HSC Public Health Agency

AGENDA

88th Meeting of the Public Health Agency board to be held on Thursday 20 October 2016, at 1:30pm, Conference Rooms, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1.30	Welcome and Apologies		Chair
2.	1.30	Declaration of Interests		Chair
3.	1.30	Minutes of previous meeting held on 15 September 2016		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.50	Finance Update		Mr Cummings
		To include: PHA Financial Performance Report	**PHA/01/10/16 (for Noting)**	
		Fraud and Bribery Policy and Response Plan Review	**PHA/02/10/16 (for Approval)**	
		Revision of Delegated Limits – HSC(F)52-2016	**PHA/03/10/16 (for Noting)**	
8.	2.05	Governance and Audit Committee Update • Minutes of 3 June 2016 meeting • Verbal briefing from Chair	**PHA/04/10/16 (for Noting)**	Mr Coulter

9.	2.30	Mid-Year Assurance Statement	**PHA/05/10/16 (for Approval)**	Chief Executive
10.	2.40	Freedom of Information Internal Review Procedures	**PHA/06/10/16 (for Approval)**	Mr McClean
11.	2.50	Annual Quality Report	**PHA/07/10/16 (for Approval)**	Mrs Hinds
12.	3.05	Any Other Business		

13. **Date, Time and Venue of Next Meeting**
Thursday 17 November 2016
1:30pm
Conference Rooms 3+4
12/22 Linenhall Street
Belfast
BT2 8BS

Public Health Agency

MINUTES

Minutes of the 87th Meeting of the Public Health Agency board held on Thursday 15th September 2016 at 2:30pm, Conference Room, Ormeau Baths, 18 Ormeau Avenue Belfast, BT2 8HS

PRESENT:

Mr Andrew Dougal	-	Chair
Dr Eddie Rooney	-	Chief Executive
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr 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 Paul Cummings	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Mr Robert Graham	-	Secretariat

APOLOGIES:

Mr Brian Coulter	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB

		Action
89/16	**Item 1 – Welcome and Apologies**	
89/16.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Brian Coulter, Ms Deepa Mann-Kler and Mrs Fionnuala McAndrew.	
90/16	**Item 2 - Declaration of Interests**	
90/16.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

91/16 Item 3 – Minutes of previous meeting held on 18 August 2016

91/16.1 The minutes of the previous meeting, held on 18 August 2016, were approved as an accurate record of the meeting.

92/16 Item 4 – Matters Arising

92/16.1 There were no matters arising.

93/16 Item 5 – Chair's Business

93/16.1 The Chair paid tribute to the work of the Chief Executive in this, Dr Rooney's final Board meeting.

93/16.2 The Chair said that Dr Rooney's diverse background of experience was essential in bringing together the disparate and diffuse functions which were to be lead and to be delivered by the new Public Health Agency.

93/16.3 The Chair said that Dr Rooney's interpersonal skills insured that he was able to negotiate with and to persuade people from all sections of the community and from all strata in society and that people felt that they were listened to and knew that their position and opinions on public health issues were respected and taken into account. He added that the work of the PHA is held in high regard at every level in our community, at the grassroots and in the highest levels of government thanks, in no small part, to Dr Rooney's outstanding leadership.

93/16.4 The Chair gave examples of projects and initiatives that Dr Rooney had been personally involved in and said that understanding of the need for personal contact with those who use our services has contributed to the culture and value base in the PHA which sets it apart from other organisations.

93/16.5 The Chair said Dr Rooney empowered staff to do their best and that by being a visible and approachable Chief Executive, he is highly regarded and respected by staff.

93/16.6 In conclusion, the Chair said that the Board of the Public Health Agency would wish to put on record its sincere appreciation of the extent to which Dr Rooney has advanced the cause of public

	health and the public health programmes which have been initiated and delivered by Dr Rooney and his colleagues.
93/16.7	The Chief Executive thanked the Board, and said that it had been a joint journey and that the Agency was going through an exciting and challenging time. He added that nothing has changed in terms of what needs to be done and PHA's contribution to that. He said that he had enjoyed every minute and wished the Agency well in the future.
93/16.8	The Chair advised members that he had received correspondence from the Permanent Secretary advising that Valerie Watts would be taking on the role of interim Chief Executive following Dr Rooney's retirement.
93/16.9	The Chair said that he had been in contact with other public sector organisations regarding ICT solutions for non-executives and that he hoped to progress this matter.
94/16	**Item 6 – Chief Executive's Business**
94/16.1	The Chief Executive said that he had nothing to report.
95/16	**Item 7 – PHA Financial Performance Report (PHA/01/09/16)**
95/16.1	Mr Cummings presented the Finance Report for the period up to 31 July 2016. He advised that the surplus for the year-to-date had reduced to £1m. He drew members' attention to the Trust expenditure and said that there is still significant expenditure planned and that a break even position is still forecast.
95/16.2	Mr Cummings said that the deficit within the management and administration budget had been halved as the costs of staff leaving through the Voluntary Exit Scheme began to take effect.
95/16.3	The Chair asked whether the change of categorisation of R&D expenditure from revenue to capital would reduce the possibility of virement. Mr Cummings said that this was the case as any surplus would have to be returned to the Department of Health. He also explained that whereby in previous year, PHA had been able to redistribute surplus revenue funds to R&D, this will no longer be possible.

95/16.4 Mr Drew commented on the prompt payment performance and said it was excellent.

95/16.5 Members noted the Finance Report.

96/16 Item 8 – Presentation on Connected Health

96/16.1 Mr Eddie Ritson joined the meeting for this item and delivered a presentation to members on telemonitoring and eHealth. He explained the difference between telehealth and telecare and said that, in the main, there has been more progress in relation to telecare vis-à-vis telehealth. He advised that a research study has been carried out and that it is currently going through a peer review process.

96/16.2 Alderman Porter said that it appears to be the case that patients appreciate the value of telehealth, but that clinicians do not. Mr Ritson said that he would agree that is a controversial area. Mrs Hinds said that if you look at the uptake on a Trust-by-Trust basis, it would need only one person to be convinced and then they could encourage others. She said that the HSC system requires less pilot schemes, and more instances of spreading good practice. She added that in her opinion, the amount of support that telecare can provide is significant, but she accepted that it is difficult to change behaviour.

96/16.3 The Chair suggested that PHA should look at how success in uptake was achieved. Mr Ritson said that it would depend on the characteristics of the staff working with the service and cited the example of nurses within the South Eastern Trust. Mr Ritson also observed that if the telemonitoring service received a glowing evaluation, would the present service model be continued.

96/16.4 Mr Drew asked if the telemonitoring service was up for renewal. He said that it would be difficult to develop a business case that would fully support it. He added that given the pace of technological change, should clients be using their own mobile devices. However, he went on to note that this may be difficult if there is a reliability on Broadband and WiFi services. Mr Ritson agreed that the use of clients' own devices would be a major change, and he explained that the current system does not rely on WiFi. He said that in general the system is underused.

96/16.5	The Chair asked that even if there is greater uptake, are there the resources to deliver. Mr Ritson said that there are recurrent resources, but that when developing the business case these resources must be appropriately used. He added that the technology is moving ahead of the evidence base to support it. Alderman Porter asked if incentives had been considered to encourage take up. Mr Ritson said that the idea of incentives had been considered, but it was felt that if telecare was deemed as the right thing to do for GPs, why should there be financial incentives to use it.
96/16.6	The Chair asked about a marketing strategy and using service users, carer or healthcare professionals to be advocates of the service. Mr Ritson said that, although the level of buy-in to existing services could be better, that going forward there is a thirst for finding new ways of working.
96/16.7	Mr McClean asked about Trust management. Mr Ritson said that Trust management are becoming more enthusiastic about the potential of telecare. The Chief Executive advised that at the commencement of the contract, telemonitoring and telecare seemed like a “bolt-on” and that evaluation showed it to be patchy; in some areas very good, in other areas, not so good. He added that the focus was around saving time and initially there had been some strong resistance. The Chief Executive went on to say that now, the context has moved on hugely as the health sector is now lagging behind when it comes to technology and the key outcome now is not about saving time, but better patient outcomes.
96/16.8	Alderman Porter said that any new system has to look different than the previous one. Mr Drew asked about the next steps. Mr Ritson said that the current contract is likely to be extended. Mr Drew said that he would support that as at the moment we do not know what the requirements are for any new system and that it is critical that overheads are reduced, with better patient outcomes.
96/16.9	The Chair asked who HSC would consult with regarding a set of requirements. Mr Drew asked if there was any evidence abroad in this area. Mr Ritson said that industry views telehealth and telecare as a massive opportunity, and that there is frustration that the health sector has not advanced yet so there is great potential.

96/16.10 The Chair thanked Mr Ritson for his presentation and members noted the update on connected health.

At this point Councillor Ashe left the meeting.

97/16 Item 9 – Presentation on Palliative Care

97/16.1 The Chair welcomed Ms Corrina Grimes and Mr Paul Turley to the meeting and invited them to give a presentation on palliative care.

97/16.2 Mr Turley began the presentation by giving members a definition of palliative care and other terms used. He made reference to the recent RQIA review of the implementation of the Palliative and End of Life Care Strategy which concluded that significant progress was made during the period 2010 to 2015 towards implementing the recommendations of the strategy.

97/16.3 Ms Grimes gave members an overview of the regional palliative care programme structure which includes a palliative care board co-chaired by Mary Hinds and Dean Sullivan. She outlined the membership of the board and highlighted some of its key work priorities, including the identification of people who are likely to be in the last year of their life and having an identified key worker for each patient, ideally a District Nurse.

97/16.4 Ms Grimes moved on to talk about Advanced Care Planning and distributed to members some of the materials produced by PHA. She outlined other workstreams and finished the presentation by showing members a video which highlighted the message that your last moments in life should mean as much as your first.

97/16.5 Following the presentation she welcomed questions from members.

97/16.6 The Chair asked about what mechanisms are in place for obtaining independent feedback from next of kin. Ms Grimes explained that this would be part of the role of the key worker, and that there have been pieces of work undertaken relating to specific conditions, including one by the Cancer Registry. The Chair noted that a carer may be reluctant to give honest feedback to the key worker. Mrs Hinds said that there is further work being developed. Mr Turley said that this showed the level

of complexity that exists across services, and that there is a need to create a structure where organisations can work in partnership. He cited the example of Transforming Your Care, where external engagement had been valuable in reviewing services. Ms Grimes said that all complaints are reviewed and any outstanding issues are added to the palliative care workplan. The Chair noted that complaints are an opportunity for improvement.

97/16.7 Alderman Porter asked about the challenges within nursing homes, and also older people with special needs. Ms Grimes said that nursing homes are a key stakeholder, and as such there has been a lot of work to deliver education in nursing homes as part of Project Echo. With regard to individuals with special needs, she said that there needs to be a particular piece of work to look at this. Mr Turley suggested that advocates or carers could assist.

97/16.8 Mr Mahaffy asked about resources for this work. Mrs Hinds advised that there are issues with regard to the number of district nurses, and that she co-chairs a group which has developed a paper for endorsement regarding the roles of key workers and district nurses. She said that one of the strongest messages coming out from this work was the need to respect the privacy of people's homes and not have too many different types of workers visiting people in their home.

97/16.9 Dr Harper asked about up-skilling GPs. Ms Grimes said that some educational work had been done, including advanced care planning training. However, Dr Harper suggested that a more proactive approach was required and that perhaps GPs should have to undertake training as part of their annual appraisal. Ms Grimes that the GMC are happy to assist with this. Dr Harper went on to ask about the extent to which GP advice is easily available given demographic issues. Ms Grimes advised that one of the recommendations which came from the recent RQIA review of palliative care related to the need to formalise out of hours arrangements. Mrs Hinds added that there is a multi-disciplinary approach being taken to planning in this area of work.

97/16.10 The Chair asked whether there were any examples of families being given financial resources to purchase their own palliative

care. Mr Turley said that accessing direct payments has proved difficult for people.

97/16.11 Mrs Hinds noted that much of the work being undertaken now is building up work commenced by Dr Jenny Gingles who has now retired. She said that the low number of recommendations in the recent RQIA review is testament to her work.

97/16.12 The Chief Executive acknowledged that the work being carried out in this area is complex as there are different ways to deal with the different issues, but that it should be as easy to engage with people at the end of live, as it is at the beginning of their life.

97/16.13 The Chair thanked Ms Grimes and Mr Turley for their presentation and members noted the update on palliative care.

At this point Mr Cummings and Mrs Erskine left the meeting.

98/16 Item 10 – AHP Strategy – Final Implementation Report (PHA/02/09/16)

98/16.1 The Chair welcomed Michelle Tennyson and Geraldine Teague to the meeting.

98/16.2 Mrs Tennyson explained to members that the AHP Implementation Strategy is a 5-year Strategy and PHA is responsible for its delivery. She explained that today's report is a concluding report on the implementation. She said that Ms Teague was leading on this work and invited her to give an overview of the progress to date.

98/16.3 Ms Teague outlined to members the wide range of Allied Health Professions and the four key themes of the AHP Strategy, namely promoting person centred practice and care, delivering safe and effective practice and care, maximising resources for success and supporting and developing the AHP workforce.

98/16.4 In terms of key achievements from the implementation of the Strategy, Ms Teague highlighted enhanced partnership working, reform and modernisation, robust professional governance, and increased profile and cohesiveness.

98/16.5 Ms Teague advised that PHA had developed resources which

show the different roles of the different AHPs. She said that a proposal paper has been sent to the Department of Health recommending an extension to the current Strategy and outlining future key priorities. She noted that these priorities included the need to address current pressures, conducting a workforce review as well as enhancing integration and embedding research.

98/16.6 The Chair asked if there were data available on the percentage of time that therapists spend doing face-to-face sessions. Ms Teague said that there is a need to move away from the direct, hands-on approach, but this will require up-skilling. Ms Tennyson added that the percentage would be around 90% for staff at Band 5. Ms Teague said that PHA is trying to encourage group interventions and develop alternative pathways.

98/16.7 Mr Drew said that he was encouraged to see a joined-up approach and he asked whether any outcome measures had been developed. Ms Tennyson said that developing outcome measures is something PHA is very keen on, but that the challenge is to develop a set of measures that all professions can use where trends can be analysed. Mr Drew commented that if there is no impact, then it raises the question of why there are so many frameworks.

98/16.8 The Chief Executive said that over the last four years, through the work in neurological conditions, it has allowed children who have life limiting conditions to have the best life possible. He said that integration is critical. Ms Teague said that there is an excellent workforce which is willing to change practice as AHPs cannot work in isolation.

98/16.9 Members noted the final implementation report on the AHP Strategy.

99/16 Item 11 – Any Other Business

99/16.1 There was no other business.

100/16 Item 12 – Date and Time of Next Meeting

Date: Thursday 20 October 2016
Time: 1:30pm

Venue: Conference Rooms 3+4
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: _________________

Date: _________________

HSC Public Health Agency

Public Health Agency

Finance Report

2016-17

Month 5 - August 2016

Public Health Agency
2016-17 Summary Position - August 2016

	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								
Departmental Revenue Allocation	28,848	49,418	18,232	**96,497**	11,827	14,211	7,292	**33,330**
Revenue Income from Other Sources	-	14	875	**888**	-	14	348	**363**
Capital Grant Allocation & Income	6,621	5,756	-	**12,377**	2,759	1,397	-	**4,156**
Total Available Resources	35,469	55,188	19,107	**109,764**	14,586	15,622	7,641	**37,848**
Expenditure								
Trusts	35,469	-	-	**35,469**	14,779	-	-	**14,779**
Non-Trust Programme *	-	55,188	-	**55,188**	-	12,365	-	**12,365**
PHA Administration	-	-	19,107	**19,107**	-	-	7,646	**7,646**
Total Proposed Budgets	35,469	55,188	19,107	**109,764**	14,779	12,365	7,646	**34,790**
Surplus/(Deficit) - Revenue	-	-	-	-	(148)	2,417	(6)	**2,263**
Surplus/(Deficit) - Capital	-	-	-	**-**	(45)	840	-	**796**

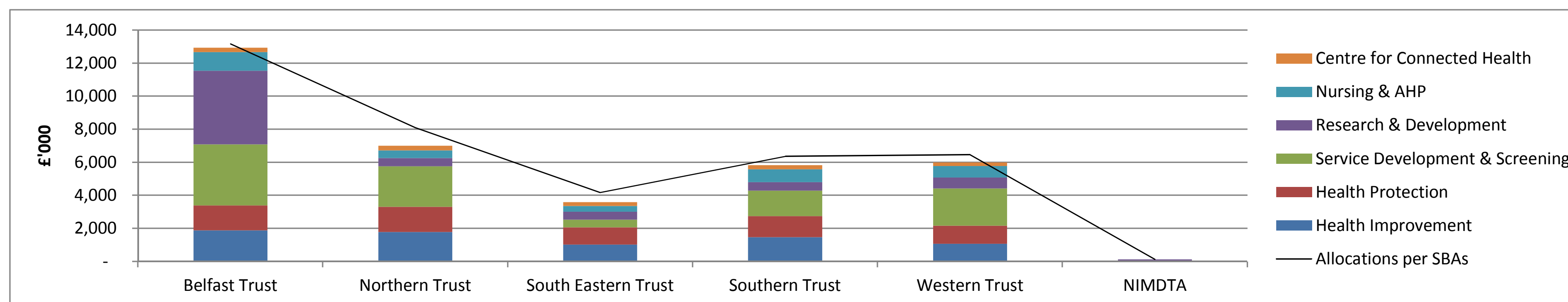
** Non-Trust Programme includes amounts which may transfer to Trusts later in the year*

The total funding available to the PHA has increased by approximately £1.1m since the last report due to the recognition of Dementia Strategy funding (£0.5m) and income relating to speciality registrars who have transferred to NIMDTA.

As advised in the opening Budget paper, revised Departmental guidance means the vast majority of PHA's Research & Development (R&D) expenditure will now be funded from a DoH capital budget (CRL), rather than a revenue budget (RRL) as was previously the case. Total CRL allocations received for R&D now total £11.4m, with additional receipts of £1.0m bringing the total to £12.4m. As a result of this change the majority of R&D programme will no longer form part of PHA's revenue breakeven requirement. However, total funds and expenditure will be shown within the Finance Reports in a combined manner, but the individual CRL and RRL breakeven targets will be monitored and highlighted separately.

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £3m, £2.3m of which relates to Revenue Budgets (RRL). Both variances are mainly due to lower than anticipated expenditure in Non-Trust Programme budgets, as detailed on page 3 of this report. It is currently anticipated that the PHA will breakeven on its full year budget.

Programme Expenditure with Trusts



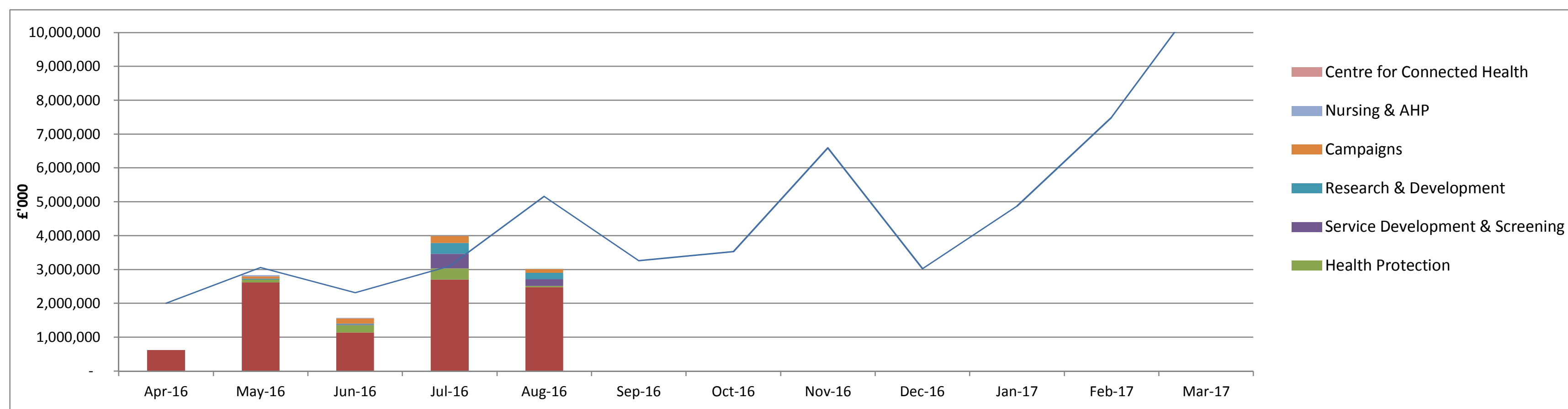
Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Current Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,884	1,780	1,030	1,477	1,068	-	**7,237**	2,855	3,016	(161)
Health Protection	1,511	1,534	1,044	1,268	1,101	-	**6,457**	2,666	2,691	(24)
Service Development & Screening	3,701	2,454	467	1,536	2,253	-	**10,411**	4,374	4,338	37
Research & Development	4,452	489	477	517	660	132	**6,728**	2,759	2,803	(45)
Nursing & AHP	1,129	462	343	784	696	-	**3,416**	1,423	1,423	-
Centre for Connected Health	252	282	227	240	220	-	**1,220**	508	508	-
Total current RRLs	**12,929**	**7,001**	**3,587**	**5,821**	**5,998**	**132**	**35,469**	**14,586**	**14,779**	**(193)**
Planned Further Allocations	**233**	**1,101**	**593**	**535**	**467**	**0**	**2,929**			

The above table shows the current Trust allocations split by budget area. These amounts are primarily Revenue Resource Limits (RRL) but also include the Capital Resource Limit (CRL) for Research and Development.

The opening SBAs provided Trusts with an initial confirmed allocation (both revenue and capital) and an indicative allocation to enable them to prepare Trust Delivery Plans. During the year some elements of this indicative allocation have been issued to Trusts. The Planned Further Allocations above show the balance of these indicative amounts which have yet to be formally allocated.

August 2016

Non-Trust Programme Expenditure



	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Total £'000
Projected Expenditure													
Health Improvement	1,246	2,368	1,389	1,582	2,674	1,412	1,557	3,711	682	2,893	3,347	2,314	**25,175**
Lifeline	225	225	225	225	225	225	225	225	225	225	225	225	**2,700**
Health Protection	27	29	25	275	611	693	1,011	1,012	1,012	1,017	2,016	1,382	**9,110**
Service Development & Screening	217	148	392	157	102	375	102	112	374	126	168	509	**2,780**
Research & Development (CRL)	8	8	8	372	1,002	19	8	948	132	8	1,147	5,129	**8,788**
Campaigns	115	115	115	115	187	165	165	165	165	165	165	215	**1,856**
Nursing & AHP	4	4	4	214	198	198	250	212	226	232	212	337	**2,091**
Safeguarding Board	-	-	-	-	-	12	-	-	-	-	-	12	**24**
Centre for Connected Health	157	157	157	157	157	157	157	157	157	157	157	157	**1,889**
Other	-	-	-	-	-	-	50	50	50	50	50	524	**774**
Total Projected Non-Trust Expenditure	**1,999**	**3,054**	**2,314**	**3,097**	**5,157**	**3,257**	**3,525**	**6,593**	**3,024**	**4,873**	**7,488**	**10,806**	**55,188**
Actual Expenditure	**620**	**2,914**	**1,663**	**4,127**	**3,040**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**12,365**
Variance	**1,379**	**140**	**651**	**(1,029)**	**2,116**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,257**

The budgets and profiles are based on the opening budgets with adjustments made as a result of additional allocations received subsequently. Expenditure is behind profiles set by Budget Managers for the year to date, mainly due to slippage in Health Improvement (£827k), Service Development & Screening (£194k), Research & Development (£840k) and the Centre for Connected Health (£787k) but these variances are due to timing only. The PHA is still projecting a breakeven position for the full year, however budget managers have advised that they are taking steps to ensure expenditure is brought back into line with profile.

August 2016

PHA Administration

2016-17 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	2,713	3,353	9,178	452	316	507	**16,520**
Goods & Services	97	1,287	387	482	49	287	**2,588**
Total Budget	**2,810**	**4,640**	**9,565**	**934**	**365**	**794**	**19,108**
Budget profiled to date							
Salaries	1,114	1,397	3,833	167	132	188	**6,831**
Goods & Services	40	540	139	13	20	57	**810**
Total	**1,155**	**1,937**	**3,972**	**180**	**152**	**244**	**7,641**
Actual expenditure to date							
Salaries	1,174	1,371	3,937	109	132	188	**6,910**
Goods & Services	54	515	126	(20)	5	57	**736**
Total	**1,227**	**1,886**	**4,062**	**90**	**137**	**244**	**7,646**
Surplus/(Deficit) to date							
Salaries	(59)	26	(103)	58	(0)	0	**(79)**
Goods & Services	(13)	26	13	33	16	0	**74**
Surplus/(Deficit)	**(72)**	**52**	**(90)**	**90**	**15**	**0**	**(6)**

The total PHA funding allocation from the DoH in 2016-17 has been reduced by 10%, which equates to £1.6m. Although this reduction has initially been set against Commissioning funds by the DoH as an interim measure, the PHA Investment Plan requires the Administration budgets to deliver a contribution towards this reduction to enable PHA to achieve breakeven in-year.

The Administration savings target is based on anticipated savings as a result of restructuring following the VES 2015-16 process, the implementation of which is estimated to generate a net £0.45m after funded other pressures and priorities. Salaries budgets have been updated in line with these plans.

The year-to-date salaries budgets of both Nursing and Public Health are under some pressure. This is due to a combination of incremental drift and in-year costs of VES posts only vacated at the end of quarter 1. The position is expected to improve as the year progresses, and all Directorate surpluses and deficits will be closely reviewed in the coming months to enable the overall PHA Administration budget to breakeven in 2016-17.

PHA Prompt Payment

Prompt Payment Statistics

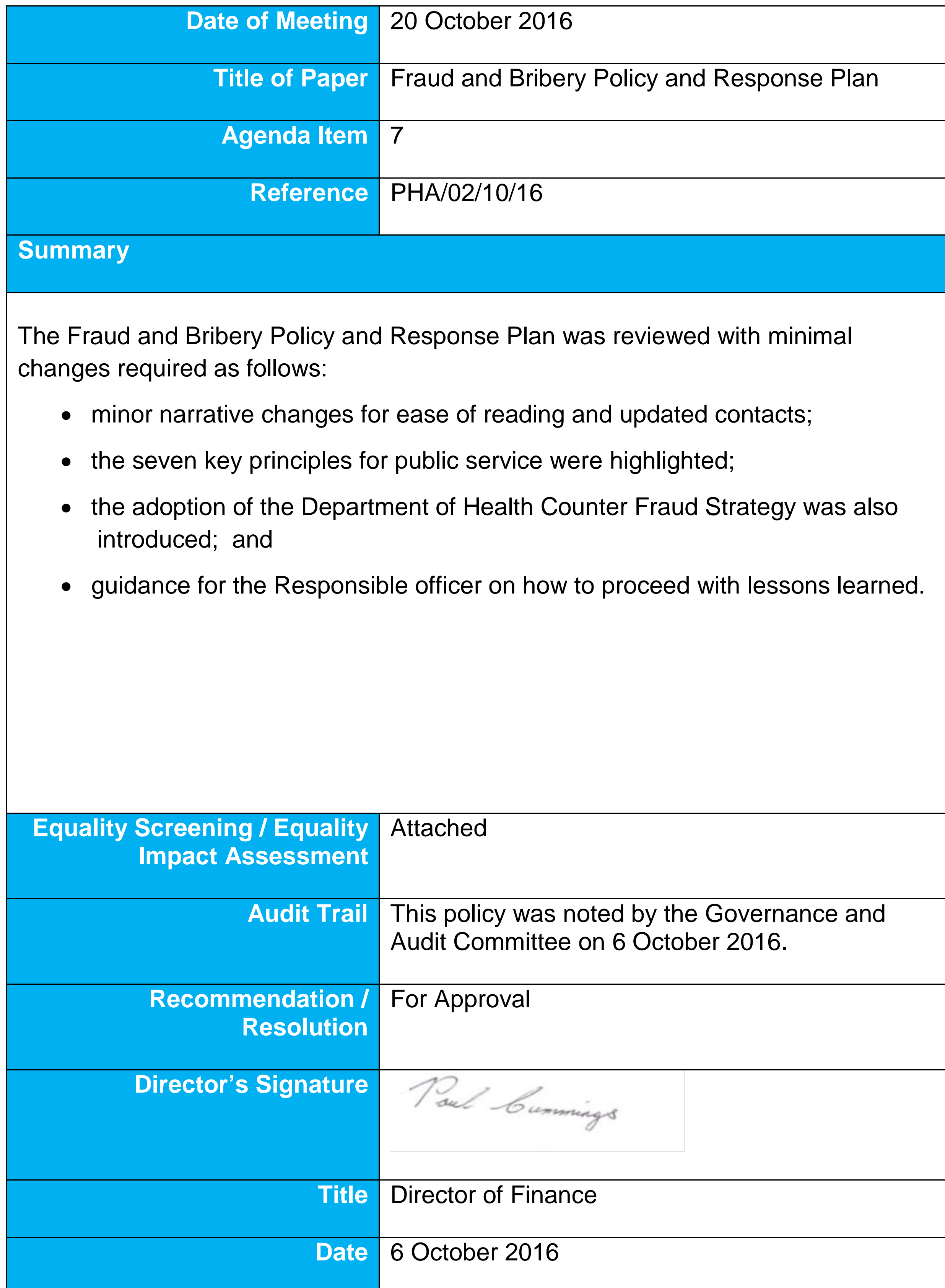
	August 2016 Value	August 2016 Volume	Cumulative position as at 31 August 2016 Value	Cumulative position as at 31 August 2016 Volume
Total bills paid (relating to Prompt Payment target)	£5,550,484	441	£18,496,278	2,258
Total bills paid on time (within 30 days or under other agreed terms)	£4,899,491	402	£17,466,512	2,133
Percentage of bills paid on time	**88.3%**	**91.2%**	**94.4%**	**94.5%**

Prompt Payment performance for the year to date shows that on both value and volume the PHA ha fallen below the 30 day target of 95%. This is mainly as a result of poor performance in August resulting in only 88.3% of invoices by value being paid within 30 days or terms. The reasons for this are currently under review.

