified following discussions with Finance and the public health and nursing directorates.
101/15.3	Alderman Porter asked whether any sectors were being disadvantaged unduly because of the cuts to programme budgets. Mr McClean said that no specific sector was losing out, and that most of PHA's programme funding continued to support the community and voluntary sector.
101/15.4	The Chair noted that the funding on suicide prevention was higher than that of mental health and asked how the determinations were made in terms of where the money is spent. Dr Harper advised that the responsibility of

	commissioning core services within mental health lies with the HSCB, and that PHA's role is a preventative one, therefore the majority of the funding is allocated to the Lifeline contract. She added that there are legacy budgets as well as demand-led services and that in some instances direction is given to PHA to comply with DHSSPS priorities.
101/15.5	Mrs McKissick asked for further detail on initiatives relating to older people's services and nursing. Mrs Hinds agreed to share this information with Mrs McKissick.
101/15.6	The Chief Executive noted that there were legacy budgets inherited by PHA, and also specific ring-fenced budgets, but that DHSSPS had begun to give greater flexibility to PHA in this regard. He said that PHA's procurement processes had allowed for more consistency in approach.
101/15.7	Mr Drew asked whether some of these contracts should be approved by the Board. Mr McClean said that many of the contracts are contained within programme planning proposals which are signed off annually by the Board. Mr Christie added that there is a Scheme of Delegated Authority (SODA), which is line with both Standing Orders and Standing Financial Instructions that these are reviewed and approved annually by the Board. Alderman Porter said that there is a balance to be struck between the Board setting strategic direction and micro-managing the many contracts and he felt that there was currently an appropriate balance. Mr Drew made reference to the recent Northern Ireland Audit Office report on the Northern Ireland Events Company. Mr Christie noted that the report had been raised at the Governance and Audit Committee.
101/15.8	The Chair asked about the outcomes of projects and how these were objectively analysed, and if they were 1-year or 3-year contracts. Mr McClean said that there were mainly 3-year contracts, but with evaluation built in. Mr Christie reiterated that the Board approves the PHA's Standing Orders and Standing Financial Instructions, as well as its Assurance Framework, which gives assurances in areas such as procurement.
101/15.9	The Board noted the Investment Plan update.

102/15	**Item 9 – Governance and Audit Committee Update (PHA/03/10/15)**
102/15.1	Mr Coulter advised members that the draft minutes of the meeting of 10 June had now been formally approved by the Committee. He said that at the meeting on 10 June, the Annual Report and Accounts had been prepared, and that the Committee had met in private with the external auditors, but that there were no major issues. At the meeting in June, Mr Coulter said that the Committee had considered the Corporate Risk Register on which two new risks had been added.
102/15.2	Mr Coulter moved on to update members on the meeting of 14 October. He began by saying that members had considered the recent NIAO report on the Northern Ireland Events Company. The Chair said that all members should read this report.
102/15.3	Mr Coulter said that the Committee had received the Report to those Charged with Governance, which commended staff on the high standard of financial reporting and accounting. He said that the report cited two risks which related to BSO Shared Services and contracts with the community and voluntary sector, however progress was being made in both these areas.
102/15.4	Mr Coulter updated members on the Internal Audit progress report and said that Internal Audit would be carrying out a follow-up audit on any critical issues. He said that the Committee had again considered the Corporate Risk Register and that a further new risk had been added relating to property management. He acknowledged that there been a significant amount of activity recently in seeking out options for PHA, but with no resolved outcome as yet. Mr Coulter added that 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 he was content that members are engaged in the risk management process under the current arrangements.
102/15.6	Mr Coulter said that the Committee had considered the Assurance Framework and also correspondence relating to the Controls Assurance Standards of which 15 of the 22 apply to PHA, three of which will be audited by Internal Audit. He said that the Committee had considered a suite of ICT Security Policies, as well as the Mid-Year Assurance Statement which is

	being recommended to the Board today for approval.
102/15.7	Mr Coulter advised that the Committee had received a report on HSCB/PHA/BSO Emergency Preparedness. He asked whether there were any ramifications in the light of the recent re-emergence of an Ebola case in Scotland. Dr Harper said that the same protocols would apply and that there would be follow-up with anyone who may have been in contact with this individual. Mr Coulter queried whether GPs are equipped to recognise Ebola, but Dr Harper said that GPs and staff in emergency departments are aware of the arrangements.
102/15.8	The Chair returned to the issue about accommodation and said that he had discussed this with the Chief Executive, and that this was a priority area going forward.
102/15.9	The Board noted the Governance and Audit Committee update.
103/15	**Item 10 – Mid-Year Assurance Statement (PHA/04/10/15)**
103/15.1	The Chief Executive highlighted the internal control divergences within the Mid-Year Assurance Statement and in particular the issues relating to accommodation. He acknowledged that, to date, two full business cases had been prepared relating to accommodation which had taken a lot of effort, but there remained no solution at this time.
103/15.2	The Chief Executive said that the issue of accommodation will be raised at the Mid-Year Accountability Review meeting, and that a joint meeting should take place with Health Estates and PHA's sponsor branch. He acknowledged that the current situation is unsatisfactory.
103/15.3	The Board approved the Mid-Year Assurance Statement.
104/15	**Item 11 – Review of Disability Action Plan 2013-18 (PHA/05/10/15)**
104/15.1	Mr McClean said that the Disability Action Plan had been reviewed and noted that since Dr Jeremy Harbison had stepped down from the Board, there was a need to appoint another non-executive as a disability champion. He drew members' attention to the action plan and particularly the action relating to PHA

	giving opportunities to those with disabilities, as appropriate.
104/15.2	Mr McClean advised that all directorates had been involved in the development of this Plan and sought members' approval to forward this to the Equality Commission.
104/15.3	The Chair asked how many PHA staff were registered as disabled. Mr McClean said that no staff were formally registered, but was aware that a number of staff may otherwise be considered as having a disability and had been involved in recent work.
104/15.4	The Board approved the Disability Action Plan.
105/15	**Item 12 – Presentation on Public Information Campaigns**
105/15.1	Mr McClean welcomed Mr Stephen Wilson and Ms Linda Giles to the meeting and invited them to given an update on Public Information Campaigns. Mr Wilson cautioned that campaigns should not be seen as the be all and end all of creating awareness of particular issues.
105/15.2	Ms Giles gave members an overview of the campaigns for 2015/16 and the process for approval of these which involves PHA, DHSSPS and the Government Advertising Unit. She showed how the overall funding for campaigns has decreased in recent years before explaining to members how a campaign is developed, from the initial research stage through to evaluation.
105/15.3	To finish, Ms Giles showed members some materials being used in current campaigns relating to cancer, sexual health and obesity.
105/15.4	Mr McClean said that during any campaign there is always engagement with the target audience. The Chair asked this is facilitated. Mr Wilson explained that this is through a range of stakeholder groups. He added that it is important that all campaigns can demonstrate value for money and effectiveness. He said that although PHA has not committed at this point to undertaking an alcohol and drugs campaign, as evidence to date suggests that this is not a successful method of changing behaviour, albeit that PHA still intends to get messages out through different media.

105/15.5	The Chair asked about the reduction in funding. Mr Wilson said that this has been reduced year-on-year, but that there may be some possibility that the current level of funding would be retained for 2016/17. He said that PHA had asked about a 3-year programme, but commitment could not be given on that.
105/15.6	Mr Coulter asked about the cancer campaigns. He said that the breast cancer campaign was a gender-specific one and he asked whether there would be a similar campaign for prostate cancer. He also asked about co-ordinating campaigns with other organisations. Mr Wilson said that PHA had spent a lot of time with its advertising partners considering the best strategy, based on the experience in England. He explained that there are issues in terms of belief that you can recover from cancer, and that is the message that is relevant across all types of cancer. He added that across each of the types of cancers, there are different signs and symptoms and this has to be taken into account when developing a campaign.
105/15.7	Mr Wilson said that PHA had planned to do a 3-year campaign across a range of cancers, based on the experience of England and Scotland, and closely involving the different cancer charities in Northern Ireland. He added that a planned campaign on bowel cancer had been dropped, but an alternative campaign may be looked at.
105/15.8	The Chair commended the professionalism and quality of the work undertaken on campaigns.
105/15.9	The Board noted the update on Public Information Campaigns.
106/15	**Item 13 – PHA Tobacco Control Update**
106/15.1	Dr Harper presented a report on tobacco control. She reaffirmed that PHA's position is that e-cigarettes are not a licensed nicotine replacement therapy. Mr Coulter asked the passive smoking effects of e-cigarettes, but Dr Harper said that was no evidence yet about this. She said that the use of e-cigarettes should be included in policies on smoking in public places. The Chair said that he would like to see a ban on vaping in public.
106/15.2	Mr Drew asked about the HSC smoking ban. Dr Harper said that this would come into effect next year.

106/15.3	The Board noted the update on tobacco control issues.
107/15	**Item 14 – Update on Corporate Strategy**
107/15.1	The Chair said that members would have received the write-up following the Board away day on the Corporate Strategy. He said that the next step is to transfer the recommendation from the away day into a series of steps to finalise the development of the Strategy. He noted that the next meeting of the Corporate Strategy Project Board is due to take place on 20 October.
107/15.2	The Chief Executive said that the development of the Strategy is a live exercise, and that this next meeting will look at all of these issues, including the chairing of that Project Board, as it is a non-executive-led Project Board.
107/15.3	The Board noted the update on the Corporate Strategy.
108/15	**Item 15 – Any Other Business**
108/15.1	Mrs McKissick asked when the next reports on 10,000 Voices were due to be published. Mrs Hinds advised that they would be brought to the next meeting of the PHA Board.
109/15	**Item 16 – Date and Time of Next Meeting**

Date: Thursday 19 November 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 including Mid- Year Statement of Financial Position (Balance Sheet)

2015-16

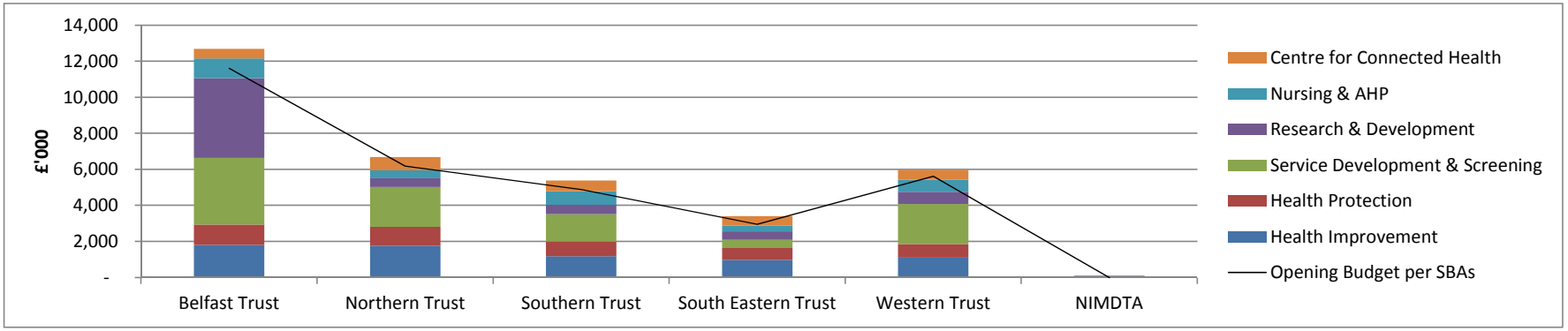
Month 6 - September 2015

Public Health Agency
2015-16 Summary Position - September 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	34,267	49,876	21,667	**105,810**	17,112	16,276	9,548	**42,937**
Income from Other Sources	-	654	542	**1,196**	-	628	268	**896**
Total Available Resources	34,267	50,529	22,210	**107,006**	17,112	16,904	9,816	**43,833**
Expenditure								
Trusts	34,267	-	-	**34,267**	17,112	-	-	**17,112**
Non-Trust Programme	-	50,529	-	**50,529**	-	17,129	-	**17,129**
PHA Administration	-	-	22,209	**22,209**	-	-	9,571	**9,571**
Total Proposed Budgets	34,267	50,529	22,209	**107,006**	17,112	17,129	9,571	**43,812**
Surplus/(Deficit)	-	-	-	**-**	-	(224)	245	**21**

The year to date financial position for the PHA shows an underspend against profiled budget of £21k. The detailed reasons for this are explained on pages 3 and 4 of this report. It is currently anticipated that the PHA will breakeven on its full year budget, based on current plans which will be discussed at the mid-year review meeting on 3 November 2015.

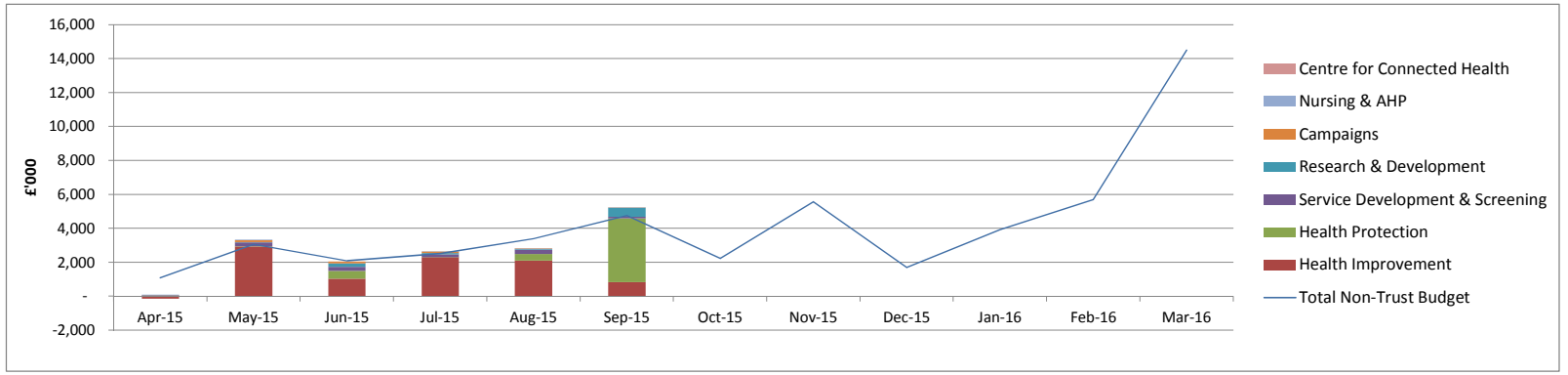
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	Southern Trust £'000	South Eastern Trust £'000	Western Trust £'000	NIMDTA £'000	Total £'000
Health Improvement	1,809	1,770	1,187	974	1,114	-	**6,855**
Health Protection	1,138	1,040	820	659	742	-	**4,400**
Service Development & Screening	3,701	2,223	1,520	460	2,227	-	**10,130**
Research & Development	4,411	475	506	465	675	107	**6,638**
Nursing & AHP	1,099	445	765	327	677	-	**3,312**
Centre for Connected Health	536	732	590	525	549	-	**2,932**
Total current RRLs	**12,693**	**6,685**	**5,388**	**3,411**	**5,983**	**107**	**34,267**
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 September additional commitments of £190k (net) were made to HSC Trusts in respect of NI New Entrants; Needle exchange; Long Term Conditions & Mental Health; Integrated Treatment; and Nutrition for Frail Elderly.

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	916	3,267	686	2,384	2,883	4,953	**23,929**	8,840	9,109	(269)
Lifeline	292	292	292	292	292	292	292	292	292	292	292	292	**3,500**	1,750	1,184	566
Health Protection	-	15	418	12	460	3,026	564	431	385	787	671	3,201	**9,970**	3,930	4,635	(705)
Service Development & Screening	83	368	85	83	368	93	127	380	123	106	395	303	**2,514**	1,079	1,022	57
Research & Development	-	-	237	60	45	501	173	1,120	113	112	1,181	4,486	**8,027**	843	852	(9)
Campaigns	-	1	131	58	32	230	160	75	75	215	155	364	**1,496**	452	355	97
Nursing & AHP	-	3	3	-	3	-	-	3	23	39	123	861	**1,060**	10	65	(56)
Centre for Connected Health	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	33	**33**	-	(93)	93
Total Non-Trust Budget	**1,094**	**3,056**	**2,085**	**2,511**	**3,390**	**4,768**	**2,231**	**5,568**	**1,698**	**3,935**	**5,700**	**14,493**	**50,529**	**16,905**	**17,129**	**(224)**
Actual Expenditure	**233**	**3,506**	**2,306**	**2,681**	**3,109**	**5,292**	**-**	**-**	**-**	**-**	**-**	**-**	**17,129**			

The Non-Trust Programme budget increased by £1.9m since the last report due to the receipt of allocations from DHSSPS primarily for Pertussis and Meningococcal Vaccination Programmes.

The financial position to date shows expenditure is £224k ahead of profile. This is primarily due to a number of Health Protection payments for vaccination costs being made earlier than anticipated and the continuing underspend on the Lifeline contract. 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	2,828	3,480	10,088	287	305	475	**17,463**
Goods & Services	216	1,421	560	(120)	81	382	**2,539**
VER Scheme	-	-	-	2,207	-	-	**2,207**
Total Budget	**3,043**	**4,901**	**10,648**	**2,374**	**386**	**857**	**22,209**
Budget profiled to date							
Salaries	1,398	1,739	5,030	134	155	227	**8,683**
Goods & Services	103	695	258	(60)	42	96	**1,133**
Total	**1,500**	**2,434**	**5,289**	**74**	**196**	**323**	**9,816**
Actual expenditure to date							
Salaries	1,414	1,747	4,997	121	161	227	**8,667**
Goods & Services	58	593	177	(31)	11	96	**904**
Total	**1,472**	**2,339**	**5,174**	**90**	**173**	**323**	**9,571**
Surplus/(Deficit) to date							
Salaries	(17)	(7)	33	13	(6)	0	**16**
Goods & Services	45	102	81	(29)	30	0	**229**
Year to date Surplus/(Deficit)	**28**	**95**	**114**	**(16)**	**24**	**0**	**245**

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 towards this retraction 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 £1.1m. 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. While cumulatively to date a surplus of £0.245m is shown, 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

	September 2015 Value	September 2015 Volume	Cumulative position as at 30 September 2015 Value	Cumulative position as at 30 September 2015 Volume
Total bills paid (relating to Prompt Payment target)	£4,645,501	368	£23,119,035	2,895
Total bills paid on time (within 30 days or under other agreed terms)	£4,604,902	329	£21,987,949	2,622
Percentage of bills paid on time	**99.1%**	**89.4%**	**95.1%**	**90.6%**

BSO Shared Services have now produced a comprehensive prompt payment report for PHA. A regional review of the accuracy of the BSO calculation, supported by legal advice, has resulted in a cumulative positive adjustment to the PHA figures for 2015/16. This has been reflected in the figures in the table above and the BSO report will be used to calculate the published figures from September 2015 onwards.

Prompt Payment performance for the first six months of 2015-16 shows that on value paid (95.1%) the PHA is meeting the 30 day target of 95%, while the volume of invoices is slightly below the target at 91%. Generally PHA is making excellent progress on ensuring that high value invoices are processed promptly, supported by the September value performance of 99.1%.

In addition, 10 day prompt payment performance was 82.7% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2015-16 of 60%.

Statement of Financial Position as at 30th September 2015

	30th September 2015 (Month 6) £000	31st March 2015 (Published Accounts) £000
Non-current assets		
Property, plant and equipment	352	377
Intangible assets	125	141
Total non-current assets	477	518
Current assets		
Trade and other receivables	790	812
Other current assets	221	150
Cash and cash equivalents	334	276
Total current assets	1,345	1,238
Current liabilities		
Trade and other payables	(6,851)	(7,014)
Provisions	0	(10)
Total current liabilities	(6,851)	(7,024)
Non-current liabilities		
Provisions	0	0
Total non-current liabilities	0	0
Total assets employed	**(5,029)**	**(5,268)**
Financed by taxpayers' equity		
Revaluation reserve	34	36
General reserve	(5,063)	(5,304)
Total taxpayers' equity	**(5,029)**	**(5,268)**

The mid-year Statement of Financial Position (Balance Sheet) is displayed against the audited position as at 31st March 2015.

There have been no significant movements since the 2014-15 year end.

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 November 2015
Title of Paper	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 30 September 2015
Agenda Item	8
Reference	PHA/02/11/15

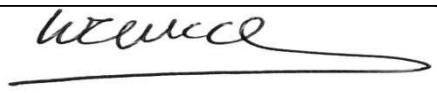
Summary

The updates provided are for the period ending 30th September 2015. This is the first update on the Annual Business Plan targets for this year as the Plan has just recently been approved.

This document also provides an update on all FIVE Commissioning Plan Direction targets for which the PHA is responsible. Two of these Commissioning Plan Direction targets are included within the Annual Business Plan. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

There are a total of **66 targets** in the Annual Business Plan and a further **3 targets** in the Commissioning Plan Directions.

Of these 69 targets - **49** are coded as green for achievability, **18** as amber and **2** as red.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was approved by AMT on 10 November.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	10 November 2015

DRAFT

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2015 – 2016

& Commissioning Plan Directions 2015

September 2015

Overview

This report provides an initial update on achievement of the targets identified in the **PHA Annual Business Plan 2015-16** and in the **Commissioning Plan Directions (Northern Ireland) 2015**.

The updates provided are for the period ending 30th September 2015. This is the first update on the Annual Business Plan targets for this year as the Plan has just recently been approved. These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target.

This document also provides an update on all FIVE Commissioning Plan Direction targets for which the PHA is responsible. Two of these Commissioning Plan Direction targets are included within the Annual Business Plan. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

There are a total of **66 targets** in the Annual Business Plan and a further **3 targets** in the Commissioning Plan Directions.

Of these 69 targets - **49** are coded as green for achievability, **18** as amber and **2** as red.