The 10 day prompt payment performance remained strong at 87% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2016-17 of 60%.

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	20 October 2016
Title of Paper	Fraud and Bribery Policy and Response Plan
Agenda Item	7
Reference	PHA/02/10/16

Summary

The Fraud and Bribery Policy and Response Plan was reviewed with minimal changes required as follows:

- minor narrative changes for ease of reading and updated contacts;
- the seven key principles for public service were highlighted;
- the adoption of the Department of Health Counter Fraud Strategy was also introduced; and
- guidance for the Responsible officer on how to proceed with lessons learned.

Equality Screening / Equality Impact Assessment	Attached
Audit Trail	This policy was noted by the Governance and Audit Committee on 6 October 2016.
Recommendation / Resolution	For Approval
Director's Signature	Paul Cummings
Title	Director of Finance
Date	6 October 2016

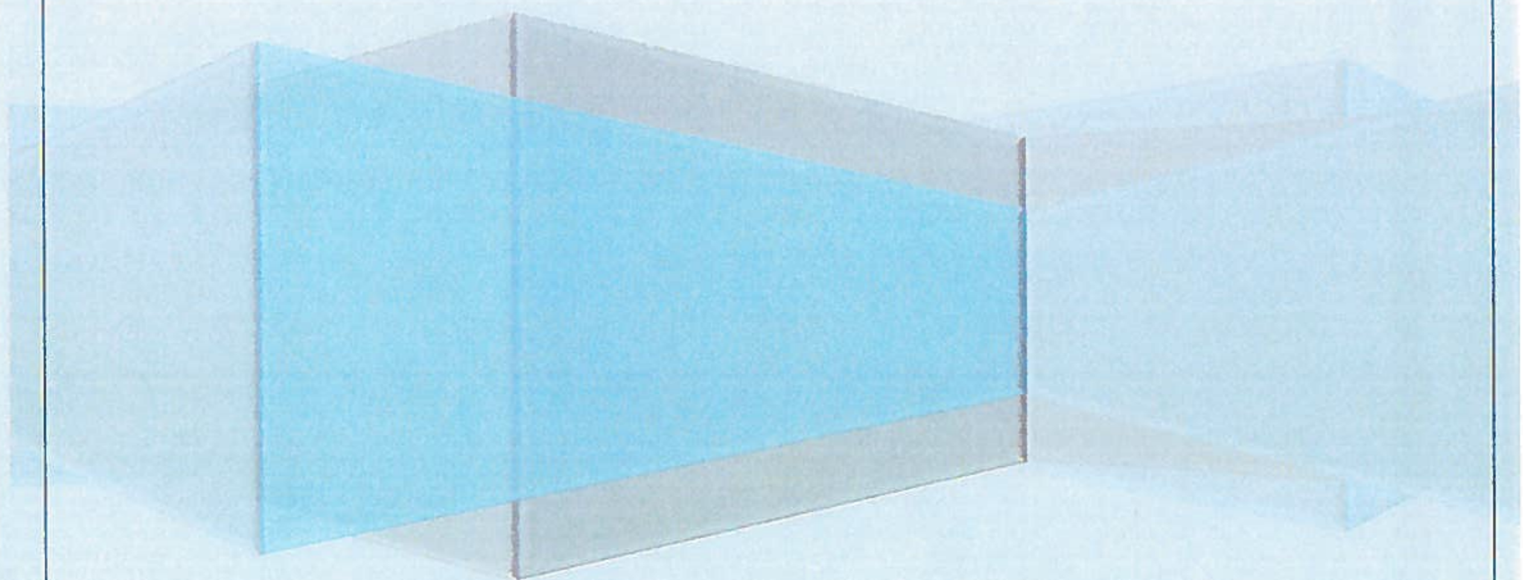
Public Health Agency

FRAUD AND BRIBERY RESPONSE PLAN

Version 2

Revised

26 September 2016



HSC Public Health Agency

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

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HSC Public Health Agency

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

1.0 INTRODUCTION

This document is intended to provide direction and assistance to those officers and directors who find themselves having to deal with suspected cases of theft, fraud, bribery or corruption. It gives a framework for response and provides advice and information on various aspects and implications of an investigation.

One of the basic principles of public sector organisations is the proper use and stewardship of public funds. It is therefore important that all those who work in the public sector are aware of the risk of fraud and the means by which the rules against fraud and other illegal acts, such as bribery involving dishonesty or damage to property, may be enforced. For simplicity all such offences are hereafter referred to as "fraud", except where the context indicates otherwise. This document sets out both the policy and the response plan for detected or suspected fraud both within or committed upon the PHA.

This document is not intended to provide direction on the prevention of fraud as the PHA already has procedures in place which reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, Whistleblowing Policy, Escalation Policy, documented procedures and a system of internal control and of risk assessment management.

Under the Fraud Act 2006, fraud is a specific offence in law. The Fraud Act 2006 supplements the Theft Act (Northern Ireland) 1969 and the Theft (Northern Ireland) Order 1978. Fraud is used to describe acts such as deception, bribery, forgery, extortion, corruption, theft, conspiracy, embezzlement, misappropriation, false representation, concealment of material facts and collusion.

For practical purposes, fraud may be considered to be the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party. The criminal act is the attempt to deceive and attempted fraud is therefore treated as seriously as accomplished fraud.

HSC Public Health Agency

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

The Bribery Act 2010 was introduced on 1 July 2011 in Northern Ireland. Previously this was a crime under Common law but now a crime under Criminal law with a stricter definition.

According to the Act a bribe is a financial or other advantage intended to induce or reward the improper performance of a person's function or activity, where benefit could create a conflict between personal interests and business interests.

The basic principle is if the offering/accepting of a simple gift could be seen to influence a decision, then it is classed as potential bribery.

PHA staff will be supported by a dedicated Fraud Liaison Officer service provided by the Director of Finance (HSCB), the Counter Fraud & Probity Services Team (BSO) and on-going fraud awareness training in support of the PHA's anti-fraud culture.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

2.0 PUBLIC SERVICE VALUES

High standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. The Human Resource Code of Conduct details the Standards of Business Conduct for HSCNI staff in the circular HSS (Gen1)1/95.

The Code of Conduct for HSC Bodies published by the DOH(HSS Executive) in 1994 set out the following public service values:

Accountability:	Everything done by those who work in the HSC must be able to stand the tests of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.
Probity:	There should be an absolute standard of honesty in dealing with the assets of the HSC: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of HPSS duties.
Openness:	There should be sufficient openness about HSC activities to promote confidence between the HPSS body and its staff, patients, clients and the public.

These standards have been further enshrined in public life by the 7 key principles for public service:

- Selflessness
- Integrity
- Objectivity
- Leadership
- Accountability
- Openness
- Honesty

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

In support of the PHA's anti-fraud culture, all those who work in the Agency will be made aware of and be expected to act in accordance with these values.

3.0 POLICY

The PHA board is absolutely committed to maintaining an honest and open atmosphere which supports the elimination of the potential for fraud within or upon the Agency and adopts a zero tolerance approach to fraud. This will be underpinned through the system of internal control and risk assessment, and to the rigorous investigation of any suspected or actual cases of alleged fraud.

The PHA board wishes to encourage anyone having reasonable suspicions of fraud to report them as soon as possible. It is the policy of the PHA, which will be rigorously enforced, that all members of staff can be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes 'reasonably held suspicions' shall mean any suspicions other than those which are groundless and/or raised maliciously. Further guidance on the protection afforded to staff is contained in the PHA's policy on Whistleblowing.

Where a fraud is proven, a criminal prosecution will always be considered at the same time as other internal or external actions, e.g. disciplinary procedure or referral to a third party organisation. The HSCB will always seek to recover any losses resulting from the fraud, if necessary through civil court proceedings.

The PHA has adopted the DOH Counter Fraud Strategy as the basis for its anti-fraud activities. The key elements of this Strategy are as follows:

- The creation of an anti-fraud culture;
- Maximum deterrence of fraud;
- Successful prevention of fraud;
- Prompt detection of fraud;
- Professional investigation of detected fraud;
- Effective sanctions, including appropriate legal action against anyone found guilty of committing fraud; and

- Effective methods for seeking recovery of money defrauded or imposition of other legal remedies.

This policy should also be read in conjunction with the PHA Whistle blowing policy which provides detailed guidance on internal and external reporting methods.

4.0 ROLES AND RESPONSIBILITIES

4.1 Individual roles within investigation and reporting

Chief Executive
Director of Operations
Assistant Director - Counter Fraud and Probity Service (BSO)
Director of Finance (HSCB)
Fraud Liaison Officer (HSCB)

Responsibility for investigating fraud has been delegated to the HSC Regional Counter Fraud and Probity Service (CFPS) BSO in conjunction with the Fraud Liaison service provided by the Director of Finance (HSCB), on behalf of the PHA.

For contact details of the CFPS and the Fraud Liaison Officer please see appendix 1.

The CFPS are required to report, in conjunction with the Fraud Liaison Officer and the Chief Executive, to third parties such as the PSNI.

The Director of Finance (HSCB) shall consult the Chief Executive at an early stage in cases where the loss may be above the delegated limit of £10,000 or where the incident may lead to adverse publicity.

The Fraud Liaison Officer shall set out arrangements for the investigation whilst the Director of Finance retains an overview of progress and will periodically report to the Governance and Audit Committee.

The Director of Operations shall be kept informed by the Fraud Liaison Officer.

4.2 Director of Human Resources (BSO)

Where a member of staff is to be interviewed or disciplined the Director of Human Resources (BSO) shall be consulted.

4.3 Whistleblowing – Nominated Officer

The nominated officer under the Whistleblowing policy is the Director of Operations of the PHA. He/She is authorised to receive complaints anonymously and will decide whether the matter raised needs to be reported to the Chief Executive. Please refer to the separate Whistleblowing policy for further details.

4.4 All PHA staff

All staff have a duty to protect the assets of the PHA, (assets include information and goodwill as well as property), underpinned by conducting the business of the PHA with reference to the code of conduct and the 7 Public Sector principles. Managers may have suspicions reported to them by employees and this manual provides guidance on initial steps to be taken prior to handing formally to CFPS for further investigation.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

5.0 THE RESPONSE PLAN

5.1 Introduction

The flowcharts in Appendices 2 & 3 describe the PHA intended response to a reported suspicion of fraud or bribery (see section 7). The flowcharts are intended to provide procedures to inform employees and managers of initial steps to be followed to facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any further criminal or civil action.

Each situation is different; therefore the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 5.2 (Commentary on Flowchart Items).

Under no circumstances should a member of staff speak or write to representatives of the press, TV, radio, or to another third party about a suspected fraud without the express authority of the Chief Executive. Care needs to be taken to ensure that nothing is done that could give rise to an action for slander or libel.

In some cases, e.g. if a major diversion of funds is suspected, speed of response will be crucial to avoid financial loss and the Director of Finance will, in conjunction with the Assistant Director of Counter Fraud and Probity Service and the Chief Executive, initiate actions to mitigate or end loss.

The PHA Fraud Liaison Officer (Finance Department HSCB) will liaise with CFPS which will in turn contact any relevant outside bodies e.g. PSNI.

5.2 Commentary on Flowchart Items – Appendix 2

REPORTING FRAUD- From initial Suspicion to outcome

5.2.1 Step 1-Reporting Fraud - Options for Employee

(i) Internal

As per Appendix 2 there are a range of Officers who employees can report suspicions to. Consideration of appropriate persons should be in this order:

- Line manager – up to Head of Department level;
- Head of Department;
- Director;
- Chief Executive;
- Chairperson.

(ii) Website or Hotline

All HSC employees and members of the public can telephone the Regional HSC Fraud reporting Hotline on **0800 096 33 96** or report through their internet site www.reporthealthfraud.hscni.net. These are managed by the CFPS (BSO) on behalf of the HSC and reports may be made on a confidential basis.

(iii) Whistleblowing

The nominated officer under the Whistleblowing policy (the Director of Operations) is authorised to treat inquiries confidentially and anonymously if so requested by the employee contacting him/her. The nominated officer should review the legitimacy of the registered suspicion and will liaise as necessary with the Director of Finance or FLO (HSCB) and will respond tactfully and appropriately to concerns raised.

The Whistleblowing Policy also provides a list of external bodies which employees may raise concerns with; please refer to the policy (within CONNECT) for full details.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

5.2.2 Step 2 - Agreement on next steps

If suspicions appear well grounded the Fraud Liaison Officer should be contacted promptly with all relevant information from either the CFPS if reported externally eg, via the hotline or the web or the manager/nominated officer if internally reported. The Fraud Liaison Officer will review the circumstances and provide guidance on steps to be taken by the PHA employees in accordance with Appendix 2.

5.2.3 Step 3 – Informing Counter Fraud and Probity Service and recording on the Regional database

The Fraud Liaison Officer will contact the Assistant Director of CFPS to provide all details received directly from PHA immediately. Information received directly from CFPS (website and hotline) will be advised to the FLO on a timely basis. Details of all reported suspicions will be entered into the Regional Fraud database, including those dismissed as minor or otherwise not investigated. The database will be updated as and when necessary, detailing actions taken and conclusions reached. The FLO and CFPS have access to this information and the Director of Operations will be kept apprised of progress. CFPS will, on PHA's behalf advise any 3rd parties as deemed necessary e.g. PSNI, NIAO.

The Director of Finance will ensure that any significant matters are reported to the Chief Executive, Director of Operations, DOH and the confidential section of the PHA Board as appropriate.

Where the loss may exceed the delegated limit of £10,000 (or such lower limit as the PHA may determine) or where the incident may lead to adverse publicity the Director of Finance will consult the Chief Executive. Weaknesses in Internal Controls should be corrected as soon as possible.

Progress reports will be produced by the FLO for the Governance and Audit Committee on a regular basis.

5.2.4 Step 4 – Discussion and Agreement On Way Forward

The FLO will co-ordinate and advise appropriate personnel on next steps in conjunction with CFPS.

5.2.5 Step 5 - Three possible routes of investigation and outcome:

(i) No action necessary, FLO will update database, close case and there will be no referral to CFPS;

(ii) Referral to the Assistant Director of CFPS who will appoint an investigator;

(iii) Further internal investigation required – this may lead to no action or a CFPS investigation.

Further details on each of these outcomes are contained in 5.2.6 below

5.2.6 Step 6 – Counter Fraud & Probity Service Investigation

Has a criminal act taken place?

In some cases this question may be asked more than once during an investigation. The answer to the question determines if there is to be a fraud investigation (or other criminal investigation). In practice it may not be obvious if a criminal act has taken place. There will be close liaison between CFPS (BSO) and the FLO along with other senior PHA staff who will agree the best course of action based on all relevant evidence.

Outcomes

(i) Criminal act has taken place and case is referred to PSNI, see below for further details;

(ii) No continuation of the criminal investigation but further internal investigation, disciplinary procedures, referral to professional body and/or a civil action may be necessary, see below for further details;

(iii) No action necessary and CFPS will advise the Fraud Liaison Officer to formally close Fraud Case.

Please also note that elements of (i) and (ii) above could be taken forward in parallel.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

Referral to Outside Agency (ref 5.2.6 (i) above)

After review of evidence CFPS may need to refer the case to an outside body, e.g. PSNI. This may result in a lengthy process. The FLO will continue to update the Regional Fraud Database and the PHA based on information provided by CFPS (BSO). The outcome from these investigations will either be:

(i) Criminal Prosecution; or

(ii) Case closed – no further action by the outside agency. This may however lead to further internal investigations (refer back to paragraph 5.2.6(ii) for next steps).

If appropriate the FLO will close the case on the Regional Fraud database recording a full description of findings or sentencing and loss and recovery as necessary.

Investigate internally (ref 5.2.6 (ii) above)

If it appears a criminal act has not taken place CFPS will hand the case back to the FLO, the next step may involve an internal investigation to determine the facts, what if any disciplinary action is needed, what can be done to recover a loss e.g. through a civil action and what may need to be done to improve the internal control framework, if appropriate, to prevent the event from happening again.

Outcomes

It may be appropriate to initiate disciplinary procedures, or refer to a professional body and if this is the case these should only be carried out on the advice and guidance from the Director of Human Resources (BSO) for PHA staff issues, or the Directorate of Legal Services where appropriate.

Civil actions should only be considered after receiving advice and support from the Directorate of Legal Services.

The outcome of these processes will be monitored and recorded by the Fraud Liaison officer as appropriate.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

Please note that disciplinary and referral to professional bodies can run in parallel, but care is taken not to prejudice any criminal case.

5.2.7 Step 7 - Resultant Loss

If a loss has occurred it should be reported in the Annual Financial Statements and the Director of Finance shall provide advice to the PHA on the appropriate actions to be taken to recover the loss taking into account circular HSS (F) 36/98.

This circular sets out delegated limits for approving the write off of losses and special payments. Losses as a result of fraud and theft over £10,000 require the approval of the DOH before they can be written off.

5.2.8 Final Recording by Fraud Liaison Officer

When all processes have been concluded, the FLO will record all outcomes on the Regional CFPS database and update the Director of Operations and the Governance and Audit committee.

5.2.9 Lessons learned

The responsible officer for the area under review should identify if there are lessons to be learnt and any required changes in the control environment. The appropriate Director and the FLO should be notified to ensure prompt implementation.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

5.3 Commentary on Flowchart Items – Appendix 3

Guidance for PHA staff on gathering initial evidence (Pre referral to the Fraud Liaison Officer and CFPS)

At time of first report by employee the following steps should be taken by a Manager if a fraudulent act is believed to have taken place. The Fraud Liaison Officer will assist managers at each stage if further information or support is required.

5.3.1 Step 1 - Physical evidence

If there is any physical evidence this should be seized by the employee or Manager, if possible. It is essential that this is held securely and a record is kept of the time and place they were taken.

5.3.2 Step 2 - Collection of evidence

If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record.

5.3.3 Steps 3 – 5 Witnesses

Events should be discussed with the witness if appropriate and a complete record kept of any discussions.

5.3.4 Step 6 - Reporting suspicions

Promptly contact the FLO and provide all evidence, care should be taken regarding discussing suspicions with anyone else. The FLO will advise of any actions to be taken and may arrange a case conference with CFPS (BSO).

The FLO will keep the Director of Operations and the Governance and Audit Committee (and others as appropriate) up to date until the case is concluded.

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

5.3.5 Step 7 - Further Action

Further action will be discussed and agreed with Director of Finance (HSCB), Fraud Liaison Officer, Director of Operations, Chief Executive and others as necessary.

6.0 LEGAL REDRESS AFTER CFPS (BSO) INVESTIGATION.

Criminal law may impose sanctions on the defendant for causing loss, while Civil law may assist the PHA to recover its loss. Guidance should be sought from the Directorate of Legal Services (BSO) in conjunction with the FLO and CFPS.

7.0 THE BRIBERY ACT 2010

If any employee holds reasonable suspicions of an act of Bribery they should report their suspicions immediately according to the Fraud Response plan and the procedures laid out in Appendices 2 & 3.

8. FURTHER GUIDANCE ON FRAUD

Employees of the PHA will be provided with regular awareness material to ensure that the PHA's anti-fraud culture is promoted.

HSC Public Health Agency

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

Appendix 1

CONTACT LIST

PUBLIC HEALTH AGENCY

Chief Executive
PHA
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553712

Director of Operations
PHA
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553940

Assistant Director Planning and Operational Services
PHA
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553605

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

BUSINESS SERVICES ORGANISATION

Director of Human Resources
BSO
2 Franklin Street
Belfast
BT2 8DQ

Tel: 02890 535626

Assistant Director Counter Fraud and Probity Services
BSO
2 Franklin Street
Belfast
BT2 8DQ

Tel: 02890 535574

HEALTH AND SOCIAL CARE BOARD

Director of Finance
HSCB
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553900

Assistant Director of Finance
HSCB
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553900

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

Fraud Liaison Officer/ Head Accountant
HSCB
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 02890 553926

Deputy Fraud Liaison Officer/Accountant
HSCB
12-22 Linenhall Street
Belfast
BT2 8BS

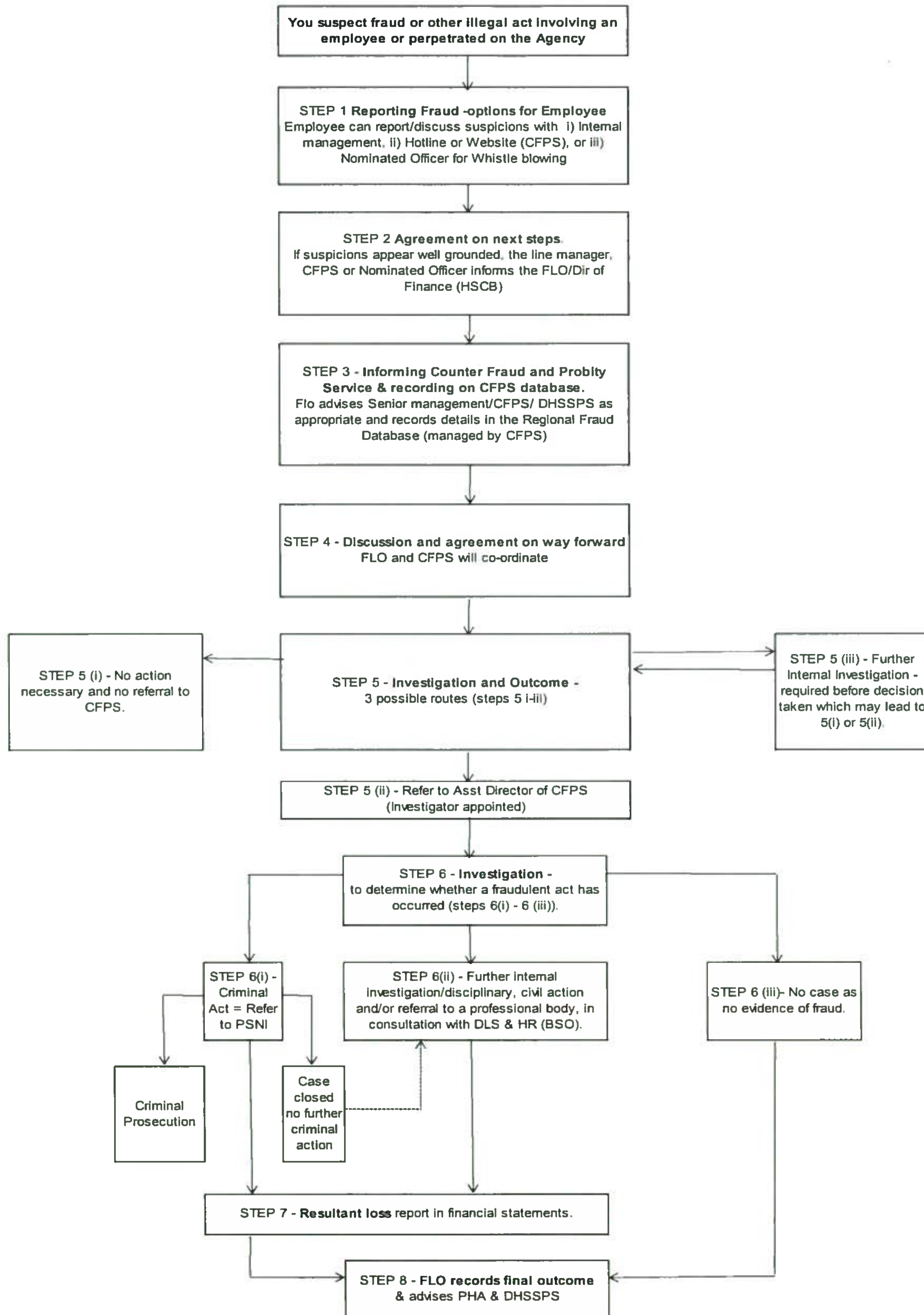
Tel: 02890 553926

Public Health Agency

FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

APPENDIX 2

REPORTING FRAUD - Overall summary from initial suspicion to CFPS outcome of investigation (reference section 5.2)

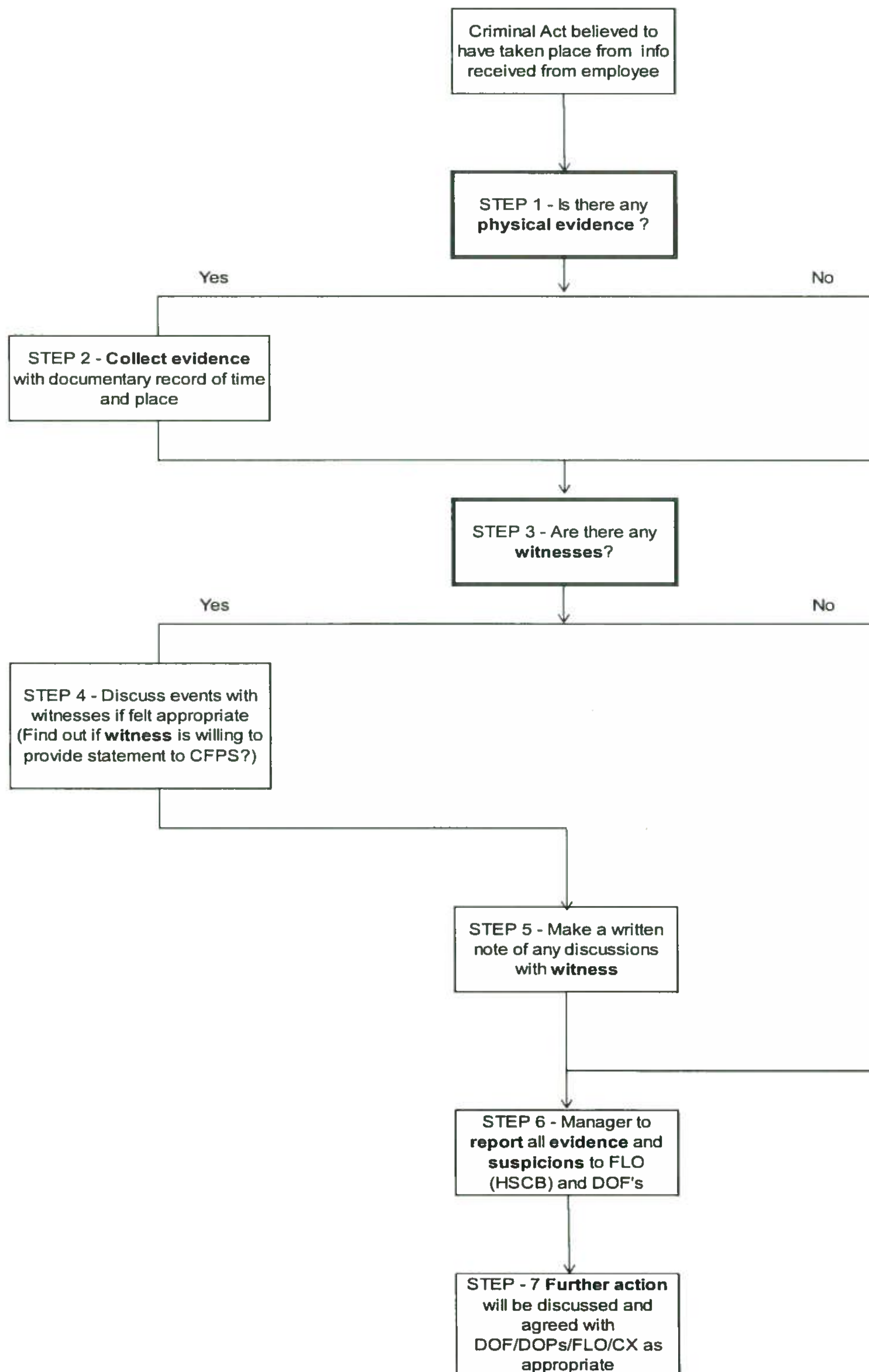


FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

APPENDIX 3

GATHERING EVIDENCE - Initial PHA investigation at time of first report by employee

(reference section 5.3)



FRAUD AND BRIBERY RESPONSE POLICY AND PLAN

GLOSSARY

BSO – Business Services Organisation

CFPS – Counter Fraud and Probity Service

DLS – Directorate of Legal Services (BSO)

DOF – Director of Finance (HSCB)

DOPs – Director of Operations (PHA)

HSC – Health and Social Care

HSCB – Health and Social Care Board

PHA – Public Health Organisation

DOH – Department of Health

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	20 October 2016
Title of Paper	Revision of Delegated Limits HSC(F) 52-2016
Agenda Item	7
Reference	PHA/03/10/16

Summary

Delegated limits for Health and Social Care (HSC) bodies were previously outlined in circular HSC(F) 67/2012 issued in 2012. Following the restructuring of the new Departments, the Department of Finance (DoF) has updated some of the delegated limits, and provided guidance on the revised arrangements for Departmental delegations.

Circular HSC(F) 52/2016, issued on the 15th September 2016, sets out the PHA's delegated authority to commit and incur expenditure. The main changes to the existing delegations are set out in the table below, the most notable being the introduction of a delegated limit for PHA R&D in relation to capital expenditure.

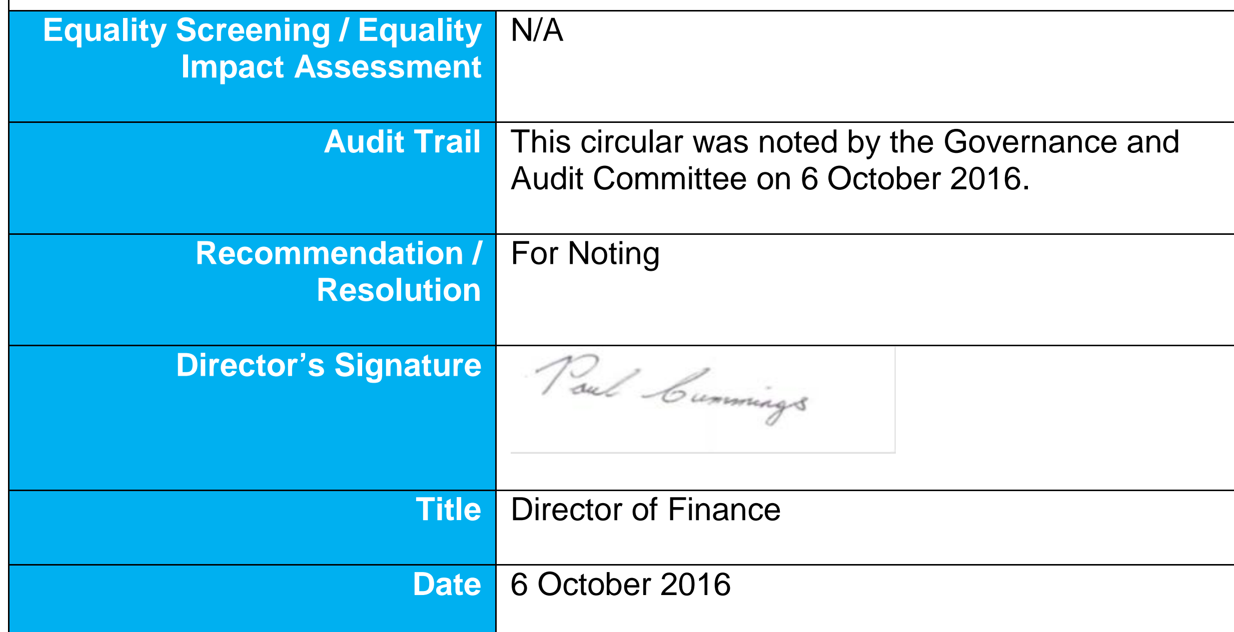
Area of Delegation	PHA Delegated Limit (New)	PHA Delegated Limit (Previous)	Increase
Capital Expenditure (excluding hospital schemes)	PHA - £50,000 PHA R&D - £1,500,000	£50,000 -	- £1,500,000
Gifts	£250	£100	£150
Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances	£1,000 (pay & allowances) £1,000 (pensions)	£1,000 (pay & allowances) £500 (pensions)	- £500 (pensions)

Ex-Gratia Financial Remedy Payments (i.e. those made to complainants through an organisation's internal complaints procedures/processes)	£500	£250	£250

All proposed expenditure which is set to exceed the PHA delegated limit must receive the appropriate prior approval from the DoH/DoF before committing to spend. The DoH have reiterated that any expenditure which falls outside the PHA's delegated authority levels and which has not been approved by DoH/DoF is deemed irregular and could result in qualified accounts and investigation by PAC.

In addition, all expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even it appears to offer value for money taken in isolation **must** have Departmental approval before expenditure is committed.

Having reviewing these changes, they will be formally included in the Standing Orders, Standing Financial Instructions and the Scheme of Delegated Authority at the next annual review, which is scheduled for the start of 2017. The minor change for Gifts and Hospitality has been communicated to the Operations Directorate for update within the policy.



Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This circular was noted by the Governance and Audit Committee on 6 October 2016.
Recommendation / Resolution	For Noting
Director's Signature	Paul Cummings
Title	Director of Finance
Date	6 October 2016

<table>
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Revised HSC & NIFRS Delegated Limits and requirements for Departmental / DoF approval

Circular Reference: HSC(F) 52-2016

Date of Issue: 15 September 2016</td></tr>
<tr><td>For Action by:

Chief Executives, Directors of Finance, Litigation Managers of all HSC Bodies and NIFRS

Summary of Contents:

This circular sets revised delegated limits for HSC bodies and NIFRS

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Financial Policy, Accountability and Counter Fraud Unit
Department of Health
Room D3, Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 9076 5689
DoH
fpau@health-ni.gov.uk</td><td>Related documents:

DAO(DFP) 06/2012

Superseded Documents:

HSC(F) 67/2012
HSC(F) 07/2016

Status of Contents:
For information and action

DoH website:

https://www.health-ni.gov.uk/</td></tr>
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Revision of HSC and NIFRS Delegated Limits and requirements for Departmental/ DoF approval

1. DoF has updated some of the delegated limits per (DAO (DPF) 06/12) providing guidance on the revised arrangements for Departmental delegations, following the restructuring of the new nine Departments, and the associated requirements for DoF approval. The revised DAO can be found at: https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodfp0612_revised%20280716_0.pdf . The principles of DAO (DFP) 06/12 still remain and reminds organisations of the guidance contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money and the requirement to ensure that the principles of appraisals are applied when expending resources. The relevant extracts are included at **Annex A**.

2. This circular sets out the delegations between DoH and Health and Social Care bodies and NIFRS and conveys delegated authority to commit and incur expenditure subject to the restrictions set out at table A below and per **Annex B and Annex C.**

3. The main changes to delegated limits are:
   - Capital Projects
     - DoH delegated limit excluding hospital schemes has increased from £1m to £2m
     - Trusts delegated limit, excluding hospital schemes, has increased from £500k to £1.5m
     - New delegated limit introduced for PHA lead Research and development of £1.5m
     - Trusts delegated limit for hospital schemes has also increased from £500k to £1.5m
   - Gifts has increased from £100 to £250 for all bodies;
   - Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes increased from £250 to £500;

- Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances ; Pensions from £500 to £1,000;
- Clinical negligence – delegated limit increased from £500k to £1m;
- Delegated limit for all leases for Office / warehouse / storage accommodation is nil for all bodies;
- DoH Delegated limit for EU Peace IV and In VA Programmes has increased from £2m to £5m. Delegated limits for all bodies remains NIL;

4. The table below summarises the main financial delegated limits where the Department has given delegated authority to HSC and NIFRS to spend within those limits. This must be read in conjunction with **Annex B** and **Annex C which contains a full list of delegations for which HSC bodies and NIFRS have NO delegated authority other than those listed below.**

5. All proposed expenditure which is set to exceed the HSC/NIFRS delegated limit must receive the appropriate prior approval before commitment to spend.

TABLE A

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
Use of External Consultants	HSC Bodies - £10,000 NIFRS - £10,000	£75,000
Capital Expenditure (excluding hospital schemes)	HSC Board &Trusts - £1,500,000 BSO £250,000	£2,000,000
	PHA - £50,000	
	PHA R&D - £1,500,000	
	NIBTS - £200,000	
	Other HSC Bodies - £10,000	
	NIFRS - £250,000	
Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure	HSC Board &Trusts - £1,500,000 BSO - £250,000 PHA - £50,000 NIBTS - £200,000 Other HSC Bodies - £10,000	£5,000,000
IT Projects	HSC Board; Trusts; BSO; PHA; £250,000	£1,000,000

Area of Delegation	**HSC/NIFRS Delegated Limit**	**DoH Delegated Limit**
	NIBTS - £200,000 NIMDTA - £20,000 Other HSC Bodies - £10,000 NIFRS - £250,000	
Gifts	£250	£250
Losses – write off of cash losses and cash equivalents, bookkeeping losses, exchange rate fluctuations, fruitless payments and constructive losses, property in stores or in use due to any deliberate act	HSC Bodies £10,000 NIFRS - £1,000	n/a*
Losses -. The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI	All HSC Bodies and NIFRS - Nil**	Nil**
Losses - Waived of Abandoned claims	HSC Bodies £10,000 NIFRS - £1,000	£100,000
Special payments / Ex-Gratia Payments	All HSC Bodies - £10,000 NIFRS - £1,000	£100,000
Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances	All HSC Bodies and NIFRS - £1,000 (pay & allowances) £1,000 (pensions)	£20,000
Overpayments - Foregoing the recoupment of overpayments of grants	All HSC Bodies and NIFRS - Nil**	Nil**
Special severance payments	All HSC Bodies and NIFRS - Nil**	Nil**
Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes)	All HSC Bodies and NIFRS - £500	£500
Ex-Gratia Payments to be made as a result of a recommendation from the NI Public Services Ombudsman	All HSC Bodies - £10,000 NIFRS - £1,000	£50,000
Compensation payments for Clinical Negligence (to include interim payments if overall settlement is expected to exceed delegated limits) To include agreement of Periodic Payment Orders (PPOs)	HSC Bodies £1.000,000 NIFRS n/a	£2,000,000
Compensation payments following legal advice (This would include all personal injury and public liability claims)	HSC Bodies - £25,000 NIFRS - £1,000	£100,000
Compensation payments without legal advice	All HSC Bodies and NIFRS - Nil	£10,000
Extra-Statutory and Extra-Regulatory payments	All HSC Bodies and NIFRS - Nil	£100,000

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
Confidentiality Agreements	Nil	Nil
Grants: Revenue Capital	All HSC Bodies and NIFRS £500k per annum £200k in total	 £500k per annum £200k in total
Leases for office accommodation/ warehousing / storage	- All HSC Bodies and NIFRS Nil	Nil
Pay remits	All HSC Bodies and NIFRS Nil	Nil
Revenue Business cases	NIFRS - £250,000 All other HSC Bodies – fully delegated	Nil

* DoH has full delegated authority

** Prior DoH and DoF approval required in all cases

6. It is mandatory for HSC bodies and NIFRS to obtain prior Departmental approval for expenditure above those limits outlined above and per Annex B & C attached. Failure to obtain the required DoF approvals will result in regularity and propriety issues. Any expenditure which falls outside a Department's delegated authority and which has not been approved by DoF is deemed irregular and could result in qualified accounts and investigation by PAC.

7. Where expenditure proposals exceed the Department's delegated limits, DoF Supply will act as the approving authority.

8. All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation **must** have Departmental and DoF approval before expenditure is committed.

Further Guidance

9. For further details on these categories of expenditure, including approvals procedures, HSC Bodies and NIFRS should refer to Managing Public Money

Northern Ireland[1] and NIGEAE[2], as well as current Departmental finance guidance on:

- The use of professional services (including consultants)
- Losses and special payments
- Claims handling (including clinical negligence and personal injury litigation)
- Fraud
- Capital

Process for approval of expenditure

10. Any payments / expenditure that require Departmental approval must be submitted through Financial Policy and Accountability Unit, who will act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted. This is to ensure that appropriate Departmental approvals have been obtained and that regularity, propriety and VFM have been adhered to.

11. It has been agreed that the Infrastructure Investment Director will be the contact point for all such submissions concerning capital.

Should you have any queries please contact the following

Paula Shearer 02890 765689
Sharon Allen (Capital) 02890 523169

Action Required

12. HSC Bodies and NIFRS to note the requirements to obtain prior Departmental approval before committing expenditure outside the delegations conveyed by this letter. This circular should therefore be circulated as appropriate

[1] https://www.finance-ni.gov.uk/articles/managing-public-money-ni-mpmni
[2] https://www.finance-ni.gov.uk/topics/finance/northern-ireland-guide-expenditure-appraisal-and-evaluation-nigeae

throughout your organisation, and schemes of delegation revised and updated accordingly.

Yours sincerely

PAULA SHEARER
Financial Policy, Accountability and Counter Fraud Unit

Annex A

Extract from revised DAO (DFP) 06/2012

Expenditure Appraisal and Evaluation

1. FD(DFP) 20/09 draws departments' attention to the Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), which contains DoF's core guidance on the appraisal, evaluation, approval and management of policies, programmes and projects. The principles of appraisal should be applied, with <u>proportionate</u> effort, to every proposal for spending or saving public money, or proportionate changes in the use of public sector resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

    - involve capital or current spending, or both;
    - are large or small;
    - are above or below delegated limits.

2. Appraisal is a systematic process for examining alternative uses of resources. It is designed to assist in defining problems and finding the solutions which offer the best value for money. It is a way of thinking expenditure proposals through, right from the emergence of the need for a project through its implementation, to post-project evaluation. It is the established vehicle for planning and approving projects and other expenditures. Good appraisal leads to better decisions and use of resources. It facilitates good project management and project evaluation. Appraisal is not optional; it is an essential part of good financial management, which is vital to decision-making and crucial to accountability. But it must also be proportionate.

3. It is important to begin applying appraisal early in the gestation of any proposal which has expenditure or resource implications. The justification for incurring any expenditure at all should be considered. Appraisal should be applied from the emergence of a need right through to the recommendation of the most

cost-effective course of action. It should not be regarded merely as the means to refine the details of a predetermined option.

4. It should be noted that delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

Implementation of delegated authority

5. This DAO restates a number of working arrangements which are intended to facilitate the efficient implementation of delegated authority and the achievement of accountability and value for money. They are part of the internal controls of a department and should facilitate an Accounting Officer in signing the Governance Statement.

Management Arrangements

i. Departments should nominate a senior official, preferably the Departmental Finance Director, to assist in the discharge of all aspects of the delegation arrangements within the department. This official should act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted, unless alternative arrangements are agreed with DoF. Departments should inform DoF of the name and job title of this point of contact and notify DoF of any subsequent change.

ii. Expenditure above delegated limits generally requires specific DoF approval. The normal procedure for seeking DoF approval is to submit a suitable business case to the appropriate DoF Supply Division in accordance with the guidance in NIGEAE.

iii. All cases presented to DoF for approval must confirm that the department is content with the regularity, propriety and value for money

of the project and the project has the necessary approvals within the departmental Accounting Officer's delegated arrangements. Where it is clear to DoF that a case has been submitted without proper departmental approval procedures being followed, the case will be returned without consideration.

iv. It should be noted that where DoF approval is required, expenditure should not be committed until DoF approval has been granted. Where DoF's approval has not been sought, DoF will not generally grant retrospective approval where the relevant expenditure has already been committed or the works have commenced.

v. The practice of consulting DoF informally during the course of development of a project is strongly encouraged, particularly where the project is deemed to be complicated, novel or contentious. However, such informed consultation does not remove the need for a department to formally submit the project for DoF approval if that is required. DoF will not confirm its formal view of any proposal unless the department has provided confirmation of its Accounting Officer's view (under the responsibility of the Accounting Officer) on the regularity, propriety and value for money of the relevant proposed expenditure.

Appraisals and Post Project Evaluations

vi. All departments should ensure that their operating procedures and guidance on conducting economic appraisals comply with NIGEAE, are recorded in a Finance Manual, that this Manual is kept updated regularly, and that those who are involved in the economic appraisal process have access to it.

vii. The Departmental Finance Director should ensure that commensurate Post Project Evaluations (PPEs) are completed in accordance with the principles set out in NIGEAE that lessons learnt are shared within the department (and, where appropriate, with other departments). A copy of the PPE should be forwarded to DoF Supply if it formed a condition of

the approval. Departmental Finance Manuals should ensure that appropriate procedures are established for PPEs.

Review of Processes

viii. Each department should carry out an annual review (independent of the spending areas) of the processes in relation to the appraisal of cases and PPEs that fall within its delegated limits, to ensure that the proper processes are being followed and the delegation limits set out in this DAO adhered to. If a department has evidence-based confidence in its internal controls, it may decide to implement a cycle of reviews, taking a different part of the department each year.

Review of Economic Appraisals/PPEs

ix. In addition to the annual review of processes described at (viii) above, departments should conduct ad hoc 'test drilling' of economic appraisals and PPEs that fall (a) within their delegated limits and (b) within the delegated limits given to their sponsored bodies, to ensure that the appropriate appraisal standards have been applied in accordance with NIGEAE guidance and that decisions have been taken on a proper basis. The review should be undertaken independent of the spending area. A department may undertake a cycle of reviews concentrating on the higher risk areas. A report of the findings of the examination of individual cases should be provided by departments to the Departmental Accounting Officer and to DoF Supply on an annual basis, by 30 June each year. This should provide further assurance to the Departmental Accounting Officer in signing off the Annual Governance Statement.

x. Departments should submit to DoF Supply a list of all appraisals above the level agreed with their Supply Officer. Supply may request a sample of those cases for review, to confirm the effectiveness of departments' control systems (in line with the criteria in MPMNI A.2.3.8). Any

necessary corrective action identified should be implemented within an agreed timescale.

ANNEX B

AREAS REQUIRING DoF APPROVAL FOR ALL DEPARTMENTS

	Details	**Reference**
Where DoF approval (in writing) is required:		
Use of Resources		
1	Public statements which might imply a willingness on the part of the Executive to commit resources or incur expenditure beyond agreed levels	MPMNI Box A.2.3.A
2	Guarantees, indemnities or general statements/ letters of comfort which could create a contingent liability	MPMNI Box A.2.3.A
3	All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation	MPMNI Box A.2.3.A Box 2.3
4	Expenditure that could create pressures which could lead to a breach of: 1. Departmental Expenditure Limits (DELs); 2. resource limits or capital limits; or 3. Estimates provision.	MPMNI Box A.2.3.B
5	Expenditure that would entail contractual commitments to significant levels of spending in future years for which plans have not been set	MPMNI Box A.2.3.B
6	Legislation with financial implications as per guidance in MPMNI	MPMNI A.2.2.1
7	New services under the sole authority of the Budget Act	MPMNI A.2.5.15
8	Loans – on borrowing from the Northern Ireland Consolidated Fund for Contingencies	MPMNI A.2.5.9 MPMNI A.2.5.11
Accounting Officers		
9	Appointment of the permanent head of each central government department to be its Accounting Officer	MPMNI 3.2.1
10	Appointment of an Accounting Officer for a Trading Fund (TF)	Financial Provisions NI Order 1993 and MPMNI 3.2.2
Internal Management		
11	Gifts – Giving any individual gift in excess of £250. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.12.3
12	Insurance – Decision to purchase commercial insurance.	MPMNI 4.4.1 – 4.4.2

	Details	Reference
13	Losses – The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI Annex A.4
14	Losses - Waived or Abandoned claims above £100,000 and Special payments e.g. ex gratia over £100,000. To include the foregoing the recoupment of overpayments of pay, pensions and allowances over £20,000 and the recoupment of overpayments of grants. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.10.2 & Box A.4.10.A MPMNI A.4.11
15	Payments – Advance payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.5
16	Payments – Deferred payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.9
17	Payments - Special severance payments - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.13.9
18	Payments – Financial Remedy Payments over £500 (ie payments made to complainants through an organisations internal complaints procedures/processes) and payments over £50,000 to be made as a result of a recommendation from the Northern Ireland Public Services Ombudsman	MPMNI A.4.14.8
Funding		
19	Banking – Proposals to open an account outside the pool or any proposed changes to Banking Pool arrangements	MPMNI 5.8.2 MPMNI A.5.7.3 MPMNI Box A.5.7.B
20	Banking – Requests for indemnities that commercial banks may seek to replace their normal arrangements	MPMNI Box A.5.7B
21	Borrowing from the Private Sector for all Arms Length Bodies (ALBs)	MPMNI 5.7.1
22	Borrowing on terms more costly than those usually available to government	MPMNI A.5.6.11
23	Borrowing – foreign borrowing	MPMNI A.5.6.12
24	Foreign Currency - Any proposals to negotiate contracts in foreign currencies other than the euro, yen or US dollar	MPMNI A.5.7.13
25	Income - Use of income and cash by departments to meet expenditure needs if there is no specific legislation	MPMNI A.5.3.1 MPMNI A.5.3.5
26	Income & Receipts - Increases to the amount that can be treated as an accruing resource	MPMNI A.5.3.8 MPMNI A.5.3.9

	Details	Reference
	during a financial year in order to finance a comparable increase in expenditure as per in-year monitoring/budgeting guidance	
27	Liabilities – Departments seeking statutory authority to accept liabilities	MPMNI A.5.5.5
28	Liabilities – Assuming statutory liabilities including the liabilities of any sponsored bodies in excess of £1 million for any single transaction	MPMNI A.5.5.14
29	Liabilities – Reporting non-statutory, where required, to the Assembly	MPMNI A.5.5.23
30	Liabilities – Reporting a contingent liability in confidence by writing to the Chair of the PAC	MPMNI A.5.5.28
31	Liabilities – Departments should consult DoF about reporting a liability during recess and outside Assembly sessions during a dissolution	MPMNI A.5.5.30 MPMNI A.5.5.34
32	Loans – proposals to make voted loans and premature repayment	MPMNI 5.6.1 MPMNI A.5.6.2
Fees, Charges and Levies		
33	Charges - Primary legislation to empower charging	MPMNI 6.2.1
34	Charges - Restructuring charges using the Fees and Charges (NI) Order 1988 No. 929 (N.I.8) in line with guidance in MPMNI	MPMNI Box 6.2
35	Charges - Public sector supplier moving away from full cost charging	MPMNI A.6.4.8
36	Interdepartmental Transactions – where the transaction may require legislative procedures or where DoF agreement is required under statute	MPMNI A.6.6.3
Working with Others		
37	Agency framework documents and the methods of financing an agency	MPMNI 7.4.2 & Box 7.2
38	All Management Statements and Financial Memorandums (MSFM) or other relationship documents	MPMNI 7.7.6
39	The establishment or termination of an NDPB	Public Bodies: A Guide for NI Departments
40	The establishment and operation of a Trading Fund including sources of capital	Financial Provisions NI Order 1993 and MPMNI A.6.6.3, MPMNI 7.5.2, 7.5.4 & Box 7.3
41	Provision of funding by way of an Endowment Fund	A.5.1.10
42	Grants to Councils under the Local Government (Finance) Act (NI) 2011	Local Government (Finance) Act (NI) 2011
Other Delegations		
43	Wider market projects where the full annual cost or aggregated annual income from such	MPMNI A.7.6.6

	Details	Reference
	services exceeds, or is expected to exceed thresholds agreed by DoF	
44	Assets - Transfer or disposal of assets at less than market value.	
45	Assets – to appropriate any sums realised as a result of selling an asset above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
46	Assets – to allow an organisation to retain receipts arising from the sale of assets funded by grant or grant-in-aid above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
47	Compensation payments without legal advice - Individual compensation claims settled out of court over £10,000. - **Refer to Table A for HSC and NIFRS Delegation**	
48	Compensation payments following legal advice - Individual compensation claims settled out of court over £100,000 where the legal advice is that the department will not win the case if contested in court. - **Refer to Table A for HSC and NIFRS Delegation**	
49	Consultants – Expenditure on external consultancy projects over £75,000 Expenditure on external consultancy assignments co-funded by the Strategic Investment Board over £150k – **Refer to Table A for HSC and NIFRS Delegation**	FD(DOF)07/12 Minute to Principal Finance Officers dated 19 April 2004
50	Estimates – form and content of Main and Supplementary Estimates.	Supply Estimates in Northern Ireland – A Guidance Manual
51	Virement	Supply Estimates in Northern Ireland – A Guidance Manual
52	Fraud – any departure from immediate reporting (not including National Fraud Initiative (NFI) for which separate arrangements have been agreed	FD(DFP) 02/13
53	IT projects over £1 million **Refer to Table A for HSC and NIFRS Delegation**	CONSIDER AGAINST AGILE
54	Capital Projects - All other expenditure on Capital Projects involving over £2million of Central Government expenditure unless other delegations specifically allow - **Refer to Table A for HSC and NIFRS Delegation**	
55	Projects - All PFI + 3PD projects at key stages as stipulated in NIGEAE	NI Guide to Expenditure Appraisal and Evaluation MPMNI A.7.5.4 FD(DFP) 20/09 FD(DFP) 17/11

	Details	Reference
56	Receipts – repayment of CFERs from the Northern Ireland Consolidated Fund	
57	Redundancy – All staff redundancy schemes not covered by existing regulations or which are more generous than existing NICS scheme.	
58	EU - All expenditure over £2 million under the EU Programmes for which the Special EU Programmes Body is responsible	Letter to Finance Directors & EUSG Members 2 March 2011
59	Pay Remits - **Refer to Table A for HSC and NIFRS Delegation**	FD Letter - Pay Remit Approval Process and Guidance
60	All leases for Office Accommodation (including supporting storage or warehousing) – both new and existing extension or renewal beyond break points. Excluding offices outside Northern Ireland - **Refer to Table A for HSC and NIFRS Delegation**	Letter to Accounting Officers 28 July 2014

Annex C

Specific DEPARTMENT OF HEALTH delegations

Ref number	Details	**Reference**
Where DFP approval (in writing) is required:		
1	Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure over £5m. **Refer to Table A for HSC and NIFRS Delegation**	
2	Third Party Development schemes for health and social care/ service provision.	
3	All grants/awards to the Voluntary and Community Sector: Revenue Grants £500,000 per annum Capital Grants £200,000 - **Refer to Table A for HSC and NIFRS Delegation**	
4	Medical/Clinical Negligence settlements over £2m. - **Refer to Table A for HSC and NIFRS Delegation**	
5	Staff redundancy schemes.	
6	Provisions concerning appointment of officers.	Fire Services (NI) Order 1984
7	Doctors Qualifications.	HPSS Order 1972 Article 107(6)
8	Doctors Rights/Working Conditions.	HPSS Order 1972 Article 107(6)
9	Requirement to maintain list of Doctors/Dentists by Boards/Departments.	HPSS Order 1972 Article 107(6)
10	Terms of Service for Medical Professionals.	HPSS Order 1972 Article 107(6)
11	Prescription Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
12	Optical Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
13	Dental Charges.	HPSS Order 1972 Article 98 (2) Schedule 15

Public Health Agency

MINUTES

Minutes of the Governance and Audit Committee
held on 3 June 2016, 10:00 am
CR4, 2nd floor, 12-22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mr Brian Coulter	Chair
Mr Leslie Drew	Non-Executive Director
Ms Deepa Mann-Kler	Non-Executive Director

IN ATTENDANCE:

Dr Eddie Rooney	Chief Executive, PHA
Mr Edmond McClean	Director of Operations, PHA
Miss Rosemary Taylor	AD Planning & Operational Services, PHA
Mr Paul Cummings	Director of Finance, HSCB
Mr Simon Christie	AD Finance, HSCB
Mrs Tracey McCaig	Head Accountant, HSCB
Mrs Catherine McKeown	Internal Audit, BSO
Mr Brian O'Neill	NI Audit Office
Ms Christine Hagan	ASM
Mrs Michelle Tennyson	AD AHP/PPI
Ms Patricia McStay	LSA Midwifery Officer *(For Item 12)*

APOLOGIES:

Mr Thomas Mahaffy	Non-Executive Director

33/16	**Item 1 – Welcome and Apologies**	**Action**
	The Chair welcomed everyone to the meeting and introduced Ms Deepa Mann-Kler and advised that Ms Mann-Kler would be replacing Alderman Paul Porter on this committee. The Chair recorded his thanks on behalf of GAC to Alderman Porter for his diligent and enthusiast contributions to this committee since 2012.	
34/16	**Item 2 - Declaration of Interests**	
	The Chair asked if anyone had any interests to declare relevant to any items on the agenda. No interests were declared.	
35/16	**Item 3 - Chair's Business**	
	The Chair conveyed his thanks to Mr Leslie Drew for chairing the last meeting of the GAC.	

36/16 **Item 4 - Notes of previous Meeting – 11 April 2016**

The minutes of the previous meeting, held on 11 April 2016, were approved.

37/16 **Item 5 - Matters Arising**

23/6: Assurance Framework 2015-17
Mr McClean advised that the diagrammatic summary of the framework was being prepared.

38/16 24/16: Local Supervisory Authority Nursing and Allied Health
Item 14 on agenda.

39/16 29/16: GAC Annual Report
A copy of the GAC Annual Report for 2015/16, amended to take account of comments at the previous meeting, was tabled. Members were content with the additional penultimate paragraph, and the Report will now go to the next PHA board meeting.

40/16 **Item 6 - Internal Audit Shared Service Update**

Mrs McKeown advised that five reports, relating to BSO Shared Services, had been finalised since the last meeting of the GAC. She focused on two reports, Recruitment Shared Services which was provided with an unacceptable level of assurance and Payroll Shared Services which was provided with a limited level of assurance.

41/16 Recruitment Shared Services

Mrs McKeown advised that an unacceptable level of assurance had been awarded and that there were 7 priority 1 findings:

- ERec System Issues
- Standard Operating Procedures
- Performance Management
- Managing Customer Queries
- Information Governance
- User Access Rights
- Customer Issues and Complaints

Mr Drew questioned the testing of software before implementation and asked why these issues had not been identified before the

system went live. In response to this question Mr Cummings said that the software had been purchased with limited resources and has proved to be inappropriate to meet the needs of the HSC organisations.

Mr Coulter advised that whilst this was not the primary responsibility of the PHA, it did raise questions as to what risks it would expose the PHA.

Ms Mann-Kler stated that an unacceptable level of assurance was a major concern and she asked for clarity on the impact on the PHA and questioned the levels of assurance. Mr Cummings replied that the risk for the PHA was less significant than for other HSC organisations including the HSCB.

Members **noted** the report.

42/16 Payroll Shared Service

Mrs McKeown summarised the report and advised it had received a limited level of assurance with 6 priority 1 findings:

- Management of Overpayments
- Authorisation of Manual Payments
- Maternity Payments
- Variance monitoring
- Pensions
- System Access Controls

Members raised their concerns on the priority 1 findings in the report. Ms Mann-Kler noted that there were strong governance issues which needed to be addressed and resolved.