The two targets with a “Red” status are:

- **3.7 – Taking forward the recommendations on the DHSSPS Regional Learning System**. Some recommendations are dependant on funding which is not currently available. (Page 20)
- **3.20 – Long Term Conditions Regional Implementation Group**. No funding for self-management programmes. (Page 27)

1. PROTECTING HEALTH

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
1.1) Work with the HSC Trusts to secure a further reduction of 20% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA bloodstream infection. *(Commissioning Plan Direction target)*	This HCAI reduction target is a composite target comprising individual Trust reductions in MRSA and CDI cases to be delivered during 2015-16. At 30th Sept the regional MRSA target is significantly above trajectory - 46 cases have been reported compared to an upper trajectory limit of 24 cases (+22 cases). Within this regional position two trusts (South-Eastern and Southern) are on or below their individual trajectory limits. Northern Trust has exceeded its MRSA target (14 cases, target +4). Belfast Trust has also exceeded its MRSA target (21 cases, target +3). At 30th Sept the regional CDI target is also above trajectory - 205 cases have been reported compared to an upper trajectory limit of 154 cases (+51 cases). No Trust is within or near their individual trajectory limit. The largest trajectory exceedences are reported by SET (+16 cases), Southern (+12 cases) and Northern (+9 cases) Trusts.	A			PHA HCAI lead has visited each Trust to discuss current HCAI improvement challenges and explore potential to align IPC/HCAI and quality improvement (QI) skills and capability going forward. Trusts continue to highlight challenges relating to prescribing in primary care. PHA HCAI lead met with HSCB Directorate of Integrated Care (Pharmacy & GMS divisions) on 21st Sept to discuss stewardship and planned service developments (practice based pharmacists) DHSSPS has also asked PHA to work with Trusts to agree a broader set of indicators relating to HCAI and AMRS which would provide a broader assessment of HCAI position/progress. HCAI lead will progress with Trusts. DH(L) & PHE patient safety alert in relation to antimicrobial stewardship and resistance discussed at SAMRHAI (16th Oct). Alert will also issue in NI. PHA HCAI lead will meet with RQIA to clarify context and approach to recommendations (x4) for PHA in recently published reports of IPC governance arrangements in Trusts.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
1.2) Develop PHA resilience to maintain a prolonged response to a major incident.	▪ PHA draft plan to go to AMT end October / November for approval ▪ A proposed training programme for 'Operational Response Cell' staff in the plan is to be agreed and staff time and resources allocated to same. This would be joint training with HSCB as the same functions are needed for the Joint Response Plan. ▪ A further piece of HR work is also proposed in relation to AfC staff working in an emergency	G			
1.3) During 2015/16 have emergency response plans in place to respond to a case of Ebola Virus Disease (EVD) in Northern Ireland.	Continuation of regional EBV teleconference until June 2015. Ebola Stock Take Workshop Sept 2015. Report and recommendations re forward planning to issue. Outbreak in West Africa diminishing but vigilance still required.	G			
1.4) Continue and enhance proactive communications of health protection issues, including vaccination, hand hygiene, observance days, etc.	Proactive communications through multiple channels continues, highlighting a range of health protection issues across the year. This includes communication through news releases and social media.	G			

2. IMPROVING HEALTH AND WELLBEING & TACKLING HEALTH INEQUALITIES					
Target from Business Plan	**Progress**	**Achievability** Sept	Dec	Mar	**Mitigating actions where performance is Amber / Red**
Giving Every Child the Best Start - Theme 1 Making Life Better					
2.1) Implement Phase One of Early Intervention Transformation Programme in relation to universal midwifery, health visiting and pre-school services (Work stream one).	Analysis of readiness to implement completed following completion of questionnaire (National Implementation research Network) indicates that four out of five HSC Trusts are ready to implement group based care & education and five HSC Trusts are ready to implement the Three Year Plus Review; Evidence based operational manuals for practitioners being developed; Solihull training programme being delivered by CEC on schedule; Outcomes Based Accountability (OBA) have been held in all HSC Trusts. Regional outcomes measures will be agreed by end of November; IPTs issued to HSC Trusts for completion by 30 November; Enquiries by research teams received in relation to PHA/AP/EITP research call relating to Work Stream one.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.2) Implement Phase One of the Early Intervention service and family support hubs. (Work stream two)	Procurement has progressed and is on schedule with contracts issued from August 2015. Some further tendering required on parenting programmes.	G			
2.3) Lead the expansion of Family Nurse Partnership to two further Trusts (funding permitting)	FNP available in two additional HSC Trusts (SET & NT). Implementation plan being led by PHA in accordance with FNP licence and fidelity requirements. 440 mothers have received the programme to date.	G			
2.4) Implement the regional Infant Mental Health plan and commission training to HSC and early year's workforce.	Public Consultation process completed and 35 responses received. Analysis being undertaken and revised Plan will be launched in January 2016. Infant Mental Health service development being considered by HSCB and plans produced by CAMHS commissioners. Infant Mental Health 2015/16 training programme planned and being delivered with Solihull Approach Training Plan being developed.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.5) Implement the Action Plan for the Breastfeeding Strategy for Northern Ireland.	Breastfeeding Action Plan being rolled out with infant feeding data and Key Performance Indicators regularly reviewed by BSISG. Rates appear to be static and increased effort is being given to key aspects of the Action Plan. Focus group research findings shared with BSISG, action to be taken regarding staff update training. WHO Code seminar requested and organised to be held 26 October. Next Breastfeeding Strategy Implementation Steering Group meeting scheduled to take place on 16 December 2015.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
Equipped Throughout Life – Theme 2 Making Life Better					
2.6) Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care & Improvement Steering Group on behalf of PHA & HSCB ensuring that good practice is promoted and health inequalities are identified and addressed in this area, and that services are responsive and make adequate adaptation to meet the health care needs of people with a learning disability.	The Regional Learning Disability Healthcare & Improvement Steering Group continues to work to progress improvement in the healthcare and health & social wellbeing of people with learning disabilities and to reduce inequalities in health for this client group. There are three Forums for specific areas of improvement:- 1. Regional Health & Wellbeing Improvement; 2. Regional Health Care Facilitators; and; 3. Regional General Hospital Care Forum: Learning Disabilities 4. During 2014/15 the Health Care Facilitators and Health & Wellbeing Improvement Forums developed a two year plan to deliver on the strategic objectives. Recommendations requiring action in 2015/16 are being progressed. Health Care Facilitators Forum and Health Improvement & Wellbeing Forums have developed strong links within services areas and are working together to increase awareness of Health Care needs of people with Learning Disability and are influencing Health Improvement Plans. The Regional General Hospital Care Forum: Learning Disabilities was established in January 2015 and has identified priorities within their work plan to take forward during 2015/16. To date:- • A scoping exercise has been undertaken across HSC Trusts to establish progress against the recommendations within the GAIN Guidelines • A draft Regional Hospital Passport has been developed for consultation and piloting.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
Empowering Healthy Living – Theme 3 Making Life Better					
2.7) Continue and enhance proactive communications on health improvement to reflect PHA programmes, campaigns, observance days and partnerships.	Campaigns delivered for Cancer Awareness, Sexual Health. Planning underway for programme remainder – obesity, smoking, stroke awareness, mental health, and dementia.	G			
2.8) Ensure Trusts continue to deliver Telehealth and Telecare services including through the Telemonitoring NI contract, to targets set by the PHA.	Telehealth - at the end of September at total of 215,009 Monitored Patient Days (MPD) of Telehealth had been delivered through the Telemonitoring NI contract and 7,934 MPD through U-Tell in South Eastern Trust, against a target of 498,000MPD for the year. This represents an outturn of 45% for 6 months. The indications are that the total regional target will not be achieved in year at the current level of referrals. Telecare - at the end of September at total of 531,545 MPD of Telecare had been delivered against a target of 842,735MPD for the year. This represents an outturn of 63% for 6 months. The target will be achieved this year.	A			Trusts are reviewing their Implementation Plans for Telehealth and working to produce recovery plans to address the anticipated shortfall.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.9) Embed the new drug and alcohol services tendered under the New Strategic Direction on Alcohol and Drugs (NSDAD) 2011-16 and the PHA/HSCB Drug and Alcohol Commissioning Framework 2013-16.	Work is underway developing care pathways across key interfaces to ensure that clients can access a stepped care model of care. Monitoring arrangements are in place and progress against KPI's is underway.	G			
2.10) Implement the Tobacco Control Implementation Plan including Brief Intervention Training, smoking cessation services, enforcement control and Public Information.	The Tobacco Strategy Implementation Plan is being rolled out with KPI monitoring presented quarterly or annually to the TSISG (depending on data availability). Brief Intervention Training is being offered in HSCTs and with other groups such as Optometrists. It is anticipated that the delivery of BIT will escalate with the implementation of Smoke Free campuses in March 2016. Enforcement work is progressing well with test purchasing exercises being carried out across the region. Preliminary work has been undertaken on the new PIC.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.11) Support and lead multi-agency partnerships to oversee regional and local delivery of Protect Life and Mental and Emotional Wellbeing strategies such as the regional Bamford structures and local Protecting Life Implementation Groups' Action Plans.	Bamford Multi-Sectorial Working Group meets on a quarterly basis with good representation from all sectors. A regional action plan is being rolled out. Local and regional priorities are discussed at each meeting and shared actions and resources are being taken forward by the groups.	G			
2.12) Implement the obesity prevention action plan including: weight management programmes for children, adults, and pregnant women; development of a common regional Physical Activity Referral programme; implementation of Active Travel programme in schools; implementation of Active Travel Plan Belfast and public information and awareness	The multi-agency Action Plan was agreed in July 2015 and progress is monitored through the Regional Obesity Prevention Implementation Group. Progress remains on track against a number of key areas, including: - Active Travel schools programme – schools recruited for 2015/16 school year - Weigh to a healthy pregnancy programme – evaluation complete and planning to mainstream the programme is on-going - Public information - campaign brief for 2015/16 under development Physical activity referral schemes – progressing towards a shift to the new service model and development of a supporting IT system	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
2.13) Take forward recommendations of the RQIA 'Review of specialist Sexual Health services in Northern Ireland' in partnership with DHSSPSNI, HSCB and HSC Trusts.	A joint workshop for Specialist Sexual Health Trust Liaison Group and the Specialist Sexual Health Commissioning Group was held on 1 May 2015. The current position was reviewed and key areas of work requiring regional action identified. Working groups to take forward the review of evidence and develop recommendations will be established. A draft Action Plan is being developed for agreement by the groups.	G			
Creating the Conditions – Theme 4 Making Life Better					
2.14) Develop and implement programmes which tackle poverty (including fuel, food and finance poverty) and maximize access to benefits, grants and a range of services for vulnerable groups e.g. Home Safety check schemes.	Implement regional MARA programme – all aspects of programme on track; • Regional Fareshare programme redistributing 100,000 meals per quarter to 70 community food members throughout NI; • Regional Keep Warm Scheme for Rough Sleepers – equipment and clothing secured by lead partner ready for distribution via street outreach services to rough sleepers as required; • Regional Keep Warm Keep Well Scheme for Vulnerable Adults and Children –Below EU Threshold Tender Strategy submitted and approved by PHA Procurement Board on 14.10.15; • Range of benefits maximisation schemes/ Advice for Health Schemes in place across NI, supported by PHA – providing access to advice	G			

	services for those with mental ill health and addictions issues; • Fuel Poverty – on-going support via PHA for Oil Buying Clubs, pilot programmes with local Councils on Affordable Warmth, energy efficiency measures being accessed for eligible households through NISEP scheme, energy efficiency awareness raising events targeting local community/ residents.				
2.15) Further develop the Travelers Health and Wellbeing Forum and delivery of the regional Action Plan.	Regional Forum for Travellers Health established and Annual Action Plan agreed. New programmes have been commissioned to meet Travellers' needs and posts established to promote Traveller engagement in health and wellbeing in three HSC Trusts. Mental health and emotional wellbeing programme specific to Travellers' needs commissioned.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
Empowering Communities – Theme 5 Making Life Better					
2.16) Work with local government to align community planning and regeneration with support for community development and public health goals.	Work continues with local government to align community planning and regeneration with support for community development and public health goals. PHA continues to engage with councils regarding new structures and processes affected by local government reform and as well as contributing to the community planning processes with each council, work continues through the existing partnerships. PHA has and continues to engage with councils, individually and collectively, regarding the alignment of community planning and Making Life Better, the Public Health Strategic Framework, to develop a shared programme of action.	G			
Developing Collaboration – Theme 6 Making Life Better					
2.17) Continue to work with key stakeholders (including local partnerships) to take forward the implementation of Making Life Better.	Work continues with key stakeholders to take forward the implementation of Making Life Better. The Regional Project Board is established and meets every quarter with a current focus on developing a programme of action in line with Making Life Better priorities. A process of engagement has begun across HSC to discuss how HSC organisations can individually and collectively implement Making Life Better. Engagement with local government is also underway to identify key areas of joint working in line with community planning and Making Life Better.	G			

3. IMPROVING THE QUALITY OF HSC SERVICES

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.1) Oversee and lead on the regional implementation of Phase 1 and pilot phase 4 of the electronic caseload analysis tool (ECATS) for district nursing and HV.	Phase 1 has been implemented Phase 4 for health visiting currently software uploaded to BSO platform. Pilot on-going October/November in South Eastern HSC Trust. Further refinements on district nursing required. Business case approved	A			In relation to District Nursing the recruitment of staff remains a challenge for HSCTs in terms of appointing to permanent posts this will be dependent on the numbers of graduates coming out this year who take up positions in N.I. Further refinements are required for phase 3 to reflect population data. This will be dependent on the data analysis for the collection of current activity from the HURST/ECATs model.
3.2) Continue to implement phases 2-4 of the Delivering Safe and Effective Care Project (ED, DN and HV), and agree monitoring arrangements with HSCB for implementation of Phase 1	• Phase 2 – ED model approved in principle. Further national benchmarking TBA • Minor injury model approved for allocation • District nursing phase 3 – Hurst activity training completed. Data collection for workforce model on 19th -26th October with data analysis Nov/Dec • Monitoring arrangements Phase 1 achieved.	A			National benchmarking across UK sites will take place before the end of November. Phase two may be considered in a series of stages the first concentrating on core ED services and MI service model.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.3) Agree SBA volumes for CNS activity in acute settings and identify, develop and agree job plans with associated SBA volumes for CNS roles in acute/community and community settings.	The achievement of the above target should be set at amber, as while there have been job plans agreed for CNS posts in acute settings along with indicative activity levels that could be equated to SBA volumes, internal Trust processes are still on-going to provide technical support on clinical coding for nurse led activity on patient administration systems. Internal Trust processes are still on-going in relation to the roll out of job planning for acute/community and community based CNS roles. PHA Nurse Consultants will concentrate on a small cohort of acute/community and community based CNS roles to develop evidence based commissioning specs and service modernisation plans, for example Neurology CNS roles.	A			In the interim a number of commissioning specifications for CNS roles in an acute setting have been developed using best practice and professional guidance for which SBA volumes will be agreed moving forward, for example Cancer CNS roles.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.4) Along with HSCB lead the implementation of the NI Dementia Strategy and lead the OFMDFM/AP funded Dementia Signature Project (due to complete June 2017). Including the following key areas: • Information, support and advice including media campaign • Training including dedicated work with HSC Safety Forum, using a QI approach, to develop and implement a localized care bundle to prevent or treat patients with delirium • Innovative respite and short breaks • Regional review of memory OP services	• Information, support and advice including media campaign A survey has been undertaken to ascertain people's knowledge and attitudes to three areas of dementia: symptoms, stigma and risk factors. The results will then be used to target a public awareness campaign. • Training A NI Dementia Learning and Development Framework is currently being developed. Workshops are underway with a range of key stakeholders and a draft framework is due by Jan 2016. Work has begun on a Delirium Collaborative in acute wards as well as ED. Targets have been agreed to implement a delirium bundle over the next two years. • Innovative short breaks and respite A scoping report has been completed looking at current forms of respite/short breaks. A number of recommendations have been made for short break pilots based on conversations with people with dementia and their informal care givers. Procurement is currently underway to progress some pilots. A short break directory of services is also being developed. • Regional Review of memory OP services This work is at phase 3 stage looking at capacity and demand in clinics and a dementia pathway is under development. A scoping of all clinics has been undertaken and it is anticipated that this work will be completed by March 2016.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.5) Ensure adherence to statutory midwifery supervision	In accordance with the Midwives rules and standards (Rule 5) 6 Supervisors of midwives have successfully completed the Preparation for Supervision of Midwives Modules at QUB and have been appointed as Supervisors of Midwives within the H&SCT's. A further 10 Midwives have commenced the preparation for Supervision of Midwives and will complete in June 2016. (Rule 8) LSA Conference held on the 18th of Sept 15 to ensure that all supervisors of midwives met their 6 hours of CPD per practice year for Midwifery supervision. (Rule 9) The Ratio of Supervisors to midwives has been maintained at 1:13 below that of the recommended NMC ratio of 1:15. However this may change in the next quarter and there have been a number of retirements and resignations with more pending. (Rule 10) There are 2 Local action plans and 2 practice programmes for midwives currently in progress. (Rule 11) the Annual Audits of the H&SCT's to ensure the maintenance of the standards of practice by midwives and the standards of Supervision of the practice of midwives have been completed for 2015. (Rule 13) LSA Annual report was submitted in Sept 15 and NMC Quarterly return for 30th Sept 15 has been submitted. (Rule 14) There have been no Midwives suspended form Practice by the LSA for the period ending Sept 15	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.6) Q2020 – Lead the development of the Annual Quality Report in conjunction with the HSCB.	This was completed and approved by HSCB/PHA Boards by end September.	G			
3.7) Take forward recommendations on the DHSSPS Regional Learning System (RLS).	Whilst discussions have taken place regarding which recommendations could be taken forward regionally as a priority, new funding to facilitate this not been identified to allow this to proceed. There are, however a number of recommendations which would be considered “no cost” in nature and which could be taken forward locally and regionally through existing HSC regional groups as part of the Regional Learning System Project (RLSP). Safety Strategy Unit will be exploring with stakeholders how specific recommendations in the RLS report together with those recommendations in the Donaldson report relating to the reshaping of existing adverse incident reporting systems can be taken forward	R			The Safety Strategy Unit will be exploring with stakeholders how specific recommendations in the RLS report together with those recommendations in the Donaldson report relating to the reshaping of existing adverse incident reporting systems can be taken forward.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.8) Working with HSCB continue to lead a programme of work to drive the reform of AHP services including • Improving data quality • Development of minimum staff activity levels • Capacity and demand analysis	The PHA is continuing to work alongside the HSCB in completing the Demand & Capacity analysis across five Trusts. Initial meetings have been held with all Trusts, agreement reached on the template and calculations being used to work out any capacity gaps. To date:- WHSCT - exercise completed NHSCT - work being finalised SEHSCT- work in progress SHSCT - work in progress BHSCT - work in progress This work when completed will give expected activity levels across all the professions The PHA continues to work alongside HSCB information colleagues to improve data quality.	G			
3.9) Continue the Regional Medicines management Dietician Initiative	Work is on-going to progress the regional medicines management service to a commissioned service through the HSC Trusts. Letter send to Trust on 13th October 2015 to seek formal Trust agreement to proceed with commissioning Prescribing Support Services and with transfer of MMDT staff. Trusts are ask to confirm by 28th October 2015, commitment to finalise the service specification, specification of staffing structure and agreement around timelines for commissioning.	A			The PHA continues to work with and provide the professional advice to HSCB Medicines Management colleagues

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.10) Continue to take forward the implementation of the AHP Strategy, providing strategic direction, collaborating with HSC Trusts and other relevant partners regarding implementation of actions and the production of bi-annual progress reports.	The implementation of the AHP Strategy is now in year 3 of the action plan. A number of developments have been progressed through close collaboration with a range of organisations: • Regional review of band 5 AHP recruitment • Development of AHP professional governance maps across all organisations • Provision of professional advice for outside contracting requirements of AHP services/professionals Development of a AHP supervision e-learning programme which is currently being piloted	G			
3.11) Continue the Review of AHP Support for Children/Young people with Statements of Special Educational Needs. Working with relevant partners, provide an interim report on findings and common themes identified from Phase 2 and work towards the agreement of a proposed regional model and implementation plan.	The Review of AHP support for children/young people with statements of special educational needs is nearing completion. Common themes have been identified in phase 2 through working with and seeking views from relevant partners, including parents and children. Work is near completion on the agreement of a proposed regional framework and implementation plan. The proposed regional framework and implementation plan identify actions required in the key areas of: • Working together • Timely responses • Appropriate therapy environment and equipment • Informed and skilled workforce • Best use of resource	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.12) On behalf of PHA work alongside DoJ, DHSSPSNI & HSCB to consider / explore the potential issues surrounding the transfer of health care from Juvenile Justice System and PSNI	Departmental officials lead on this matter and it has been determined that no transfer of healthcare from YJA will occur at this time given the DHSSPS current position on not accepting any transfer of financial responsibility without meeting the requirements as laid out in Richard Pengelly's letter to HSCB. Youth Justice Agency (YJA) remains responsible for healthcare in Woodlands The C/EX YJA has escalated the nurse staffing shortage to the Board and PHA due to the significant risks and PHA nursing support is being provided to identify appropriate nursing workforce plan for Woodlands.	A			PHA/HSCB officials continue to meet with PSNI and Youth Justice Agency to provide support and advice regarding potential changes to healthcare provision in Police Custody and Woodlands.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.13) Lead, co-ordinate and monitor on behalf of the Department the implementation of the mental health nursing strategy 'Developing Excellence, Supporting Recovery'.	DESR regional meetings held 4 times per annum with lead nurse representation from HSCB, Trusts, Education providers, vol/com organisations, carers and service user representatives. All organisations, as appropriate are working to progress the actions contained within the DESR Action Plan however, progress across the region is variable. Particular difficulties have arisen related to budgeting constraints and the ability of Trusts to release nursing staff for training. However where training has been prioritised there has been an increase in uptake in courses providing psychological intervention skills. Good progress has occurred in development of partnership working with services users and co-production of recovery orientated courses. Experts by Experience are also involved in teaching nursing students and nursing student are able to participate in Recovery College courses. A number of innovative practice initiatives have occurred and one Trust has developed a bespoke supervision framework to facilitate nurses in reflective practice.	A			Some additional funding from HSCB/PHA has been provided to enable staff to attend relevant training courses.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.14) Lead on the sustainability phase of developing recovery services across the region working with key stakeholders both locally, nationally and internationally. Undertake an evaluation of recovery services using quality indicators.	In support of the mental health care pathway development which was coproduced by service users, carers and professionals regionally, Recovery Colleges have now been established across Northern Ireland. Recovery Colleges provide a fresh adult learning approach to mental health care through blending 'expert by experience' and professional knowledge into the delivery of therapeutic educational programmes. In order to deliver comprehensive user-led education and training programmes in Recovery Colleges, Trusts agreed to use a hub and spoke model to drive the programmes forward with recurrent monies to fund sessional peer trainers. They have now all employed Recovery college coordinators to manage the following:- • A range of co-produced courses developed with more in development. • A cohort of Peer, Mental Health Practitioner and Carer Trainers trained to deliver programmes • Job descriptions and Person Specifications for Peer Trainers developed. • Venues identification and agreed use. • A college prospectus each semester • Assistance to all new students • Collecting evaluation data • PR Evaluation Regional and Trust Recovery Evaluation Groups are established to retain an overview of all recovery focussed evaluation. A Regional evaluation tool has been agreed (Inspire) following evaluation workshop. Time line agreed for first evaluation report.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.15) The HSC Safety Forum will work with Trusts to support the further spread of the Sepsis 6 bundle beyond the pilot areas identified in the 2014/15 period.	Trusts have nominated areas to work on sepsis6 in 15/16. Engagement discussed at Quality 2020 implementation Team and DPH meeting with Medical Directors. Clinical teams meeting with Safety Forum in November 2015 to discuss methods of implementation.	G			
3.16) The HSC Safety Forum will work with Mental Health teams to • Improve the physical health and well-being of mental health patients and • Improve approaches to crisis prevention and response.	Trusts have presented data on work which shows progress on various elements of improving physical health e.g. weight loss, health monitoring & drug therapies. Will continue in background. Crisis prevention and response has been subsumed into a new improvement collaborative aiming to use QI methodology to implement the recommendations from the thematic review of 100 suicides. This approach is supported by, and agreed with, the Mental Health commissioning team.	G			
3.17) Work with the HSCB to take forward the review of the Cancer Services Framework.	Cancer Services Framework 2015/16 was agreed by AMT and SMT and forwarded to DHSSPSNI – (September 2015)	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.18) Work with the HSCB to take forward the Cardiovascular Services Framework Implementation Plan.	The Progress Report for Year 1 (2014-15) Implementation of the Cardiovascular Service Framework was submitted to DHSSPS in October 2015. There have been difficulties with data collection for some of the key performance indicators. Work is on-going to address these issues or find alternative data sources or proxy measures. The Steering Group meet three times per year to oversee implementation of the Framework.	A			Work is on-going with Section Leads and HSC Trusts to address data collection issues and find alternative data sources or proxy measures.
3.19) Develop an Implementation Plan for the Respiratory Service Framework, following consultation.	A draft implementation plan has been developed in consultation with key stakeholders. The implementation plan covers the proposed structure and processes including monitoring and reporting arrangements. The final draft of the implementation plan will require approval from the DPH in her role as a professional lead for the RSF implementation and will require formal endorsement by the AMT and SMT for onward submission to the DHSSPS.	G			
3.20) Continue to lead the Long Term Conditions Regional Implementation Group to deliver on its action plan, and commission patient and self-management programmes as outlined in PFG, subject to funding.	Long Term Conditions regional group has been established and meets 3-4 times per year.	R			No additional recurrent monies identified for self-management programmes. ICPs have invested non-recurring funds in SM programmes.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
3.21) Lead on the Implementation of PPI Policy in HSC, including roll out of PPI Standards, Monitoring and Training in order to help improve quality, safety and effectiveness of services.	Standards have been completed and launched. Work is now on-going to raise awareness of these and to encourage compliance with them. The Monitoring process has been designed and approved by the DHSSPS. The PHA have led on the implementation of the process with HSC Trusts and have utilised it internally. It has also been undertaken with the RQIA. Plans are being considered for extension of this across the HSC. The PHA have led on the development of a generic PPI training programme for HSC. This is nearing completion with plans to roll out from the winter of 2015 onwards	G			
3.22) In support of safe and effective person centred care, Commissioners through the Director of Nursing PHA should require of organisations and bodies from which services are commissioned, that appropriate systems are in place to ensure that nurses and midwives are appropriately supported to fulfil regulatory requirements of the	Systems have been developed to ensure that the HSC Trusts have appropriate systems in place to support nurse/midwives to fulfil the NMC revalidation requirements. Business case submitted to DHSSPSNI for additional resources to support implementation of systems for revalidation. Early indications are that HSC Trusts will gain administrative support. PHA/HSCB has not received confirmation of additional resources. Two regional monitoring templates have been developed: 1. A Regional HSC Trust Monthly Revalidation Assurance Template:	A			Two regional monitoring templates have been developed: 1. A Regional HSC Trust Monthly Revalidation Assurance Template: a. To provide confirmation that systems are in place to support nurses/midwives to meet revalidation requirements b. To raise concerns 2. Regional HSC Nursing Assurance Framework developed in partnership with the HSC Trusts: This includes a Biannual

NMC, in particular the introduction of revalidation for Nurses and midwives from 31 December 2015.	a. To provide confirmation that systems are in place to support nurses/midwives to meet revalidation requirements b. To raise concerns Regional HSC Nursing Assurance Framework developed in partnership with the HSC Trusts: This includes a Biannual Monitoring template for professional issues including revalidation requirements:				Monitoring template for professional issues including revalidation requirements: deliver awareness sessions to HSCB/PHA nurses and midwives

4. IMPROVING THE EARLY DETECTION OF ILLNESS

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
4.1) Complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group by inviting 50% of all eligible men and women with an uptake of at least 55% of those invited. *(Commissioning Plan Direction target)*	Age extension was introduced from 1st April 2014. 25.7% of the eligible population were invited to participate in screening during April - September 2015. Uptake is measured at 12 weeks and 6 months after the issue of an invite. - The 12 week uptake for Northern Ireland April - June 2015 is 57.6%. - The 6 month uptake for Northern Ireland April 2014 – March 2015 is 56.8%	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
4.2) Implement actions to address the recommendations in the RQIA review of the Diabetic Retinopathy Screening Programme	The recommendations are being addressed through the Diabetic Eye Screening Programme Modernisation Project. However, some of the 40 recommendations will not be implemented within the timeframes set in the DHSSPS action plan.	A			The Project Team agrees with the recommendations but will not be able to implement some on time due to: • Delays in recruitment processes within BHSCT; • The absence of data sources; • Reliance on progress by other work streams e.g. Developing Eyecare Partnerships (DEP); • Staff absences in PHA DESP staff. The team is attempting to mitigate these issues by: • Liaising with relevant BHSCT staff; • Considering alternative methods of data collection (eg audits, prospective data collection); • Working with DEP • Seeking HR and scrutiny solutions to staffing issues.

5. USING EVIDENCE, FOSTERING INNOVATION AND REFORM

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
5.1) Carry out a regional Review of school nursing service	PHA business case (approved AMT June 2015) submitted to DHSSPS against annual non-recurrent funding of 90k in relation to implementation of Healthy Futures unsuccessful due to financial restraints. This business case included a proposal to commission the Royal College of Nursing (RCN) through Single Tender Action: • to carry out a comprehensive evidence review in relation to the potential contribution of school nursing services to improving the health and wellbeing of children, families and communities from a regional, national and international perspective • to identify innovative public health models that can support service development and improvement for school nursing services within an overall 5-19 service within a Northern Ireland context • to engage with and be informed by service leads, practitioners and experts including the facilitation of networking and visits to centres of excellence as appropriate • to provide a full, evidence based option appraisal in keeping with the recommendations of Healthy Futures	A			Planned evidence review postponed. Public Health Nurse Consultant will continue to work with the school nurse service on regional basis to progress within a revised timescale.

	• support the PHA with implementation through participation in Healthy Child Healthy Futures Programme Board Progress has been made by the PHA public health nursing team in relation to three key areas: 1. Engagement with specialist school nursing practitioners and managers to identify areas for improvement – regional workshop facilitated by PHA 2. Agreement for standardised roles and responsibilities for Band 5 & 6 public health nurses working within school health – job descriptions gathered and being analysed 3. Regional school health profile proformas being developed for use by school nursing teams for testing and piloting that will include data gathering in relation to the health, wellbeing and safeguarding needs of school age population. Public Health Nursing Team for Children & Young People are working with PHA Health Improvement colleagues to identify opportunities for collaboration in relation to school population.				

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
5.2) Ensure the delivery of commissioned research to evaluate Telemonitoring NI	Due to unforeseen delays encountered at the start of the research an extension to Feb 16 was sought by QUB and approved by PHA. To-date the following activities have been implemented: ***Descriptive study (Study 1)*** Analysis of Telehealth dataset commenced in July/August 2015 after the data was provided to the HBS. QUB anticipate this will be deliverable by Feb '16. ***Quantitative research (Study 2)*** Study 2 involving new referrals commenced in June 2015 for 3 months. The response has been poor and did not meet the sample size required of 259. To-date only 8 patients consented to participate and only 1 patient returned the questionnaire. ***Qualitative research (Study 3)*** A number of interviews with health professionals and stroke patients/carers have been conducted. A series of patient focus groups has commenced at various Trusts locations. Analysis of health professional interviews is ongoing and is likely to continue into December. ***Telecare study (Study 4)*** Data Access Agreements relating to the Telecare have been submitted and approved by Trusts. Telecare data extraction is being progressed. Depending on timelines for the analysis of the Telehealth data, QUB anticipate to start the analysis of the Telecare data after December 2015.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
5.3) Support researchers to secure research funding from external sources including NIHR evaluation, trials and studies co-ordinating centre (NETSCC), Horizon 2020 & other EU sources.	Since the investment began there have been 13 successful NI-led applications to NETSCC with one of those awarded during this reporting period. A further four applications are under consideration. One additional EU project involving BHSCT was contracted during the reporting period (Total value €50 million/23 partners)	G			
5.4) Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas.	HSC R&D Division works closely with the NIPHRN to ensure opportunities for research in PHA priority areas are progressed. Email alerts are used to keep the communication channels open and information flows into and out of the NIPHRN to support PHA engagement in funding opportunities and in the formation of Research Development Groups. Workshop events on key PHA topic areas have been organised such as smoking cessation in pregnancy and antenatal infection. We are currently scoping the potential for organising a similar event on breastfeeding.	G			
5.5) Commission Research and Produce a Best Practice Report on PPI.	Research report commissioned and first draft delivered. The final version of the research report is anticipated by mid-November with the Barriers report to be completed by the end of the year, and subsequent submission to the DHSSPS	G			

6. DEVELOPING OUR STAFF AND ENSURING EFFECTIVE PROCESSES

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.1) Provide Professional Leadership, Advice and Guidance on PPI.	This is an on-going responsibility within the PHA and with HSC partners. Work is being undertaken to develop guides to assist in this work	G			
6.2) Develop a new PHA 3 Year Action Plan for PPI	Initial discussions and planning has commenced. Engagement is now being organised with wider stakeholders on the plan	G			
6.3) Ensure that by 30th June 2015 90% of staff will have had an annual appraisal of their performance during 2014/15.	Over 90% of staff have received their annual appraisal as at 30th June 2015.	G			
6.4) Ensure that by 31 March 2016 100% of doctors working in PHA have been subject to an annual appraisal.	During 2015/16, 8 PHA Consultants are due for revalidation. At 30 Sept, 4 Consultants have been put forward and have successfully completed revalidation.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.5) Continue to take forward implementation of the PHA Procurement Plan.	The PHA continues to progress the procurement plan. As a result of the new EU Procurement Directive and the introduction of the “light touch regime” the PHA has reviewed its procurement processes to meet the requirements of the new legislation. This has included working with DLS and PALS to develop a suite of documents for under threshold procurements. Internal guidance, incorporating the learning from the 2014/15 procurements is also being developed. Planning is underway for a number of ‘under threshold’ procurements to be taken forward before the end of 2015/16: • Active Travel • Belfast Advice Project • Keep Warm Keep Well • Rough Sleepers • Readers Project • Smoking Cessation Training Services • Workplace Health and Well-being Support Work is continuing on Mental Health and Suicide Prevention Phases II & III; and the pre tender consultation for the Lifeline service is currently underway. The PHA Procurement Board continues to meet to oversee this work.	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.6) Achieve substantive compliance for all 15 controls assurance standards applicable to the Public Health Agency	On target to meet substantive compliance for all 15 controls assurance standards applicable to PHA.	G			
6.7) Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	On target – review of the BCP undertaken (summer 2015) – revised plan available October 2015. Test of BCP planned for 5 November 2015.	G			
6.8) Explore the introduction and feasibility of EDRMS in PHA and depending on the outcome of this commence development of a business case.	Resource constraints have delayed work on a full EDRMS. However, alternative options are being considered, with a demonstration of 'RecordPoint' scheduled for 23 October 2015.	A			As an interim solution PHA is exploring the use of 'RecordPoint' to enable management and audit of electronic records in line with the disposal policy. The possibility of using this as a 'full' solution will also be explored.
6.9) Finalise the new PHA Corporate Strategy-building on the engagement carried out in 2014/15 and taking account of the 15% reduction to PHA Administration Budget.	Work continues to develop the PHA Corporate Strategy, building on the engagement exercise carried out in 2014/15. A PHA board away day was held in September 2015 to look at the future Corporate Strategy. The PHA Corporate Priorities and Strategy Project Board continues to meet to take forward the development of the new strategy.	A			The Corporate Priorities and Strategy Project Board agreed at its last meeting, that given the forthcoming Assembly Elections the timetable should be put back, to allow a draft to be ready by April/May 2016, to go out for public consultation late May/early June 2016 following the elections.

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.10) Meet DHSSPS financial, budget and reporting requirements	All deadlines in relation to Monthly monitoring to the DHSSPS have been met and the year-end annual accounts completed.	G			
6.11) Develop and agree a new Internal communications strategy and action plan to ensure PHA business is supported by efficient and effective internal communication systems.	Internal Communications Action Plan - Several actions completed and under way including redevelopment of Connect, introduction of generic email addresses for improved internal email communication, investigation of weekly update, scoping merits of digital signage, scoping feasibility of email branding, proposal for standard corporate auto signature.	G			
6.12) Review and Revise PHA digital assets including PHA Corporate and Intranet sites.	Planning and delivery for re-presentation of public health data (health topic sites) aligned to NI Direct/HSC Online project. Scoping underway re paper for AMT Process to redevelop PHA Intranet site Connect in progress through PaLS.	G			
6.13) Continue and enhance social media activity to extend the reach and expand the types of content used	The development of social media continues, with increasing reach across all channels and further use of rich media such as graphics and videos enhancing the 'viral' aspect of messaging, which secures wider engagement with the PHA's work	G			

Target from Business Plan	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.14) Revalidation champions will provide on-going support to registrants and managers across the PHA and HSCB, as well as engaging with GP employed nurses	Staff have been nominated across organisations i.e. HSC Trusts, PHA/HSCB to attend MIAD master classes via NIPEC. Dates have been confirmed these nominees will cascade training received to support individual nurses/midwives and line managers to fulfil revalidation requirements	A			Nominated Revalidation Champions to attend training in Nov. Will continue to place revalidation information on HSCB,PHA and primary care intranets Deliver awareness sessions to HSCB/PHA nurses and midwives Secure additional resources to deliver awareness sessions to general practice employed nurses.
6.15) Establish a professional forum	Professional Nursing and Midwifery Forum established. schedule = 1/4ly meetings: 12th June 2015 1st October next meeting scheduled for January Additional 'learning sets' will be arranged to cover professional issues.	G			
6.16) Develop and implement the Nurses and Midwives verification of NMC policy	Policy for the Verification of NMC registration is still in draft. Awaiting confirmation from HR of the ability of the HRPTS system to monitor additional 3yr revalidation date and 2yr 6mth reminder field for preparation of sign off.	A			Awaiting confirmation from HR in relation to functionality of the HRPTS system to monitor additional 3yr revalidation date and 2yr 6mth reminder field for preparation of sign off.

Health & Social Care (Commissioning Plan) Direction (NI) 2015 - Targets

See Also - Annual Business Plan Targets 1.1 and 4.1

Target	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
From April 2016,all eligible pregnant women, aged 18 and over, with a BMI of 40KG/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with a uptake of at least 65% of those invited.	Weigh to a Healthy Pregnancy programme – evaluation complete and planning to mainstream the programme is on-going.	G			
By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme. (See Also 2.3)	FNP Programme available in all HSC Trusts. Funding for additional sites / service within the five Trusts so that all eligible mothers are offered a place on the FNP programme has not been identified. Work in underway to profile the number of parents eligible to receive FNP who have not been offered a place and the reasons for this.	A			Roll out of FNP to all eligible parents to be included in list of service developments. A number of family nurses on Sick Leave and therefore Case Loads had to be closed. Further resources may need to be identified to provide cover for unplanned sick leave.

Target	Progress	Achievability Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
By March 2016, implement the Normative Nursing Range for all specialist and acute medicine and surgical inpatient units	Work has been ongoing to implement Phase 1 of the Delivering Care project across all medical and surgical wards. Trusts have provided the HSCB and PHA with three progress reports which provide updates at September 2014, May 2015 and September 2015. As previously advised, the total number of permanent and temporary nursing staff required to fully implement Phase 1 is 4,819.62 WTE. Funding of some £12m has been provided to Trusts to support the full implementation of Phase 1. Following the latest returns from Trusts, there are currently 4,353.15 WTE permanent and temporary staff across the region. To meet the target position, a further 457.46 WTE permanent and temporary staff will be required. Trusts have indicated that the recruitment of permanent and temporary staff has been particularly challenging in recent months and do not expect any significant progress in this area due to the limited potential to attract additional nursing staff. It should be noted that there are a total 5,079.92 WTE staff (including bank and agency staff) across the region, 260.3 WTE more than the target position	A			The HSCB are currently in discussions with the Department regarding the challenges with recruitment of permanent and temporary nursing staff in Trusts.

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 November 2015
Title of Paper	10,000 Voices Phase 2: Regional Report Relating to Care in Your Own Home (October 2015)
Agenda Item	12
Reference	PHA/03/11/15

Summary

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.

Patient and client experience is now widely recognised as a key indicator of quality of care and is central to many of the strategic drivers for health and social care improvement and innovation in Northern Ireland.

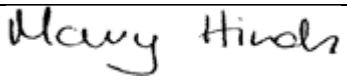
The 10,000 Voices initiative was commissioned and funded by HSCB and PHA to provide a robust and systematic mechanism for patients and clients to share their experiences of health and social care so that future commissioning and delivery of services will be more patient focused. Through the 10,000 Voices the processes have been established to introduce Experience Led Commissioning into Northern Ireland. 10,000 Voices

Process

The 10,000 Voices Initiative is being progressed in a phased approach across all HSC Trusts. Phase 2 of 10,000 Voices collected patient stories from people who received care in their own home. This report presents the analysis of the information which has been received from February 2014- September 2015.

The Trust Facilitators developed engagement plans to collect stories across a range of areas and settings. A total of 1399 Stories were received across the five HSC Trusts. A number of areas for action have been identified within the local Trusts; however there are also a number of issues which will require a regional approach to improve the experience of people who receive care in their own homes, these are:

1 Isolation and loneliness
2 Timing of calls and time allocation
3 Care of clients with dementia
4 Communication

Next steps A range of activities will be taken forward to address the issues highlighted in the analysis of the information from Phase 2 of 10,000 Voices.	
Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For approval
Director's Signature	
Title	Director of Nursing and AHPs
Date	12 November 2015

Public Health Agency

Health and Social Care Board

TEN THOUSAND VOICES

PHASE TWO

REGIONAL REPORT RELATING TO

CARE IN YOUR OWN HOME

FINAL DRAFT OCTOBER 2015

Foreword

I am pleased to present the regional report on the findings from the second phase of the '10,000 Voices' Initiative. This Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA), to introduce a more patient focused approach to shaping the way services are delivered and commissioned. It is important for us to 'see and hear' through the eyes and ears of the patient and remember that that each experience is unique for every patient/client. 10,000 Voices provides a mechanism for patients and clients not only to share their experience of the health services, both positive and negative, but also to affect and inform change.

Patient and client experience is a key indicator of quality and is central to many of the strategic drivers for health and social care improvement and innovation. For instance 'Patient and Client Focus' is one of three key elements outlined in the Quality 2020 Strategy (DHSSPS 2012) and highlights that all patient and clients are entitled to be treated with dignity and respect and should be fully involved in decisions effecting their treatment and support. In addition, Transforming Your Care" (DHSSPS 2011) focuses on reforming and modernising services, so that they are centred on people rather than institutions, therefore placing patient and client experience at the heart of health and social care reform.

Transforming Your Care aims to make home or the community the hub of care and to prevent, where possible hospital admission. It is therefore very timely that through the 10,000 Voices Initiative we extended the second phase to hear about the experiences of those who receive care in their own home. To date (30 September 2015) we have received a total of 1399 stories from patients, carers and families who receive care in their own home.

I am delighted that so many people have taken the time to share their experiences of Health and Social Care through the 10,000 Voices Initiative and wish to thank all those who participated; their contribution has been invaluable and will undoubtedly influence the delivery and commissioning of services.

Mary Hinds

Executive Summary

This report presents the analysis of the information which has been received during Phase 2 of 10,000 Voices (February 2014 –September 2015) from patients/clients/carers and family members who receive care in their own homes.

Engagement to collect stories from clients who receive care at home took place across a broad range of areas and settings. A total of 1399 stories have been received to date and the facility for collecting stories remains live. Sixty percent of the stories were submitted by the person who received the care, with the remaining being completed on behalf of the person receiving the care, by carers or by a family member. The majority of respondents were older people with 72% over 70 years of age and the largest age group of clients receiving care at home was the over 80 age group. (Page 11)

Most of the care was delivered by domiciliary care workers, including home helps, home care staff and health care assistants, however there was also a range of other professional groups and staff involved in care delivery. (Page 13)

A high proportion of clients report that their overall feelings about receiving care in their own home are positive or strongly positive. These people have told us that they are very appreciative of the care they receive, they want to remain as independent as possible and they want to continue to live in their own home for as long as possible. Many consider their carers to be professional, caring and helpful; some of these clients also report that their care needs are not always met in the allocated time. For people who have been receiving care in their home over a prolonged period of time, many consider their carers to be like their friends and family, however they have some anxiety if they do not have the same carers providing their care.

The remaining clients who report their overall feelings to be less positive have told us that they feel the carers are very rushed and do not always have enough time to deliver their care and that they also feel that they don't have enough input into decisions about their care. Meeting care needs in the allocated time varies across the professional groups and support services who provide the care (Page 15-18). A small proportion of clients find that on occasions staff can be abrupt and do not always behave in a respectful way towards them

Many of the stories highlight the isolation and loneliness that people who live alone experience and how they are very grateful for the company and security that staff provide when they are delivering care. For residents who live in sheltered accommodation or supported living and receive care in this setting, many describe the positive aspects of living in this type of accommodation as well as a high level of satisfaction with their care.

Most clients have told us that they want to remain in their own home for as long as possible with the adequate level of care delivered in a timely and responsive manner.

It is clear that there are lot of positive messages in the information which has been obtained from clients who receive care in their own home. It is important that these positive messages are shared with the relevant staff, with members of the public as well as with those who commission services. Areas for action to improve the experience of people who receive care in their own homes have been identified through the local Trust findings and are being progressed.

There are a number of emerging issues which will require a regional approach in progressing actions to improve their experience of people who receive care in their own homes. These are:

1. Isolation and loneliness*:* Many stories describe the isolation and loneliness experienced by people who live alone and who depend on carers coming into their homes; these stories indicate that these clients are very appreciative of the service which is provided to them. For many of these people their carers are the only people they see on a day to day basis. People who attend day centres appreciate and enjoy the company that they receive and for those who live in sheltered accommodation they enjoy the comfort and security that this type of housing offers.

Action: As it is recognised that social isolation extends to broader areas than health and social care, one of the best mechanisms to address this will be by working collaboratively with individuals, communities and partner organisations through the implementation of Making Life Better (DHSSPS 2013- 2023). The first steps to progressing this action will include a workshop with key stakeholders.

2. Timing of calls and time allocation: In the analysis of the stories it is clear that people feel staff are rushing to get everything done in the time allocated, and that although the carers do the best they can, needs are often not met and clients frequently have to rely on family and friends to provide further assistance.
The timing of calls are not always suitable to client's lifestyle, for example many patients feel that they return to bed too early in the evening, also timings can be inconsistent at times.

Action: The findings from this phase of 10,000 Voices have been recognised in the review of domiciliary care in Northern Ireland and will be addressed through this review.

3. Care of clients with dementia: Some stories indicate that those providing care do not always have adequate knowledge and skills to care for clients with dementia.

Action: The findings in relation to the knowledge and skills of staff will be addressed through the NI Dementia Learning and Development Framework, which is currently being developed by HSCB and PHA.

4. Communication*:* Some stories highlight that there can be inconsistency in who delivers the care and this often leads to mixed messages in communication with the client not always knowing who is caring for them. It is therefore vital that all staff introduce themselves and wear name badges. It is also important to clients that their carers know ***wha*t *matters*** to them before leaving their house, for example– drinks, phones at reach, pull back curtains.
Some respondents indicate that they are not always sure what happens to their personal information (11%), with stories highlighting a lack of privacy within their own home.
Actions: The actions in relation to communication, including informing clients what happens to their personal information, will continue to be addressed by Trusts. For those who receive care at home on a long term basis wherever possible the care should be provided by a consistent team of carers who have established a relationship with the client. Extending the ***Hello my name is*** campaign to community

settings has been included as a Patient Client Experience priority regional for 2015/2016.

Contents

1.0 Introduction and background

The PHA / HSCB commissioned the 10,000 voices Initiative to enable engagement with patients/clients to focus on **what matters** to them as well as **what is the matter** with them when using health and social care services.

The 10,000 Voices Initiative asks patients to share their experience of health and social care services by “telling their story”. This is important because national and international evidence has shown us that ‘patient stories’ provide an insight into the services provided and therefore make them an appropriate method to improve the quality of care.

This approach is in keeping with the PHA/HSCBs commitment to involve patients, carers and families in how services are shaped and delivered in Northern Ireland (NI) and all HSC Trusts are involved with this Initiative. The 10,000 Voices Initiative will focus on a range of areas across health and social care to the gain patient and client experience.

In response to the increasing ageing population and the numbers of people living with long term conditions, more people are being facilitated to live at home or closer to home with the appropriate care. Currently over 24,000 people in Northern Ireland receive domiciliary care in their own home (DHSSPS 2015). Phase two of the 10,000 Voices Initiative has provided an opportunity for people to tell us about their experience of receiving care in their own home.

2.0 The Survey

The survey was designed with public engagement through a series of workshops across NI at which patients, families, carers, and HSC staff participated.

Those filling in the survey are asked to tell us about their experience of receiving care in their own home, to help others to understand what it is like from a patient perspective. They can choose to share all or part of their experience. The survey can be completed by the patient themselves, their carers, family or others. They are asked to respond to a series of questions, which are formatted in the shape of a triangle. In each of these questions the respondent reviews 3 statements and places

a “dot” nearest to the statement that reflects their experience. They complete the survey by answering a few multiple choice questions.

2.1 Accessibility

The survey has been promoted through a variety of ways. Trust Facilitators have engaged with patients, carers and families in a range of areas, including community groups, shopping centres, schools/colleges and factories, residential facilities, sheltered housing associations as well as within hospital settings. The survey can be completed using a paper copy, online or through a Digital App. It has been translated into 6 languages (Chinese simple, Chinese complex, Latvian, Slovak, Lithuanian and Polish) and can also be completed using a voice recording facility on the App.

2.2 Completing the survey

Patients, clients, carers and family members are asked not to give their name or the name of any staff that provided care and are advised not to worry about spelling or grammar. They are asked to give their story a title and to select key words which describe their experience, the titles and key words are often indicative of the nature of the experience the person has had. Some of the titles which have been provided by people who receive care in their own home are shown below:

It is clear that people appreciate the opportunity to provide feedback on their experience as shown in the comments below:

I value all service received, particularly value obvious ongoing evaluation of service provision, of which this survey is an example and feel privileged to be a part of the 10,000 Voices submitting opinions with a view to continuously improve standards of care.

Thank you for taking the time to talk to me

3.0 The Results

Phase two of the 10,000 Voices Initiative commenced in February 2014 and the patient stories received until 30 September 2015 have been included in this review. The table below shows the number of stories received in each Trust area:

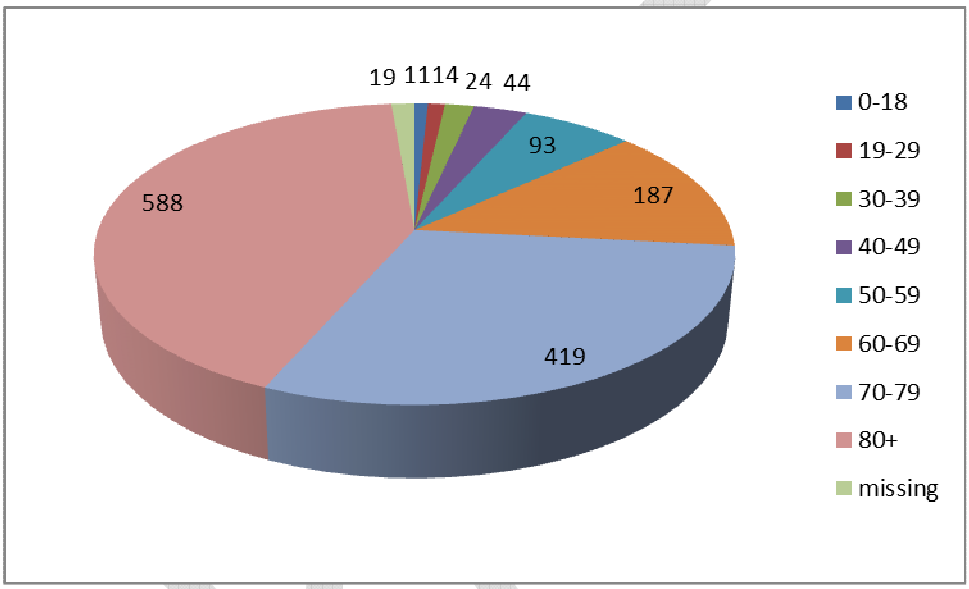
Table 1: Numbers of stories received in each Trust	
Area	**Number of stories received**
Belfast Health and Social Care Trust	285
Northern Health and Social Care Trust	152
Southern Health and Social Care Trust	187
South Eastern Health and Social Care Trust	394
Western Health and Social Care Trust	381
Total	**1399**

Who completed the survey?

- 60% completed by person receiving care
- 23% completed on behalf of person receiving care
- 10% completed by carer
- 7% completed by other person (family member)
- 66% stories relate to care provided by Trust staff
- 62% female, 37% male, 1% missing data

Age group of respondents

The majority of participants were older people, with 42% over 80 years of age, representing a client group who are increasingly dependent on others to have their care needs met and who are often frail and vulnerable individuals , many of whom have ongoing, long term complex needs. The chart below shows the number of responses per age group.