Mr Drew said there was a risk of reputational damage to the organisation unless urgent action was taken to address the implementation of the recommendations. Mr Christie replied that this had already been an issue for the HSC Trusts.
Mr Cummings also raised his concern that earlier findings had not been addressed within timescales and that limited assurance for two consecutive financial years was unacceptable. He suggested that the Chair of the BSO Audit Committee be contacted to seek their views on the findings as this issue will be raised at the next PHA board meeting.

Dr Rooney advised that he plans to meet with the Chief Executive BSO and it was noted that the BSO Action Plan to address identified deficiencies will form part of the agenda.

- Dr Rooney to share the aforesaid BSO Action Plan together with his observations arising from his meeting with the BSO CEO with the GAC.
- BSO CEO be invited to attend the next GAC meeting to report on progress on the shared services deficiencies.
- Letter of concern be sent to the Chair BSO GAC.

Members **noted** the report.

43/16 Item 7 - HIA Annual Report

Mrs McKeown presented the HIA Annual report and summarised the key points to members. She advised that there was a satisfactory system of internal control to meet the organisations objectives.

Members **noted** the report.

44/16 Item 8 - Fraud Liaison Officer Update Report

Mr Cummings presented the report to members and advised that there were no new cases of suspected fraud reported since the last meeting. He added that the CFPS continued to investigate the two cases in the last report.

Ms Mann-Kler questioned the cost of the National Fraud Initiative (NFI) to the PHA. Mr Cummings advised that whilst the PHA did not benefit from this initiative, all HSC organisations were required by law to submit data to NFI on a regular basis.

Members **noted** the update.

45/16 Item 9 - Annual Report and Accounts incorporating Governance Statement and Letter of Representation

Mr Chrisite presented the PHA Annual Report and Accounts for the year ending 31 March 2016 including the Governance Statement to members and summarised the report to members for recommendation for PHA board approval.

Miss Taylor advised that two minor changes to the Governance Statement had been requested in respect of the placement of the External Audit section and to move 'Quality, Quantity and Financial Controls' from a resolved to a continuing control issue. Members agreed these changes.

Members recommended the annual report and the annual accounts including the governance statement (with the above amendments) to the PHA board for approval.

Mr McClean/ Mr Christie

46/16 Item 10 - External Auditor's Report To Those Charged With Governance (Draft)

Ms Hagan presented the draft report to those charged with Governance to members for noting and gave a verbal summary of the report advising that there were no substantive changes.

Members **noted** the report.

47/16 Item 11 - Annual meeting with Auditors (External and Internal) without officers present

Officers left the room for this part of the meeting.

Auditors present were asked about their view on the impact of the VES upon PHA. It was noted that External Audit is conducting an exercise across organisations on the impact of the VES and this will be reported upon once complete. GAC expressed the import of knowing how such an initiative comprised of a necessary degree of arbitrariness impacted upon PHA essential service delivery as noted in our Corporate Risk Register. Discussion took place around earlier expressed concerns regarding vulnerabilities arising from poor services from BSO with particular reference to the monopoly position of the latter. The positive response of PHA staff to the conduct and findings of audit in general was acknowledged as was the valued contribution of auditors.

48/16 Item 12 - Local Supervisory Authority Nursing and Allied Health Directorate (LSA) Update

The Chair welcomed Patricia McStay to the meeting. Ms McStay gave members a brief update on the recent Internal Audit Priority 2 finding regarding the safe practise and the system of internal control and the CPD hours recorded on the central LSA

	database. She said that there were 103 supervisors on the database and that 95 had recorded their CPD to date. She gave a brief overview of the reasons why the 8 remaining supervisors had yet to record their CPD. The Chair thanked Ms McStay for this update. Ms McStay left the meeting at 11.30 am.	
49/16	**Item 13 - Corporate Risk Register (at 31 March 2016)** Mr McClean presented the Corporate Risk Register (as at 31 March 2016) for approval. He confirmed that two new risks had been added: CR37: Organisation's Web Development and Maintenance Function and CR38: Review of Functions and Reorganisation. He also added that one risk had been removed from the register: CR25: PHA Belfast Accommodation. Mr McClean advised that there has been progress on the Web Development and Maintenance Function since this was added to the Risk Register. Members **approved** the Corporate Risk Register and recommended it to the PHA board for approval.	 **Mr McClean**
50/16	**Item 14 – Information Governance** <u>IG Update 2015/16 and Action Plan 2016/17</u> Miss Taylor presented the action plan to members for noting. Ms Mann-Kler asked about Third Party Contracts. Miss Taylor replied that clauses were included in contracts. Members **noted** the update and action plan.	
51/16	**Access to Information Policy** Miss Taylor presented the Access to Information Policy for approval. Members **approved** the Access to Information Policy and recommended it to the PHA board for approval.	 **Mr McClean**

52/16	**Data Breach Incident Policy** Miss Taylor presented the Data Breach Incident and asked members to approval the policy. Ms Mann-Kler asked if penetration testing had been carried out. Miss Taylor replied that generally BSO ITS were responsible for IT systems penetration testing working with PHA in respect of PHA websites. Members **approved** the Data Breach Incident Response Policy and recommended it to the PHA board for approval.	**Mr McClean**
53/16	**Item 15 - Single Tender Actions for Goods and Services Procurement 2015/16** Mr McClean presented the STA report and advised that there had been an overall reduction in the number of STAs submitted during the 2015/16 financial year. Members **noted** the report.	
54/16	**Item 16 - Audit Committee Self-Assessment Checklist** The Chair advised that the Self-Assessment had been reviewed and updated; there were however no significant changes from last year. Arising from discussion on NED induction Miss Taylor agreed to provide Ms Mann-Kler with relevant GAC documentation and to arrange for a briefing meeting for her. Members **approved** the Self-Assessment.	**Miss Taylor**
55/16	**Item 17 - SBNI Declaration of Assurance** Mr McClean presented the annual SBNI Declaration of Assurance as at 31 March 2016 to members for noting. Members **noted** the report.	

Public Health Agency

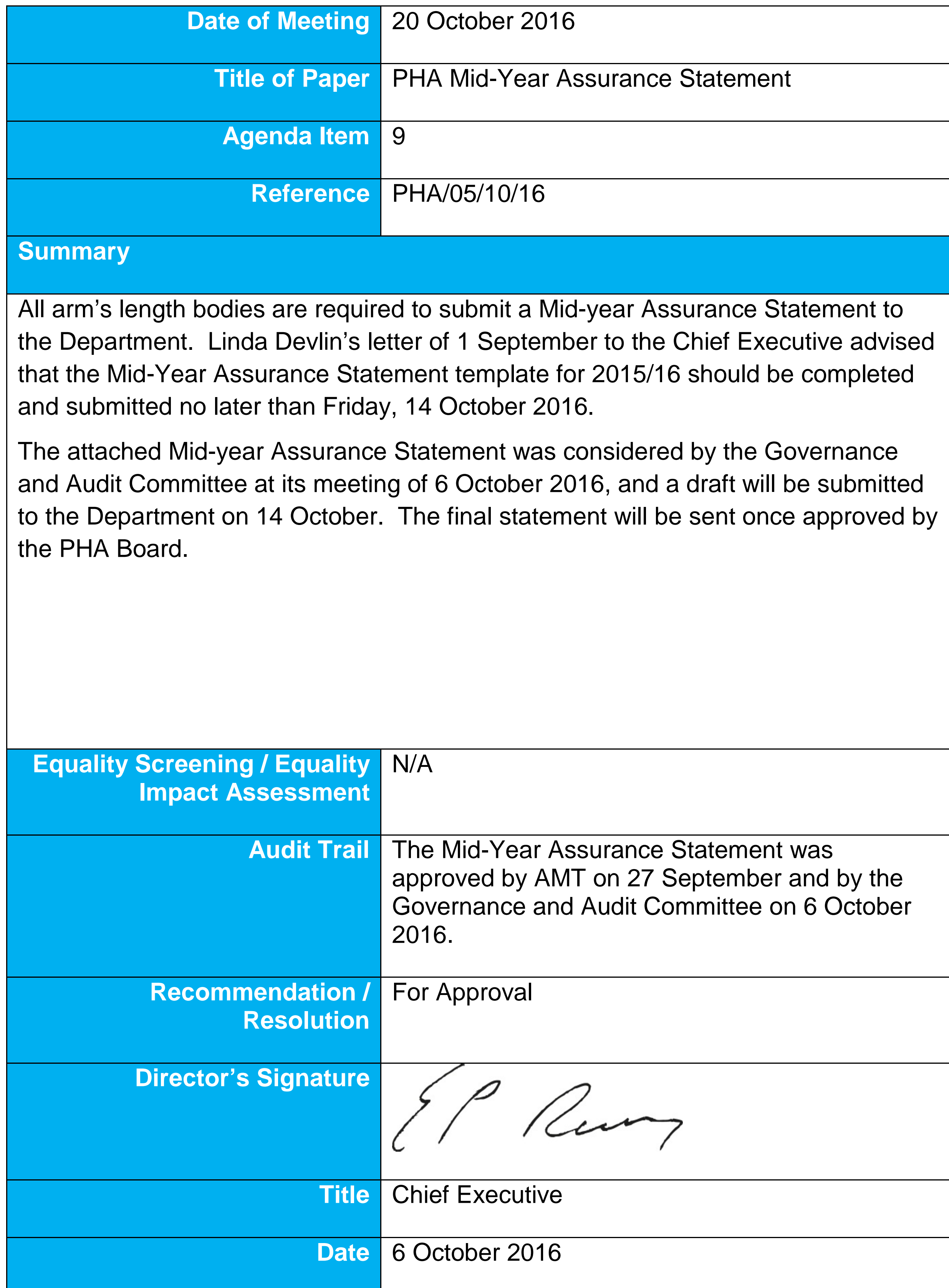
56/16	**Item 18 - Date of next meeting** 6 October 2016 at 10.00 am		

Signed **Brian Coulter**

Date **6 October 2016**

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	20 October 2016
Title of Paper	PHA Mid-Year Assurance Statement
Agenda Item	9
Reference	PHA/05/10/16
Summary	
All arm's length bodies are required to submit a Mid-year Assurance Statement to the Department. Linda Devlin's letter of 1 September to the Chief Executive advised that the Mid-Year Assurance Statement template for 2015/16 should be completed and submitted no later than Friday, 14 October 2016. The attached Mid-year Assurance Statement was considered by the Governance and Audit Committee at its meeting of 6 October 2016, and a draft will be submitted to the Department on 14 October. The final statement will be sent once approved by the PHA Board.	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Mid-Year Assurance Statement was approved by AMT on 27 September and by the Governance and Audit Committee on 6 October 2016.
Recommendation / Resolution	For Approval
Director's Signature	[signature]
Title	Chief Executive
Date	6 October 2016

PUBLIC HEALTH AGENCY MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the Public Health Agency as at 30 September 2016

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 16 June 2016. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Governance and Audit Committee and the Remuneration Committee have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board. Minutes of board meetings are available to further attest to this.

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Register is presented to the Governance and Audit Committee for discussion and approval and all significant risks are reported to the Board – most recently on 16 June 2016.

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set out in the organisation's business plan as approved by the Department.

5. Finance

I confirm that proper financial controls are in place to enable me to ensure value for money, propriety and regularity of expenditure under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

Adequacy and adherence to these controls are regularly reviewed through the completion of Controls Assurance assessments and by Internal and External Auditors. Any issues are detailed in sections 6-8.

6. Controls Assurance

I confirm implementation of action plans arising from the year-end self-assessments of compliance with Controls Assurance Standards.

7. External Audit Reports

There were no priority 1 or 2 recommendations made by the External Auditor in the 2015/16 Report to Those Charged with Governance.

8. Internal Audit

I confirm implementation of the majority of accepted recommendations made by internal audit.

Internal Audit carried out a full review of the recommendations from the 2015/16 internal audits and provided a detailed progress report to the Governance and Audit committee on 6 October 2016. A copy of this report is available if required. Of the 60 recommendations identified, 82% have been fully implemented and 18% partially implemented. Action is currently being taken to ensure the remaining recommendations are being fully implemented.

Two reports have been finalised for 2016/17:

The Management of Health and Social Well-being Improvement Contracts (including visits to voluntary organisations)	Satisfactory assurance for the management of contracts; Satisfactory assurance for 5 voluntary organisations; Limited assurance for one voluntary organisation.
The Centre for Connected Health and	Satisfactory assurance for control over

Social Care.	CCHSC; Limited assurance for corporate oversight and review of outcomes within CCHSC.

Management have accepted all recommendations made by the Internal Auditor and are progressing towards implementation; progress is regularly reviewed by the Governance and Audit Committee.

9. RQIA and Other Reports

The RQIA Review of the Diabetic Eye Screening programme was published in May 2015. A modernisation programme was established and action plan developed. Progress is being reported by PHA to DoH and is on track.

10. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

11. Board Governance Self Assessment Tool

I confirm completion of the Board Governance Self-Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

12. Internal Control Divergences

The following issues were recorded in the Governance Statement, and continue to be considered as Internal Control Divergences.

Quality, Quantity and Financial Controls

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these

services continues to increase and the budget available for commissioning them remains constrained, the actions taken by the PHA during 2015/16 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget.
The PHA is continuing to take appropriate actions and manage its budget to ensure the most effective service provision possible within budget constraints during 2016/17.

Business Services Transformation Project/Shared Services

The Payroll and Recruitment Shared Services, provided by the Business Services Organisation (BSO) continue to have outstanding priority 1 recommendations and had received limited and unacceptable assurances respectively from the Internal Auditor.

The Chief Executive of the BSO has advised that there is now a formal recovery plan in place for Recruitment and a quality improvement process for Payroll.
The recommendations in respect of Payroll are not considered significant for the PHA.

However, Recruitment recommendations, whilst having lesser impact directly for PHA, are also of concern regarding the wider HSC and the impact that this may be having on the timely recruitment of essential staff vacancies throughout the region.

At the mid-year follow up the Internal Auditor has advised that while progress has been made both shared services remain with limited assurance.

The PHA Governance and Audit Committee will continue to keep this under review.

Management of Contracts with the Community and Voluntary Sector

The 2016/17 Internal Audit report on the management of health and social wellbeing improvement contracts provided satisfactory assurance on the system of internal controls over PHA's procurement and management of health and social wellbeing contracts, reflecting the significant work that has been undertaken by the PHA.

However, while Internal Audit acknowledged the improving position, procurement of services continues to be a priority one finding. Further progress has now been made and at the end of March 2016 PHA had awarded 68 contracts with an annual value of £7.4m.

The PHA's Procurement Plan is a live document, and is continually revised to ensure that all contracts are included and the timelines set are achievable given the significant resources required to manage each Tender. Progress against the Procurement Plan is monitored by the PHA Procurement Board.

PHA also continues to work closely with BSO Procurement and Logistics Service (PALS) and Directorate of Legal Services (DLS) to develop appropriate social care procurement processes and documentation. This work is overseen by the PHA Procurement Board.

It is recognised however that social care procurement is a new area for the wider HSC, and the PHA continues to work closely with colleagues in HSCB, BSO, the HSC Trusts and the DOH, to develop and put in place appropriate and proportionate regional processes that meet the new procurement regulations.

Reduction in the PHA Management and Administration Budget

The 2015/16 management and administration allocation for the PHA was reduced by 15% (£2.8m). The reduction is recurrent and is part of the collective Departmental response to address the overall DOH funding gap. In order to meet this significant budget reduction, the PHA introduced a number of controls reducing goods and services expenditure, along with vacancy controls. However in order to achieve the savings required on a recurring basis it was necessary to avail of the Voluntary Exit Scheme (VES).

As the end dates of staff leaving under VES were phased in with effect from January 2016 through to June 2016, the full impact of these reductions will be felt during 2016/17. The loss of the knowledge and experience of the staff and of the posts, will have a significant impact on how the PHA undertakes its business during 2016/17. While the PHA is taking measures to ensure that core and essential work is maintained, it is likely that there will be an impact on some areas of work during 2016/17. The PHA continues to liaise with DOH to ensure that they are aware of the situation.

Additionally the PHA budget has been reduced by a further £1.6m or 10% of the management and administration budget for 2016/17. While in-year savings have been identified, the PHA continues to work to find a recurring source of funding.

The PHA will continue to work closely with the DOH in this regard.

Emergency Department (ED)

Performance against the 4-hour and 12-hour ED standards remains below the level required (95% of patients attending an ED are either treated and discharged home, or admitted, within four hours of their arrival; and no patient should wait longer than 12 hours).

Regionally during the period 1 April to 31 August 2016, there has been an increase in the number of patients who waited longer than 12 hours (1,573) compared with the same period last year (1,295). In particular, there has been an increase in the number of patients waiting longer than 12 hours in three of the five Trusts – Northern, Southern and Western Trusts. In contrast, there has been a reduction in the number of patients who waited longer than 12 hours in Belfast Trust – 340 in 2016/17 compared to 585 in 2015/16.

In relation to performance against the 4-hour standard, regionally during the first five months of 2016/17, 75% of patients were treated and discharged, or admitted within four hours compared with 77% during the same period in 2015/16.

Improving performance against the 4 and 12 hour standards remains a priority and work continues with HSC Trusts under the new regional unscheduled care arrangements, jointly led by the Health and Social Care Board (HSCB) and PHA, to take this work forward, and support Locality Network Groups to bring their resilience planning process for 2016/17 to a timely conclusion in advance of the winter period.

13. Mid-year assurance report from Chief Internal Auditor

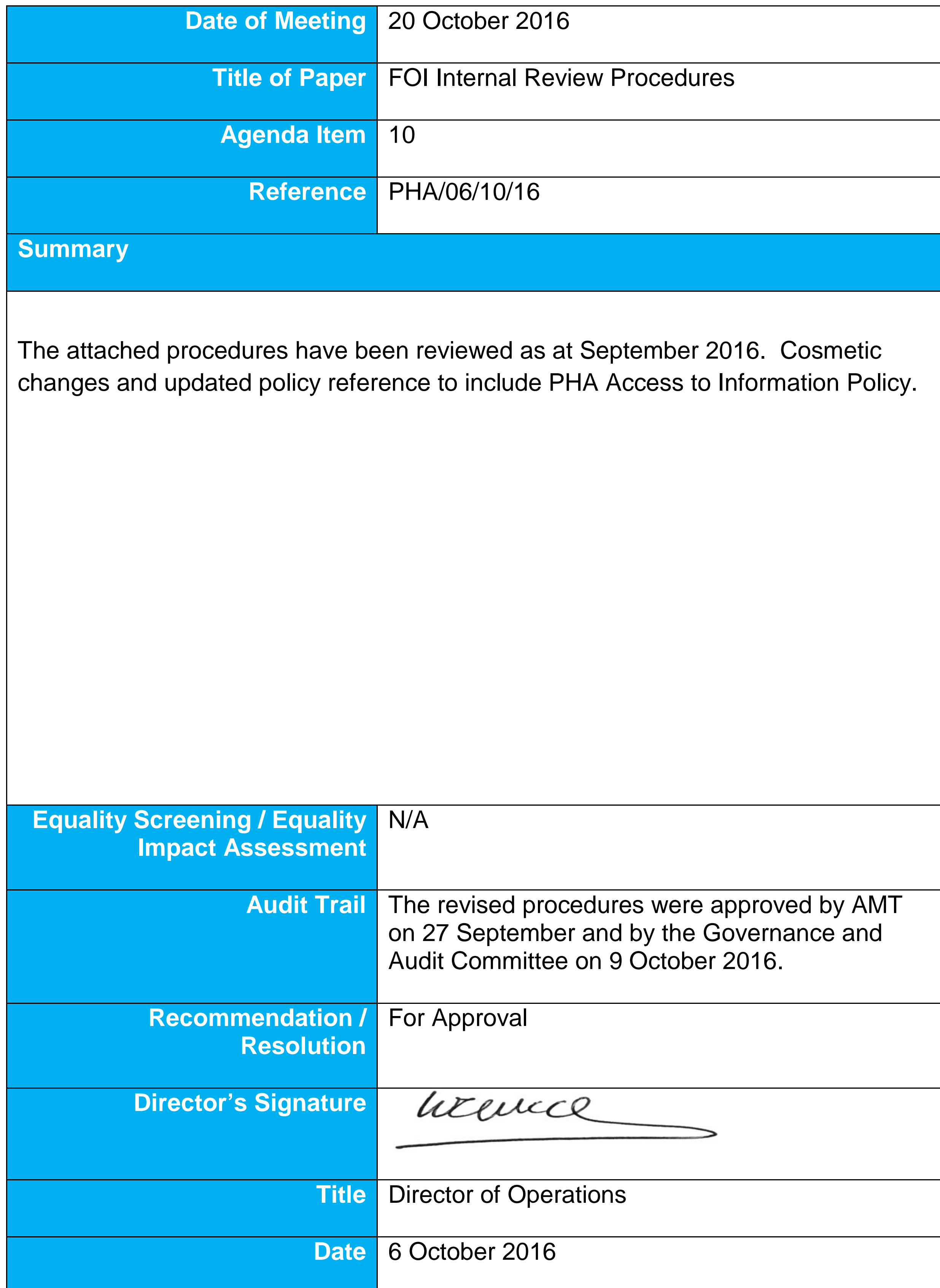
I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations e.g. Controls Assurance Action Plans and Risk Register Action Plans.

Signed *Date*

CHIEF EXECUTIVE & ACCOUNTING OFFICER

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	20 October 2016
Title of Paper	FOI Internal Review Procedures
Agenda Item	10
Reference	PHA/06/10/16
Summary	
The attached procedures have been reviewed as at September 2016. Cosmetic changes and updated policy reference to include PHA Access to Information Policy.	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The revised procedures were approved by AMT on 27 September and by the Governance and Audit Committee on 9 October 2016.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	6 October 2016

Public Health Agency

Freedom of Information Internal Review Procedures

Version	**3.0**
Approved by IGSG	**19/09/2016**
Approved by AMT	
Approved by GAC	
Approved by PHA Board	
Review Date	**31/03/2020**
Version 2 Approved by AMT/GAC	**19/11/2013 & 05/12/2013**

September 2016

1. Introduction

Section 45 Code of Practice of the Freedom of Information Act 2000 places a duty on all Public Authorities that fall within the scope of the Act to put in place procedures to deal with complaints received in relation to requests for access to information under the provisions set out in Freedom of Information Act 2000. This is to ensure that applicants have a first review stage in the event that they are unhappy with a Public Authorities decision on release of information, or the process by which that decision was reached.

Examples of potential complaints received:

- Applicant is unhappy that not all information sought has been released and an exemption has been applied
- Applicant is unhappy because their request took longer than the given 20 working days
- Applicant feels an exemption has been incorrectly applied
- Applicant feels that a fee is excessive or incorrectly applied

Application of this Procedure
This procedure is intended to outline the mechanisms through which complaints about the handling of information requests are to be processed and addressed within the Public Health Agency (PHA).

2. Definitions

Freedom of Information Request	Any request for information covered by the Freedom of Information Act 2000. This must be in writing, including email, and must clearly state what information is sought. It must also have a return address for correspondence. The requestor does not have to indicate that they are seeking the information under FOI legislation.
IGM	Information Governance Manager
Information Commissioner (ICO)	The regulator appointed by Parliament who enforces the provisions of information access legislation.

Review Panel	The panel of one or more suitably knowledgeable individuals who will assess the factors pertaining of any complaint that is covered by this procedure
Reviewer	An individual who was not involved in or privy to the decision-making process relating to the initial response sent to the requestor. Where it is reasonable and practicable, this person should be more senior to those involved in the initial decision.

3. Organisational Scope

This procedure is applicable to all business areas and units, all employees of the PHA and can be extended to include agents or contractors of the PHA whose information may on occasion fall within the scope of this Act. Failure to comply with this procedure may result in the PHA operating in breach of the law and exposing the organisation and individual employees to serious consequences, both financial, and other, imposed by the Information Commissioner or the Courts.

4. Context

This procedure applies to complaints received in relation to the handling of or release of information under the provisions of the Freedom of Information Act 2000 (FOI). However, this procedure can be applied to complaints received in relation to the handling of requests for information processed under the provisions of the Environmental Information Regulation 2004 (EIR).

4.1 General requests for access to information under the provisions of the Freedom of Information Act 2000.

4.1.1 The ‘Code of Practice on the Discharge of Public Authorities’ functions under Part 1 of the Freedom of

Information Act 2000', requires the PHA to have in place a process to allow applicants a right of request for an internal review of the way in which their information request was handled and processed by the PHA. It is therefore imperative that the PHA and its employees adhere to this internal review procedure and are fully aware of its contents.

4.1.2 Section 17(7)(a) of the Freedom of Information Act 2000 states that the existence of such an internal review procedure must be communicated to any individual whose information access request has been unsuccessful either in part of in full. In the event that information is withheld from an applicant, ether in part of in full, an explanation will be provided to the applicant, advising which if any of the exemptions are being applied, and information on what right of appeal the applicant has available to them.

4.1.3 Under Section 50 of the Act a person may apply to the Information Commissioner for a decision as to whether a request for information has not been dealt with in accordance with the requirements of the Act. In most cases, the Commissioner will ask to see evidence that the requestor has exhausted the internal review process afforded to them under section 45 of the Act with the Public Authority in question. It is therefore imperative that the PHA retain good quality records of any internal review for release to the Information Commissioner upon request at the second stage of an appeal.

4.2 Requests for access to Environmental Information (as defined in the Environmental Information Regulations 2004)

4.2.1 The 'Code of Practice on the discharge of the obligations of Public Authorities under the Environmental Information Regulations 2004' also requires Public Authorities such as the PHA to have a process to allow applicants a right of request for an internal review of the way in which their request for environmental information was handled and processed by the PHA. It is therefore imperative that the PHA and its employees adhere to this internal review procedure and are fully aware of its contents.

4.2.2 As with the provisions of the Freedom of information Act, the PHA must communicate this process to the requestor in the event that their request has been unsuccessful either in part or in full.

4.2.3 Once again, the requestor will in most cases, have to provide the Information Commissioner with evidence that they have exhausted the internal review process with the Public Authority before his office will consider the matter further.

4.3 Requests for Access to Personal Information (Subject Access Request under Section 7 of the Data Protection Act 1998)

4.3.1 The PHA is not required to have an internal review process in place in the event that a complaint is received in relation to the handling of, or response to a Subject Access Request. However, in the event that a complaint is received, this procedure may be used to address those concerns raised by the individual seeking access to personal information.

5 Procedure

5.1 Individuals who have submitted information access requests may be unhappy with the way in which the PHA has handled their request.

- Applicant is unhappy that not all information sought has been released and an exemption has been applied
- Applicant is unhappy because their request took longer than the given 20 working days
- Applicant feels an exemption has been incorrectly applied
- Applicant is unhappy that an exemption has been applied and no rational or explanation for this has been provided.
- Applicant feels that a fee is excessive or incorrectly applied.

It is important to be aware that the internal review process provides the Public Authority a second opportunity to consider a request for information, and to fully review how a previous decision was reached, through a full evaluation of the case. It is

important that once a determination has been reached in any internal review that lessons learned are fed through to those concerned, and remedial action is taken as and when required to ensure any failures in process are robustly addressed.

5.2 If a member of staff receives a specific, or implied complaint (i.e. any written communication, including one transmitted via email, expressing dissatisfaction with a PHA response to a request for information), from an individual who had previously received a response to a request for information, then the receiving officer should immediately contact the Information Governance Unit at the following address:

Information Governance Office
Public Health Agency
Tower Hill
Armagh
BT61 9DR

5.3 What happens once a complaint has been received

5.3.1 In all cases, complaints will be acknowledged by the Information Governance Unit. There is no timescale stipulated within the legislation for completing a review, however in all circumstances the PHA will endeavour to complete it within a reasonable timescale and communicate the outcome to the requestor. Should any significant delays be experienced, the requestor will be advised of this in writing by the Information Governance Unit and will be provided with a reason for the delay.

5.3.2 The Information Asset Owner will be notified and the Information Governance Manager or a designated deputy will request copies of all material connected with the processing of the request from the Nominated Information handler. All documentation is to be released to the IG Unit as failure to supply all material may result in an organisational failure to comply with the law, and severe sanction for those involved. The following statement has been directly extracted from the FOI Act.

Any person is guilty of an offence under the Freedom of Information Act, 'if he alters, defaces, blocks, erases, destroys or conceals any record held by the public authority, with the intention of preventing the disclosure by that authority of all, or any part, of the information to the communication of which the applicant would have been entitled'.

Timeliness is also key and a request for such information must be treated as an organisational priority and responded to as a matter of urgency by the Nominated Information handler.

5.3.3 All PHA employees and agents are expected to cooperate fully with any review being conducted under this Procedure and to provide full access to all relevant information, and to provide clarification on any matters required by the review panel.

5.3.4 Once all background information and all preparatory work has been completed by the IG Unit, a brief chronology and written summary will be prepared for consideration by the Review Panel. All key drivers pertaining to the outcome of the original decision will be included, and be available for inspection by the Review Panel. These papers will include the original request and subsequent correspondence with the requestor.

5.4 Make up of the Review Panel

5.4.1 Internal reviews will be conducted by a panel of one or more individuals who were not involved in the original process or privy to the decision making process in relation to the information that forms the focus of the complaint. Where at all reasonable, the Reviewer should not be the designated information 'owner'.

The Director of Operations, in consultation with the Information Governance Manager will appoint the Review Panel.