Stories were collected from a range of settings, for example:

- Domiciliary care in clients own homes
- Supported living facilities
- Rehab and re-enablement
- Community Nursing Rapid Response Service
- District Nursing
- Hospital diversion teams
- Floating support workers (Rathlin Island)
- Occupational therapists/ Physiotherapists
- Community Children's Nursing Service

Who provides the care?

Participants are asked to identify who provides their care, as can be seen in the table below the majority of stories included in this review were from clients whose care is provided by Trust staff: For clients who indicated *other* their care was often provided by a combination of Trust staff and independent providers and family members

Table 2: Responses to "Who provides the care?"

	Regional total	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Trust staff	928 (66%)	183 (64%)	99 (65%)	246(62%)	128 (68%)	272 (71%)
Independent provider	204 (15%)	54 (19%)	20(13%)	80 (20%)	20 (11%)	30 (8%)
Not sure	134 (10%)	25 (9%)	12 (9%)	34 (9%)	29 (16%)	34 (9%)
Other	133 (9%)	23 (8%)	21 (14%)	34 (9%)	10 (5%)	45 (12%)
Total	1399	285	152	394	187	381

Who delivers the care?

Care delivery to clients who live at home is often provided by several health care professionals and support services who are involved in both the assessment and review of care needs and the actual delivery of care. Participants are asked to identify which health care professionals/ support services are involved in their care, in many cases they identify more than one service. Therefore the numbers are not reflective of the total number of patients but rather the number of patients who have can identify with a particular service.

Ninety per cent of respondents identified domiciliary care staff, home helps and health care assistants as the providers of their care. However 36% identified AHPs, 29% social workers /assessors and 13% nursing, reflecting the range of professions involved in providing care at home.

Table 3 below presents the breakdown of staff and services identified:

Table 3: Breakdown of staff involved in providing care						
Services Provided	**BHSCT**	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total Numbers**
Domiciliary Care / Home Help / Home Care Staff / Health Care Assistants	265	114	423	156	301	**1259**
Social worker/assessor	66	36	97	64	143	**407**
Rapid Response / CNRRS / Hospital Diversion Teams	2	11	51	0	11	**74**
District nursing / Specialist Nursing	12	21	10	11	58	**112**
AHP including Physiotherapist / OT / Podiatry / Speech and Language Therapist	54	56	189	73	135	**507**
Sheltered Housing / support housing Services	24	0	36	7	0	**67**
Rehab/Re-ablement Services	0	0	6	5	2	**15**
Mental Health Services	1	0	2	5	7	**15**

Overall satisfaction with care provided at home

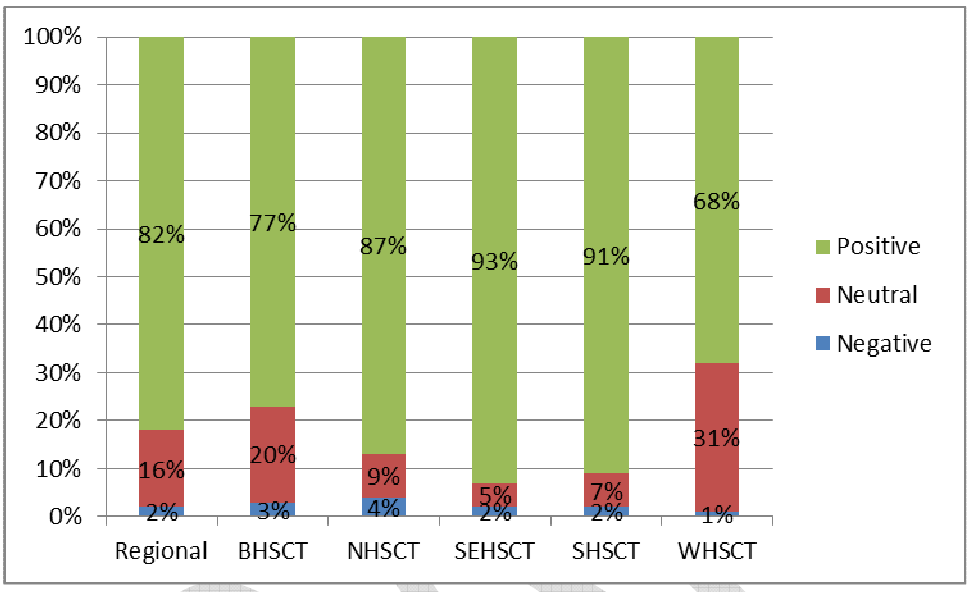
When asked about their overall feelings about their experience of receiving their care at home, a high percentage (79%) of clients rated their experience as strongly positive or positive. The key messages in stories which highlight positive aspects of patient experience are appreciation of being able to remain at home and remaining as independent as possible. Many clients report that they find that their carers are kind, helpful, understanding, caring and compassionate and providing outstanding care, however they also recognise that frequently the carers are rushed and do not always have enough time to deliver their care in the allocated time or at a time suitable to them.

Impact of receiving care at home

Whilst 79% of clients stated their overall feelings about receiving their care at home was positive or strongly positive, 82% also state that the impact of receiving their

care at home has been strongly positive or positive, with 3% negative or strongly negative and 15% not sure or neutral. Maintaining Independence was reported as one of the most positive aspects of receiving care at home.

There are some variations noted in the responses from the individual Trusts as shown below in relation to the impact of receiving care at home.



The number of stories which are rated to neutral/not sure is highest in BHSCT and WHSCT, key messages in these stories are as follows:

- Inconsistency in the carers who provide the care
- Getting the care package established
- Needing additional help
- Timing and time allocation of calls
- Feeling safe in place of care

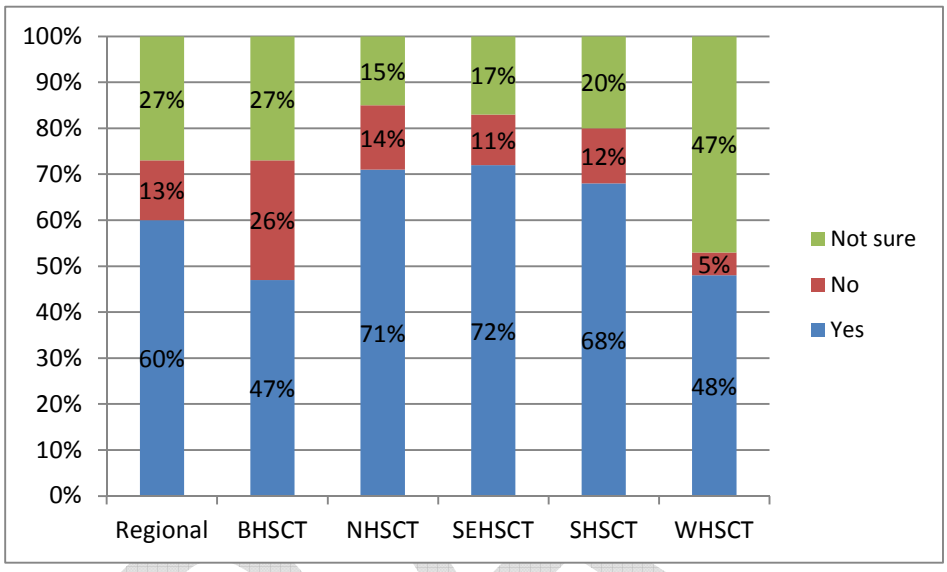
Experience of care was obtained from 3 Trusts (BHSCT, SEHSCT and SHSCT) from clients who live in sheltered accommodation/supported living. The individual stories reflect very positive experiences with this type of accommodation and the associated care and overall the vast majority of these clients report that the impact of receiving their care in this setting was strongly positive/ positive.

Meeting care needs in the allocated time:

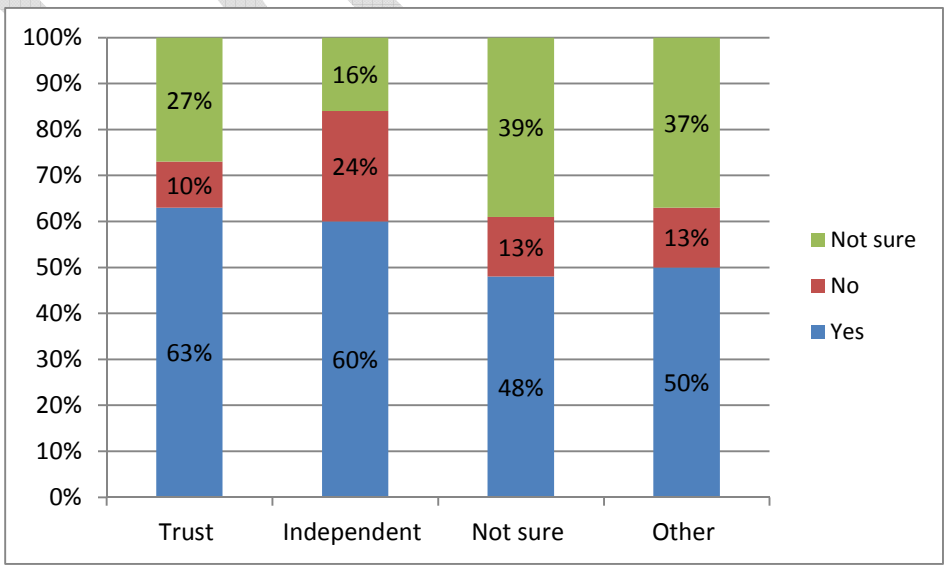
Almost two thirds reported that they are aware of the time allocated for delivery of care in their own home, 28% were not sure what time is allocated and 11% do not

know what time is allocated for their care. Many of the stories reflect that clients feel their needs are not met in the allocated time as illustrated in the response to the question: ***Do you feel your care needs are met in the allocated time***? There is some variation between the Trusts in the overall responses to this question as shown below:

Overall responses to: ***Do you feel your care needs are met in the allocated time***?



Responses in relation to care being met in allocated time by who provides the care are shown below:

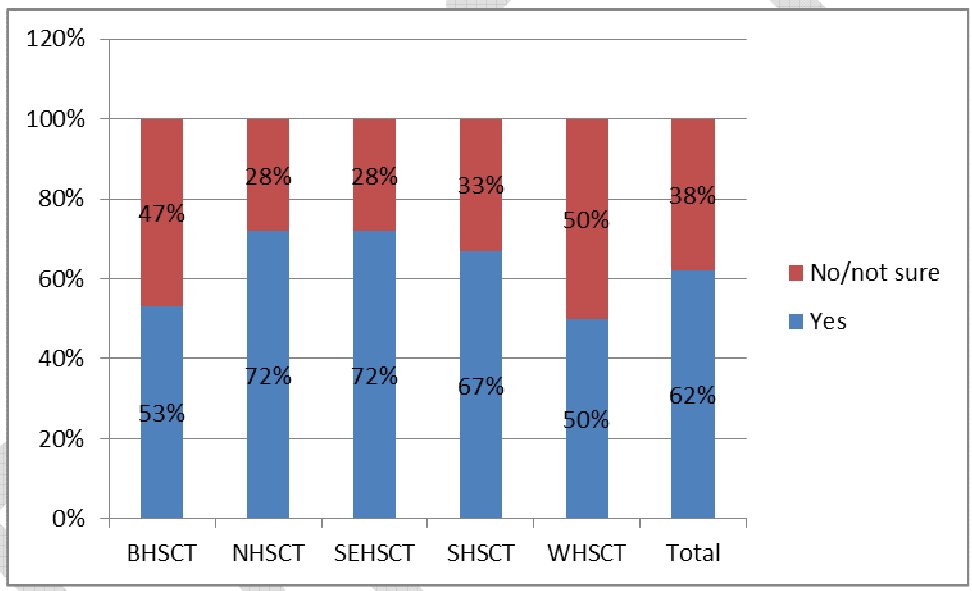


Commentary

This is analysed further, as illustrated below for patients who identified domiciliary care, home help, home care and health care assistants as being involved in delivering their care. Almost three quarters of clients in NHSCT and SEHSCT felt that their care needs were met in the allocated time, with 67% of clients in SHSCT.It is noted that there is a higher percentage of patients who state that their care needs are not met or are not sure if they are met in the allocated time in BHSCT and WHSCT (47% and 50%) for this group of clients.

Domiciliary Care / Home Help / Home Care Staff / Health Care Assistants:

Are your care needs met in the allocated time?

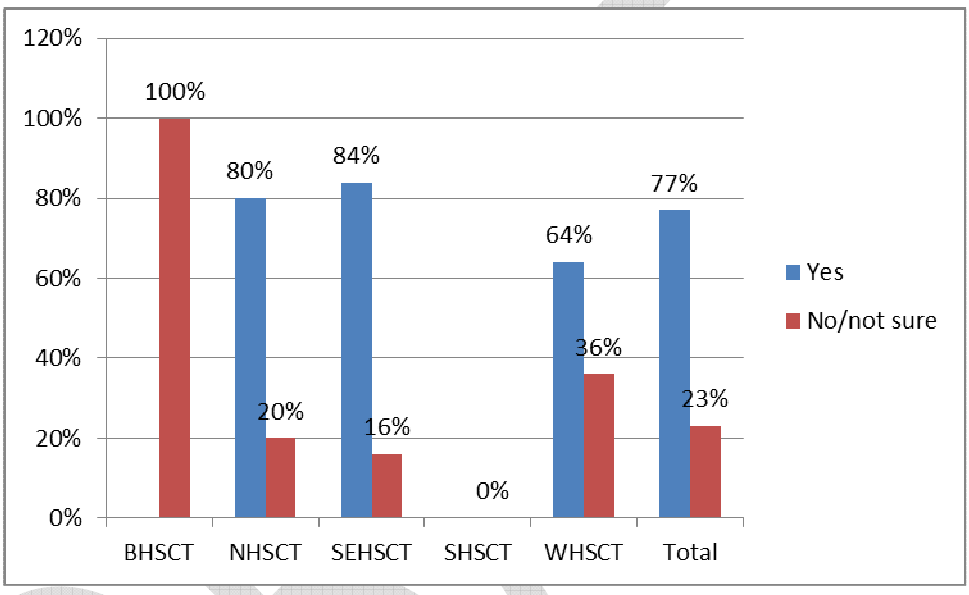


Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	265	114	423	156	301	1259
Yes	53%	72%	72%	67%	50%	62%
No/not sure	47%	28%	28%	33%	50%	38%

For clients who receive input from nursing services, a higher percentage of people feel their care needs are met in the allocated time when this is provided on a short term focused period, for example administration of blood or intravenous antibiotics by a rapid response team/hospital diversion team. These people are very grateful that they can receive this high level of care in their own home, thus avoiding hospital admission.

Rapid Response / CNRRS / Hospital Diversion Teams:

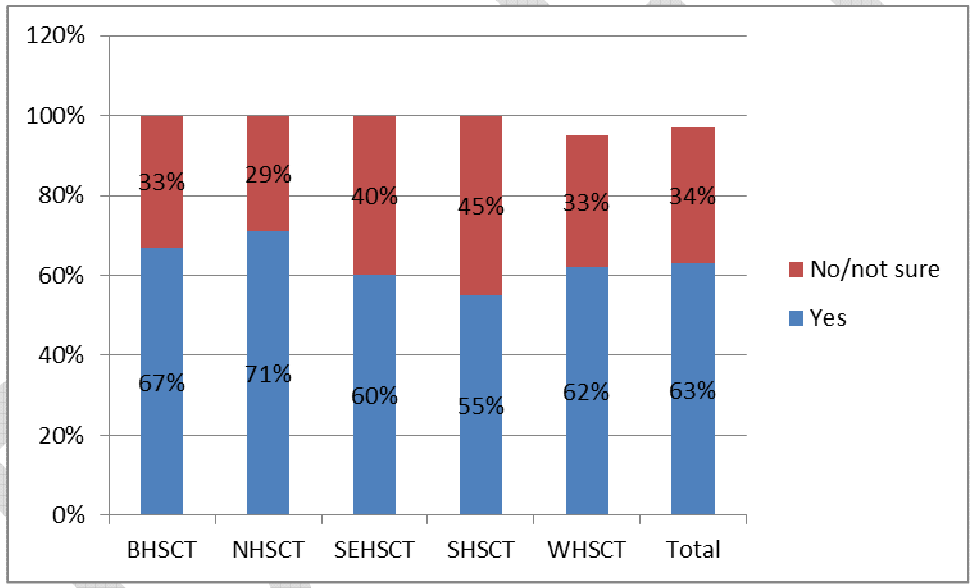
Are your care needs met in the allocated time?



Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	2	11	51	0	11	74
Yes	0%	80%	84%	0%	64%	77%
No/not sure	100%	20%	16%	0%	36%	23%

Stories from clients who had care provided by district nurses and specialist nurses were included in this review . The numbers are much lower than other professional groups, therefore the ability to make comparisons is somewhat limited. Information in the patient stories indicate that the clients who have identified district or specialist nursing as being involved in delivering their care, have on going, long term and often complex needs with many reporting that their care needs are not met in the allocated time. However as the majority of these peole also receive care from a range of other profesionals and support services, when examining the responses in relation to time allocation,this needs to be considered across the range of services and not attributed solely to district nursing.

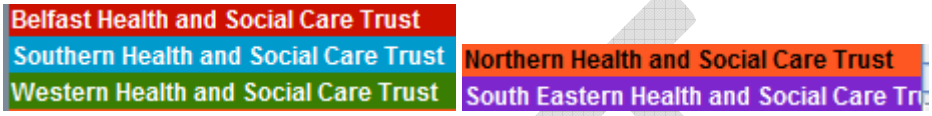
District nursing / Specialist Nursing



Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	12	21	10	11	55	109
Yes	67%	71%	60%	55%	62%	63%
No/not sure	33%	29%	40%	45%	33%	34%

4.0 Responses to signifiers

This section provides the responses to the survey questions with relevant extracts from the patient stories. It should be noted that the percentage ratings are approximate and represent the cluster responses at each of the corners of the triangle only and do not account for the response which are outside these areas. The responses to the questions have been colour coded to represent the Trusts as follows:



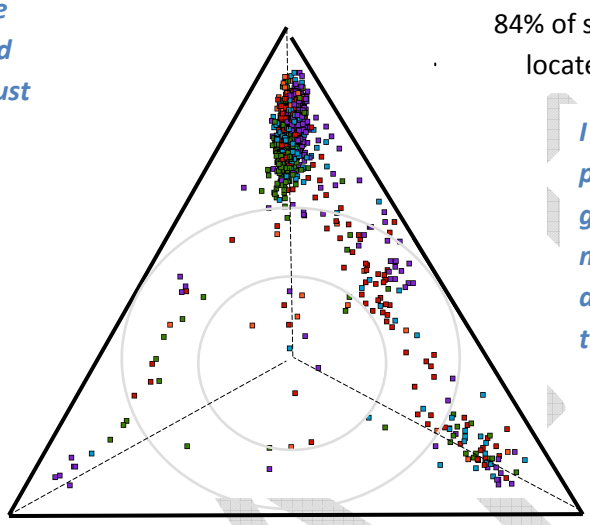
Q1: Where would you choose to have your care?

I am delighted that I can be cared for at home

I live on my own and have carers come in the am and evening, they have only just started and have made a huge difference

84% of stories are located here

I am very grateful for the care package I receive and my carer goes above and beyond for me. I am given care at home and getting the right treatment.



We both want to be together at home but I think this is going to be impossible as I will not be able to get more hours of help

I think it would be more appropriate to go to hospital/other care environment

I like being at home but am not sure that I receive everything I need

Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
I am delighted that I can be cared for at home	73%	84%	81%	85%	89%	**84%**
I think it would be more appropriate to go to hospital/other care environment	0%	0%	2%	0.5%	1%	**1%**
I like being at home but am not sure that I receive everything I need	8%	2%	4%	9%	4%	**6%**

Discussion:

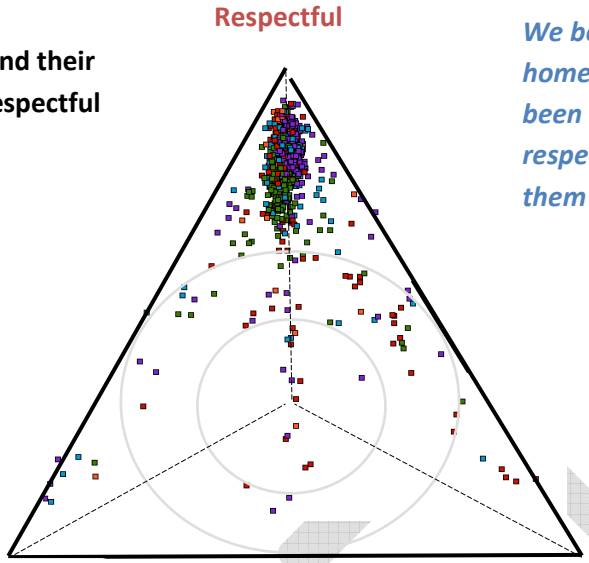
The majority of people (84%) are delighted that they can be cared for at home, with many stories describing the respect and compassion shown by a range of staff, who assess, plan, deliver and review their care. These stories also indicate the appreciation of people who can receive care which enables them to continue to live

in their own home. To most clients being cared for at home appears to have a positive impact on their independence and how they feel.

Around 6% like being at home but are not sure that they receive everything they need and many report that they feel lonely and isolated. These stories have the following key messages: Staff do not always have the adequate skills and knowledge to care for patients with dementia, the issue of the time allocation for delivery of care is further noted and clients sometimes find that the carers are abrupt in their attitude.

A small minority of people think it would be more appropriate to go to another care environment, which includes remaining in hospital or going to a fold.

Question 2: Overall do you feel that the carers are?



Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
Respectful	85%	89%	89%	92%	93%	**89%**
Unprofessional	0%	1%	0.5%	1%	0.5%	**0.5%**
Dismissive	0.5%	0%	0.5%	0.5%	0%	**1%**

Discussion:

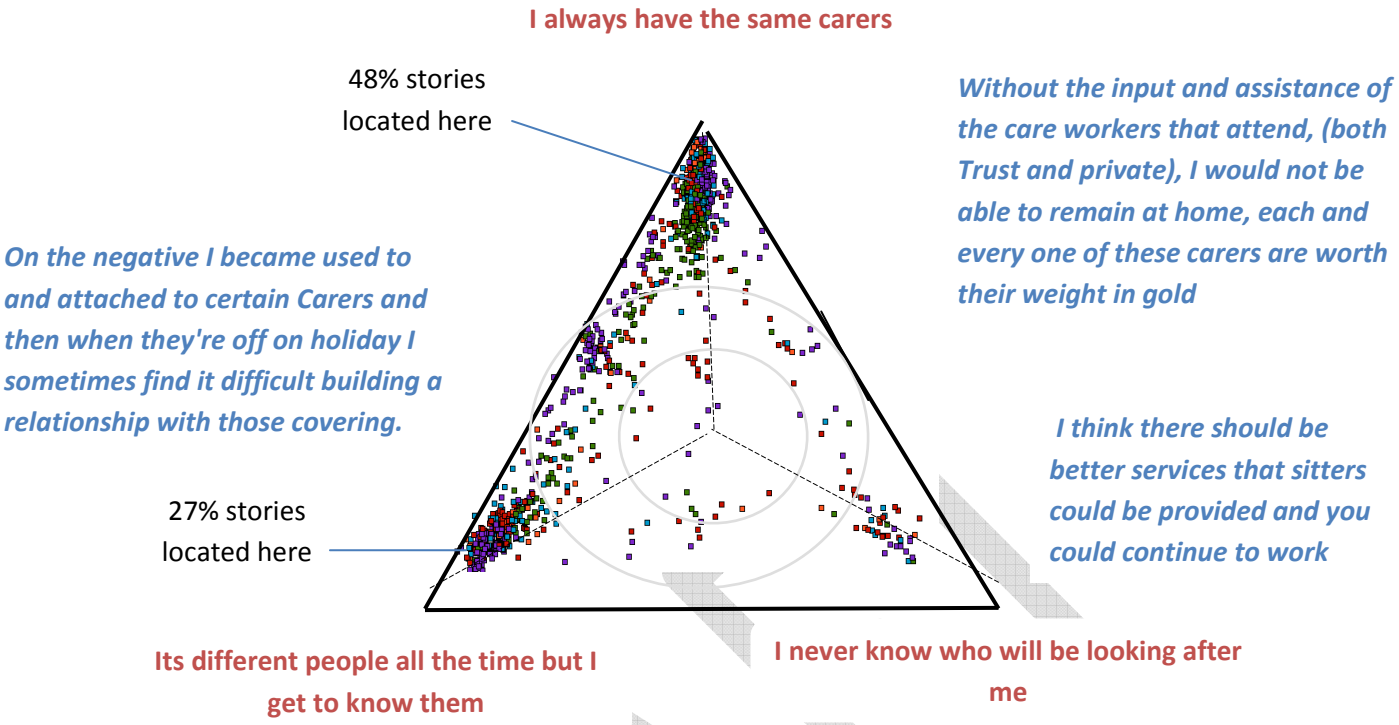
It is very encouraging to note that overall 89% of clients find their carers to be respectful, an example of one of the stories, encompassing members of the multi-disciplinary team is shown below:

……was on many pills and still am. I couldn't stand alone. …..I can now walk with a rolator and stand independently for 4 minutes. I have climbed my 12 stairs with help behind me. Every day I have Carers to get me out of bed and washed, breakfasted and comfortable and I am progressing each day. Carers also make my lunch. My family look after my care after lunch time. I feel so delighted to be on my feet again. The encouragement from Physiotherapists has been marvellous. ……The carers and healthcare assistants are pleasant and considerate; they are cheerful

workers and are always willing to help. The Social Worker is considerate of my needs. The physiotherapist is always helpful and the OT is a great help and the advice of both means I make new advances with each visit.