5.4.2 Review Panel members may, dependant on the complexity and nature of the information requested, be drawn from:

- Agency Management Team
- Non-Executive Directors
- SIRO
- Data Guardian
- Information Governance Unit
- Senior Managers

Panel members must bring any potential conflict of interest to the attention of the Information Governance Manager at the earliest opportunity in order that the integrity of the review and the Review Panel is not challenged and the outcome of process is open, transparent and robust.

5.5 How the Internal Review is Conducted

5.5.1 Internal reviews should not be overly bureaucratic in nature, but should be conducted as a fair and impartial review of previous decisions made during the initial consideration of whether to release or withhold information, either in part of in full.

5.5.2 The Review Panel will review the chronology, written summary of the facts and any supporting documentation. The review panel will also consider the entire information that has been requested, and look at what information, if any, has been released from that to the requestor, and the rationale/reasoning as to why other information has been withheld.

It is not the role of the Review Panel to ‘re-do’ the original exercise to determine whether they agree with the outcome.

The Review Panel will consider processes, for example

- Was an acknowledgement of receipt sent to the requestor within 3 working days

- Was the requestor informed at that time that the PHA held the information they sought
- Was the request responded to within 20 working days
- Was the requestor informed of the exemption upon which the PHA was relying
- If a Public Interest Test was applicable, was this carried out and did the arguments merit release or non release
- Was a fee applied and if so, was this excessive/incorrect
- Did the PHA negotiate with the requestor to reduce the size of the request
- Did the PHA provide ‘advice and assistance’ as is required by the Act
- Was the requestor provided with information informing them of their right to request an internal review of the initial decision
- Was the Review Panel convened within a reasonable time period from receipt of the complaint

With regard to the question of whether or not the information should or should not have been released, the Review Panel may wish to consider the following:

- Was the information exempt from release to the requestor
- If the information is exempt from release, was the correct exemption applied
- If an exemption was applied, was this satisfactorily explained to the requestor
- Could the PHA reasonably anonymise or otherwise manipulate the information so as to respond substantially to the request whilst still maintaining whatever sensitivity exists or existed with that information
- Could part of the information have been released to the requestor

5.5.3 Possible outcomes of an Internal Review

The above list at 5.5.2 is neither exhaustive nor does it restrict the Review Panel in its deliberations. The Review Panel may seek expert opinion in any matter that it feels it requires external input, and may seek Legal advice, advice from the Information Governance Manager or may seek statements from those involved in the original decision making process in order to reach a fully informed decision. It is occasions such as this where expert opinion may be required that may inadvertently lead to delays in the Review process, and as at 5.3.1 above, this should be conveyed to the complainant.

Scenario 1
The Review Panel may conclude that the exemption should not have been applied to the information that has been withheld and should release the information, along with an apology to the complainant at the earliest opportunity. The Information Governance Manager should be informed of the fact and remedial action taken if deemed necessary.

Scenario 2
The Review Panel may conclude that the processes were not followed correctly, that the wrong exemption was applied, and that the panel was not convened at the earliest possible opportunity, but still deem that the information in question is exempt from release. In these circumstances an apology for failures in process should be provided to the complainant, and the decision to continue to withhold the information conveyed at the earliest opportunity, correctly citing the applicable exemption.

Scenario 3
The Panel may conclude that the information has an applicable exemption, that the processes were correctly followed, but that there is an overriding Public Interest in releasing the information, and that this out weights the applicable exemption. In this circumstance, as above, the information should be conveyed to the requestor at the earliest opportunity, whether or not an apology should be offered will be determined by the factors involved at a given time.

It is the responsibility of the Information Governance Department to communicate the outcome of the review to the requestor.

Note: Once the Review Panel has made its decision, and this decision has been conveyed to the requestor, irrespective of what that decision is the requestor has the right to refer the matter to the Information Commissioner for his consideration. The complainant should be provided with details of how to do this.

5.5.4 The Information Governance Manager or his/her designated deputy, will provide administrative support to the Review Panel, and will ensure that minutes of all deliberations of the Review Panel are recorded in the review file.

5.5.5 The Information Governance Unit will ensure that any subsequent actions or recommendations coming from the panel's deliberations are conveyed to the complainant, keeping an accurate record of all actions. An accurate record of the review process is essential in the event that there is any subsequent investigation by the Information Commissioners office.

5.6 Timescale for Internal Review Process

5.6.1 There is no timescale outlined in the legislation for completing a review, however the Review Panel should aim to complete it in as timely a fashion as possible, however not substituting timeliness for thoroughness. Any substantial delays should be communicated to the requestor at regular intervals by the Information Governance Department.

5.7 Monitoring of Complaints and Internal Reviews

5.7.1 Robust records are to be kept of the outcome of all internal reviews and cross referenced to the original request file.

5.7.2 The Information Governance Manager will monitor the volume and type of complaints received on foot of responses to information requests, including FOI requests, and take what remedial action he/she deems fit to address weaknesses in the processes to maintain organisational compliance.

5.7.3 In circumstances where patterns of non-compliance with all relevant information covering information requests is identified, or failure to adhere to Corporate policies and procedures governing this area, the Information Governance Manager in conjunction with the Director of Operations may ask Internal Audit to carry out a more detailed analysis of particular business areas to ensure corporate compliance.

5.8 External Investigations of Complaints against the Public Health Agency

5.8.1 Any complaint received may eventually be escalated to an external regulator, such as the Information Commissioner. It is the responsibility of the Information Governance Unit to liase with the investigating body and provide any supporting evidence or prepare what responses are required from that body to effectively carry out their review. This process will be overseen by the Information Governance Manager who will report on progress to the Assistant Director of Planning & Operational Services.

5.8.2 Any communication received at any of the PHA's locations, from the Information Commissioners Office, must be forwarded immediately to the Information Governance Unit at the address details provided at 5.2 of this Procedure

5.8.3 The PHA and its Officers are legally obliged to cooperate with any such investigation and all employees are duty bound to provide whatever

assistance is required in the preparation of responses or collation of documentation in relation to any such investigations. Reference should be made to the extract at 5.3.2 in relation to interfering with a legitimate request or failure to provide documentation on foot of a request from the Information Commissioners Office.

6 Seeking expert opinion

The Information Governance Manager or his/her designated deputy will, if required, seek expert legal advice from the Directorate of Legal Services. Any such communications will be governed by the understanding that such communications are governed by the concept of Legal Professional Privilege.

7 Review

This procedure will be reviewed no later than March 2020.

8. Procedure Owner

The Information Governance Manager reports to the Senior Operations Manager (Delivery) and is accountable to the Assistant Director of Planning & Operational Services and ultimately the Director of Operations.

9 Responsibilities

9.1 The PHA Board has corporate responsibility for the implementation of this procedure, for monitoring its effectiveness and ensuring that all legal responsibilities are met. The PHA Board will also ensure that the FOI Internal Review Procedure is available on the PHA's Intranet or from the PHA Information Governance Manager.

9.1.1 The PHA Board will discharge its responsibilities in relation to this policy document through the Director of Operations to whom the Information Governance Manager is ultimately accountable.

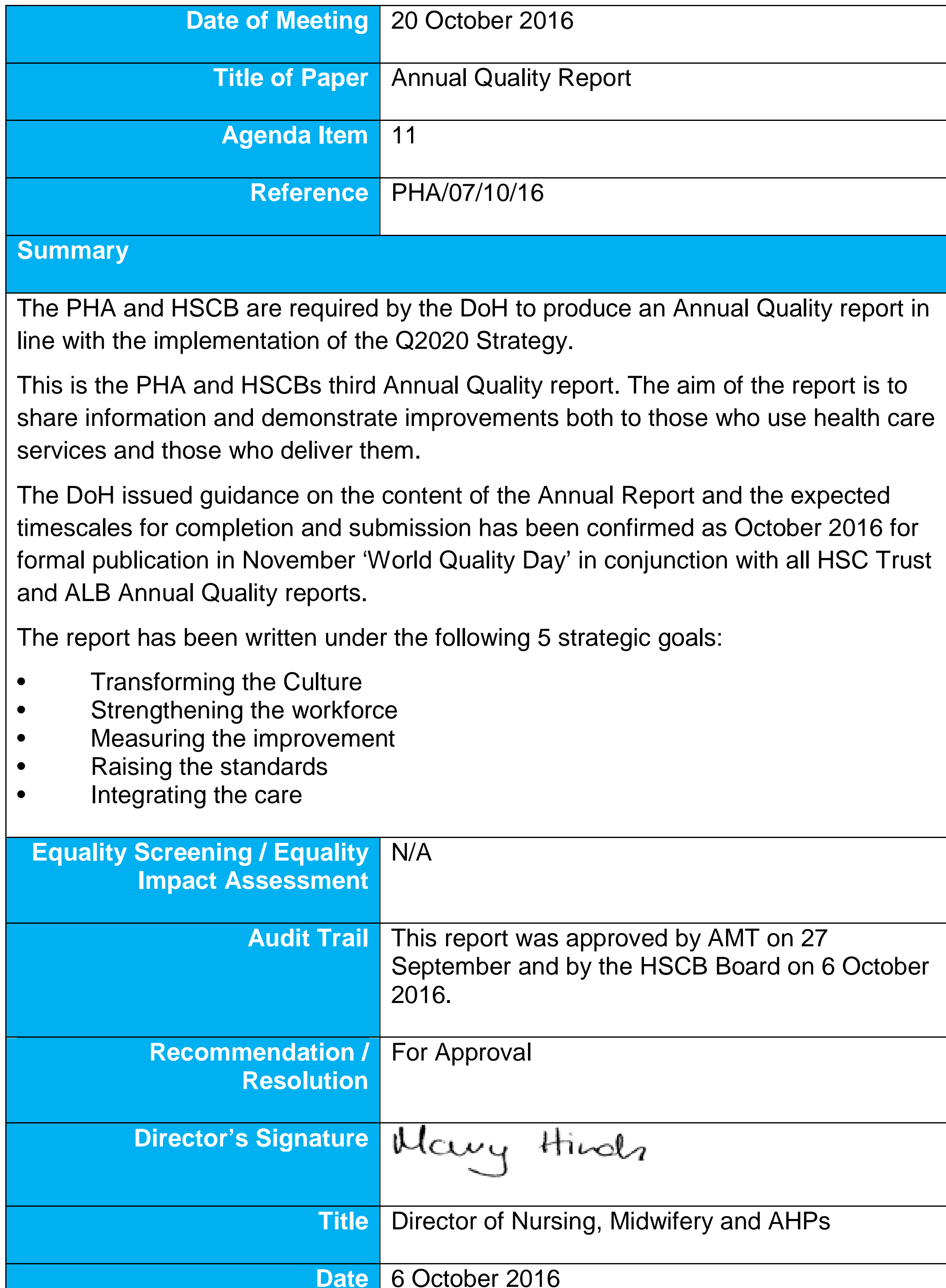
9.1.2 The Information Governance Manager is the operational day-to-day owner of this document.

10 Interaction with other PHA policies

This policy should be read in conjunction with the PHA's Access to Information Policy and Data Protection/Confidentiality Policy, which provides applicants with a Subject Access Request pro-forma when seeking access to their personal information.

HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	20 October 2016
Title of Paper	Annual Quality Report
Agenda Item	11
Reference	PHA/07/10/16

Summary

The PHA and HSCB are required by the DoH to produce an Annual Quality report in line with the implementation of the Q2020 Strategy.

This is the PHA and HSCBs third Annual Quality report. The aim of the report is to share information and demonstrate improvements both to those who use health care services and those who deliver them.

The DoH issued guidance on the content of the Annual Report and the expected timescales for completion and submission has been confirmed as October 2016 for formal publication in November 'World Quality Day' in conjunction with all HSC Trust and ALB Annual Quality reports.

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

- Transforming the Culture
- Strengthening the workforce
- Measuring the improvement
- Raising the standards
- Integrating the care

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was approved by AMT on 27 September and by the HSCB Board on 6 October 2016.
Recommendation / Resolution	For Approval
Director's Signature	Mary Hinds
Title	Director of Nursing, Midwifery and AHPs
Date	6 October 2016

Annual Quality Report

2015/2016

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

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Chief Executives' foreword

Welcome to the third Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA).

The HSCB and PHA are committed to ensuring safe, high quality services and putting patients, clients and their carers at the centre of everything we do. We continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves. We remain focused on modernising how our services are delivered, ensuring that they are responsive to the needs of a changing population.

This report highlights the broad range of work undertaken by both HSCB and PHA during 2015/16. While it is impossible to include information about every service the HSCB and PHA provide, nevertheless it is our hope that this report goes some way to reassure our patients, clients and the public of our commitment to ensuring safe, effective and high quality care. The report has been structured around the core Quality 2020 themes: **Transforming the culture, Strengthening the workforce, Measuring improvements, Raising the standards** and **Integrating the care**.

An important focus during the year has been the implementation of *Making Life Better* – the whole system strategic framework for public health. *Making Life Better* includes a range of strategic actions for government departments and other agencies and also sets the direction for a number of supporting areas for joint working at regional and local levels.

These are happening at a time of renewed focus on working together to achieve a world class health and social care system.

Finally, we recognise that our key asset is our staff; their dedication and commitment in ensuring safe, effective and patient client focused services is a source of great strength for the HSCB and PHA. We would like to thank all the staff for their continuing efforts over the past year, there will always be areas for improvement and we will continue to aim for the highest quality in the care we provide and put our patients at the heart of everything we do.

Theme one:

Transforming the culture

How we measure and report on our work

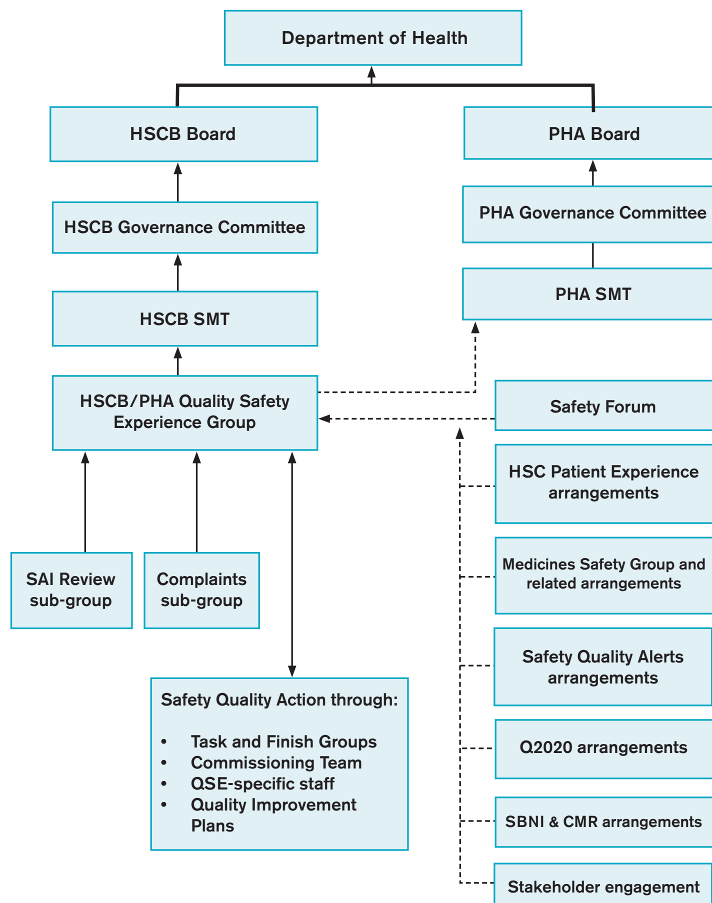
Within the HSCB and PHA, there is a comprehensive governance and assurance structure to support quality and safety. In particular there are two joint strategic groups which specifically review, monitor and report on safety, effectiveness and patient client focus: The **quality, safety and experience group (QSE) and the safety and quality alerts (SQA)** team.

These groups provide assurance to the PHA and HSCB boards' that matters of quality and safety are paramount and actions are taken to improve the quality and safety of services, and, ultimately, to improve the experiences of patients and clients.

Quality, safety and experience group

The QSE group was established in November 2013 to oversee all issues relating to safety, effectiveness and patient client focus within the HSCB and PHA. This group is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals. It allows senior staff to share information, approve policy and identify areas of concern.

An overview of the QSE structures is outlined below:



Regional serious adverse incident review sub-group

The regional serious adverse incident review sub-group (RSAIRSG) is chaired by the HSCB governance manager and the PHA senior manager for safety, quality and patient experience. Membership comprises professional representatives from the HSCB, the PHA and the Regulation & Quality Improvement Authority (RQIA). The RSAIRSG provides assurances that appropriate structures, systems and processes are in place within the HSCB and PHA for the management and follow up of serious adverse incidents (SAIs) arising during the course of the business of an HSC organisation or commissioned service.

The RSAIRSG also has responsibility (in conjunction with the QSE and SQA team) to ensure that trends, examples of best practice and learning are identified and disseminated in a timely manner. A number of professional groups from the RSAIRSG have been established to consider SAI review reports in order to close and/or identify learning issues.

2015/16 professional groups

- Paediatrics and child health;
- Maternity;
- Mental health (including prison health);
- Acute.

These groups benefit from:

- multi-professional input and a wider circle of experience;
- group sign off, with decisions not made by one individual;
- more complete understanding of the range of SAI issues within these service areas, leading to the identification of regional trends.

Regional complaints sub-group

The regional complaints sub-group (RCSG) is chaired by the HSCB complaints and litigation manager. Membership comprises professional representatives from the HSCB, the PHA and the Patient Client Council (PCC).

Since the implementation of 'Complaints in HSC' in 2009, the number of complaints received by HSCTs and family practitioner service (FPS) each year has increased from just under 5,000 in 2009 to approximately 6,181 in 2015/16.

Top three categories of complaints

1. Attitude/communication;
2. Treatment/care;
3. Waiting lists/delays/ cancellations.

The RCSG reviews complaints information received from HSCTs and family practitioner services, as well as complaints received by the HSCB and PHA. Areas of concern, patterns, trends and information from complaints is shared with established professional groups. This ensures that issues of complaint inform key areas of work on the quality of patient experience and safety, including thematic reviews and strategy and policy development.

This RCSG considers whether there is any regional learning and/or makes recommendation(s) to QSE on suggested courses of action as a result of an individual complaint, pattern or trend.

Safety and quality alerts team

The SQA team was formed in April 2012 and provides a mechanism for gaining regional assurance that alerts and guidance have been implemented, or that there is an existing robust system in place to ensure implementation.

Table 1: Category 1 alerts as of 31 March 2016

Alert type	Total
DoH safety and quality alerts/circulars	**212**
Learning letters	**30**
Reminder letters	**19**
National patient safety alerting system alerts (NPSAs)	**28**
Safety or quality related letters	**17**
RQIA reports and independent inquiries	**71**
NCEPOD report and other confidential enquiries	**23**
GAIN reports	**7**
Total	**407**

Progress on all of the above are contained in a HSCB/PHA bi-annual safety and quality alerts report which is made available to HSC organisations and the Department of Health (DoH).

During 2015/16, the SQA team have issued a number of learning/reminder of best practice letters as a result of a SAI that has occurred within a HSC organisation/commissioned or FPS (see reminder of best practice table below).

The HSCB/PHA have worked with HSCTs to implement a number of key quality improvements, which include:

- ensuring protocols are in place for anaphylaxis in both hospital and community settings and that staff are provided with regular training in the management and treatment of anaphylaxis;
- development of an agreed list of pre-prepared products in relation to magnesium sulphate, through the regional medicines governance team;
- ensuring agreed referral pathways from emergency departments (EDs) to the maternity service are in place within each HSCT and that relevant staff are made aware of the pathway, including how to access the relevant contact telephone numbers;
- review of protocols for the management of major obstetric trauma by HSCT senior ED and obstetric clinicians;
- ensuring that staff follow best professional practice as recommended by ATLS/MOET training courses and manuals;
- ensuring that appropriately senior ED and obstetric staff are called to the ED as soon as it is known that a major obstetric trauma case is arriving;
- ensuring that relevant staff have appropriate skills update training, for example through in-house clinical scenario simulation drills;
- review of protocols for the ambulance transfer of pregnant women to confirm they are in line with the recommendations of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) report in relation to the prevention of hypotension from uterine pressure on the inferior vena cava;
- review of the additional training needs for ambulance staff in the techniques to prevent hypotension from uterine pressure on the inferior vena cava, and plans to address any such training needs;
- review and (as necessary) update HSCTs existing protocols or procedures in services looking after transplant patients to ensure that they reflect the requirements as detailed within the reminder of good practice letter;
- review and amend protocols for the perioperative preparation of patients to take account of the requirements as detailed within the reminder of good practice letter issued.;
- dissemination of a reminder of good practice letter to the HSC, which provides advice and highlights the requirements under current guidance on the management for patients/clients with swallow/dysphagia problems;
- review of HSCT protocols for the detection of pregnant/potentially pregnant women in ED to ensure that they reflect the content as set out in the 'Requirements under current guidance' section of the reminder of good practice letter issued as a result of an SAI;

In addition the HSCB and PHA jointly issue a bi-annual SAI learning report to the wider HSC. This learning report provides an overview of best practice reminders, learning letters, thematic reviews and other learning initiatives, undertaken or reported on during the period of reporting.

Serious adverse incidents

The management and follow up of serious adverse incidents

The HSCB and PHA have a responsibility to coordinate the management and follow up of SAIs. The aim of the SAI process is to:

- provide a mechanism to share learning, focusing on quality, leading to service improvement for service users;
- provide guidance on the SAI criteria, responsibilities and the process for reporting, investigation, dissemination and implementation of learning arising from SAIs;
- ensure the process works simultaneously with all other statutory and regulatory organisations;
- provide a culture of openness and transparency that encourages the reporting of SAIs;
- ensure trends, best practice and learning are identified, disseminated and implemented in a timely manner, in order to reduce recurrence;
- maintain a high quality of information and documentation within a time-bound process.

Internal process for managing SAIs reported to the HSCB/PHA

- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all reported SAIs on a weekly basis.
- Each SAI has a nominated professional who is the designated review officer (DRO).
- Reports, themes and learning are shared with the SAIRSG and the QSE group to agree regional learning actions.
- The SQA team provide an assurance mechanism for any actions to be taken forward as a result of regional learning.

During 2015/16, a number of issues were identified within the current SAI process that required immediate implementation and were therefore issued to all arm's-length bodies in June 2015. These were:

- a revised SAI service user/family/carer engagement checklist to enable easier data input and more meaningful information output, allowing for a systematic approach to monitor this information;
- minor revisions to both the Level 1 and Level 2/3 review templates and to also incorporate the above checklist.

In addition the HSCB and PHA issued guidance to all HSC organisations to assist both reporting organisations and HSCB/PHA staff when managing:

- SAIs that are also being reviewed as adult or children's safeguarding incidents;
- interface incidents that have been reported via the SAI process;
- early alerts that have reported in line with DoH process.

The HSCB procedure for the reporting and follow up of SAIs (October 2013) is currently under review and will take account of the recommendations made within the Donaldson Report, *The Right Time, The Right Place* and the RQIA/Guidelines and Audit Implementation Network (GAIN) SAI reviews outlined below.

SAI reviews

During 2015/16 the DoH commissioned two regional projects from GAIN who are now aligned within RQIA. The two projects are:

- identifying learning from SAIs across Northern Ireland (including the death of a patient);
- examining learning arising from SAIs involving suicide, homicide and serious self-harm.

Both projects are being carried out in partnership with the HSCB, PHA and HSCTs. In taking the projects forward, a project board and project team has been established for each, with membership drawn from all relevant organisations.

Service user and family involvement in SAIs

The HSCB procedure for the reporting and follow up of SAIs makes clear the need for appropriate communication and involvement of service users, relatives and carers. Following DoH communication and consultation across the HSC, the HSCB developed and issued guidance in February 2015 for HSC organisations when engaging with service users/families who have been involved in a SAI.

The purpose of the guidance is to ensure that communications with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner, thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. A leaflet has also developed to provide information for service users/families/carers on the process.

Given the unique position of FPS within the HSC, bespoke guidance based on the HSC SAI procedure has been developed in year specifically to assist FPS contractors and Directorate of Integrated Care (DoIC) staff who assist in the investigation and management of SAIs within primary care and in particular regarding the family/user/carer elements of the SAI process. A

leaflet also provides information for patients/families on the process. It is anticipated that these documents will be issued to practices very shortly following endorsement from their respective representative bodies. Feedback received to date has been positive.

Learning from serious adverse incidents

The key aim of our SAI process is to reduce the risk of recurrence and improve patient safety by learning from incidents, not only within the reporting organisation, but across the HSC as a whole.

The HSCB and PHA use a variety of mechanisms to share learning in a timely manner for implementation, including:

- Learning letters;
- Reminder of good practice letters;
- Newsletters;
- Thematic reviews;
- Training;
- Audits, guidelines and resources;
- Learning reports.

Learning letters/reminder of good practice letters

Last year the following learning letters and reminder letters of good practice were issued. Some of these have already been referred to above in relation to the improvements taken forward by SQA Team:

Reminder of best practice letters	Date published
Safe disposal of patients' drugs in the community	19 May 2015
Assessment of a potential undisclosed/unknown pregnancy – advice for ED staff	28 May 2015
Assessment of domestic violence	28 May 2015
Assessment and management of trauma in pregnancy – advice for ED and maternity staff	28 May 2015
Prescribing and dispensing high risk drugs eg immunosuppressants such as tacrolimus	30 June 2015
Services for infants/young children with suspected hearing impairment	30 June 2015
Supervision in accordance with individual care plans	14 July 2015

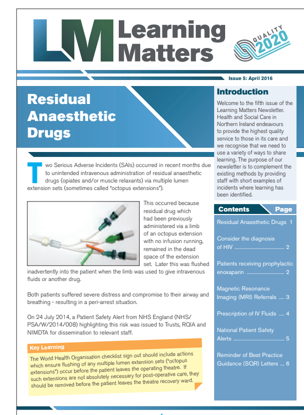
Preventing shoulder dystocia and brachial plexus injury	20 July 2015
Alcohol-based skin preparation solutions and the risk of fire in operating theatres	15 Sept 2015
Identifying an acutely unwell child on arrival at an ED	21 Sept 2015
Management and advice for patients/clients with swallow/dysphagia problems	1 October 2015
Management of patients who are on combined anticoagulant and/or antiplatelet therapy, pre and post a procedure/surgery	14 October 2015
Safe use of oral bowel-cleansing agents	8 January 2016
Reminder of risks associated with long term oral bisphosphonate therapy	12 January 2016
Residual anaesthetic drugs in cannulae and intravenous lines	19 January 2016

Newsletters

The HSCB and PHA have developed a number of newsletters to share learning from complaints, SAIs and adverse incidents (AIs) with the HSC.

Some of these include:

- Learning matters
- Optometric practice
- Medicines safety matters
- Prescribing matters
- General practice
- Medicines management



LM Learning Matters

QUALITY 2020

Issue 5: April 2016

Residual Anaesthetic Drugs

Two Serious Adverse Incidents (SAIs) occurred in recent months due to unintended intravenous administration of residual anaesthetic drugs (opiates and/or muscle relaxants) via multiple lumen extension sets (sometimes called "octopus extensions").

This occurred because residual drug which had been previously administered via a limb of an octopus extension with no infusion running, remained in the dead space of the extension set. Later this was flushed inadvertently into the patient when the limb was used to give intravenous fluids or another drug.

Both patients suffered severe distress and compromise to their airway and breathing - resulting in a peri-arrest situation.

On 24 July 2014, a Patient Safety Alert from NHS England (NHS/PSA/W/2014/008) highlighting this risk was issued to Trusts, RQIA and NIMDTA for dissemination to relevant staff.

Key Learning

The World Health Organisation checklist sign out should include actions which ensure flushing of any multiple lumen extension sets ("octopus extensions") occur before the patient leaves the operating theatre. If such extensions are not absolutely necessary for post-operative care, they should be removed before the patient leaves the theatre recovery ward.

Introduction

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

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1

Thematic reviews

Thematic reviews are commissioned by the QSE group to focus on specific areas to identify themes or trends. Recommendations are disseminated across the HSC.

The following thematic reviews have been completed and issued during 2015/16:

- thematic review of patients with a fall resulting in moderate to severe harm;
- thematic review of SAIs relating to the misidentification of patients.

Other thematic reviews approved by QSE to be undertaken during 2015/16 are:

- thematic review of AIs relating to the prescribing, supply and administration of insulin;
- thematic review of SAIs related to choking on food.

Collaborative working

Improved care in mental health

The mental health quality improvement collaborative was established by the HSC Safety Forum in 2014 in partnership with all HSCTs. The forum's first success was the redesign of processes and cultural change regarding the physical health needs of mental health patients. There were measurable improvements in areas such as reliable monitoring of blood pressure, body mass index and the use of health passports.

In 2015/16, the collaborative used the recommendations of a thematic review of suicides by the PHA to shape a programme designed to improve the culture of learning and reflective practice to support staff and improve the patient/client journey. The programme has:

- completed a safety climate survey across all HSCTs;
- is trialling tools to both guide and measure reflective practice in teams;
- is exploring the best way to use safety briefings and structured communication tools such as SBARD (Situation, Background, Assessment, Recommendation, Decision).

Improved care in nursing homes

The work of the Northern Ireland nursing home quality improvement collaborative in 2015/16 was centred on palliative/end of life care (PEoLC). Using innovative Project ECHO methodology, the HSC Safety Forum worked in partnership with NI Hospice to deliver this programme to 26 nursing homes throughout Northern Ireland. Last year the ECHO project delivered 10 x 2 hour tele-mentoring sessions. Up to 70 staff participated in these tele-linked sessions on many aspects of PEoLC. The sessions included case presentations by nursing home staff to facilitate the sharing of learning and quality improvement training.
Feedback from 92 participants showed:

- 100% felt it helped translate knowledge into practice more than other teaching sessions they had been involved in;
- 100% felt it improved the care they provided for patients;
- 100% would recommend it to others;
- 100% would participate again.