For the small minority of clients who feel that staff are unprofessional or dismissive, the main areas of concern are lack of privacy, not having time for the individual as a person, care of patients with dementia and staff not attending satisfactorily to personal care needs.

Question 3: Do you always know will be providing your care?



Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
I always have the same carers	41%	45%	40%	52%	66%	**48%**
Its different people but I get to know them	32%	32%	27%	34%	16%	**29%**
I never know who will be looking after me	6%	6%	3%	4%	2%	**4%**

Discussion

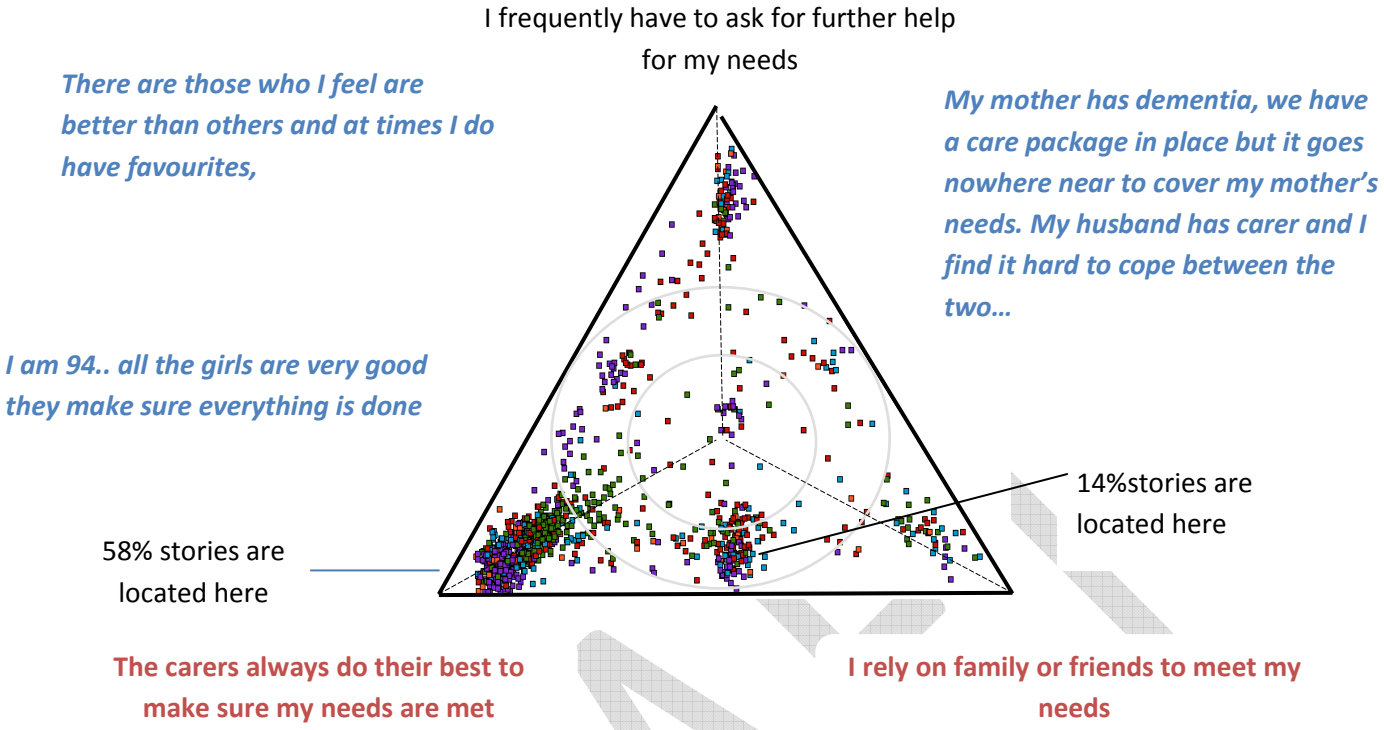
Almost half of the participants overall report that they have the same carers all the time and they feel very comfortable with these carers coming into their home on a regular and ongoing basis. The percentage of clients who always have the same carers is highest in the WHSCT and lowest in SEHSCT.

In some cases this care package has been in place for a number of years with one client saying he has had the same carer for 15 years. Some stories consider the carers to part of the family, with statements like “she is like a daughter to me”.

Over a quarter of responses, with some variation cross the Trusts and groups of staff, indicate that although clients have different people looking after them they do get to know them and a small number (4%) never know who will be looking after them. It is also vital that when clients meet carers for the first time that they introduce themselves, not only to initiate a therapeutic relationship but also to instil a sense of safety and security for the client.

It is noted that in this triad there are also a substantial number of responses at the left side in between the two responses. These stories indicate that clients sometimes find it difficult to get to know their carers. While it is recognised that there will be circumstances when it is not always be possible for the same carers to be present, there is a need to ensure that a consistent and individual approach to care is co-ordinated.

Question 4: Do you feel your needs are always met by the care you receive?



Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
I frequently have to ask for further help for my needs	10%	13%	9%	6%	4%	**8%**
The carers always do their best to make sure my needs are met	46%	59%	55%	55%	65%	**58%**
I rely on family or friends to meet my needs	5%	3%	2%	8%	5%	**4%**

Discussion

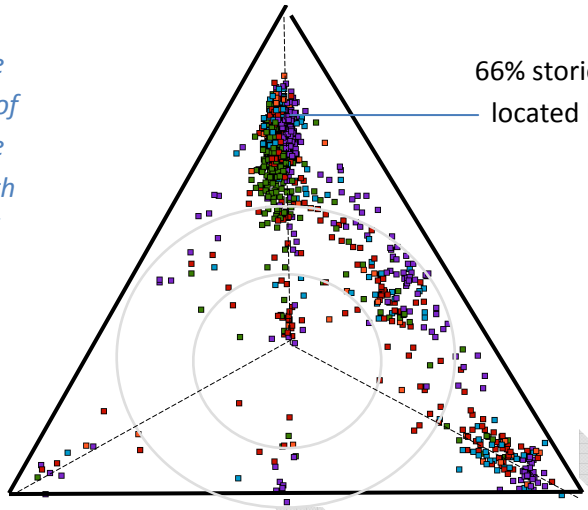
The time allocation to deliver care is a consistent theme throughout the responses to this question in all Trusts and clearly impacts on the areas of satisfaction with care. It is interesting to note that in the response to the question: ***Do you feel your care needs are met in the allocated time*** the highest percentage of no/not sure response were attributed to the WHSCT, whilst in the responses to this signifier in the WHSCT 65% of clients feel that the carers do their best to make sure their needs are met

Overall, 58% feel the carers do their best to make sure care needs are met, however there is also a cluster of responses in between the two statements: ***The carers always do their best to make sure my needs are met*** and ***I rely on family or friends to meet my needs***, which when added to the remaining responses equates to almost a quarter having to ask for further help or rely on family and friends to provide additional support. Some of these stories have been written by carers who feel that the level of care is inadequate as highlighted in the story above.

Question 5: How involved are you in planning your treatment?

I am fully involved

I was able to get out of the hospital much earlier because the Rapid Response Team were able to come to my house and give me the rest of my treatment at home. They came twice a day to give me my drip with the antibiotics. It was such a relief to be able to sleep in my own bed and sit in my own chair. They are an excellent team.



I know I need the help the care team give me but I wish I had more say… the time I get up, the time I eat, the time I go to bed

No-one seems to listen to what I want

I am just told how things are going to be

Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
I am fully involved	52%	75%	61%	67%	85%	**66%**
No-one seems to listen to what I want	1%	2%	2%	0.5%	0.5%	**1%**
I am just told how things are going to be	15%	9%	9%	19%	3%	**10%**

Discussion

Overall, two thirds of clients feel that they are fully involved in planning in their treatment, which is vital in promoting a person centred approach to care and treating the person as an individual. There is some variation in the responses across the Trusts with a higher proportion of clients in WHSCT and NHSCT indicating that they feel fully involved in planning their treatment. Many of these people who receive care at home have ongoing and complex needs and have input from a number of professionals and support services over a prolonged period of time.

The remaining responses distributed throughout this triad indicate that people feel partially involved in planning their treatment, with 10% reporting that they are just told how things are going to be.

A small number of clients, with little variation across the Trusts feel that no-one seems to listen to them. These stories describe how clients feel that their voice is not always listened in relation to personal preference, for example the time they wish to get up at or return to bed, as illustrated below:

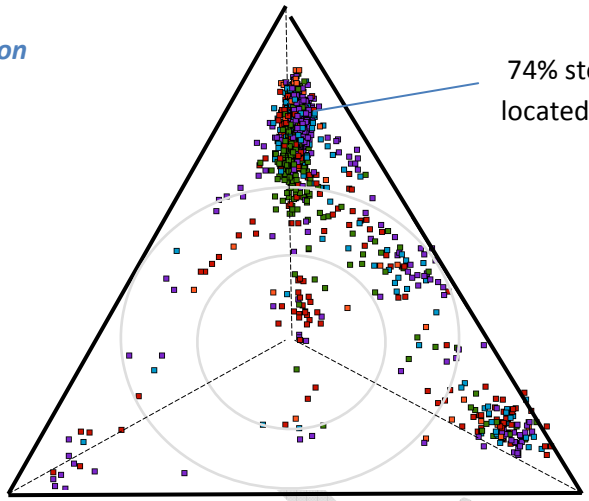
That being said, I sometimes find the care I receive to be a bit impersonal. The attitude appears to be "we know best." I would like to have more say in what my care is like, I am just told how it is going to be.

There is no apparent variation in the responses to this question in the level of involvement in care from the professional groups and support services identified.

Question 6: Is what you are told about your care?

These girls are a credit to the Trust and themselves with not only their professionalism but their friendly and calming nature… have given us a better understanding of his condition which has put us more at ease

Easy to understand and relevant



That being said, I sometimes find the care I receive to be a bit impersonal. The attitude appears to be "we know best." I would like to have more say in what my care is like.

Mum is 92 and likes to have the same Carers on a regular basis. She does not like new people, especially in the mornings, as she finds it difficult to explain what she requires.

It depends on who I see

It never makes sense

Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
Easy to understand and relevant	55%	83%	71%	72%	79%	**74%**
It never makes sense	2%	0%	2%	1%	0%	**1%**
It depends on who I see	15%	5%	8%	13%	5%	**9%**

Discussion

Over 70% of clients, across all the Trusts, feel they what they are told about their care is easy to understand and relevant, the range is from 55% in BHSCT – 83% in NHSCT. Many of these stories highlight how staff take time to explain to clients what is happening in relation to their ongoing care needs with clients reporting that they find the staff are easy to talk to and take the time to listen to their worries and concerns.

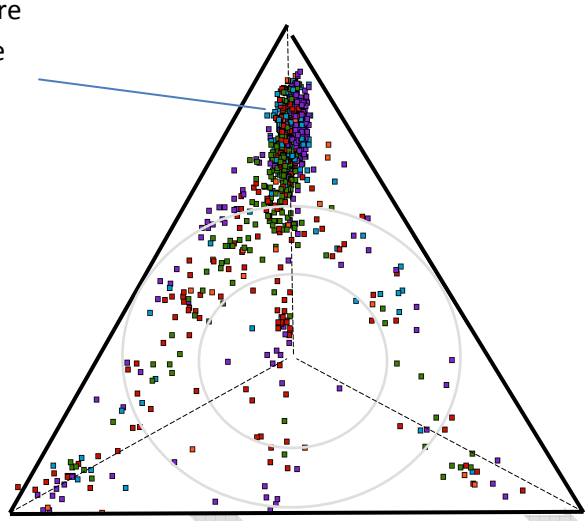
In 9% of cases the information received depends on who provides the care with examples of mixed messages, inconsistency in information and clients having to

explain about their treatment when they do not have the same carers. Some stories highlight the lack of communication between the provider organisations as illustrated in the story below:

The only issues I have experienced is that, when dealing with Palliative care, there can be some lack of communication between the different agencies meaning my wife sometimes does not get the required medication on time. This is not acceptable to me given the requirements she has. I can speak out but would be concerned about others who do not feel confident to do so.

For the small number of clients who cannot make sense of the information they receive, the stories are more indicative of dissatisfaction with the attitude of staff rather that the information they actually receive

Question 7: How are you feeling about receiving your care at home?



Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
Positive and confident	59%	80%	78%	84%	80%	**76%**
Just about coping	3%	3%	3%	3%	2%	**3%**
Very anxious	3%	2%	1%	1%	2%	**2%**

Discussion

Over 70% of clients feel positive and confident about receiving their care at home with many of these stories describing the professionalism, clinical expertise, care and compassion of the staff who provide the care over a prolonged period of time. There is no apparent variation in the responses aligned to the professional groups or support services who provide they care, however some variation is noted across the Trusts.

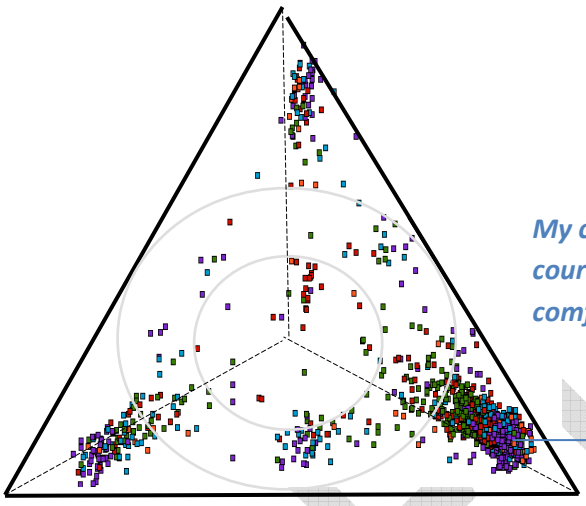
For those who do not feel positive and confident about their care at home, the key messages in the stories are inconsistency in the carers who provide care, care of

patients with dementia, lack of privacy and the time allocation to provide care. In the stories which indicate that the clients or their carers are *just about coping,* the key messages are not enough support and the isolation and loneliness experienced by people who live alone. These stories were most prevalent in the clients who were more than 80 years old.

Question 8: Do your carers ensure your information is kept private?

I feel uncomfortable that others know what is happening

……. was very difficult with confidentially, conversations with visitors to my home that were private was talked about in the community.



My carers are polite, respectful and courteous.. they make me feel comfortable in my own home

67% stories are located here

I don't know what happens to my information

I feel staff are always respectful and aware of my need for privacy

Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
I feel uncomfortable that others know what is happening	5%	12%	6%	7%	3%	**6%**
I don't know what happens to my information	5%	7%	12%	18%	10%	**11%**
I feel staff are always respectful and aware of my need for privacy	72%	64%	64%	51%	51%	**67%**

Discussion:

Overall, over two thirds of the clients feel that staff are always respectful and aware of the clients need for privacy, however around 18% of all respondents reported feeling uncomfortable that others know what is happening, that they do not know what is happening with their information, or both. In these stories some clients also describe how they feel they have a lack of privacy in their own home due to the

amount of people who are involved in their care. Clients need to have confidence that at all times their information will be kept private and confidential.

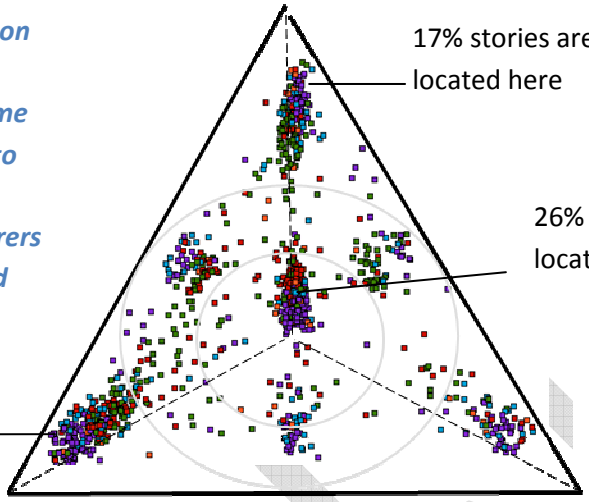
There was some variation in the responses across the Trusts but there did not appear to be any variation in the professional groups/ support services involved.

Question 9: What is most important to you in your care?

I grew up on a farm and was very lucky to have married a farmer. We have 40 acres of ground. We used to have cows but now my husband is no longer with us ….I have three sons and 1 grandson who work on another farm. I really enjoy seeing the girls who care for me I like to have a cup of tea and chat to them sometimes. The day can be so long because my sons work. The Carers make sure I take my medication and that I am safe.

Getting the right treatment and care

I am very happy with the care they provide and I could not mange without them



I have no complaints about my care.. the team have been cheerful, friendly, professional and taken a personal interest in me

Staying at home

Care and compassion of staff

Distribution of % responses across Trusts:

Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
Getting the right treatment and care	8%	23%	13%	24%	19%	**17%**
Staying at home	21%	18%	24%	30%	22%	**24%**
Care and compassion of staff	3%	5%	10%	9%	4%	**7%**
Centre of triad (i.e all three responses)	41%	37%	28%	13%	18%	**26%**

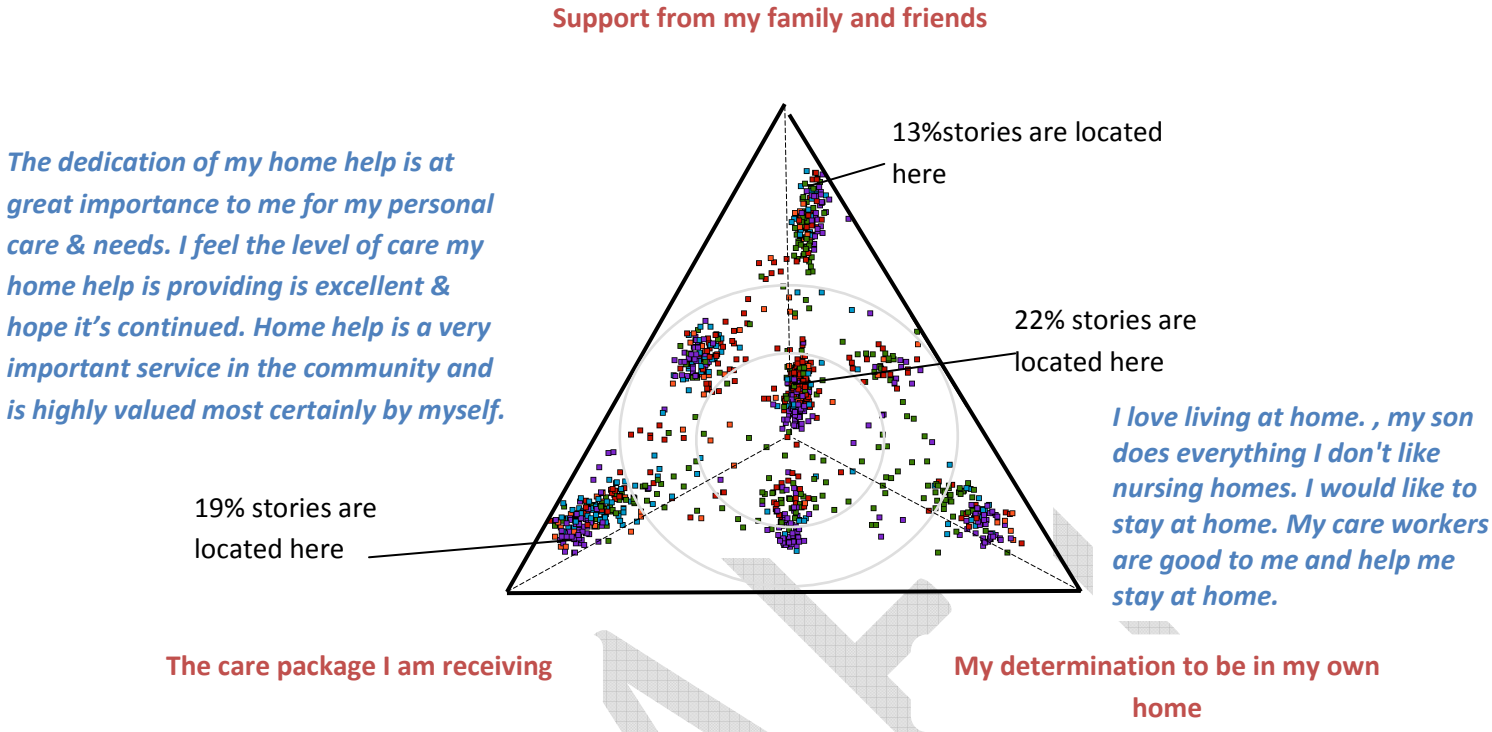
Discussion:

The responses to this signifier are fairly well distributed throughout the triad, with some variation across the Trusts, indicating that it is a combination of factors which are important to people who receive their care at home. While still reported by many as important, care and compassion of staff does not seem to be as important (7%) as getting the right treatment and care, or staying at home. The message of being

able to stay at home and remain independent is further reinforced in the stories related to this signifier.

People appear to place a high value of receiving *the right care in the right place at the right time.*

Question 10: What enables/supports you to stay at home?



Distribution of % responses across Trusts:

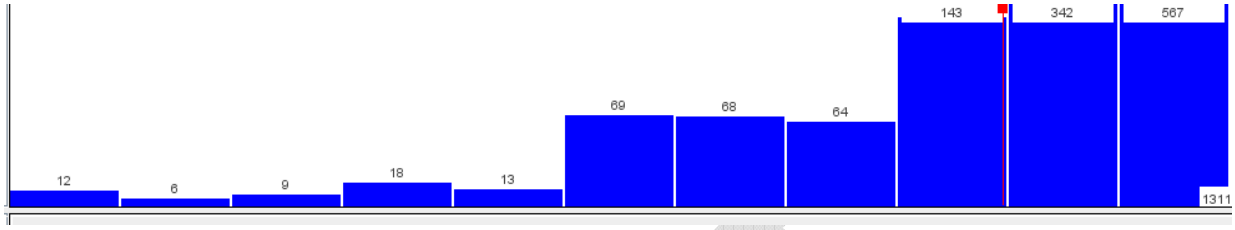
Response	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Overall
Support from my family and friends	12%	16%	10%	15%	20%	**13%**
The care package I am receiving	10%	17%	21%	33%	14%	**18%**
My determination to be in my own home	5%	6%	10%	10%	14%	**9%**
Centre of triad (i.e all three responses)	43%	25%	21%	9%	16%	**22%**

Discussion

As anticipated the responses in this triad are distributed throughout and are varied across the Trusts, indicating that it is not one single factor which enables clients to remain at home. Their own personal determination is not the main factor - a lot depends on the care package, support from family and friends, or both.

Question 11

Respondents are asked to think about their story, using a scale with two extreme descriptions, and to place a mark on the scale where they feel their story sits in relation to the descriptions, responses are shown below:



Staff just see me as a number

Staff are always so caring and compassionate

Discussion

It is very evident from the information above, that the majority of clients feel that staff are always caring and compassionate towards them. Most of the stories which are rated as negative seem to be associated with how people perceive they are seen by staff and the attitude of staff towards the client.

5.0 Issues and actions

A high proportion of stories indicate that people who receive care in their own home in all Trusts are very satisfied with the care they receive. This is demonstrated in many of the narratives which describe the compassionate care, help and support which carers deliver. Patients and clients are very grateful for the opportunity to remain in their own home and to have their independence maintained.

Throughout the initiative, patient stories (which are anonymous) have been shared with staff working within these areas. It has provided the staff with an in-depth reflective overview of patient experiences and has enabled them to view from a patient perspective how care has been delivered. This has provided the opportunity for staff to discuss as a team, how to implement improvements and develop local plans. Areas for action to improve the experience of people who receive care in their own homes have been identified through the local Trust findings and are being progressed. Examples of these include the following:

- Findings have been shared with contracts/planning with view to using information in the revision of contracts. Information in relation to the time allocated for calls is being considered for appropriate action
- Progression of a health and wellbeing caring communities model of care to try to address social isolation.
- Many of the stories received support and provide additional evidence of themes identified in user surveys
- Improving communication with people who receive care at home through the roll out of “Hello my name is “campaign
- Local training programmes for staff in relation to the care of clients with dementia
- Ongoing training in Medicines Management with home care workers

However, there are also a number of issues which will require a regional approach in progressing actions to improve their experience of people who receive care in their own homes. These are:

1. Isolation and loneliness*:* Many stories describe the isolation and loneliness experienced by people who live alone and depend on carers coming into their homes; these stories indicate that these clients are very appreciative of the service which is provided to them. For many of these people their carers are the only people they see on a day to day basis. People who attend day centres appreciate and enjoy the company that they receive and for those who live in sheltered accommodation they enjoy the comfort and security that this type of housing offers.

Action: As it is recognised that social isolation extends to broader areas than health and social care, one of the best mechanisms to address this will be by working collaboratively with individuals, communities and partner organisations through the implementation of Making Life Better (DHSSPS 2013- 2023). The first steps to progressing this action will include a workshop with key stakeholders.

2. Timing of calls and time allocation: In the analysis of the stories it is clear that people feel staff are rushing to get everything done in the time allocated, and that although the carers do the best they can, needs are often not met and clients frequently have to rely on family and friends to provide further assistance.
The timing of calls are not always suitable to client's lifestyle, for example many patients feel that they return to bed too early in the evening, also timings can be inconsistent at times.

Action: The findings from this phase of 10,000 Voices have been recognised in the review of domiciliary care in Northern Ireland and will be addressed through this review.

3. Care of clients with dementia: Some stories indicate that those providing care do not always have adequate knowledge and skills to care for clients with dementia.

Action: The findings in relation to the knowledge and skills of staff will be addressed through the NI Dementia Learning and Development Framework, which is currently being developed by HSCB and PHA

4. Communication*:* Some stories highlight that there can be inconsistency in who delivers the care and this often leads to mixed messages in communication with the

client not always knowing who is caring for them. It is therefore vital that all staff introduce themselves and wear name badges. It is also important to clients that their carers know ***what matters*** to them before leaving their house, for example– drinks, phones at reach, pull back curtains.

Some respondents indicate that they are not always sure what happens to their personal information (11%), with stories highlighting a lack of privacy within their own home.

Actions: The actions in relation to communication, including informing clients what happens to their personal information, will continue to be addressed by Trusts. For those who receive care at home on a long term basis ensure where possible that care is provided by a consistent team of carers who have established a relationship with the client. Extending the ***Hello my name is*** campaign to community settings has been included as a Patient Client Experience priority regional for 2015/2016.

6.0 Conclusion

As demonstrated in this report it is evident that staff who deliver care in clients' homes contribute significantly to ensuring safe, high quality care and positive experience for patients/clients in Northern Ireland.

10,000 Voices is one of a number of initiatives that the HSCB/PHA and Trusts are implementing to ensure that quality, safety and patient experience is at the heart of all that we do. Key to the success of the 10,000 Voices has been the partnership approach to improving and influencing patient and client experience in Northern Ireland. This enables the people who receive health and social care services to have an opportunity to have their voice heard by the staff who deliver their care and also to have assurance that by sharing their experiences they will be able to contribute to how services are shaped in the future.

7.0 References:

Domiciliary Care Services for Adults in Northern Ireland (2014), DHSSPS (2015)

DHSSPS (2011) Transforming Your Care. A review of health and social care in Northern Ireland

DHSSPS (2012) Quality 2020. A 10 year strategy to protect and improve quality in Health and Social Care in Northern Ireland

DHSSPS Making Life Better, A whole system strategic framework for Public Health 2013 - 2023

Appendix 1

Response to questions:

1. Are your care needs met in the allocated time?

2. How would you rate the impact of receiving your care at home?

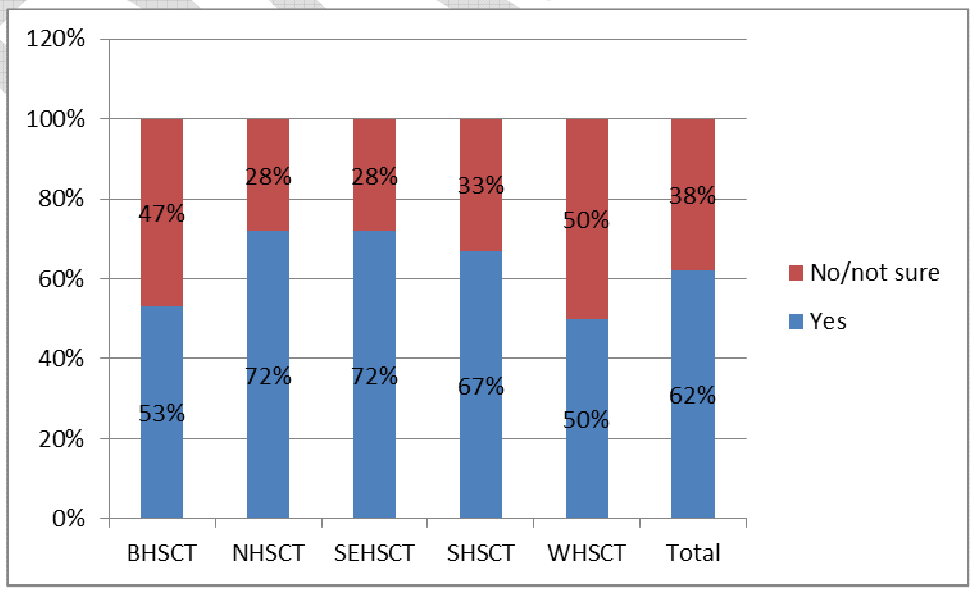
(Breakdown by who provides the care/professional grouping/support services and Trusts)

Area One: Domiciliary Care / Home Help / Home Care Staff / Health Care Assistants

Care delivery to clients who live at home is often provided by several health care professionals and support services who are involved in both the assessment and review of care needs and the actual delivery of care. Participants are asked to identify which health care professionals/ support services are involved in their care, in many cases they identify more than one service. Therefore the numbers are not reflective of the total number of patients but rather the number of patients who have can identify with a particular service.

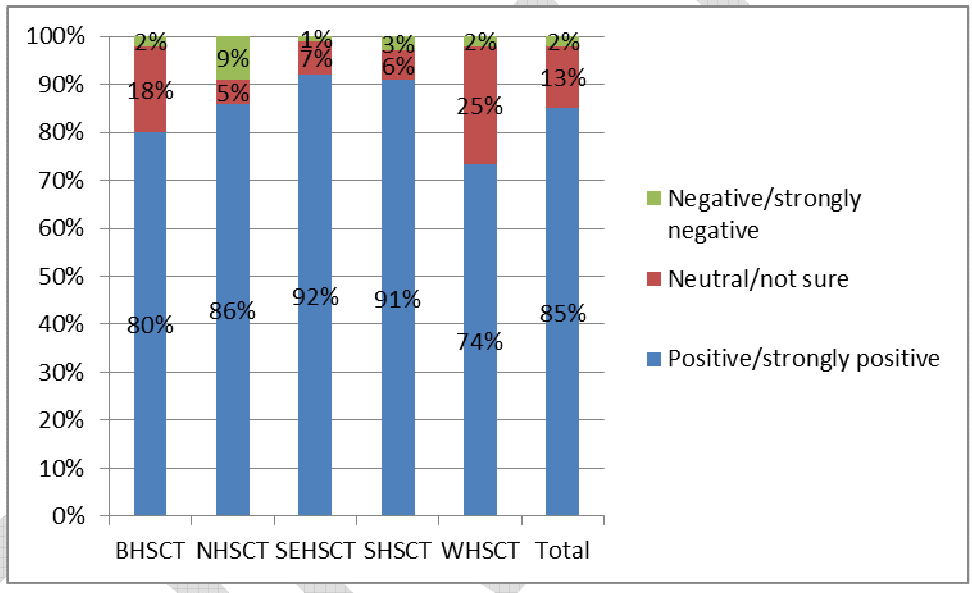
Domiciliary Care / Home Help / Home Care Staff / Health Care Assistants:

Are your care needs met in the allocated time?



Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	265	114	423	156	301	1259
Yes	53%	72%	72%	67%	50%	62%
No/not sure	47%	28%	28%	33%	50%	38%

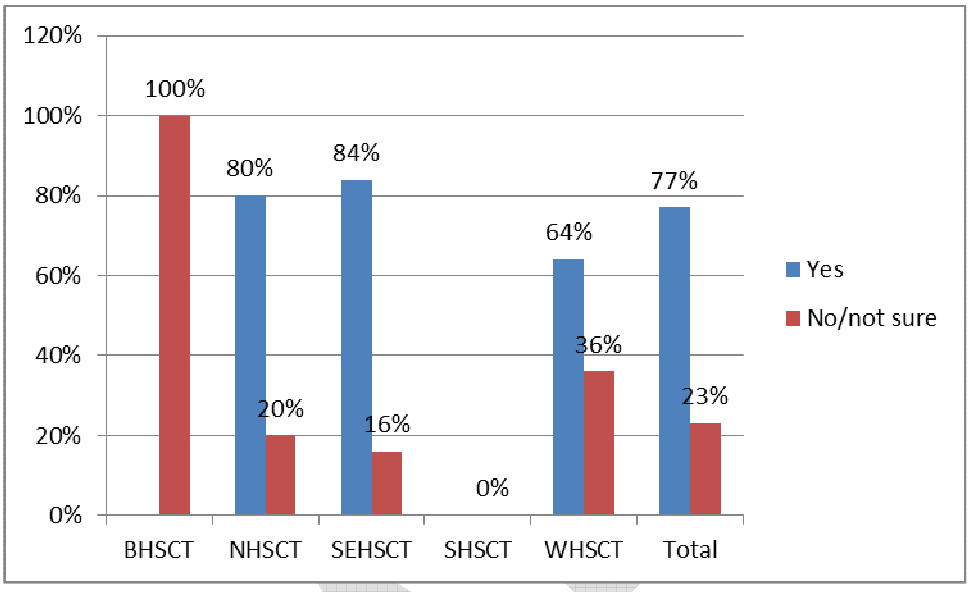
How would you rate the impact of receiving your care at home?



How would you rate the impact of receiving your care at home?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	265	114	423	156	301	1259
Positive/strongly positive	80%	86%	92%	91%	74%	85%
Neutral/not sure	18%	5%	7%	6%	25%	13%
Negative/strongly negative	2%	9%	1%	3%	2%	2%

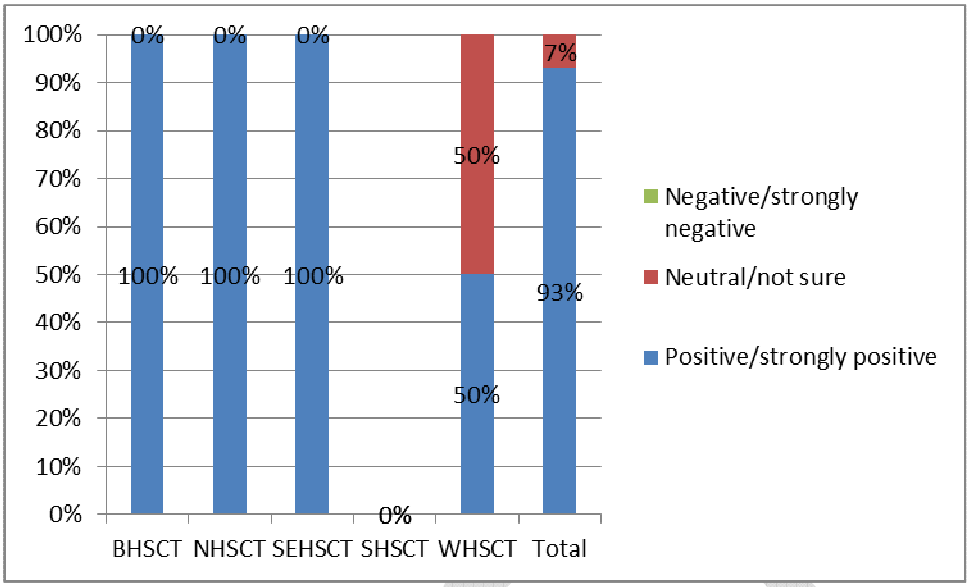
Area 2: Rapid Response / CNRRS / Hospital Diversion Teams

Are your care needs met in the allocated time?



Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	2	11	51	0	11	74
Yes	0%	80%	84%	0%	64%	77%
No/not sure	100%	20%	16%	0%	36%	23%

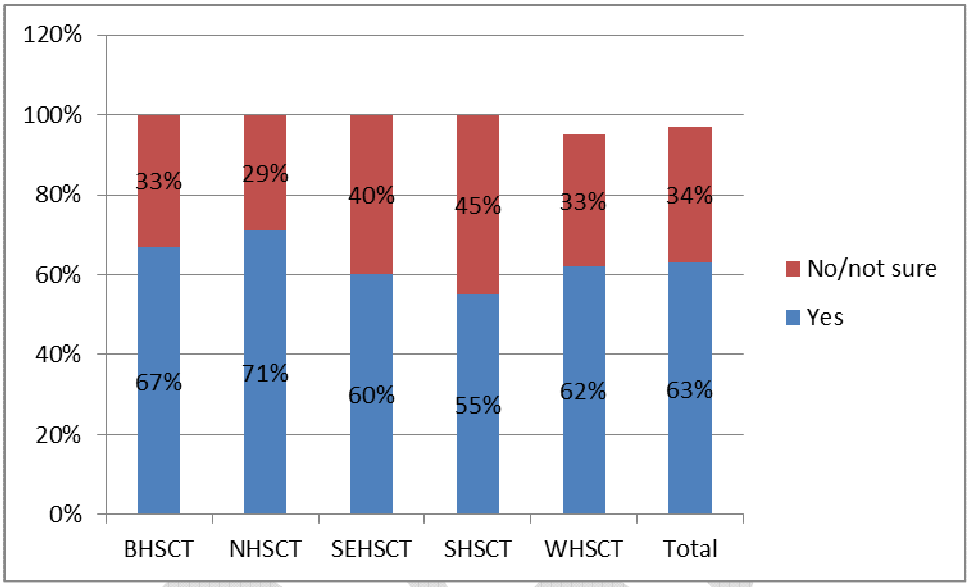
How would you rate the impact of receiving your care at home?



How would you rate the impact of receiving your care at home?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	2	11	51	0	10	74
Positive/strongly positive	100%	100%	100%	0%	50%	93%
Neutral/not sure	0%	0%	0%	0%	50%	7%
Negative/strongly negative	0%	0%	0%	0%	0%	0%

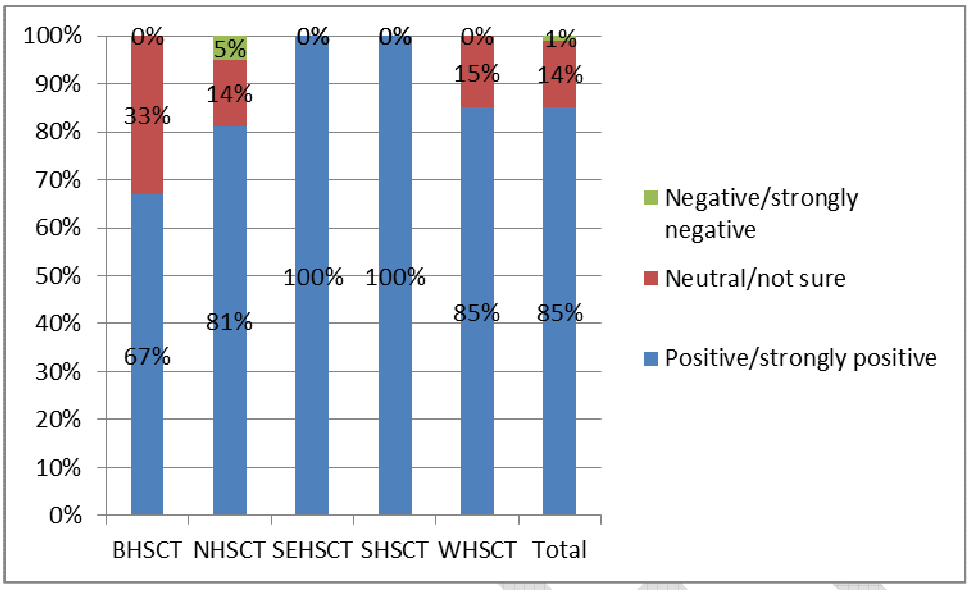
Area 3: District nursing / Specialist Nursing

Are your care needs met in the allocated time?



Are your care needs met in the allocated time?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	12	21	10	11	55	109
Yes	67%	71%	60%	55%	62%	63%
No/not sure	33%	29%	40%	45%	33%	34%

How would you rate the impact of receiving your care at home?



How would you rate the impact of receiving your care at home?						
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**Total**
Total	12	21	10	11	55	109
Positive/strongly positive	67%	81%	100%	100%	85%	85%
Neutral/not sure	33%	14%	0%	0%	15%	14%
Negative/strongly negative	0%	5%	0%	0%	0%	1%

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PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	19 November 2015
Title of Paper	10,000 Voices: Regional Report on Experience of Nursing and Midwifery Care Key Performance Indicators (KPIs)
Agenda Item	13
Reference	PHA/04/11/15

Summary

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) each have a duty under Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals; and the environment in which it provides them.

Patient and client experience is now widely recognised as a key indicator of quality of care and is central to many of the strategic drivers for health and social care improvement and innovation in Northern Ireland.

The 10,000 Voices initiative was commissioned and funded by HSCB and PHA to provide a robust and systematic mechanism for patients and clients to share their experiences of health and social care so that future commissioning and delivery of services will be more patient focused. Through the 10,000 Voices the processes have been established to introduce Experience Led Commissioning into Northern Ireland.

Listening to the experience of nursing and midwifery care is a key indicator of the quality of care our nurses and midwives deliver across a broad range of services and is at the core of the Regional Nursing and Midwifery Strategy, a 'Partnership for Care' (DHSSPS 2010).

Process

An integral component of the 10,000 Voices Initiative is the Experience of Nursing and Midwifery Care. From November 2013 – October 2014 a total of 2915 stories were received which relate to experience of nursing and midwifery care across the five HSC Trusts. The analysis of the information received provides assurance that in the majority of cases there is a high level of satisfaction with the standard of nursing and midwifery care. Many of the stories pay tribute to the care, compassion and professionalism; clearly demonstrating a high level of respect, appreciation and public confidence in our nurses and midwives. However the information we have received also provides some opportunities for reflection, development and action to

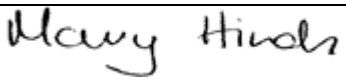
further improve and enhance patient experience of nursing and midwifery care in Northern Ireland.

The key themes identified for reflection and learning are:

1. Attitudes and behaviours
2. Promoting a more person centred approach to care
3. Communication
4. Care of patients with dementia/acute confusion
5. Ensuring staff adhere to infection prevention and control procedures
6. Assurance of standards of nursing care through safety KPIs
7. Providing support for mothers who are breastfeeding

Next steps

A range of activities will be taken forward to address the areas for reflection and learning

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For approval
Director's Signature	
Title	Director of Nursing and AHPs
Date	12 November 2015

REGIONAL REPORT OF EXPERIENCE OF NURSING AND MIDWIFERY CARE KEY PERFORMANCE INDICATORS

September 2015

Final draft

Foreword

I am pleased to present the first regional report on the experience of nursing and midwifery care in Northern Ireland, which is based on the analysis of the information, received through the‘10,000 Voices’ Initiative.

Listening to the experience of nursing and midwifery care is a key indicator of the quality of care our nurses and midwives deliver across a broad range of services and is at the core of the Regional Nursing and Midwifery Strategy, a ‘*Partnership for Care’* (DHSSPS 2010). Providing assurance on the quality of nursing and midwifery care through the patient experience domain is one of three domains being progressed in regional work which is chaired by the Chief Nursing Officer, to measure the unique contribution of nursing and midwifery care and what impact this has on the overall patient/client experience. The other two domains, ‘organisational systems’ and ‘safe and effective care’; are closely aligned to patient experience, but have their own set of specific indicators which are monitored within Trust governance systems.

From November 2013 – October 2014 a total of 2915 stories were received which relate to experience of nursing and midwifery care across the five HSC Trusts. The analysis of the information received provides assurance that in the majority of cases there is a high level of satisfaction with the standard of nursing and midwifery care. Many of the stories pay tribute to the care, compassion and professionalism; clearly demonstrating a high level of respect, appreciation and public confidence in our nurses and midwives. However the information we have received also provides some opportunities for reflection, development and action to further improve and enhance patient experience of nursing and midwifery care in Northern Ireland.

I am delighted that so many people have taken the time to share their experiences of nursing and midwifery care through the 10,000 Voices Initiative and wish to thank all those who participated; their contribution has been invaluable and will influence the delivery and commissioning of services. I would also like to pay tribute to the dedication and commitment of all who are part of nursing and midwifery teams. It is clear from what we have heard through 10,000 Voices that nurses and midwives in Northern Ireland are delivering a very high standard of care and that their contribution to the overall patient experience is greatly appreciated by patients.

Mary Hinds

CONTENTS PAGE

1.0 Introduction

The 10,000 Voices initiative aims to adopt a more patient focused approach to improving the overall patient experience by listening to and learning from the real experiences of people who have used our services. Experience of nursing and midwifery care is an integral component of all phases of the 10,000 Voices Initiative. This report presents the regional findings from the information which has been received in relation to nursing and midwifery care from November 2013 – October 2014, across all HSC Trusts in Northern Ireland(NI).

2.0 Background

A research study was commenced in NI during 2009 to develop a framework for the identification, measurement and implementation of Key Performance Indicators (KPIs) for Nursing and Midwifery. The key performance indicators were identified and tested using SenseMaker methodology by Professor Tanya McCance (McCance et al 2012) and were used in the 10,000 Voices Initiaitive.

Nursing and Midwifery Key Performance Indicators

- Nursing/midwifery staff having the same understanding of the care the patient needed
- Having confidence in the knowledge and skills of the nurse/midwife
- Feeling safe while being care for by the nurse/midwife
- Being involved in decisions about care
- The time nurses/midwives spent with the patient
- Respect from the nurse/midwife for preferences and choice
- Supporting the patient to care for self
- The nurses/midwives understanding of what is important to the patient

3.0 Summary of findings

Analysis of the information received indicates a high level of satisfaction with the standard of nursing and midwifery care.The ratings for how patients felt overall about their nursing or midwifery care are presented below:

Overall feelings about nursing and midwifery care	Number of stories (2915)
Strongly positive/positive	2638 **(90%)**
Neutral/not sure	184 **(7%)**
Strongly negative/negative	93 **(3%)**

Many of the stories pay tribute to the care, compassion and professionalism displayed by nurses and midwives in all Trusts.These stories clearly demonstrate a high level of respect, appreciation and public confidence in our nurses and midwives, as illustrated below:

Story title: Good and Kind
I have been in hospital for a couple of days, ……All staff very good. Staff communication is great. They make you feel at home. Always a kind word. Theatre staff so good, and kind. Make you feel relaxed, as I needed an epidural anaesthesia. they gave me headphones to listen to music, this kept me calm. I was nervous. Staff so good and reassuring.
Story title: Safe & secure
Staff made me feel safe & secure. Overall care splendid. Never been in hospital and was scared to come in but my experience has cured that fear. The nursing staff were great and couldn't do enough. ... They do a great job.
Story title: Professionalism
I was experiencing palpitations for 3 weeks but they became more frequent and I felt light headed and dizzy…... I was seen quickly in A&E and was extremely impressed by the nurses ability to put me at ease whilst carrying out their professional duties. On being moved to the ward, I was seen frequently by the nurses who monitored my blood pressure which was extremely high. I would like to commend the nurses involved in my care on their absolute professionalism at all times

Patients were asked to give their story a title and to select key words which described their experience, some of the story titles were as follows:

Key messages:

- Nurses and midwives have a good understanding of the care their patients need and in the majority of cases care is focused on the needs and preferences of the patient.
- In the majority of cases, patients feel safe while being cared for by nursing and midwifery staff and confidence in their skills.
- Many patients' stories describe most of our nurses and midwives as being compassionate, caring, friendly, helpful, professional and displaying a high level of clinical expertise.

4.0 The Results

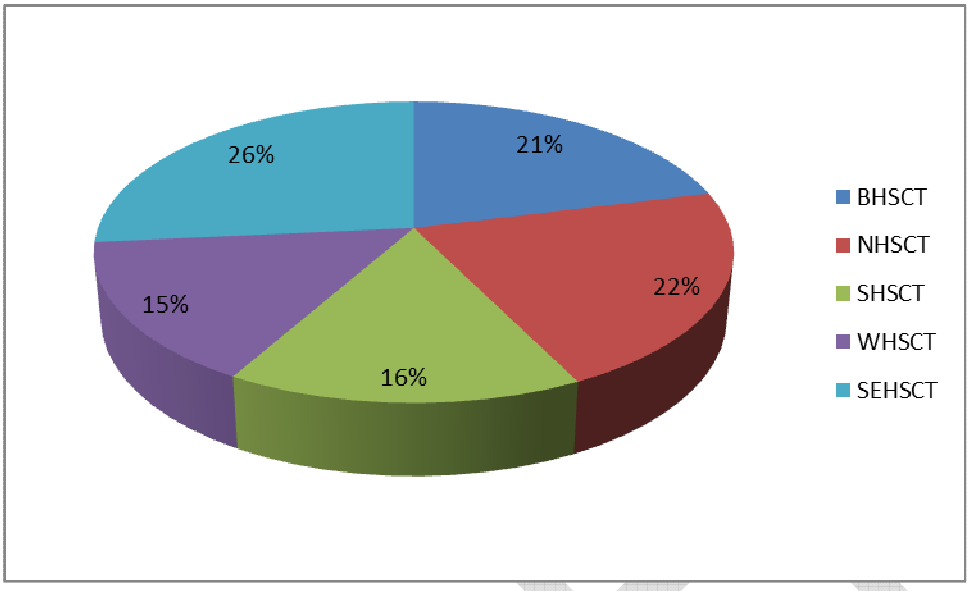
The collection of stories relating to the experience of nursing and midwifery care commenced in November 2013 and was completed on 31st October 2014. A total of 2915 stories were received as detailed below:

Table 1: Breakdown of stories received

Area	Number of stories received
Nursing	2210
Midwifery	577
Both	128
Total	**2915**

4.1 Results of experience of nursing care

Percentage of stories relating to nursing care per Trust area:



Who completed the survey?