Managed clinical networks

Paediatric networks in Northern Ireland

The HSCB, PHA, BHSCT and DoH are committed to maintaining specialist paediatric services in Northern Ireland within a high quality, safe and sustainable framework of care.

The strategic intention for specialist paediatric services is where it is safe and sustainable to do so, offer as much specialist care as possible within Northern Ireland. This may not always be possible and other options may need explored including the establishment of clinical networks with tertiary centres either in Great Britain or the Republic of Ireland, optimising the use of specialist interest areas of paediatricians across Northern Ireland, securing 'in reach' from larger providers, and/or commissioning some service elements outside Northern Ireland.

In line with this, a paediatric network manager, funded by the HSCB on the recommendation of the specialist services commissioning team and working within the Royal Belfast Hospital for Sick Children (RBHSC) has continued to lead on the following three main objectives:

(1) Formalise selected paediatric networks in Northern Ireland

The Northern Ireland paediatric gastroenterology network, the Northern Ireland paediatric epilepsy network and the Northern Ireland paediatric respiratory and allergy network have continued to build on excellent working and partnership arrangements to support clinicians and families throughout Northern Ireland. In 2015/16 the Northern Ireland paediatric endocrine and Northern Ireland paediatric neurodisability networks have commenced to deliver a programme of education and training for all interested clinicians at least four times annually.

(2) Formalise networks with other UK-based tertiary and quaternary services

In 2015/16 the BHSCT continued to formalise networks with UK providers to provide 'in-reach' services. These include very specialist clinicians coming to Northern Ireland to deliver clinics or operating theatre sessions that would otherwise be unavailable in Northern Ireland. Specialist in-reach clinics were delivered in 2015/16 including:

- urology;
- gastroenterology;
- metabolic bone;
- metabolic lysosomla storage disorders;
- endocrine;
- bone marrow transplant failure clinic;
- spasticity intervention assessment clinic;
- craniofacial assessment clinic.

In 2015/16 the BHSCT maintained formal arrangements with Great Ormond Street Hospital for delivery of a 24/7 specialist telephone clinical advice service for Northern Ireland paediatricians treating paediatric patients with suspected or confirmed endocrine and metabolic conditions when the consultant team based in the RBHSC is unavailable. Northern Ireland has also strengthened formal links with the Northern Children's Epilepsy Surgery Service (NorCESS), which is a joint service between Alder Hey

Children's Hospital NHS Foundation Trust and Royal Manchester Children's Hospital NHS Foundation Trust, to deliver an epilepsy surgery and rehabilitation service. This is one of only four designated units in the UK. BHSCT and NorCESS colleagues have visited each other's units and agreed a specific patient pathway for families in Northern Ireland.

(3) Improve the patient and family experience for families that require access to very specialist care not available in Northern Ireland

In 2015/16 the BHSCT have continued to deliver:

- a single contact point where families can speak to a member of staff for queries related to all travel, accommodation, expenses and care with relation to receiving paediatric care outside of Northern Ireland;
- patient information resources detailing the process for receiving care outside Northern Ireland including travel, accommodation and expenses;
- patient information resources regarding the specific hospital outside Northern Ireland that the family have been referred to;
- a contact number for this service 24/7.

Critical Care Network Northern Ireland

The Critical Care Network Northern Ireland (CCaNNI) work with all HSCTs and with commissioners to monitor and review issues relating to critical care staffing.

During the past year, CCaNNI have facilitated the submission of workforce data to the National CC3N Critical Care Non-Medical Workforce Survey.

The CCaNNI senior nurses committee have worked with colleagues from throughout the United Kingdom in the development of 'Step 3 Competencies' for both nursing staff new to critical care (Step 1) and for those staff completing post registration courses in critical care (Step 2 & 3).

In addition, CCaNNI have undertaken an audit of patient handover practices when a patient is transferred from the critical care setting to the ward. The audit reflects generally good practice and has helped units identify individual aspects of patient handover which can be further enhanced.

CCaNNI continue to have a key role in collecting, monitoring and reporting incidents of influenza within critical care, which form the basis of a local and national report.
Quarterly regional patient flow exercises in adult, cardiac surgical intensive care and PICU (fortnightly) are carried out and units/HSCTs are supplied with individual reports.
Eleven standardised critical care transfer trolleys with attached monitoring and ventilation equipment have been embedded in hospital sites across the region, improving the safety of transfer for critically ill adults and children. To further support this work, multi-disciplinary critical care transfer training days have been held in collaboration with colleagues from the Northern Ireland Ambulance Service with attendance from across the region.

Neonatal Network Northern Ireland

Neonatal Network Northern Ireland's (NNNI) collaborative way of working aims to achieve regional consistency in care and drive quality improvement within the network and beyond with a family centred approach. It is delivering this through a number of network led multi-disciplinary and interdependent service area working groups producing regional guidance, protocols and tools. This is further supported by the networks hosting of quarterly CPD quality improvement events focusing on key network priorities. These use a PDSA cycle approach to service improvement via engagement with the wider network and its interfacing service areas to raise standards and outcomes for patients and families. This bottom-up top-down approach supports engagement, innovation and problem solving. A cohesive network culture continues to effectively manage network cot capacity at a time of significant challenge through the facilitation of weekly regional network teleconferences. This reduces the risk of out-of-region in- and ex- utero transfers to support families. Throughout 2015/16 network led work has strived to attain agreement and consistency in care resulting in:

- the development and regional implementation of an NNNI policy for testing and isolation to prevent infection (TIPI) in neonatal units provides guidance to staff and parents to reduce risk and improve consistency in approach supporting capacity management;
- the development of regional antimicrobial guidance for neonates;
- across the perinatal spectrum the development of guideline and parental leaflet for the counselling of women at risk of delivering an extremely preterm baby.

Furthermore the NNNI's parental engagement group (co-chaired by the service user organisation Tiny Life) is a key influencer of the neonatal work plan and parental products.

The ongoing neonatal service review has assessed national evidence supporting multi-disciplinary team working to secure positive outcomes for staff and families. It has also clarified the current neonatal workforce baseline across the network, identifying requirements to strengthen the neonatal workforce in specific areas/professions/grades. Within 2015/16 it has secured:

- investment in allied health professional (AHP) services to support the multi-disciplinary neonatal team in managing complex children's needs within the neonatal setting;
- medical and nursing investment to augment the regional centre to neonatal unit to reduce risk of out of region transfers and support staffing ratios towards BAPM standards;
- investment in neonatal transport services to provide 24/7 service provision;
- support for the regional normative nursing model to be applied to neonatal nursing;
- investment in HSCT neonatal breastfeeding roles to support the regional breastfeeding strategy;

The network provides peer and professional support through continuous engagement and collaborative working to the wider network, its quarterly service improvement events and through inclusion in its projects. 2015/16 regional quality improvement projects include:

- supporting breastfeeding within neonatal units;
- thermoregulation of neonatal babies.

The ongoing analysis of the NNNI regional discharge questionnaire from parents across Northern Ireland provides a measurement improvement tool for units and on regional service provision. In 2015/16 the questionnaire themes were revised to support areas of interest. The outcomes were presented at the Neonatal Nurse Association Conference.

Standards continue to be raised by focusing on priorities, utilising time specific task and finish groups to develop tools, guidance and documents to improve consistency across the region in service delivery.

The NNNI operates most effectively by engaging staff from related interfacing areas with parental representation through its series of task and finish groups. By taking a complete care pathway approach the network's work plan seeks to raise the quality of care linking with other networks and service areas as necessary to drive up quality for families and utilise opportunities for investment and support. In 2015/16 the network hosted a regional perinatal event to support a work area. This will now become an annual event.

Northern Ireland Pathology Network

The Northern Ireland Pathology Network enables HSC pathology services to plan and implement regional standardisation and quality improvement initiatives in partnership with stakeholders including commissioners, policy makers, universities, professional bodies and patient representatives through a regional network board and seven clinical specialty forums covering the main pathology disciplines.

In 2015/16 key achievements included:

- developed proposals for HSC pathology service modernisation in line with policy and best practice, including extensive consultation with stakeholders;
- developed a business case for, and coordinated the establishment of the Northern Ireland Genomic Medicine Centre, which will enable HSC patients to take part in the UK 100,000 Genomes initiative;
- secured support for the establishment of a project to modernise HSC pathology information systems, including a project for regional primary care electronic test ordering;
- completed a partnership project engaging primary and secondary care and secured funds to establish a regional H Pylori testing service in line with NICE guidance. Commencing in autumn 2016 the service will enable GPs to test patients in primary care to see if H Pylori if the cause of their dyspepsia, and to test that treatment to eradicate H Pylori has worked;
- secured agreement for HSC Laboratories to participate in a new, enhanced national benchmarking scheme that will provide information that can be used to standardise practice and further improve quality and safety;
- formed close links with the national Digital Diagnostic Data Board to begin a process to ensure HSC pathology data will be of standard quality to other UK pathology data;
- coordinated regional initiatives to improve quality and safety including: a regional pathway and patient information for handling the transfer of specific samples for regional testing; developed regional guidance and protocols including guidance on placental histology and swabbing; and testing to manage acute kidney injury;
- supported Cancer Research UK national audit into capacity and demand for pathology services in the UK;
- facilitated the development of regional inter-HSCT pathology business management tools, including for example the development of a regional service level agreement, initiated a new regionally standardised approach to management of block funding, developed regional laboratory service contingency plan in case of disaster;
- continued programme of ongoing standardisation of practice in all HSC Laboratories to improve efficiency and ensure that clinical service users and patient receive a high quality standard service from all laboratories.

Regional Stroke Network

In November 2014 a network co-ordinator was appointed to establish a Regional Stroke Network. The network brings together stakeholders from patient groups, the voluntary sector, HSCTs, PHA, primary care and HSCB. Already a number of benefits have been achieved that will result in improved patient experience and recovery following stroke.

Stroke information system

- All five HSCTs in Northern Ireland participate in the Stroke National Audit which has facilitated local service improvement activities. The network has developed and implemented the stroke information system in a number of HSCTs to support this. This allows detailed analysis of performance against NICE quality standards and DoH targets.

Thrombectomy

- Northern Ireland is one of a limited number of UK regions with access to a new clot retrieval intervention called 'mechanical thrombectomy' for suitable stroke patients. It is provided by the Royal Victoria Hospital on weekdays on a 9 to 5 basis. Fifty three patients benefitted from thrombectomy in 2015. The stroke network is working in partnership with the BHSCT to identify options for phased expansion of this service.

- The stroke network has brought together clinicians to streamline processes to ensure the maximum number of stroke patients are identified who would benefit from the current thrombectomy service. This has involved clinician training, review of imaging pathways, agreement on patient selection processes and the development of inter-HSCT referral, transfer and repatriation procedures.

Stroke modernisation

The network has developed a comprehensive draft consultation document on the modernisation of all aspects of the stroke pathway in Northern Ireland. The HSCB plans to consult on this in 2016. This will inform the development of a new model for stroke services to deliver hyperacute stroke unit care for every stroke patient, access to mechanical thrombectomy service hours to 24/7, improved speed of access to clot busting treatments, seven day access to transient ischaemic attack (TIA) services on a walk in basis, appropriately resourced community services and continued support for stroke survivors.

Transient ischaemic attack

- The network developed an electronic TIA referral form that is now being used for all TIA referrals from primary care.

- The stroke network completed an audit of 128 TIA patients and has identified several areas for service improvement.

- The stroke network collaborated with the local commissioning groups (LCG) and ICPS to implement early supported discharge services, over seven days in the SEHSCT and BHSCT.

MAGIC project

- Northern Ireland through the Stroke Network is a partner in a three million Euro, Horizon 2020 EU procurement project. This project, through collaboration with service providers, will develop new and innovative technologies to enhance patient empowerment and rehabilitation after stroke. Over 150 stakeholders from Northern Ireland have been involved in shaping this project so far and new technology solutions will be tested in Northern Ireland stroke services in 2017/2018.

Governance in primary care

The HSCB Directorate of Integrated Care (DoIC) manages contracts across four contractor service areas: **medical, dental, ophthalmic and community pharmacy**, who provide primary care services to patients in Northern Ireland. All contractors are independent organisations or providers and operate within the framework of their own regulatory and professional codes of conduct. This report will provide some key highlights in the directorate's continuing drive to improve quality, safety and service delivery for patients in 2015/16 within each contractor service.

General medical services (GMS)

There were 349 GP practices in Northern Ireland in 2015/16

GPs play a key role in ensuring that health service provision in Northern Ireland is effective and efficient. GPs provide:

- the main point of entry to the health care system;
- person-centred, ongoing care covering whole episodes of ill health;
- delivery of the majority of care for all but the most uncommon conditions;
- coordination of care provided by others

Since the introduction of the 2004 contract, the DoIC has undertaken a schedule of review practice visits incorporating assessment, support and development to all general medical practices.

Each visit covers the following key contractual areas:

1. Quality and outcomes framework
2. Enhanced service provision
3. Clinical and social care governance
4. Statutory and mandatory contractual requirements

The new GMS contract introduced a range of improvements across the UK. These include:

- improved access to services for patients;
- better management of chronic diseases;
- higher standards of record-keeping;
- a range of nationally agreed enhanced services and the ability to develop local enhanced services in response to local need.

General dental services (GDS)

As of April 2015 in Northern Ireland, there were 1216 dentists working across 384 dental surgeries providing general dental care and treatment. A small number deliver specialist dental care and treatment eg orthodontics and oral surgery.

Quality assurance

Quality of care provided by dental practitioners is monitored by the HSCB Referral Dental Service (RDS) through post-treatment examinations. In addition under GDS Terms of Service, all dentists in each practice are required to work under a Quality Assurance Scheme and each practice must make an annual return to the HSCB through the local offices.

In 2015/16 the Quality Assurance return was revised and updated eg clarification that a Standard Operating Procedure is required for Buccal Midazolam/ Emergency Drugs irrespective of whether or not IV sedation is provided.

Also in 2015/16 a monthly news sheet has been issued through the BSO website, to communicate non-urgent alerts, news items and notices to dentists.

General ophthalmic services (GOS)

In 2015/16 there were 267 optometry practices in Northern Ireland with approximately 500 optometrists providing or assisting in the provision of General Ophthalmic Services (GOS). The health service ophthalmic services provided in these practices are eye examinations, spectacle and contact lens fitting and local enhanced eye services. The latter services relate to additional or 'enhanced' care, outside general ophthalmic services, for certain patients who present with an ophthalmic problem which require additional investigation. 'Developing Eyecare Partnerships' (DEP) is the strategy to improve eyecare provision and promote eye health. Through the DEP the HSCB is actively working with service users and other organisations to develop better patient centred eyecare services. The HSCB optometry team monitors the activity and quality of eyecare services on an ongoing basis and undertakes checks which seek feedback from patients on the quality of eyecare services. Optometry practices are requested to provide annual quality assurance information in relation to complaints, adverse incidents and ophthalmic guidance which has been issued from HSCB.

Community pharmacy

Community pharmacy

The most common primary care medical service is the prescribing of medication. Community pharmacies are responsible for dispensing and advising on these medicines and providing advice on a range of wider health issues. Currently there are 533 community pharmacies across Northern Ireland.

HSCB staff work closely with community pharmacies to ensure that appropriate governance arrangements are in place and that the services they provide are consistently delivered to a high standard.

A system has been developed around the management of adverse incidents and complaints that occur in community pharmacies, and work on the governance arrangements for the full range of services that are provided in community pharmacies is ongoing.

Transforming the culture within social care

Introducing Rapid Access Interface and Discharge (RAID) Model to Northern Ireland

The Raid Model aims to improve access to mental health care for citizens who present to Hospital Emergency Departments and reduce waits for mental health assessments with in the Acute General Hospital System.

RAID project objectives	Measurable targets
1. Reduce the length of time that people who present with a mental health problem wait in emergency department for mental health	90% of patients referred for mental health assessment will have an assessment commenced within two hours in the ED.
2. Ensure the appropriate management of patients who present to the emergency department with: i. Self-harm ii. Harmful hazardous use of alcohol and drugs iii. Mental health difficulties associated with old age	A demonstrated increase in the percentage of assessments carried out for patients in the ED within the specified categories with a month on month increase from the commencement of the service. A decrease in the percentage of patients leaving the ED without having a specialist mental health assessment with a month on month decrease from commencement of the service. Reduction in the percentage of patients with deliberate self-harm or suicidal ideation who re-present to the ED within 30 days of original assessment.
3. Reducing the overall cost of care, by reducing time spent in general hospital beds, optimising medical investigation and the use of medical and surgical facilities. This is achieved by the reduction of potentially avoidable admissions to medical or surgical wards and reduced length of stay in medical hospital beds through early intervention and detection of delirium, depression and dementia.	Percentage month on month increase in the number of assessments offered and completed for patients over 65 years in the ED. 5% reduction in the number of emergency hospital readmission with 30 days of discharge
4. Provide a seven day integrated substance misuse liaison presence across the HSCT and also provide to groups currently excluded (CAMHs and learning disability).	An increase in the percentage month on month of interventions provided for those presenting with harmful hazardous use of alcohol and substance misuse in Antrim Area and Causeway Hospital.

The RAID model has been prototyped in NHSCT and has resulted in 5% reduction in the number of emergency hospital stays, over 17% reduction in bed days and over 90% of patients referred for mental health assessment had their assessment commenced within two hours in the Emergency department. Plans are underway to roll out the RAID Model across all HSC Trusts.

Separated/unaccompanied children

Separated/unaccompanied children arriving in Northern Ireland is a relatively new and developing phenomenon for Northern Ireland. Given the adversity faced by such children and their associated circumstances of arrival in Northern Ireland it is increasingly evident that this is a highly complex and specialist area within family and childcare and interfaces with serious risks of trafficking and child exploitation. These children and young people are vulnerable to potential traffickers and the risk of such children going missing and remaining missing is significantly high. Although the number of such children entering Northern Ireland year on year is relatively small there have been incidents of these children disappearing, usually within days/weeks of entry into Northern Ireland. A major challenge faced was the availability of a suitable, safe and protective environment in which to place such children which would afford them immediate care, support and reassurance. A dedicated residential facility for separated/trafficked young people aged 13 to 18 years with capacity for eight young people was established in 2014/15. The facility provides a culturally sensitive reception and assessment residential unit aimed at protecting and safeguarding separated young people thereby reducing, if not eliminating, the risk of their disappearance. It also provides an initial stable living environment to orientate young people and to undertake immediate information gathering and assessment, embed coordinated working with key statutory and voluntary agencies and ensure safe and holistic care planning for each young person.

During its full year of operation (2015/16):

- All separated children aged 13+ presenting in Northern Ireland have been safely placed in this facility;

- Assessment, safety planning and care planning arrangements have been fully attended to;

- The risk of young people going missing has significantly reduced with no reports of any young person going missing and remaining missing from the facility to date; and

- An independent evaluation of the facility reported positively on the experiences of the young people placed in the facility in terms of their care, feeling safe and being supported

Social work staff within the facility report increased knowledge, skill and competence in working with separated children which is a welcome and much needed source of expertise for Northern Ireland to ensure the provision of high quality care and support to this particular group of children and young people.

Adults with learning disability

The Regional Health Care Facilitator Forum (sub regional group of the Learning Disability & Healthcare & Improvement Steering Group) has been working on a range of initiatives to develop quality systems and improve governance with Adults with learning disability as follows:

- **Standardised annual health check assessment form for adults with learning disability**
  The GPs and Health Care Facilitators carry out annual health checks for adults with learning disability though a Directed Enhanced Service (DES) using a health check form (based on the Cardiff annual health check). A range of different templates were being used across the Region. This forum agreed to develop a standardised form for implementation across the region and ensure that all of the new screening programmes such as AAA, Bowel cancer screening etc. had been included as well as adding some additional questions around detecting early signs of dementia. The revised form has been approved by the Regional Directed Enhanced Service Group and can be accessed on the Integrated Care website by the GP practices.

  The standardised health check form has also been converted to allow electronic entry and completion of the form which will reduce administration of the service and ensure more quality time is spent with the patient and the health outcomes to be addressed following the Heath check.

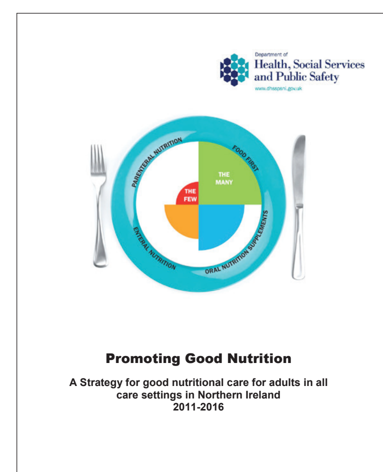
Promoting Good Nutrition strategy

The overall vision of the Promoting Good Nutrition (PGN) strategy is to improve the quality of nutritional care of adults in Northern Ireland in health and social care, whether delivered or commissioned, through the prevention, identification, and management of malnutrition in all health and social care settings, including people's own homes.

The implementation of this strategy was overseen by the PGN steering group chaired by the Director of Nursing, BHSCT on behalf of the PHA with representation from HSCB/PHA, all HSC HSCTs and other relevant HSC organisations.

The actions within the PGN strategy have been set out into the following themes:

1. training (and MUST);
2. assessment and assistance with feeding;
3. food service provision;
4. patient client experience;
5. governance and structures.



Ten key characteristics have been adopted which form the basis of good nutritional care in health and social care settings.
There has been a significant amount of work progressed across sectors to improve good nutrition, good hydration and enhance the

patient/client experience of mealtime during 2015/16. Following the evaluation it was noted that progress has been made in acute hospital settings on implementing and improving the key characteristics. It has been agreed that the focus will now be on full roll out of the PGN strategy in the community and developing and adopting an outcome based approach.

Improvements in unscheduled care

The Improving Patient Flow in HSC Services report, prepared at the request of the Chief Medical Officer and the Chief Nursing Officer, recommended a number of actions that HSCTs could take to improve patient flow. A number of these of these priorities were developed and implemented across the five larger acute hospitals within EDs and the wider hospital setting:

Emergency department professional staff

Over the past year the regional unscheduled care team, LCGs and HSCTs have been working collaboratively to put this in place, meaning a multidisciplinary assessment at the front door of the larger five hospitals to identify the most appropriate patient pathway across seven days. This has ed to a consistency across Northern Ireland in terms of seven day service in ED, meaning patients have access to the same assessment, intervention and discharge planning regardless of their day of admission. This will also contribute to a move towards discharge across seven days from current discharge patterns.

Minor injury streams in emergency departments

Minor injury streams within EDs have the ability to see and treat patients who present with a wide ange of conditions. Extending their hours of operation facilitates a higher volume of patients who can be directed to this stream and ease potential congestion within the ED.

Across the five larger sites in 2015/16 additional emergency nurse practitioners (ENPs) and nursing staff were funded to allow the minor streams to operate 12 hours a day, seven days a week, and further work taken forward to standardise the role of ENPs to maximise their potential to see patients, order investigations and provide treatments. Physiotherapists have been able to complement consultant and ENP roles, to maximise the opportunity for see, treat and discharge from learning of similar models across the UK. This right person, right place, right time approach can impact on waiting times and patient experience.

Same day/next day access to radiology services

Patients attending EDs often need investigations to confirm a diagnosis, to determine a diagnosis and treatment plan, and for those patients admitted to hospital; access to diagnostic services is important to prevent delays in their in-patient journey. Additional investment for CT, MRI and Ultrasound scans with same day/next day investigation and report production across seven days a week was made to assist improving patient flow.

Twice daily senior decision making for in-patients

Additional medical staffing was provided in 2015/16 to support HSCTs to: facilitate more frequent reviews of patients admitted to hospital; maintain timely assessment of patients; ensure treatment plans are on course; prevent delays in the patients' journey.

Theme two:

Strengthening the workforce

Strengthening the workforce

The HSCB and PHA employ over 900 staff (582 in HSCB and 319 in PHA as of March 2016) who work in a range of areas including nursing, medicine, social care, allied health professions, finance, informatics, family practitioner services, commissioning and corporate services. The HSCB and PHA are determined to invest in the development of our staff and the creation of a working environment that enables everyone to make their best contribution.

Sickness absences have an impact on quality and productivity, affect service delivery and are therefore an important factor when measuring an organisation's culture of quality. The cumulative percentage absence in respect of staff sickness for 2015/16 was 3.92% for the HSCB and 4.35% for the PHA. The BSO human resources department are continuing to work with managers within the HSCB and PHA with a view to reducing the levels of absenteeism.

Supporting staff

Staff health fairs

In June 2015 the HSCB and PHA staff in each of the four main offices were provided with the opportunity to participate in the annual health fairs which were organised by the occupational health department and human resources, BSO. Staff were able to avail of a range of advice sessions such as occupational health physio, an introduction to mindfulness, mental health awareness and stress relief, blood pressure and cholesterol checks. The fair also included a range of exhibitors including alcohol and nutrition advice, Staff Services, Cycle to Work, Carecall, Cancer Focus and Addictions NI.

Information sessions

The HSCB and PHA is committed to supporting staff in their roles and keeping staff informed on developments across the HSC system. Following the then Health Minister Simon Hamilton's announcement regarding the future of the HSCB and PHA on 4 November 2015, communications arrangements to support staff through this change management process were put in place.

inPHA

HSC Public Health Agency

The PHA Weekly Staff Newsletter

Welcome

Issue 13, 13 September 2016

Welcome to Issue 13 of inPHA, the weekly newsletter for all PHA staff.

In this issue we give a preview of the new PHA mental health campaign, focus on the development of the HSC Online portal, highlight the HSC Knowledge Exchange and look at a few ways to help you improve your health and wellbeing.

We hope you enjoy this issue and please keep the suggestions coming!

Best wishes

The CPA Team

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- New PHA mental health campaign
- Development of the HSC online portal
- HSC Knowledge Exchange
- Skills for Public Health Workshop
- Recipe Corner – healthy eating
- NICON Weekly Report
- AMT/PHA board update

Welcome – New PHA member of staff, Kyla Emerson

A warm welcome to Kyla Emerson who has taken up post this week as a Health Protection Nurse.

Kyla will be based on 4th Floor North, Linenhall Street, Belfast.

Good luck in the new post.

New PHA mental health campaign launch

For the HSCB, this has involved both the Chief Executive and Chairman leading on regular engagement sessions with staff both via video conferencing and visits across all local offices. A human resources representative was in attendance at meetings to address concerns and issues.

For the PHA this has included an offsite workshop for all PHA members of staff on 16 November 2015 and regular communications from the Chief Executive by email, intranet 'Connect' featured news items and via a new internal staff newsletter 'in PHA'.

The sessions provide an opportunity to provide information and update staff on progress in taking forward this agenda as well as an opportunity for staff to ask questions directly and discuss developments.

The sessions are also supported with regular Chief Executive emails and directorate team meetings which are aimed at ensuring staff are kept informed and involved in a timely manner.

Online information resource

A dedicated information section has been created on the HSCB and PHA staff intranet. This provides a valuable information resource, including latest published information, updated frequently asked questions and answers as well as an online facility for staff to ask questions directly to the Chief Executive.

Organisational workforce development group

The HSCB and PHA has established an organisational workforce development group which is aimed at providing support to staff during this period of change. Proposals for staff development and training are currently being developed.

PHA internal communication

Effective internal communication is essential to the efficient running of the organisation, particularly since the PHA is located over several regional offices.

To ensure this, the PHA continued to work to develop and progress an internal communications strategy and action plan which will ensure PHA business is supported by efficient and effective internal communication systems. Work to take forward the development of PHA's intranet site, Connect, was led by the internal communications working group which is made up of staff from all locations and across different bands.

Connect continues to be one of the primary internal communications channels with regular updates and organisational information provided to staff as well as carrying daily features on staff-related activities and achievements.

Important changes were also made during the year to internal emails which has assisted with the streamlining of internal communications, allowing staff to better manage and prioritise internal email.

HSC programme board – communications working group

The HSC programme board has set up a regional communications working group to ensure that staff employed across the HSC are kept informed and up to date on its work in taking forward the HSC Restructuring Programme. The HSCB is represented on this Group.

Moving forward programme

During the year the PHA promoted the moving forward programme which offers a suite of short course programmes through the HSC Leadership Centre that are tailored for middle and senior managers within HSC regional organisations.

Staff policies applied

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to promoting equality of opportunity and good relations for all groupings Under Section 75 of the *Northern Ireland Act 1998*.

The PHA has a range of policies in place that serve to advance this aim including an equality of opportunity policy.
Where an employee has become disabled during the course of their employment with the PHA, the organisation works closely with human resources who are guided by advice from occupational health.

Subsequently, reasonable adjustments can be made to accommodate the employee, including possible redeployment, in line with relevant disability legislation. This legislation is incorporated into selection and recruitment training and induction training and is highlighted in relevant policies where necessary.

The PHA is fully committed to the ongoing training and development of all members of staff and through the performance appraisal system all staff are given this opportunity irrespective of ability/disability as well as having the same opportunities to progress through the organisation.

More information on the PHA's work regarding equality is available in this report under the section entitled 'Equality' as well as on the PHA's website www.publichealth.hscni.net

Staff health and wellbeing working group

The purpose of the staff health and wellbeing working group (SHWWG) is to act as a focus for the promotion of the health and wellbeing of all staff in the PHA. The work of the group reinforces the PHA's commitment to this goal. The process of working together across all divisions has been important in building understanding and sharing perspectives. The group developed an action plan entitled 'Promoting Health and Wellbeing in the PHA as a Workplace: An Action Plan for the PHA' which recognises the importance of the workplace as a setting to promote health and wellbeing. The action plan remains a live document in order to reflect on feedback from staff and adapt to changing needs.

A regular newsletter is produced to update staff on the progress of initiatives and future developments, and the minutes of each meeting are published on the staff intranet site, Connect. During 2015/16, the group continued to lead on the implementation of a number of initiatives/programmes to assist in promoting health and wellbeing for staff.

Lesbian, gay, bisexual and/or transgender (LGB&T) forum

During 2015/16, the LGB&T HSC staff forum continued to meet quarterly, in order to ensure the provision of a safe, welcoming and open space for LGB&T staff to discuss a range of issues and to promote visibility and inclusivity in the organisation as a whole. Membership of the forum continues to grow and is supported by a confidential mailing list which is managed by PHA.

Meetings of the forum are regularly advertised via internal communication networks and are sent to all staff via email. Posters to advertise forum meetings are placed in staff areas. Connect also contains a link to the LGB&T website (http://www.lgbtstaff.hscni.net/) and a link to a dedicated LGB&T e-learning tool 'Creating Inclusive Workplaces' (http://lgbtelearning.hscni.net/). The tool aims to give participants a better understanding of LGB&T issues in the workplace.

The PHA was present at Pride festivals throughout Northern Ireland in 2015. To coincide with Pride, information stalls were organised in hospital stalls throughout the region. All staff were also invited to take part in the Pride parade, to show support for LGB&T colleagues and service users.

The PHA has been working with the Rainbow Project during 2015/16 to become the first HSC organisation to be recognised as a 'Diversity Champion'.

The Diversity Champion Northern Ireland Programme enables organisations to be recognised as having effective equality and diversity policies and practices on LGB&T issues.

This initiative is one of a number of developments over recent years to help improve the health and social wellbeing and reduce the health inequalities experienced by LGB&T individuals and their families across Northern Ireland.

PHA has been working closely with human resources to review policies and benchmark these against best practice. Training has been delivered to key personnel within the PHA and BSO and others from across wider health and social care, and feedback has been most positive.

The next stage in the process is to carry out a staff survey and a series of engagement opportunities with staff from across all divisions within the PHA.

Feedback from the survey will be invaluable and will be used to inform future developments relating to the Diversity Champion Programme.

By becoming a Diversity Champion the PHA will build upon existing good practice in helping to promote inclusive work environments where all staff feel valued and respected regardless of their sexual orientation and/or gender identity. In addition, it is hoped that by participating in the programme, the PHA will demonstrate leadership to other HSC organisations and the public sector as a whole which will encourage others to take part in the programme.

Weight loss programme

The '£ for 1lb' weight loss challenge continues to be offered in partnership with Business in the Community with the aim of supporting staff who wish to lose weight over a 12 week period, with the support of a designated 'champion' and expertise from community dieticians.

My Mood Matters/Living Life to the Full

Mental and emotional health and wellbeing in the workplace is recognised as an important issue by the PHA, both as an employer and for all employees. A range of mental and emotional wellbeing courses have been made available to staff during 2015-16, such as 'My Mood Matters' and 'Living Life to the Full: Life Skills'; both of which have evaluated very positively. The courses have been offered to each locality and have been well attended in each area.

Physical activity

SHWWG recognises the importance of regular physical activity and seeks new and innovative ways to encourage staff to incorporate movement into their daily routine. In support of the work of SHWWG, a 'Take the Stairs' (TTS) proposal has been developed.
A baseline study was conducted to ascertain the current level of stair use and to seek ways of encouraging stair use. Best practice and evidence in other public health settings were taken into account to aid SHWWG in the developing a number of posters (or 'point of decision prompts') to encourage behaviour change among staff.

It is anticipated that by changing sedentary behaviour, employees will increase their daily physical activity, reduce stress, improve muscle tone and maintain a healthy weight. This work also builds on the momentum of Active Belfast and the 'Leading the Way' initiative which seeks to use the power of the public sector in order to help shift the norm of physical activity more generally. It is hoped that a pilot will be conducted during summer/autumn 2016 to determine the impact of the initiative.

The group has also made improvements to the working environment during 2015/16 by informing the food choices in site premises to ensure healthy options are made available. Plans have also been made, and funding secured, to replenish gym equipment in the PHA headquarters. The possibility of 'female only' gym slots is also being considered.

SHWWG also continues to work with human resources to establish men's and women's health forums, negotiate concessionary rates for staff who wish to join gyms and provide information to staff on how to access other support services such as occupational health and Carecall.

A 'Wellness Day' is planned to take place in Autumn 2016. This will include sharing information on topical cancers, how to check yourself, nutrition and exercise and mental health. A physiotherapist will also be invited to offer advice on back health.

Domestic violence policy

SHWWG worked with human resources to develop a domestic violence policy. The aim of the policy is to ensure that PHA contributes to the health and wellbeing of all staff by, as far as

possible, creating a workplace which is safe and supportive for staff who are experiencing domestic violence. The policy outlines potential sources of support for individuals experiencing domestic violence and provides guidance for line managers.

Smoke-free

From Wednesday 9 March 2016 all health and social sites across Northern Ireland adopted smoke-free status. The move coincided with No Smoking Day, and means that smoking is not permitted by staff, patients, contractors or visitors on any HSC premises. This major step by the health and social care system is leading the way in helping to change the culture and highlight where smoking is unacceptable.

Support for smoking cessation, including Nicotine Replacement Therapy, was offered to all staff. A number of workshops were organised early March 2016 in different localities. A smoke-free policy has been developed with input from the equality unit. The policy seeks to guarantee staff and those who access their facilities and services, the right to air free of tobacco smoke, which contains a class "A" carcinogen, in order to improve health and wellbeing.

Active travel

During 2015/16, 'Leading the way with active travel' continued to grow. This initiative encourages employees to get more active through the way they travel, for example by foot, bicycle, or taking public transport.

PHA commissioned Sustrans to run the programme to encourage more staff in Belfast to walk or cycle to work, and it is being delivered in PHA, Belfast City Council, BHSCT, HSCB and BSO.

The programme is important in helping shift the norm and encourage greater physical activity. Accredited cycle training was offered to all staff (and the general population) to help increase confidence and safety on the road.

The PHA and HSCB have participated in the 'Active Belfast Challenge' (ABC) which encourages people in Belfast workplaces to get more active and travel more sustainably. Through logging journeys, staff can be in with a chance of winning some great prizes. Personal and workplace targets have been set including calories burned, CO2 saved, miles travelled and money saved. All journeys except single person car journeys are included. The number of workplaces participating continues to grow rapidly, as well as the number of employees participating in the month long event.

Training for HSCB, PHA and HSC staff

The HSCB and PHA firmly believe that 'quality training will produce quality staff who, in turn, will produce a quality service'. Through interventions, training and support to deliver high quality service, the HSCB and PHA have developed leadership skills at all levels to empower staff to take decisions, improve services and influence change.

SAI related training

During 2015/16 a number of training events were held:

Regional root cause analysis (RCA) training

RCA training provides the tools to support staff when conducting or reviewing an SAI investigation. Training was held on 19 May 2015.

SAI learning events

The HSC Safety Forum hosted two regional SAI learning workshops during 2015/16. The first was held in April 2015 and the second in March 2016. The events provided an opportunity to share learning from SAIs regionally. HSCTs and integrated care presented a number of case studies for discussion. A relative of a patient involved in a SAI and a senior clinician both shared their experience of the process and the impact it had on them individually and their wider family. Feedback on both events has been very positive and a third event is scheduled for April/May 2017.

Designated review officer (DRO) workshops

Workshops for DROs were carried out during September and October 2015, across each of the four locations. The rationale for holding the workshops provided DROs with a clear outline of the key stages of the:

- SAI process taking account of any recent/imminent;
- service user/family engagement process;
- learning process;
- early alert process;
- provided an overview of key documentation involved in the process.

Thematic review training

A half day training session on how to complete a thematic review was held in January 2016.

Working with HSCT SAI groups

BHSCT RCA forum for Chairs

Following the success of DROs attending the first BHSCT RCA Forum for Chairs in November 2014, DROs across a number of programmes of care were invited to attend the third forum in October 2015.

This provided HSCT RCA Chairs with a perspective on the role of a DRO within the SAI process. The meeting also provided an opportunity for DROs to share anonymised examples of well written review reports.

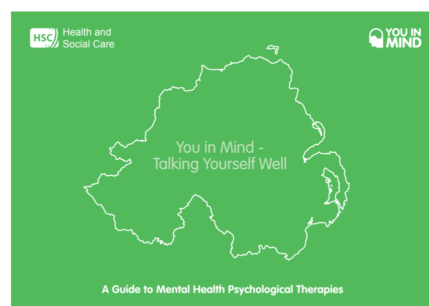
NHSCT SAI review group

The NHSCT SAI review group invited DROs across a number of programmes of care, to meet with this group of their lead directors to do a question and answer session in July 2015. The HSCT welcomed this opportunity and the session was positively evaluated by all members present.

Training in mental health

You in Mind Mental Health Psychological Therapies Guide - providing leadership in evidenced base practice and introduce of new ways of working

Delivering evidence-based psychological therapies are a critical component of mental health recovery. With the publication of many NICE Mental Health guidelines recommended talking therapies there was a need to produce a consolidated guideline which enables mental health professionals to provide personalised citizen focused psychological therapies. The guide was developed in partnership with people with lived experience and professionals involved in delivering psychological therapies services. The guide was launched on World Mental Health Day on 10 October 2015 and is now being used by all Health and Social Care Trusts to modernise mental health care. It enables HSCTs to tailor their staff continuous professional development needs in line with NICE guidelines. The new guide complements the Regional Learning Together and Working Together Mental Health Continuing Professional Development Framework. Over the last year a further 46 Mental Health staff have been trained in a range of psychological therapies.



Regional reablement service

The reablement service provides a person-centred approach to promote and maximise service users independence to allow people to remain in their own home for as long as possible. Implementation of a regional reablement dataset for performance monitoring includes key performance indicators in relation to service users starting reablement, length of stay and outcome following discharge.

A longitudinal audit was undertaken in 2015 to measure the length of benefit of reablement this demonstrated that it significantly contributes to long-term care cost avoidance and demand management. Further work has been undertaken with service users and carers to co-design a regional reablement leaflet, FAQs, and DVD. The provision of training to 30 Reablement Occupational Therapists on FIM/FAM as a regional outcome measure tool has also been undertaken.

Adult safeguarding demand and capacity modelling

Adult Safeguarding is recognised as a complex and critical area of work within HSCTs. The DHSSPS and Department of Justice (DOJ) introduced a new adult safeguarding policy; Prevention and Protection in Partnership in 2015 identifying the need for safer communities and safer organisations across all sectors and set out clear and proportionate safeguarding expectations across the full range of relevant organisations. Within the HSCTs it was recognised that demand in terms of adult safeguarding referrals was increasing year on year. In addition

staff working in this area had concerns that the complexity of adult safeguarding referrals was increasing with new types of safeguarding concerns arising such as human trafficking and disability hate crime. Set against this was a fairly constant workforce capacity that spanned a very large proportion of the adult services workforce within the HSCTs.

Review of the operating service models in the HSCTs revealed that a variety of operating models existed with the majority of the work being completed by non-specialists who had received safeguarding training. The very limited specialist safeguarding resource had adopted a largely advisory function in addition to co-working some of the most complex investigations. The modelling exercise considered both the preventative and protective elements of work. An improvement science methodology was applied to measure both the demand and the capacity elements.

The outcomes from the modelling exercise were:

- An informed demand analysis that reflected the time requirements and intensity levels of investigations
- An informed capacity analysis that reflected the volume and competencies of the adult safeguarding workforce and the degree of gap between demand needs and capacity availability
- A proposed standardised regional adult safeguarding operating model which sees safeguarding as a continuum of activity with responses becoming increasingly more targeted and specialist as the risk of harm increases. The operating model reflects the aspirations within the new Northern Ireland regional adult safeguarding policy as well as best evidence in terms of an emphasis on a prevention approach and only proceeding to a protection approach when serious harm has occurred or is likely to occur. Non-specialist staff would focus on early intervention approaches for adults at risk of harm through HSCT risk assessment processes and targeted services proportionate to need. Specialist safeguarding staff would be best placed to respond when a protection approach is required.
- Through the stepped care approach within the proposed standardised regional operating mode, adults at risk of neglect, abuse and exploitation would experience a more proportionate and effective response and HSCT resources would be more appropriately targeted.

Learning disability training

Excel training to support the implementation of data collection following annual health checks for adults with learning disability

Following on from the development of a revised data collection system to support the work of the HCFs and the annual health check, regional excel training to support the implementation of the system was identified. A half day training session has been planned for September for the HCFs, administration and Heads of Service within learning disability. The training will be delivered by the Leadership Centre. It is hoped at the end of the session participants will be able to extract the significance from a large, detailed data set, produce pivot tables to provide analysis, information tables, graphs etc. from the range of data that has been gathered. It is anticipated the excel sheet will provide key information to support future commissioning of services for adults with learning disability.

Guiding principles for personal relationships and sexual health training (for adults with learning disability, parents, carers and staff working with adults with learning disability).

Regional guidelines on personal relationships and sexual health for adults with a learning disability have been developed by the HSCB in partnership with the PHA, Family Planning Association (FPA) Belfast and the HSCTs. A regional operational protocol has also been developed by the HSCTs. The aim of the operational protocol is to ensure that services for adults with a learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities (standard 15 of The Service Framework for Learning Disability).

HSCB are keen to ensure a regional approach of training for staff to support them with the implementation of the personal relationships and sexual health operational protocol. Funding is currently being explored with the PHA to facilitate the delivery of appropriate training regionally this year.

To support this, guiding principles for personal relationships and sexual health training (for adults with learning disability, parents, carers and staff working with adults with learning disability) have been developed by the HSCB. The guiding principles define values that underpin relationship and sexuality education, to ensure best practice training is being developed and delivered. Quality improvement is a common goal and is central to the development of health and social care services. Guiding principles provide a essential level of quality to ensure safe and effective practice against which performance can be measured.

Training in social work

Post qualifying in social work

In September 2015 saw the start of the post qualifying module 'Evidence informed practitioner and organisation' between HSC organisations in conjunction with Ulster University. The objective of this module is to build the capacity of social workers in understanding and using research to inform professional practice and organisation development in social work. This module has been developed to address the need of professional social work practitioners, managers, trainers, policy-makers, regulators, reviewers and beginning researchers to:

- develop the knowledge and skills in shaping answerable practice and policy questions;
- identify and retrieve relevant research, service evaluations and professional audits;
- appraise the quality of this research and related materials;
- combine findings into a coherent message;
- disseminate conclusions and recommendations effectively in their organisation.

The module is designed to contribute to improving our social work service to service users and carers by improving professional knowledge and skills, service quality and the effectiveness of organisations delivering social care services. Services users and carers have been involved in the academic assessment of the current cohort of participants this is intended to contribute to accessibility of reviews of evidence

Launch of the social work research and continuous improvement strategy

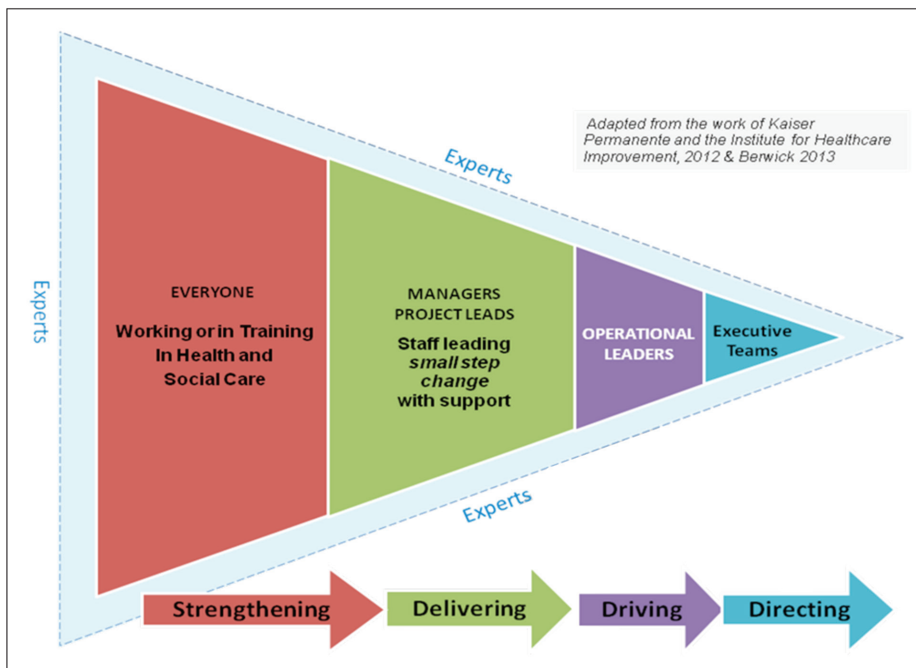
The social work research and continuous improvement strategy was launched in November 2015. A strong evidence base underpinning services is an important hallmark of any profession to build credibility and enhance service user and carer outcomes. To build an organisational culture that recognises the value and contribution of research and evidence and integration at all levels of policy development and practice and will benefit over 5,700 social work staff. The target is all social workers in Northern Ireland. Engagement and involvement of the profession and service users through- out the development of the strategy commenced the building of the necessary cultural shift. A range of outcomes, indicators and associated evidence have been developed to measure what difference we are making across the seven priority areas in the strategy.

HSC quality improvement training

In 2015/16, The HSC Safety Forum helped to progress several initiatives which support the strategic aims of Quality 2020. This was achieved in partnership with many organisations including DoH, NIPEC, HSCTs, the HSC Leadership centre and the Health Foundation. The initiatives are:

- the Quality 2020 attributes framework; supporting leadership in quality improvement and safety;
- the Improvement Network Northern Ireland;
- the Q initiative.

The attributes framework is now a key driver for quality improvement training of HSC staff across the system. The online training module for level 1 of the attributes framework is now available to all HSC staff.



Locally, the Safety Forum has been building a network of quality improvement enthusiasts in the Improvement Network Northern Ireland (INNI). The network exists to build a community of practice and a shared purpose which will improve care and improve the way we work. Our strengths lie in the size of the region, our shared policies and strategic plans and our ability to influence future strategic direction. INNI recognises that local identity, ownership and belonging is important to people. Every organisation is working to align its improvement resource to serve its purpose and the network is mindful to enable and not distract from this work. The intention is to build on the emerging hubs in each member organisation and to have a network that is the link between and across hubs.

In 2015/16 INNI hosted the inaugural Northern Ireland HSC Safety Forum Awards. Q, an initiative led by the Health Foundation, links people with commitment, experience and understanding of health and social care improvement in the UK in a community. It is anticipated that this community will expand, complimented by local networks in all four nations. In Northern Ireland, the developing local network is INNI. The Health Foundation partnered with the HSC Safety Forum as the regional recruiting body for the HSC. The founding design cohort for Q (2015) had 11 representatives from Northern Ireland, drawn from professions across health and social care.

Q will help accelerate the improvement system within the UK as well as supporting the improvement work of individual members. Q members will be well placed to be local connectors and supporters for other improvers within their locality. Q will also provide opportunities for innovation and the sharing of ideas across professions and perceived boundaries.

Training for pharmacists

Health+Pharmacy

Over 120,000 people visit a community pharmacy each day making this the most accessible healthcare venue. It has been recognised that through use of the tremendous interface that pharmacy has with the general public, there is a huge opportunity for engagement around health improvement strategies. We already see this through the large contribution that pharmacies make to smoking cessation. Building on this, HSCB and PHA have been working collaboratively with stakeholders to develop the Health+Pharmacy accreditation process. Health+Pharmacy was formally launched in February 2016 by Minister. Over 200 pharmacies are now going through the process of training and ultimately accreditation which will recognise the commitment of their pharmacies and staff to delivering health improvement activities.

Practice-based pharmacists

One of the most common interventions in health care is the prescription of a medicine. In Northern Ireland over 39 million prescription items were issued in 2015/16 with a cost of over £400m. HSCB works on an ongoing basis with primary care practitioners to review their prescribing practice, provide advice to support medicines optimisation and provide training in specific therapeutic areas. Each year, HSCB supports the delivery of thirty advanced clinical practice workshops for primary care professionals, focussing in on various disease areas. These are co-facilitated by HSCB pharmacists and secondary care consultants.

For a number of years, HSCB has also commissioned sessional pharmacy support into GP practice. Building on the experience of this sessional pharmacy support, a business case was developed in 15/16 to take forward the development of Practice Based Pharmacists over the next five years. Minister formally launched this initiative in December 2015 and work is underway to recruit the first wave of pharmacists. Their role will be to support the management of prescribing within General Practice to include repeat prescribing, medicines reconciliation, medication review and prescribing within the multidisciplinary team. It is anticipated that there will be improved outcomes for patients through improvements in the quality of prescribing as well as improved resilience within the General Practice team given the pressures there are on the GP workforce currently.

Personal & Public Involvement (PPI)

Engage and Involve

As the organisation with lead responsibility for PPI in the HSC, the PHA, working through the Regional HSC PPI Forum, identified the need for awareness raising and training to help staff to understand and embrace PPI, embedding it into their culture and practice. A PPI programme entitled “Engage and Involve” has now been co-designed with service users and carers.

Engage and Involve is an accessible and practical learning and development programme, aimed at HSC staff. The programme aims to increase awareness and understanding of PPI, stimulate thinking and encourage staff to recognise the value and benefits of engaging with service users and carers, whether that is in commissioning, service development or delivery. The programme has been developed to bring consistency of understanding and approach to PPI in the HSC locally. The Engage and Involve PPI programme consists of:

PPI e-learning - An online, self-taught introduction to PPI. Participants are recommended to undertake this training prior to delivering or attending any of the Engage and Involve modules.

Modular based taught programme - To facilitate learning based on identified needs. The modules are stand alone and can be chosen according to need. It covers areas such as practical involvement and consultation, facilitation, communication and measuring impact.

Training and workforce planning for nursing and midwifery

Delivering care framework

Workforce planning across nursing and midwifery presents many challenges as the largest professional workforce in the NHS responsible for the continuous care provision 24/7 365 days of the year.

Delivering Care sets out a framework for commissioners and providers of HSC services for planning, discussing and reviewing the apportionment of planned resources to maximise the potential for the implementation of safer nursing staffing levels in Northern Ireland. The framework currently focuses on a phased approach of implementation within the following areas:

1. General and specialist medical and surgical care hospital settings
2. Emergency departments
3. District nursing
4. Health visiting

The **Phase 1** model has been completed with an agreed staffing ratio/range agreed across Northern Ireland. The implementation has secured recurrent resources to enable HSCTs to meet the required and agreed nurse to bed ratios across medical and surgical wards. Additional senior posts have been secured including the agreement to have ward sisters and charge nurses in a 100% supervisory capacity .The PHA and the HSCB continue to monitor the target with HSCTs and report on progress to the DoH.

In relation to **Phase 2**, Northern Ireland has currently nine EDs across the five HSCTs. The staffing model for core ED has been agreed for phase 2. This reflects the activity, the attendances, the range of presenting need, the influencing factors as they apply to ED, the senior nurse experience and appropriate skill mix. This work has been progressed with completion of a sense check and benchmarking exercise by the HSCB/PHA . The implementation of phase 2 will continue throughout 2016.

Phase 3 is progressing with consideration being given to the workforce metrics that will be utilised across the region following testing of methodologies. The model for the district nursing workforce will be based a range of data intelligence which will include population requirements, interventions and activity, the development of a 24 hour community nursing model and GP aligned staff. It will incorporate the district nursing team leaders role and the implementation of allocated time to deliver on the key worker role for end of life care.

The proposed model for **Phase 4** health visiting workforce has been progressed taking into consideration the delivering care principles and assumptions as well as the factors impacting on the delivery of the health visiting service for Northern Ireland. The model sets out the key roles of the required workforce in health visiting teams including skill mix, a process for caseload scoring and reflects the delivery of the child health programme for pre-school children, responding to the needs of children with identified needs, safeguarding roles and responsibilities and participation in public health initiatives.

General practice nursing framework for Northern Ireland

"Now and into the future"

The Health Minister, in October 2015, announced the establishment of a DoH led working group to review the issues facing GP-led primary care services and to bring forward recommendations to help address demand for these services. The review of GP-led services highlighted specific challenges, a changing workforce profile and the need for a greater skill mix including nurses in GP practices.

Following discussions with a range of stakeholders it was agreed that a regional commissioning framework for primary care nursing in Northern Ireland was needed, in order to address increasing demands and challenges. The objectives of the framework were as follows:

1. Review the current provision of nursing services, including workforce profile.
2. Consider international evidence and best practice in nursing in primary care.
3. Make recommendations on future model for nursing in primary care to include:
   a. the range and type of nursing services required to meet current and future anticipated needs;
   b. educational requirements, skill mix and support to deliver services;
   c. structures and processes to support revalidation;
   d. strengthening closer integrated working with nursing colleagues in HSCTs;
   e. potential impact/opportunities afforded through collaborative initiatives;
   f. links to strategic and other developments in Northern Ireland which could potentially expand or extend the roles of nurses in primary care.
4. Explore the potential for placement of pre-registration nursing students in primary care settings.

A project steering group and working group were established to oversee and undertake this work in order to ensure there is a complete picture and understanding of this essential nursing workforce and the contribution to primary care services.

The general practice nursing framework for Northern Ireland, 'Now and into the future' provides an overview of the scope and developing role of general practice nurses in primary care. The framework is the output of the partnership working with GPs and a range of key stakeholders.

The recommendations and actions are structured within the following themes:

- **Workforce review** and proposed workforce model based on core general practice nursing activities/skill mix.
- **Core competency framework** based on regionally agreed core activities for general practice nurses.
- **Education** requirements and development planning informed by robust needs analysis.
- **Professional governance** and accountability requirements including systems and support structures for NMC revalidation and appraisal.

The steering group has endorsed the framework which will be considered as part of the DoH review of GP-led primary care services.

The key outcomes will assist with the delivery of high quality nurse-led primary care services that are person centred, delivered by a competent workforce, who are supported and developed professionally within primary care.

E-learning and assessment tool pilot

A new innovative e-learning and assessment tool has been developed and piloted with clinicians in Northern Ireland.

The application tested the interpretation of plain X-rays with doctors in training in radiology and in emergency medicine. Each test consisted of 30 plain X-rays and the clinician was given immediate feedback on the results of each test with educational information on where they had not provided the correct answer. Within the test series each clinician received a bespoke test(s) on the body areas which they had incorrectly answered in previous tests and it was demonstrated that each clinician improved their performance in interpreting these films. Over 100 doctors participated in taking weekly tests and the performance scores identified a statistically significant improvement in performance over the test series.

Another workstream in the pilot developed a cardiotocography (CTG) interpretation algorithm using the NICE Intrapartum Guidance, December 2014. The clinical group from all HSCTs involved obstetricians and midwives in the development of the decision tree interpreting the NICE guidance, and workshops involving 80 clinicians were held to test the methodology, to test the software and inform further development of the system.

A qualitative evaluation undertaken described the significant value of this approach to learning and assessment across all three workstreams with comments that the bespoke tests were equivalent to an individual tutorial for the clinician. This process also identified potential new areas for development of similar applications.

The pilot concluded in 2015/16. Discussions are in progress regarding securing a funding stream to support the mainstreaming of the current applications and the development of new applications on a regional basis.

Theme three:

Measuring improvements

Performance against standards and targets

On an annual basis the Health Minister sets out commissioning plan direction (CPD) targets and standards which represent particular areas of focus for the coming year. The Minister's vision for the integrated HSC system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment care and support. Performance against these standards and targets is reported on monthly basis to the public HSCB meeting. During 2015/16 a number of these areas have represented a significant performance challenge and the HSCB and PHA have worked closely with HSCTs to improve performance by using accredited improvement techniques and ensuring that best practice resulting in high performance in some HSCTs is shared and implemented in others. Examples of this work are outlined below.

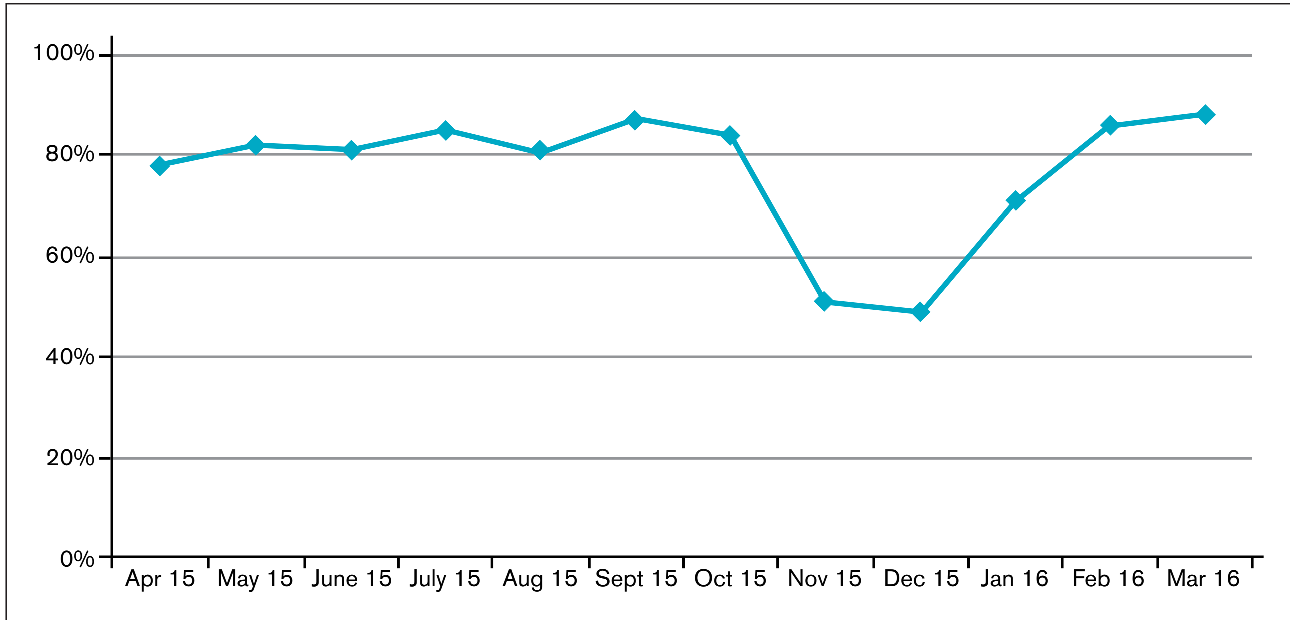
Cancer

The percentage of urgent breast cancer referrals seen within 14 days deteriorated during the quarter from October 2015 to December 2015. The reasons for the include staffing challenges in a number of HSCTs and a significant increase in urgent referrals for suspected breast cancer, in particular following Breast Cancer Awareness month in October.