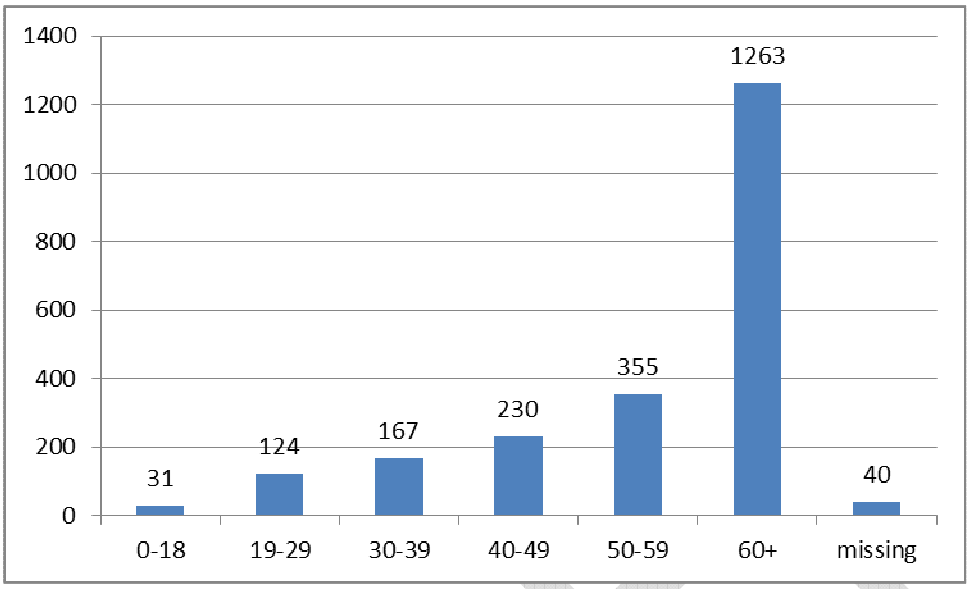
- 77% completed by person receiving care
- 16% completed on behalf of person receiving care
- 4% completed by other person (family member)
- 3% information missing

Ethnic group:

- 2191 white (99%)
- 3 Chinese
- 2 Irish Traveller
- 4 Indian
- 3 mixed ethnic group
- 7 any other ethnic group

- 54% female
- 45% male
- 0.5% missing information

Age of respondents



Length of time in hospital

Length of time in hospital	Number of stories received
Less than 24 hours	281 (13%)
1-3 days	574 (26%)
4-7 days	653 (30%)
8-14 days	334 (15%)
More than 14 days	368 (17%)

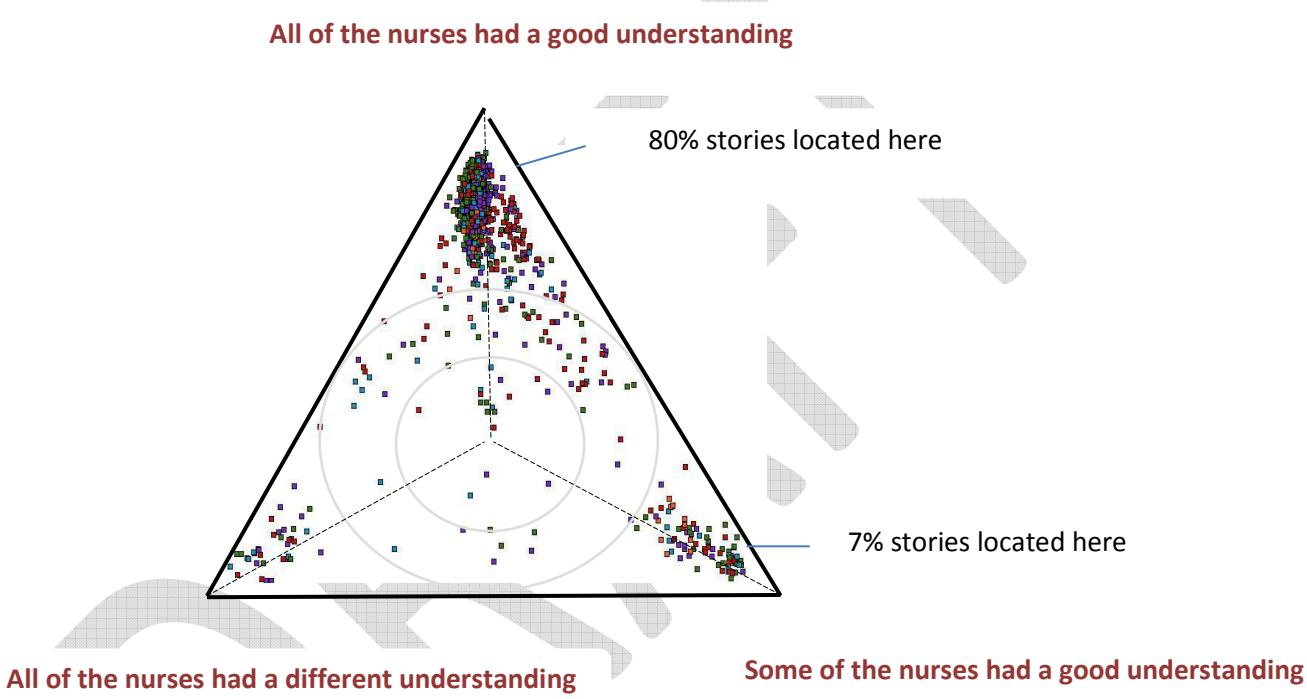
How the overall experience of nursing care was rated (missing data 1%)

Overall feelings about nursing care	Percentage of stories
Strongly positive/positive	90%
Neutral/not sure	**6%**
Strongly negative/negative	3%

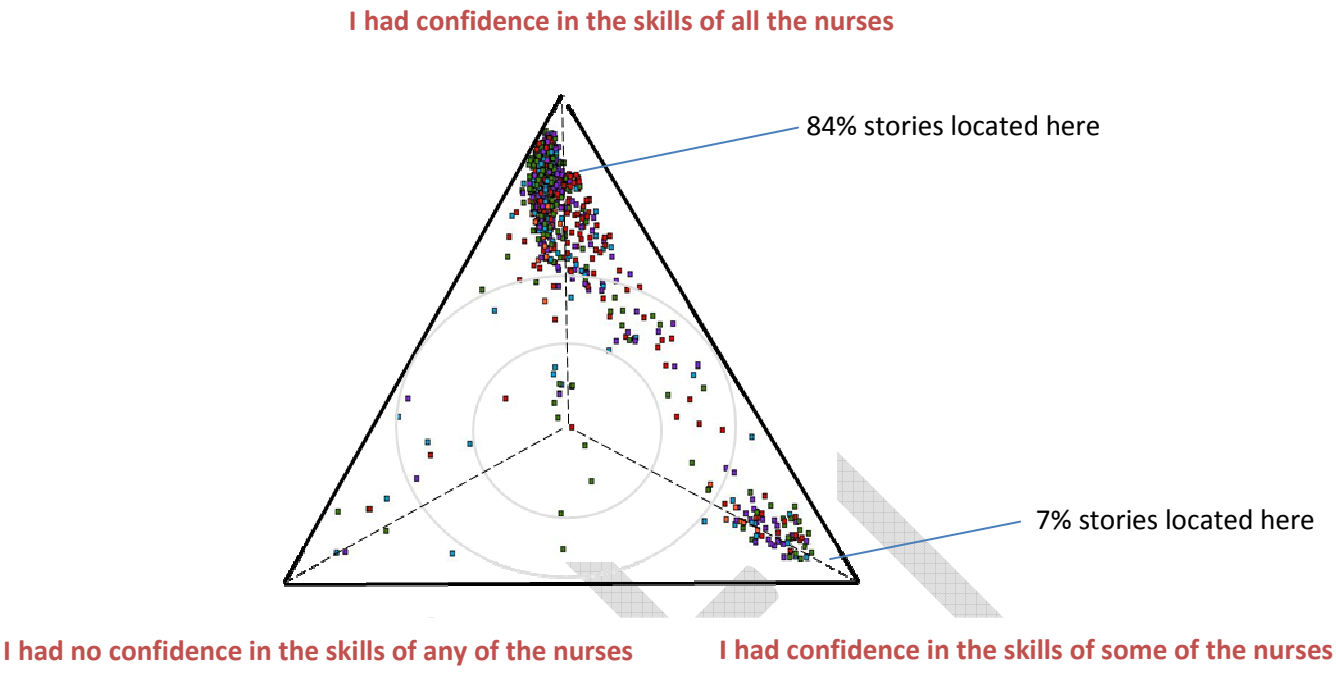
4.2 Responses to questions

The survey questions were designed in the shape of a triangle and respondents were asked to place a ‘dot’ nearest to the statement that reflected their experience. The findings from the responses are shown below. It should be noted that the percentage results provided represent approximate representation in the cluster responses only and do not account for the responses distributed throughout the triangle.

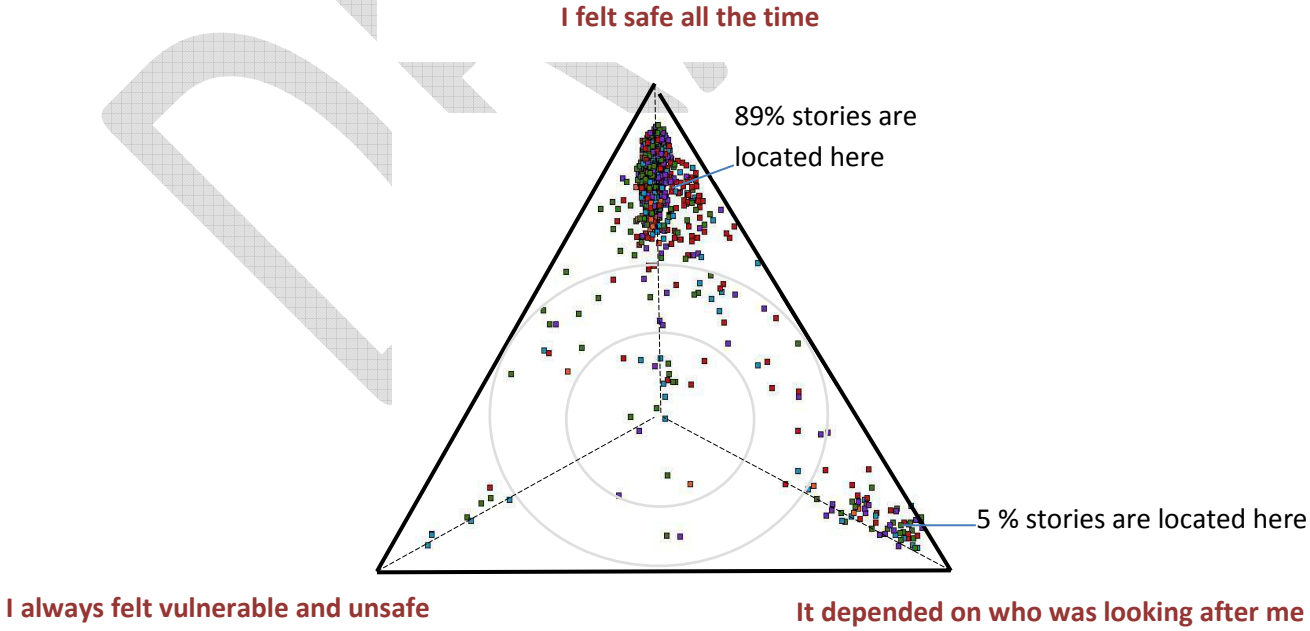
Question 1: How did you feel about the nurses’ understanding of the care you needed?



Question 2: How confident were you in the skills of the nurse?

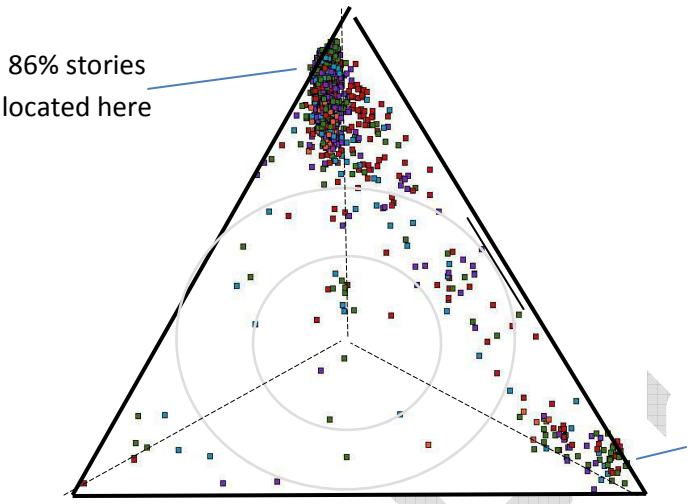


Question 3: How safe did you feel while you were being cared for by the nurses?



Question 4: How would you describe the nurses' respect for your personal preferences and choices?

All nurses took account of my preferences and choices

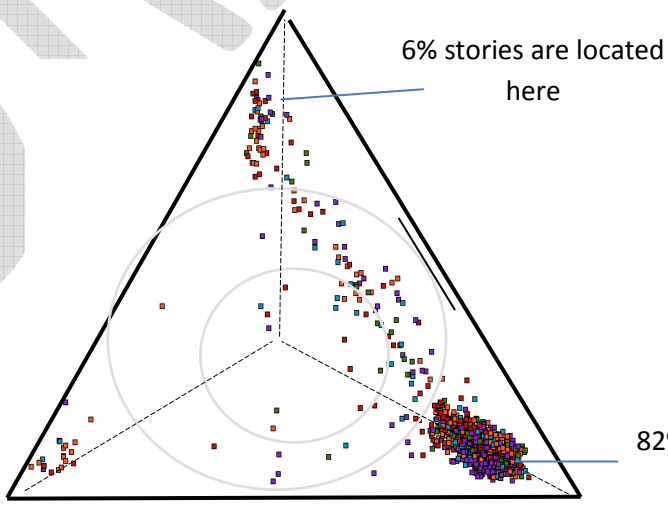


None of the nurses respected my preferences and choices

It depended on who was looking after me

Question 5: How did you feel about the amount of time that nurses spent with you?

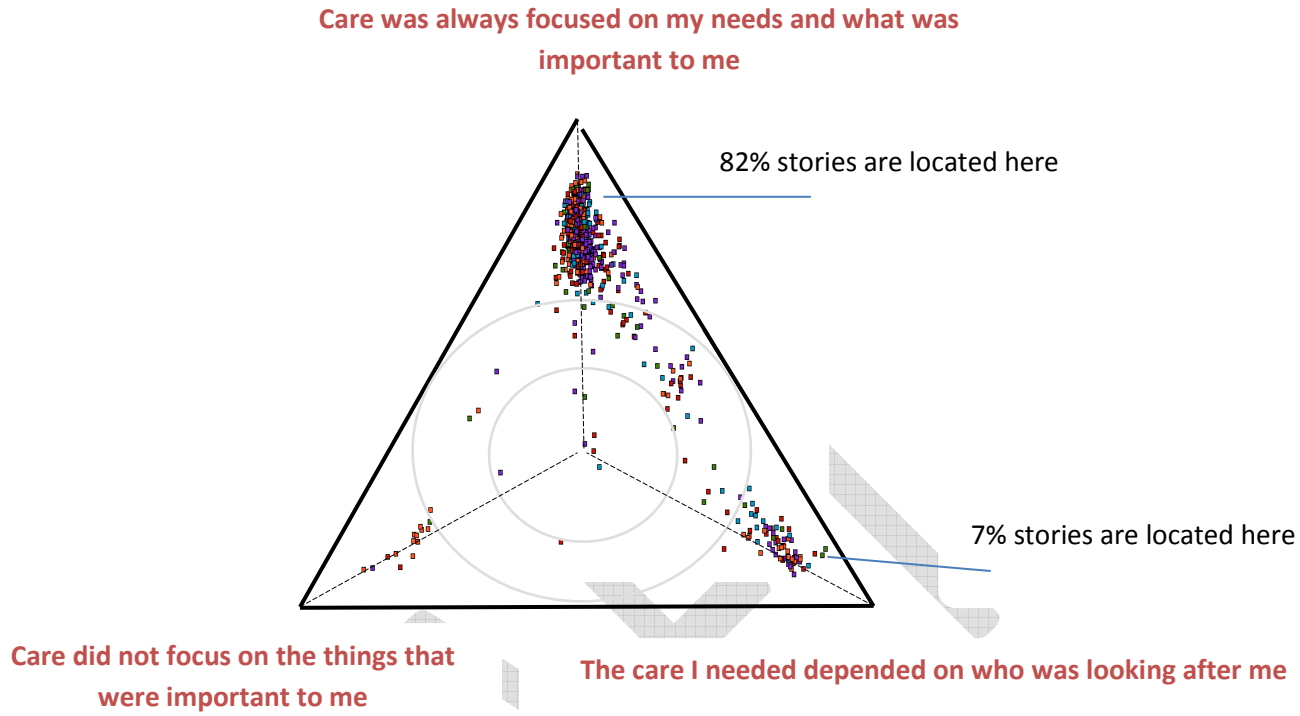
I rarely saw the nurse



The nurse was with me more than I wanted

I felt the staff gave me the time when I needed it

Question 6: How appropriate did you feel the care you received was against the things which were important/relevant to you?



5.0 Key areas for reflection and learning

Following the analysis of the themes from the responses above and the individual stories a number of key areas for reflection and learning have been identified, these are summarised below with relevant extracts from the patient stories.

Compliance with Patient/ Client Experience Standards

It is clear that in the majority of cases nurses work in a **caring, compassionate, respectful manner,** which is consistent with the Patient/Client Experience Standards (DHSSPS 2009) and professional requirements (NMC 2014 revised code)**.** There are numerous stories which describe the kindness, care and compassion shown by nurses and report how patients feel they are treated in a dignified way. However, some stories highlight the need for nurses to become more aware of their **attitude and behaviour** and how this can impact on the patient and their family and can leave the patient feeling that they are not being treated as an individual.

Story title: A very pleasant experience of being a patient

On arrival I was made very welcome by a smiling pleasant nurse. As there was no bed free I had to wait a short time before given one. I never felt ignored or forgotten about as someone kept coming and saying it wouldn't be long. Staff were at all times caring supportive and extremely professional. On transfer to theatre I was made very welcome again and all procedures explained to me by nursing staff. The staff again were extremely pleasant and helpful. Waking up in recovery I was looked after by a very experienced and caring nurse and I could see it was extremely busy but nothing was too much bother for them. On transfer back I was met by a smiling n/aux who made sure I had fresh water and tea and toast and I could reach everything I needed. The staff again were extremely caring and helpful even though they were very busy…….at all times the staff were supportive and answered any queries I may have had about my care.

Story title: Shame on them

There is a big difference between treatment and care. At no stage during that evening did the ideas of dignity, compassion, respect or even sympathy show themselves. ….the criticisms I am making are not about money or resources or staffing, it is about finding some way to recognise an extremely vulnerable patient and treat them as a human being, not a box to be ticked and shipped out the door as quickly as possible.

Clinical expertise

Many stories reflect how patients feel safe whilst being care for by nursing staff and describe the clinical expertise displayed by nurses. Some stories highlight that on occasions patients did not receive adequate care in relation to the essential aspects of nursing care, for example hygiene needs, administration of medicines, pain relief, food and nutrition and clinical observations. A few stories refer to infection and prevention control issues in relation to the environment and bed linen.

No title: *A pleasant experience ... Feeling safe and cared for ... Pleased to be treated by knowledgeable professional people*

Story title: A sad story of ineptitude

The experience of nursing care left a lot to be desired, at the time did she see a nurse manager or a clinical nurse sister ……During that period she did not have a bed bath other than being assisted with priority washing - her feet were never washed, nor was her denture/teeth care attended except where she requested it. Elderly people have fragile skin but no cognisance of this was shown or understood.

Story title: Very poor basic nursing

Bed linen was blood stained following my surgery + next day I was going to the bathroom and I asked could I get my sheets changed…..

Communication

The majority of stories describe how nurses communicate positively with patients and their families and that clear explanations are given about treatment and care. However in some cases patients feel that they do not receive enough information about their care and on some occasions receive mixed messages. The stories also highlight the need to ensure that nurses listen to patients and their families and involve them in decisions about their care. A small number of stories indicate that patients feel they are unable to attract the attention of the nurse, either by use of call bell or being able to communicate directly with nursing staff, leaving the patient feeling isolated and anxious. Some stories describe how patients and their families feel the care and support provided for patients who have dementia/confusion is not satisfactory.

Story title: When I got my lump removed

I was referred to the Breast Care Unit, where I was taken care of very well. I was put at ease as I was very nervous. The staff couldn't have been nicer and caring & explained everything I needed to know, & told me every step that would be happening. Couldn't have received any better treatment by the staff. When I went for my surgery I was well looked after and again the staff were reassuring & caring. They couldn't have been faulted; I was treated with great care especially as I was very nervous. Everything was explained to me in great detail so I know exactly what was going to happen and when. All staff that I came access were brill

Story title: A sad story of ineptitude

The pull bell during the stay was out of order and despite at least 3 requests to nursing and nursing support staff no action was taken which meant she was left without access to staff, however on her last day a ....bell was supplied

Story title: Standardisation across the health service.

XX is a vulnerable patient due to his dementia. Over the last few months he has experienced care in three hospitals. I would just like to feedback about our experiences: ……..I spoke to staff about my concerns regarding the restraint and other issues of care. On further visits he continued to be managed in a draconian way - not as an individual……. I always left him on the ward feeling apprehensive; I felt that in raising the issues of patient safety I was perceived as being a 'difficult relative'. Two months later he was admitted to a major teaching hospital. Our experience as a family was very positive, …. as a vulnerable patient was looked after by caring staff, considerate to all our needs he was looked after as a person. He was extremely agitated and required a nurse to special him - we were involved in his care at all times. The staff introduced themselves, when the night-shift came the nurse introduced herself to all patients, she followed up on any queries and included daddy in everything - even though he couldn't understand. I left that night feeling contented that my loved one was in safe and caring hands. From admission through to discharge our journey was positive. …Transfer back to our regional hospital for rehab. ….we had an altogether different experience. There were multiple communication issues, there were staff shortages which were able to be addressed once we complained.. ….I'm a great believer in patient safety and would like to see some standardisation across our health service. ….I am fully aware of the stresses in our health-service, however, I

don't feel that excuses poor care.

Staffing levels

Stories reflect how patients perceive nurses to be very busy and often patients do not want to disturb the staff.

Story title: Busy place

Yes very good experience, no faults at all. Nurses are very good - are always there when you need them. However, they are very busy and don't get to spend an awful lot of time with you but that is to be expected

Noise at night

Some patients report that due to the noise on the ward at nigh they are unable to sleep properly or have their sleep disturbed.

Story title: Busy

I felt very bad. I came in late at night. I never slept. There was a disruptive drunk patient in an opposite bed. It is difficult sometimes to get / feel better when other patients who are challenging. I have bi polar and sometimes busy ward environments are difficult for me

Story title: Unsure

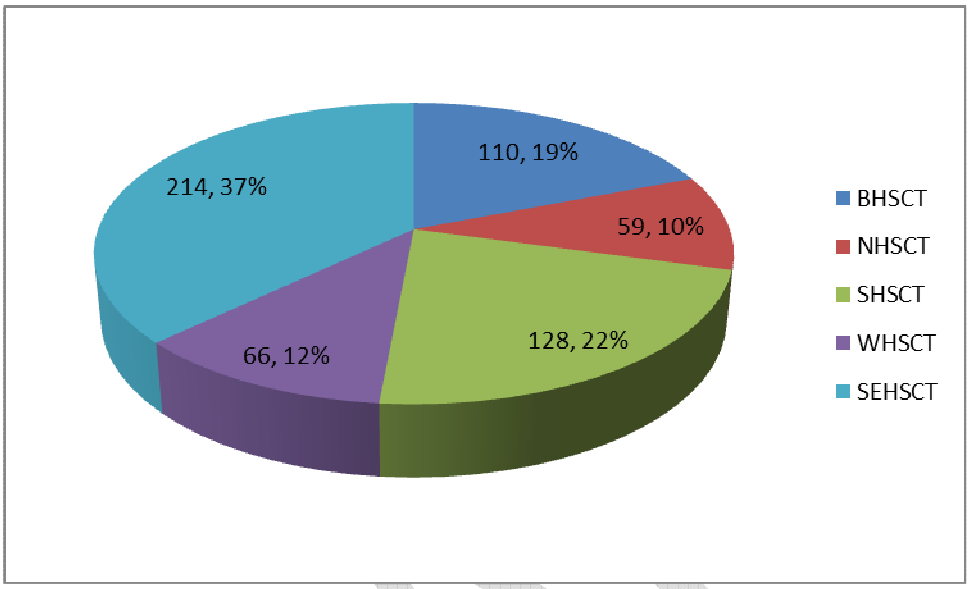
Care was good enough. Noisy at night, didn't sleep very well. Food alright.

5.1 Summary of areas for reflection, learning and development

- Attitudes and behaviours
- Promoting a more person centred approach to care
- Communication – ensuring that patients are able to attract the attention of nursing staff
- Care of patients with dementia/acute confusion
- Ensuring staff adhere to infection prevention and control procedures
- Assurance of standards of nursing care through safety KPIs

6.0 Results in relation to maternity care

A total of 577 stories relating to maternity care have been received, the percentage received from each Trust is shown below:

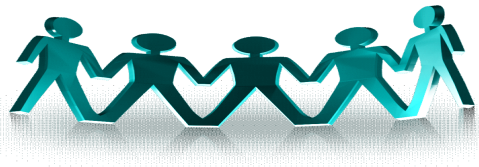


Who completed the survey?

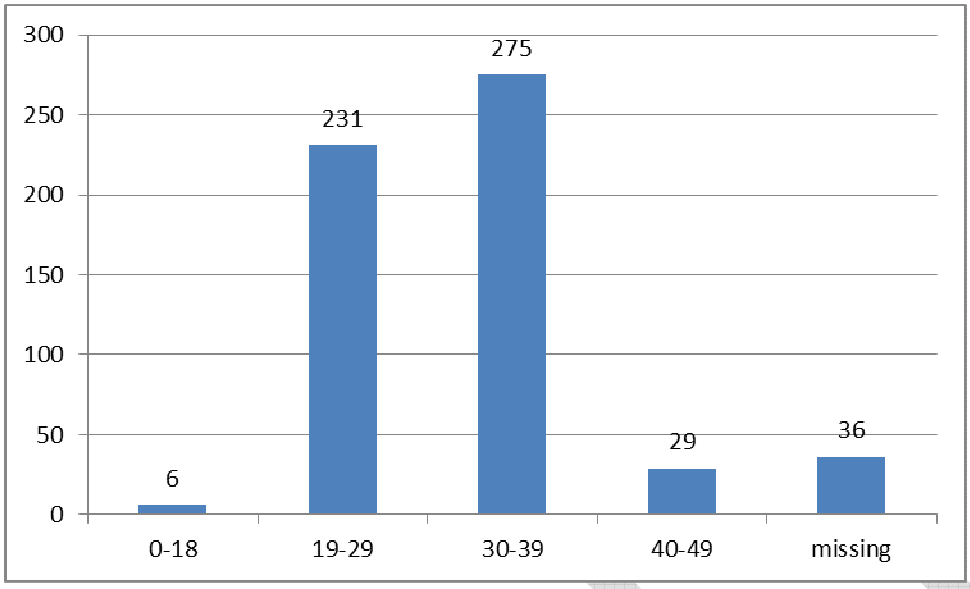
- 93% completed by woman receiving care
- 3 % completed on behalf of woman receiving care
- 1% completed by other person
- 3% information missing

Ethnic group:

- 564 white (98%)
- 2 Irish Traveller
- 2 Indian
- 1 Black African
- 2 mixed ethnic group
- 6 any other ethnic group



Age of respondents



Length of time in hospital

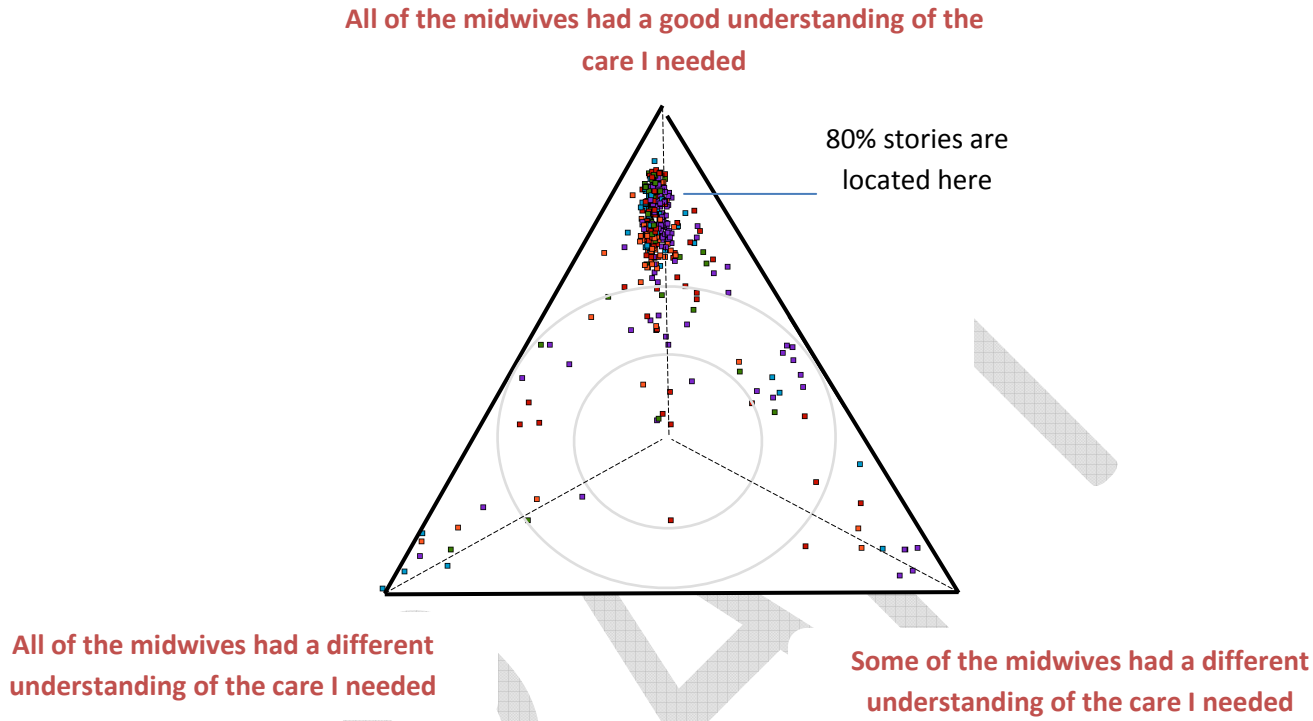
Length of time in hospital	Number of stories received
Less than 24 hours	118 (20%)
1-3 days	329 (57%)
4-7 days	94 (16%)
8-14 days	21 (4%)
More than 14 days	6 (1%)
Missing	9

How the overall experience of maternity care was rated (missing data 0.5%)

Overall feelings about maternity care	Percentage of stories
Strongly positive/positive	92%
Neutral/not sure	**5%**
Strongly negative/negative	2.5%

6.1 Responses to questions (maternity care)

Question 1: How did you feel about the midwives understanding of the care you needed?

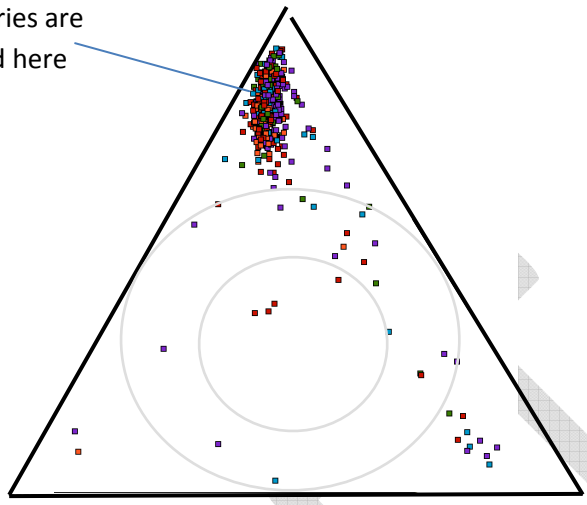


Question 2: How confident were you in the skills of the midwife?

Question 3: How safe did you feel while you were being looked after by the midwife?

I felt safe all the time

87% stories are located here



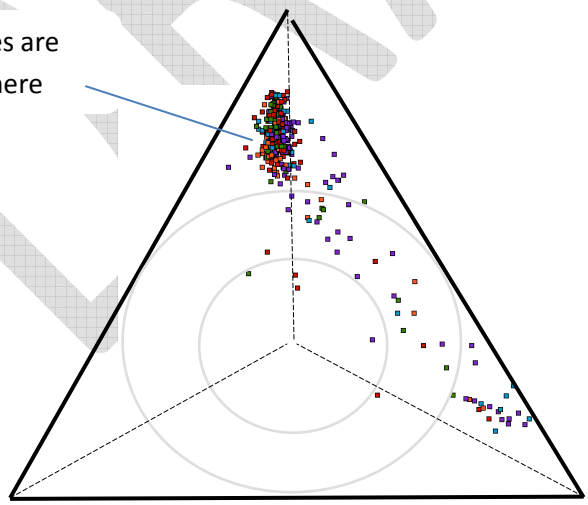
I always felt vulnerable and unsafe

It depended on who was looking after me

Question 4: How would you describe the midwives respect for your personal preferences and choices?

All midwives took account of my personal preferences and choices

82% stories are located here

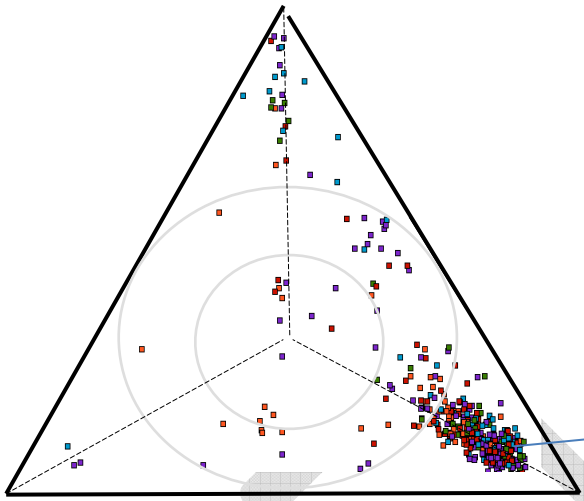


None of the midwives to of my personal preferences and choices

It depended on who was looking after me

Question 5: How did you feel about the amount of time midwives spent with you?

I rarely saw the midwife



78% stories are located here

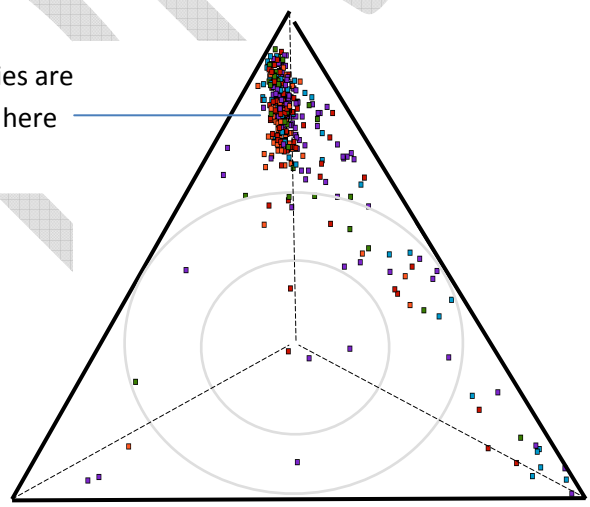
The midwife was with me more than I wanted

I felt the staff gave me the time when I needed it

Question 6: How appropriate did you feel the care you received was against the things which were important to you?

Care was always focused on my needs and what was important to me

81% stories are located here



Care did not focus on the things that were important to me

It depended on who was looking after me

7.0 Key areas for reflection and learning

Following the analysis of the themes from the responses above and the individual stories a number of key areas for reflection and learning have been identified, these are summarised below with relevant extracts from the patient stories..

Feeling of safety

Many stories reflect how women felt safe whilst being cared for by midwives. Stories reflect how midwives deliver care in a calm and controlled environment and provide reassurance, particularly in a crisis situation and when caring for parents who are having a first baby

Story title: An expecting mothers happy memories

Me and my husband have been very happy with all the care and support we have been through our time in the Maternity ward of the ….hospital. All the midwives, nurses, doctors and care staff have been so helpful, supportive, caring and helpful, during my C-section and after care here. It was my second pregnancy here and I wouldn't go anywhere else for I know and feel safe, secure and well looked after here.

Having confidence in midwives

Many stories describe the clinical expertise and professionalism displayed by midwives

No title:

Staff were efficient and dealt with my problems and concerns in a sensitive manner. Fantastic attention from the delivery midwife offering care, compassion and support throughout whole delivery. Specialist team to and delivery were informative and did their upmost to ensure the safe delivery whilst keeping me informed of the necessary decisions and procedures that were taking place.

The midwife team have been stars! They afforded me great encouragement with feeding without being overbearing and treated all sensitive issues with utter professionalism and humanity.

Communication

The majority of stories describe how midwives communicate positively with women and their partners. There are some cases in which women appear to receive mixed messages from midwives. The stories also highlight the need to ensure that midwives listen to women and

their partners, particularly when concerns are voiced. Some stories highlight the need for more information for example in relation to miscarriage and consent for theatre.

Story title: Older mum steps into motherhood for the first time

I feel I have received great care and understanding from the midwifery/nursing team. With this being my first baby, they were always on hand to give advice, support and care in a friendly and encouraging way. Without exception everyone I have met or had visits from - different departments had been very thoughtful and have taken on board that even though they are dealing with babies every day, for each person it is a unique & one off experience, so no question felt too silly to ask! So overall a very positive experience.

Story title: The loss of my baby

I wish now I had been more forthcoming and demanded that my voice be heard

Attitude

Some stories highlight the need for midwives to become more aware of their attitude and behaviour.

No title:

Only slight staff negative came with 2 slightly gruff staff members at night who could perhaps work on their communication and people skills, but that was the exception to the rule.

Support for breast feeding

Some stories highlight that mothers would like to have more support for breast feeding, particularly in the early stages after delivery. A few stories also relate to the food available for women who are breast feeding.

No title:

Food was very poor for a breast feeding mother.

Story title: My beautiful daughter:

However I have been less impressed with some of the breast feeding support. Some midwives are excellent at this. In other cases the advice has been contradictory, patronising and in some cases worse than no advice at all

….I feel I should have been given more support by staff with the feeding

Infection prevention and control

A small number of stories relate to infection prevention and control issues, such as the environment.

Story title: The infection that nearly readmitted me to hospital and nearly resulted in having to give up breast feeding.

However I took an infection (MRSA) as a direct result of cleanliness/hygiene being poor in the bathroom facilities.

My husband wasn't impressed with the overall standard of cleaning levels

Staffing levels

Women and their partners describe how they feel the staff are overworked, stay on after their shift is finished and appear to have a lot of paperwork to complete.

No title:

The antenatal and post natal wards are now mixed - this ward is busy impersonal and stressful to be a patient on - I have no criticism of the very hardworking midwives auxiliary and domestic staff but the management need to realize they are extremely overworked & it is not safe long time to answer buzzers or get attention & may many patients unable to help themselves with spinal aesthetic etc.

8.0 Summary of key areas for learning and development

- Attitudes and behaviours
- Communication – providing information and support for women who have a miscarriage and ensuring that midwives listen to mothers and their partners, particularly when they voice concerns
- Ensuring staff adhere to infection prevention and control procedures
- Assurance of standards of nursing care through safety KPIs
- Staffing levels
- Providing support for mothers who are breastfeeding

9.0 Examples of actions

As a result of the analysis of the information received from the Experience of Nursing and Midwifery Care Key Performance Indicators a number of actions have been initiated to date, examples of these include the following:

9.1 Regional Actions

- Regional findings from experience of women and their partners in Midwifery Led Units have been used to inform regional guidelines through Guidelines Audit Implementation Network (GAIN)
- Regional maternity findings have been presented at Royal College of Midwives showcasing event, and Local Supervising Authority conferences and workshops
- Development of teaching session for student nurses/midwives/student supervisor of midwives

9.2 Trust Actions

- Learning events for nurses in Trusts, allowing time for reflection and learning from the patient stories
- Development a person centred programme for Bands 2/3 nursing staff in collaboration with learning and development team
- Information from the analysis has been included in nursing induction programmes
- Development of patient experience DVD for staff induction and training
- Review of pain pathway for patients in orthopaedic wards
- Local training in the care of patients with acute confusion/dementia
- Further work on staff introductions through Hello my name is

10.0 Recommendations

It is recommended that the information from the analysis of the Experience of Nursing and Midwifery Care Key Performance Indicators should be integrated into and inform regional nursing and midwifery work streams, such as:

- Implementation of the revised regional strategy for nursing and midwifery to promote person centred nursing and midwifery practice
- The recommendations from the ongoing audit which is being conducted by the Irish National Dementia Audit on the care of people with dementia in acute settings
- Work within the regional Dementia Improvement Collaborative
- Informing pre-registration nursing and midwifery education programmes and Putting People First Programme (HSC Leadership Centre)
- Implementation and monitoring for nurse staffing as outlined in Delivering Care: Nurse staffing in Northern Ireland (DHSSPS 2014)

11.0 Conclusion

10,000 Voices is one of a number of Initiatives that the PHA and Trusts are implementing to ensure that quality, safety and patient experience is at the heart of all that we do. As is demonstrated in these findings it is evident that nurses and midwives contribute significantly to ensuring safe, high quality care and positive experience for patients/clients in NI. It is important that the positive messages from these findings are shared with nurses and midwives, with members of the public as well as with those who commission services.

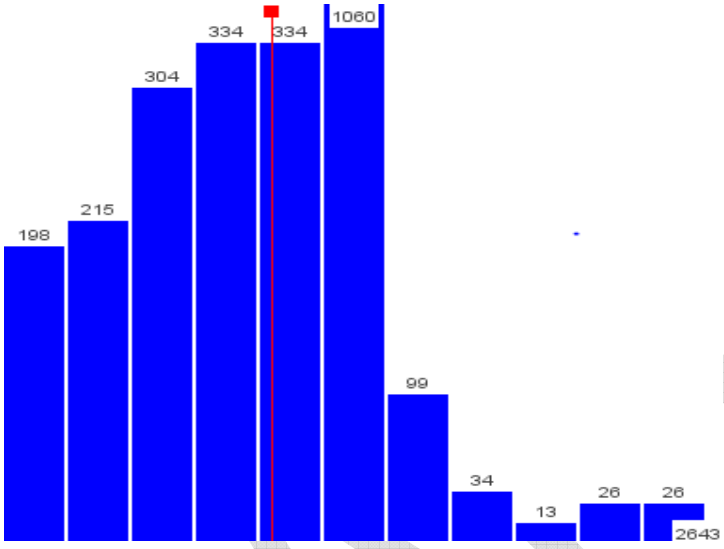
12.0 References

DHSSPS (2014): Delivering Care: Nurse staffing in Northern Ireland

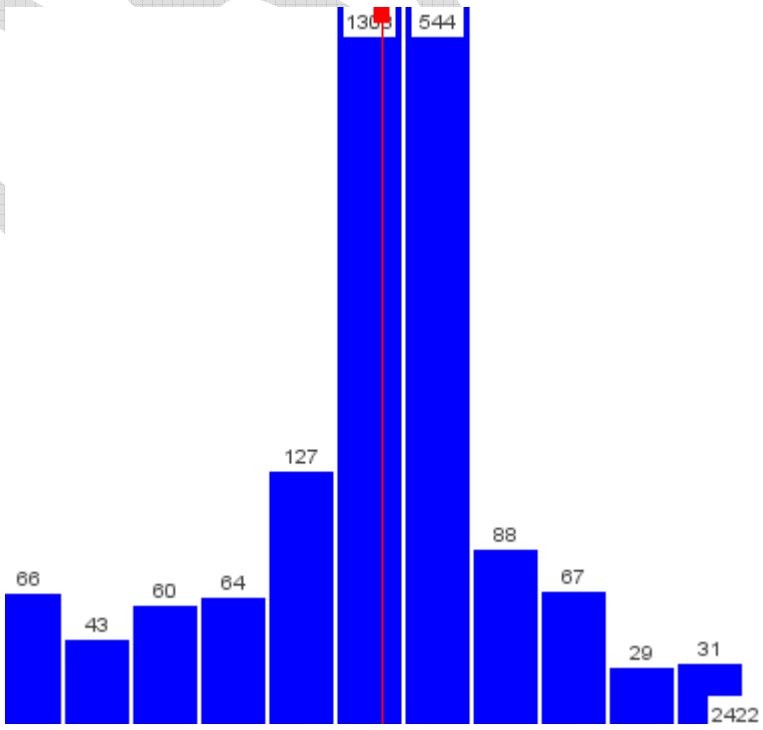
McCance , TV; Telford, L; Wilson, J; MacLeod, O; Dowd, A (2012) Identifying key performance indicators for nursing and midwifery care using a consensus approach. Journal of Clinical Nursing, 21(7 & 8): 1145-1154.

Appendix 1: Responses to slider questions

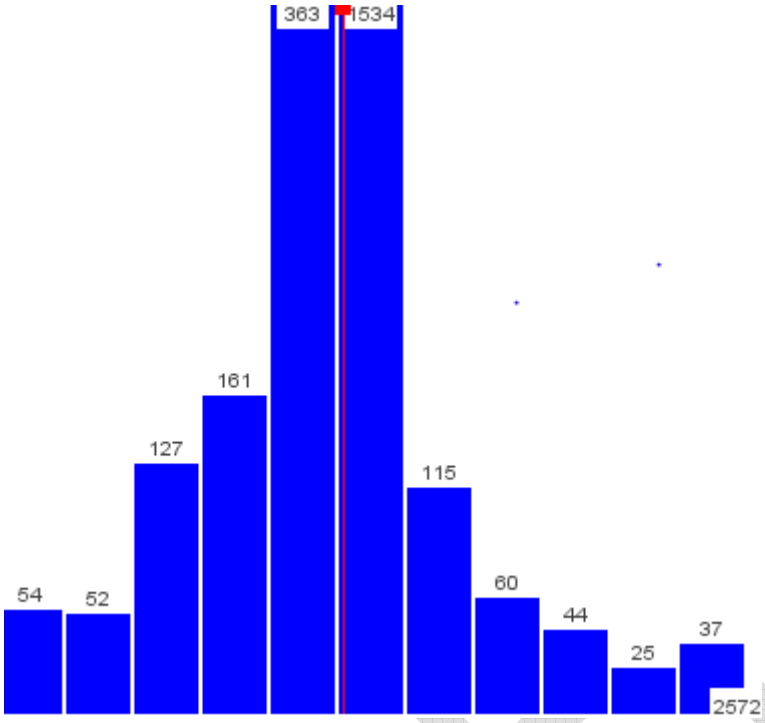
Respondents are asked to think about their story, using a scale with two extreme descriptions, and to place a mark on the scale where they feel their story sits in relation to the descriptions. The ideal response should be situated in the middle position, responses are shown below:



I felt like I was wrapped in cotton wool — I felt very unsafe

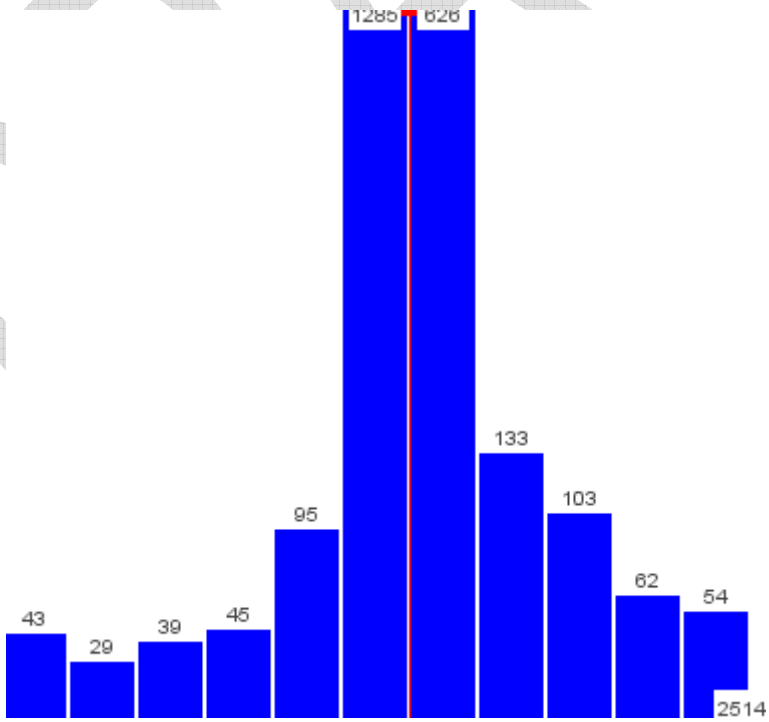


I was left too much on my own to make decisions — I wasn't included in any decisions about my care



The nurse was with me more than I wanted

I rarely saw the nurse



They left me to do everything for myself

They wouldn't let me do anything for myself

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