In order to respond to this position, the HSCB worked closely with the relevant HSCTs to put a range of measures in place including additional evening and weekend clinics to address the backlog of patients waiting. The HSCB also allocated additional funding to allow the recruitment of more staff to better respond to the higher level of demand.

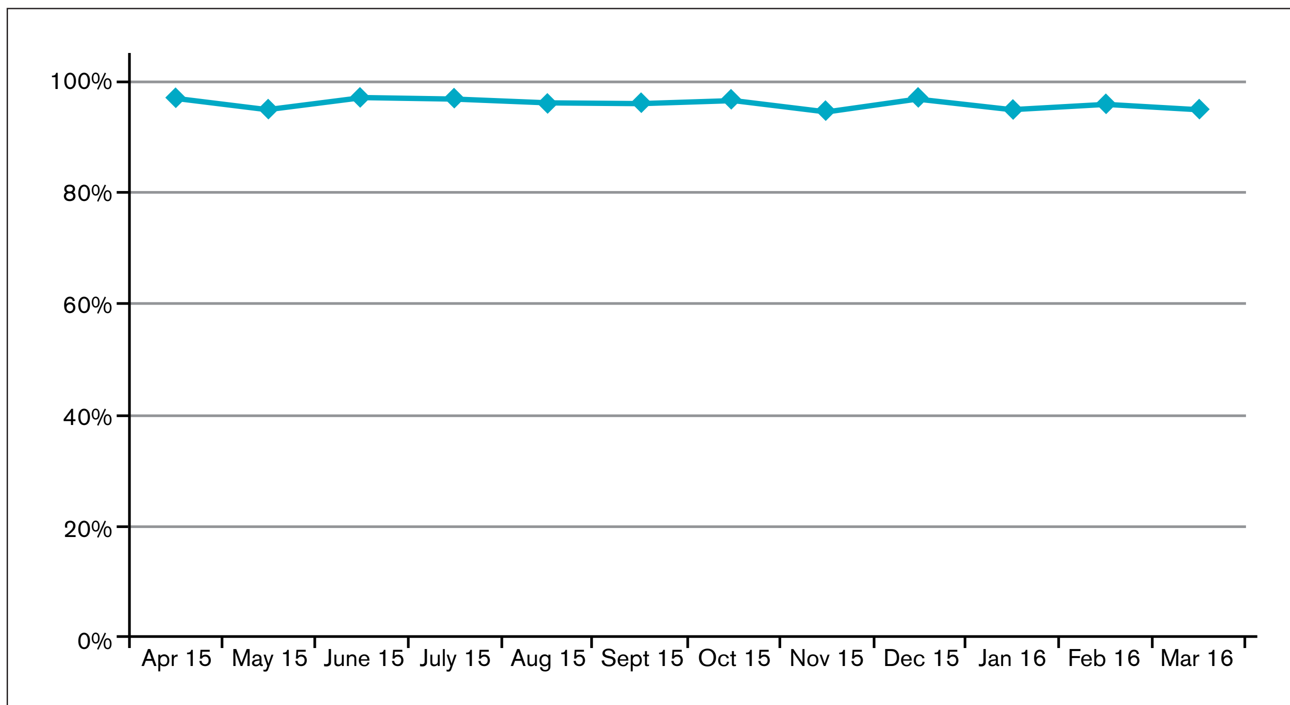
As a result of this collaboration, performance improved significantly during the final quarter of 2015/16.

Figure 1: % of patients seen within 14 days of an urgent referral for breast cancer



Furthermore, performance against the 31-day cancer access standard has continued to be strong – regionally during 2015/16, 96% of cancer patients commenced treatment within 31 days of the decision to treat (CPD standard: 98%).

Figure 2: % of cancer patients who commenced treatment within 31 days of the decision to treat

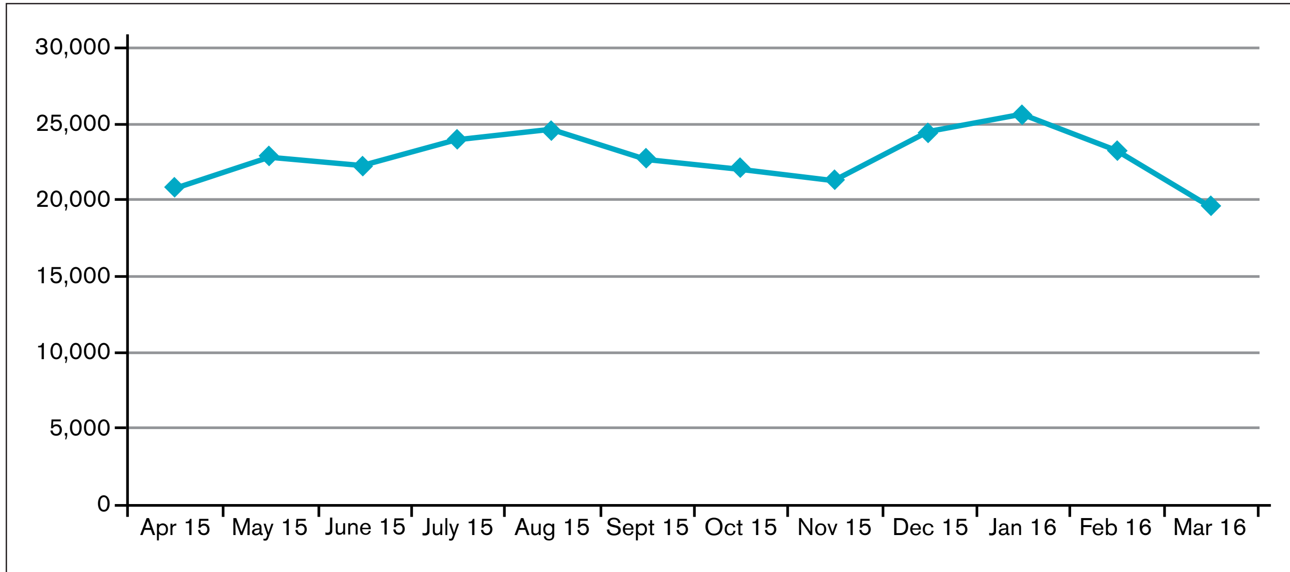


Diagnostics

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the HSCB prioritised the allocation of the funding available at the start of 2015/16 for elective care for diagnostics. As a result, the waiting time position remained broadly steady during the first eight months of the year.

The length of time patients waited for a diagnostic test improved during the final quarter of 2015/16 as a result of the impact of the additional activity associated with the non-recurrent funding allocated in November 2015. Furthermore, the HSCB has confirmed the allocation of non-recurrent funding to HSCTs to continue to undertake additional activity in the first half of 2016/17 to maintain and, where possible, improve upon the March 2016 waiting time position.

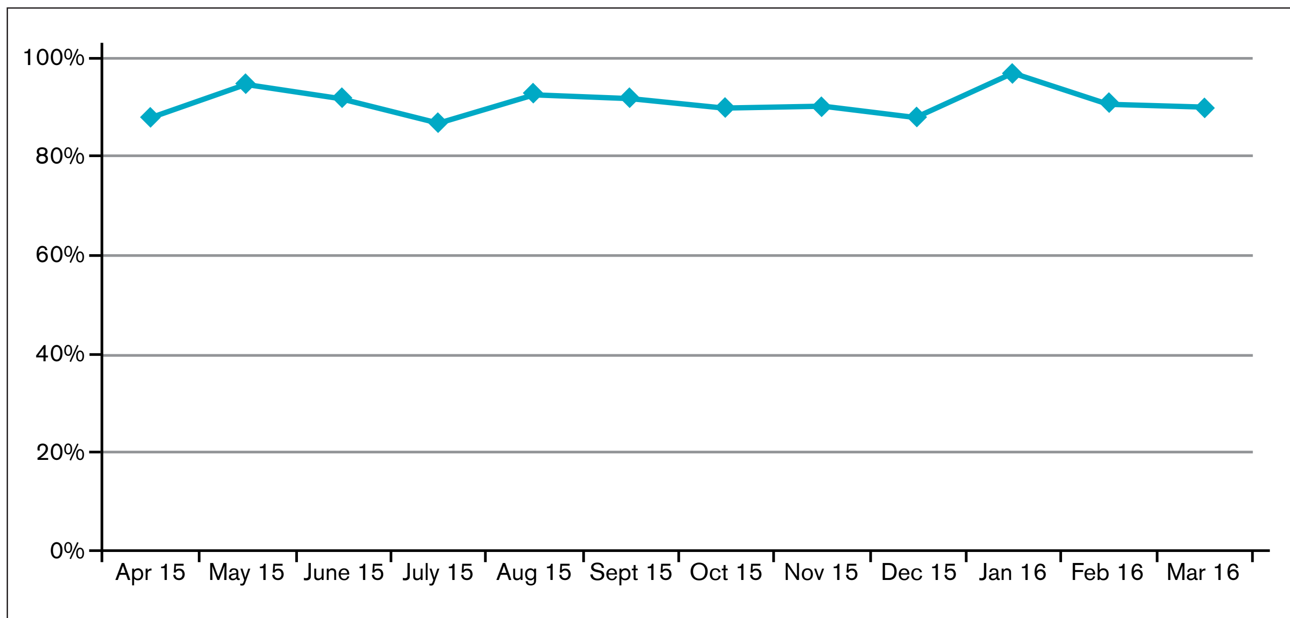
Figure 3: Diagnostic waiting times



Hip fractures

Regionally during 2015/16, 91% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (CPD standard: 95%). This represents an improved position from 2014/15 when 89% of patients were treated within 48 hours.

Figure 4: % of patients receiving treatment for hip fractures within 48 hours

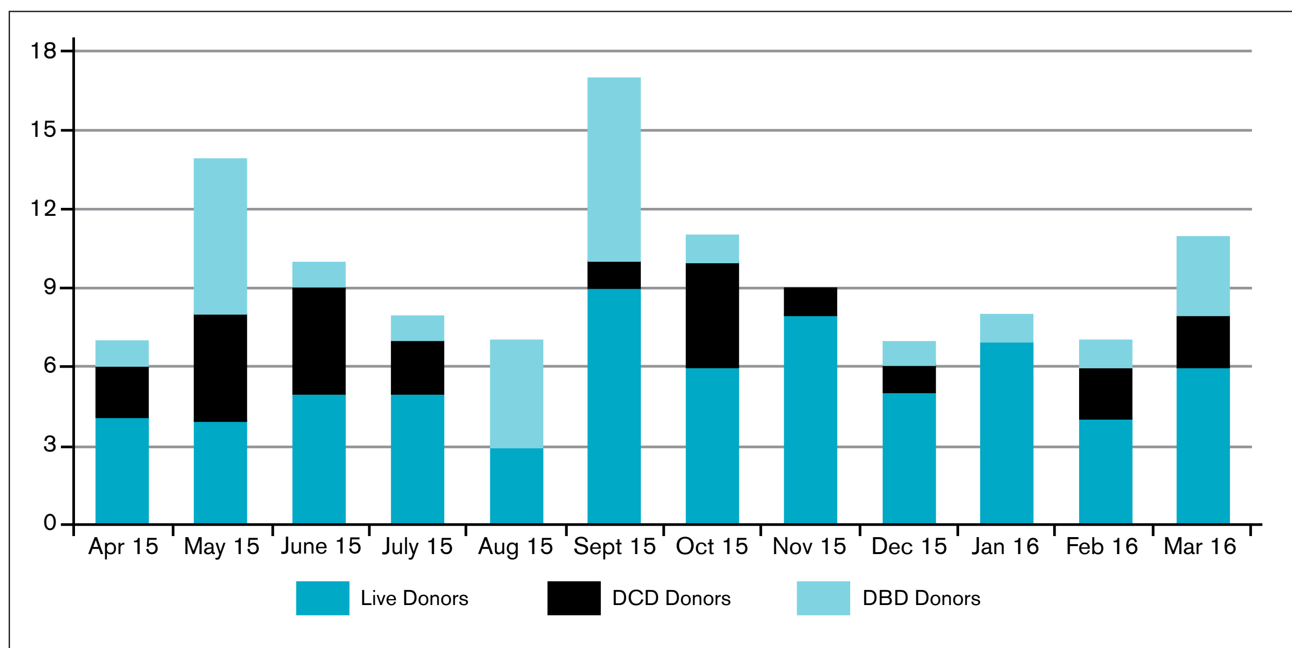


To improve the quality of access for the residents Newry and Mourne area of the Southern LCG, the HSCB has made significant investment in the trauma and orthopaedic team in the SHSCT. As a result of this investment all hip fracture patients in the SHSCT area will be treated locally rather than being transferred to Belfast.

Organ transplants

During 2015/16, a total of 116 kidney transplants, including live, DCD (donation after cardiac death) and DBD (donation after brain death) donors were delivered in Northern Ireland. This is an increase on the number of transplants delivered in 2014/15 (98).

Figure 5: Organ transplants



Quality assurance and quality improvements for population screening programmes

Population screening actively seeks to identify disease, or pre-disease conditions, in people who believe themselves to be well in relation to the disease or condition being screened for. The aim is to reduce the risk of future ill health through the provision of information and/or treatment.

Population screening programmes are complex systems of care, which comprise multiple elements. These include: policy setting; equipment procurement; staff training; quality assurance; identifying and inviting eligible people; information management; public and professional communication; taking and reading tests; follow-up and failsafe; diagnosis and intervention. Screening is a programme: not just a test.
The PHA is responsible for the quality assurance and commissioning of a number of antenatal, newborn and adult screening programmes. These are listed below.

Antenatal and newborn screening programmes:

- Antenatal infection
- Newborn blood spot
- Newborn hearing

Adult screening programmes:

- Abdominal aortic aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic eye retinopathy

Quality assurance is an integral part of screening because screening can cause harm; as well as benefit. It helps to maximise the benefits and minimise harms. The aim of quality assurance in screening is to maintain acceptable standards and continuously improve the quality of the programmes. Each screening programme has a quality assurance structure which monitors the performance of the service and facilitates continuous quality improvement. This usually takes the form of a quality assurance committee, coordinating group or quality improvement group chaired by a consultant in public health. Examples of quality assurance activity include: regular monitoring of performance against national standards; benchmarking local performance against performance in other UK countries; audit; participant satisfaction surveys; quality improvement activities; multidisciplinary quality assurance visits; the production of quality assurance reports; follow-up meetings; shared learning and training.

Quality assurance visits undertaken in 2015/16

AAA screening:

- Belfast HSCT - October 2015

Bowel screening:

- Northern HSCT - November 2015

Breast screening:

- Belfast HSCT - May 2015
- Western HSCT- December 2015

Screening programme performance

The following tables indicate that for the majority of screening programmes, key standards and targets are being met or exceeded. Work to promote informed choice about population screening programmes has been taken forward at HSCT level and regionally. This includes work to reduce barriers to accessing screening programmes and promote equality of access.

Table 2: AAA screening data for 2015/16

Pathway standard	Acceptable	Achievable	2015/16 position
Uptake (initial screening) Percentage of subjects offered screening who are tested	≥ 75%	≥ 85%	83%
Timely referral Percentage of men with AAA > 5.5cm referred within one working day	≥ 95%	100%	100%
Timely treatment/intervention by specialist (measured from date of referral) Percentage of men with aorta > 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within eight weeks	≥ 60%	≥ 80%	80%
Post-operative mortality (assessed annually) 30 day mortality following elective AAA surgery	≤ 6%	≤ 3.5%	0%

Table 3: Breast screening data for 2014/15

Measure	Standard/target/comparative data	Outcome
Uptake	Minimum standard >70%	75.3%
	Target 80%	
Round length	Minimum standard >90% first offered appointments within 36 months of previous screen Target 100%	97.4%
Invasive cancer SDR*	Minimum standard >1.0 Target >1.4	1.3

* The standardised detection ratio (SDR) measures the ratio of screen detected invasive cancers to the number expected (if the screening programme was detecting invasive cancers at a similar rate achieved by the Swedish two county randomised controlled trial).

Table 4: Bowel cancer screening uptake data for 2014/15

Measure	Standard/target/comparative data	Outcome
Uptake	55% (2014/15 commissioning directions target)	56.8%

Table 5: Cervical screening coverage data for 2014/15

Measure	Standard/target/comparative data	Outcome
5 year coverage	80%	77.1%

Table 6: Diabetic retinopathy uptake data for 2014/15

	Total Invited	Total Attended	Outcome
Northern Ireland	60562	45118	74%

Table 7: Antenatal screening data for 2014/15

Measure	Standard/target/comparative data	Outcome
90% uptake of all four screening tests	NSC IDPS 2010 standards	>99%

Table 8: Newborn blood spot screening data 2014/15 (most recent data available)

Measure	Standard/target/comparative data	Outcome
Timely sample collection	95% of first samples taken 5-8 days after birth	98.50%
Timely processing of screen positive samples (PKU, CHT and MCADD	100% of positive screening results available and clinical referral initiated within four working days of sample	PKU – 100% CHT – 100% MCADD – 100%
Coverage (% of babies, born in and still resident, who have a conclusive test result recorded on CHS by 17 days of age)	Greater than or equal to 95% for all tests	PKU – 99.2% CHT – 98.3% MCADD – 99.2% CF – 99.1% SCD – 99.2%

Table 9: Newborn hearing screening data for 2015/16 (quarter 2)

Measure	Standard/Target/ comparative data	Northern Ireland
Coverage by 4 weeks of age (the proportion of babies eligible for newborn hearing screening for whom the screening process is complete)	Minimum 95.0% Achievable 99.5%	95.80%
Coverage by 3 months of age (the proportion of babies eligible for newborn hearing screening whom the screening process is complete by 3 months of age)	99.00%	98.70%

Improving antibiotic prophylaxis in caesarean section

A relatively high proportion of pregnant women in Northern Ireland are delivered by caesarean section (C-section) - 29% of all deliveries in 2013/14 equating to 7,250 women. Up to 8% of women who have a C-section will develop a postoperative infection (580 per year in Northern Ireland). There is a strong evidence base for the use of antibiotic prophylaxis to reduce the risk of postoperative infection in a number of surgical procedures, including C-section. NICE issued an updated clinical guideline, CG 132, on C-section in November 2011. This guideline was endorsed for implementation in Northern Ireland in November 2012.

The PHA established a small working group to review current practice across all obstetric units in Northern Ireland and to guide implementation of CG 132. Using information captured through our regional C-section surgical site infection (SSI) surveillance programme, we completed a baseline audit of practice in provision of antibiotic prophylaxis during C-section delivery. We examined choice of antibiotic used for prophylaxis and timing of antibiotic administration. We used our audit findings to inform and influence change across all obstetric units and discussed and planned change with key service providers. We supported all HSCTs as they refreshed their approach to C-section prophylaxis. Using our regional SSI surveillance programme to inform two further audits of practice, we monitored patient outcomes as CG 132 was implemented over a two year period.

By June 2015 all HSCT hospitals performing C-section moved to implementing the NICE CG 132 (Table 1). In 2013 Co-amoxyclav was the antibiotic of choice for prophylaxis in 65% of C-section deliveries. Timing of prophylaxis was predominantly after cord clamping (65% of C-sections), reflecting the antibiotic of choice (Charts 1 & 2). As we supported all HSCTs to implement CG 132 between 2013 and 2015, we documented (through our regional C-section SSI surveillance programme) a change in practice across all obstetric units. By 2015 we had successfully influenced a change in the antibiotic of choice for prophylaxis, with Cefuroxime used in 90% of C-section deliveries. Linked to this change in antibiotic of choice, we documented a change in timing of administration, with almost all prophylaxis for C-section now administered prior to skin incision (Charts 1 and 2).

Over a two year period all HSCTs implemented NICE CG 132 and changed their practice in antibiotic prophylaxis. Surveillance information captured through our regional C-section SSI programme was key to informing baseline activity and to monitoring changes in practice associated with implementation of CG 132 across all obstetric units. Through our SSI programme we demonstrated this change in practice did not adversely affect patient outcomes. Our regional rate of post-discharge C-section SSI continued to show improvement, reducing from 9.6% to 6.2%. Our regional rate of in-hospital C-section SSI remained low (0.4%).

Table 10: Hospitals implementing NICE Clinical Guideline 132 on caesarean delivery

Hospital	Q4 12	Q1 13	Q2 13	Q3 13	Q4 13	Q1 14	Q2 14	Q3 14	Q4 14	Q1 15	Q2 15
Ulster	*	*	*	*	*	*	*	*	*	*	*
Craigavon area				*	*	*	*	*	*	*	*
Daisy Hill				*	*	*	*	*	*	*	*
RUMS					*	*	*	*	*	*	*
Antrim Area						*	*	*	*	*	*
Causeway							*	*	*	*	*
Altnagelvin								*	*	*	*
South West Acute											*

Chart 1: Timing of antibiotic prophylaxis in caesarean delivery (2008 – 2015)

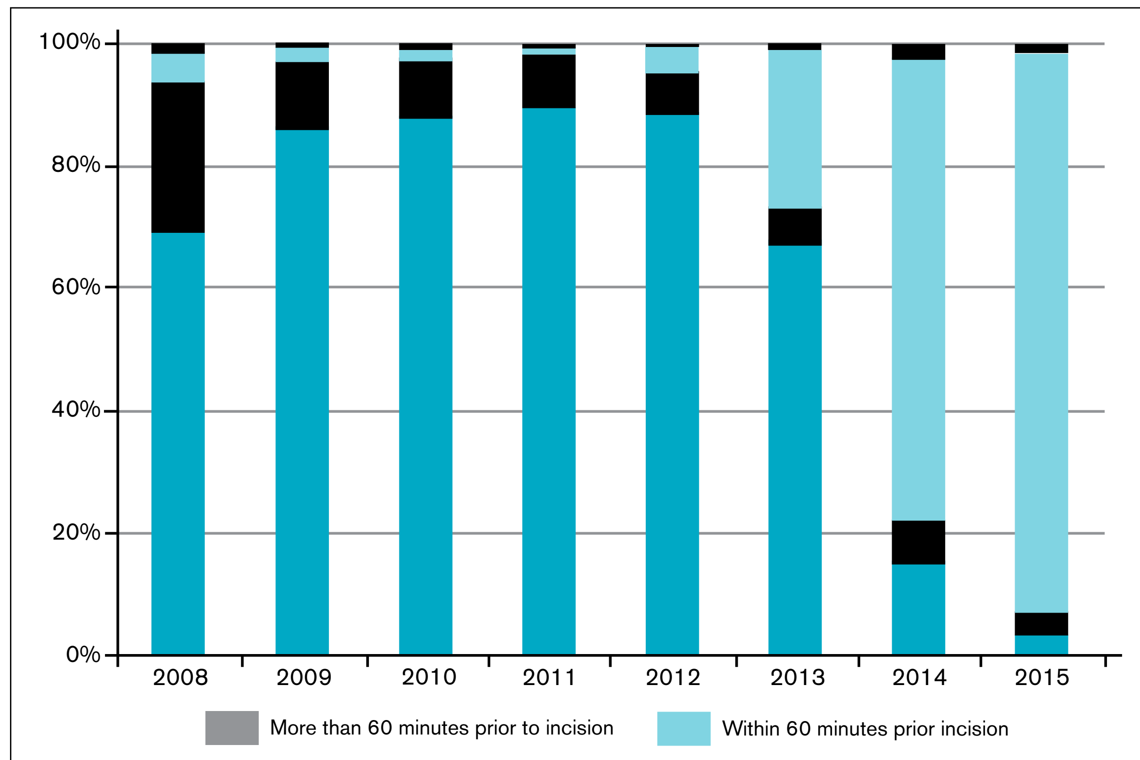
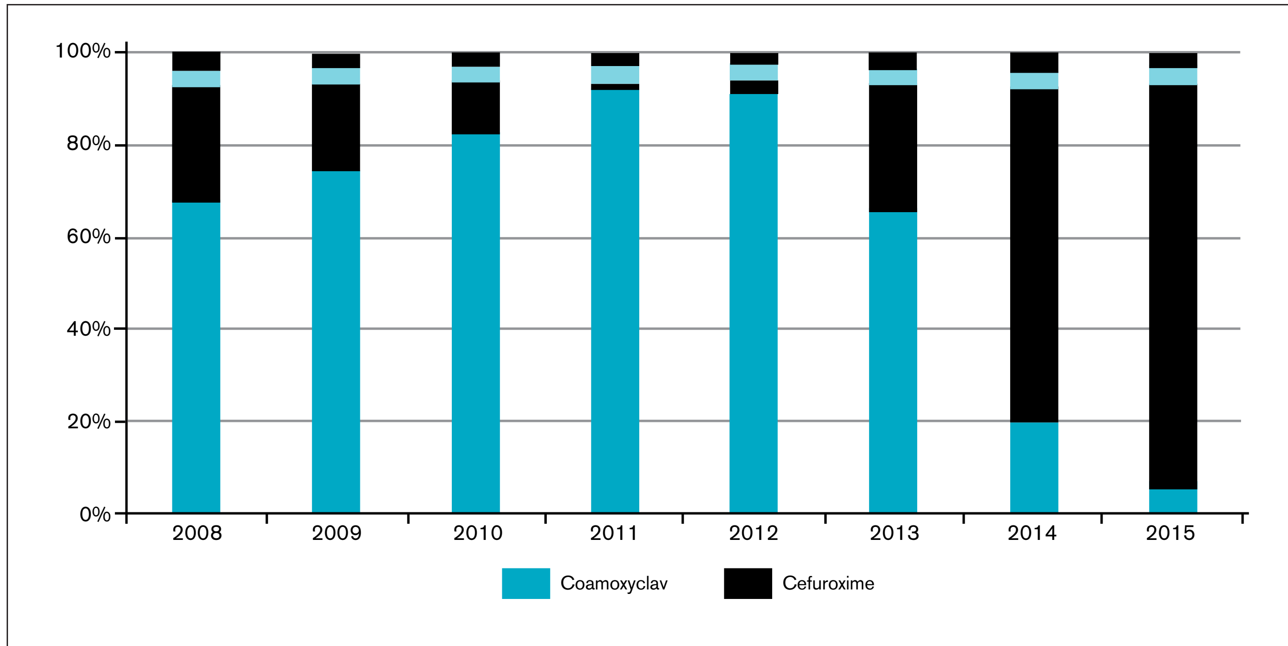


Chart 2: Antibiotic prophylaxis agent use caesarean delivery (2008 – 2015)



Quality improvement plans

The quality improvement plans are focused on key priority areas to improve the outcomes for patients/clients. HSCTs report on a number of indicators each quarter to the HSCB and PHA.

Last year we focused on:

1. Pressure ulcer prevention
2. Falls prevention
3. VTE risk assessment
4. The 'Malnutrition Universal Screening Tool' (MUST)
5. NEWS (National Early Warning Scores)
6. Omitted and delayed medications

Pressure ulcer prevention

While some pressures ulcers are unavoidable, many are preventable. The principal regional focus for 2015/16 was on the reduction of Grade 3 and 4 pressure ulcers. During last year the HSCTs implemented a process for carrying out root cause analysis (RCA) on all Grade 3 and 4 pressure ulcers, in conjunction with the roll out of the SKIN bundle.

Table 11: Regional rates and numbers of Grade 3 and 4 pressure ulcers, alongside HSCT rates by quarter and the number of avoidable pressure ulcers

Trust	No. of Grade 3 & 4 Pressure Ulcers					Rate of Grade 3 & 4 Pressure Ulcers per 1,000 Occupied Beddays				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	26	26	15	15	82	0.16	0.16	0.09	0.09	0.13
NHSCT	13	11	11	12	47	0.17	0.15	0.14	0.15	0.15
SEHSCT	9	11	7	9	36	0.12	0.15	0.09	0.12	0.12
SHSCT	3	2	2	8	15	0.05	0.03	0.03	0.11	0.06
WHSCT	5	3	5	5	18	0.07	0.05	0.07	0.07	0.07
REGION	**56**	**53**	**40**	**49**	**198**	**0.12**	**0.12**	**0.09**	**0.11**	**0.11**

Table 12: Number of avoidable Grade 3 and 4 pressure ulcers

Trust	Qtr 1	Qtr 2	Qtr 3	Qtr 4	15/16 Total
BHSCT	9	16	1	8	**34**
NHSCT	3	4	4	7	**18**
SEHSCT	2	1	3	1	**7**
SHSCT	1	0	0	2	**3**
WHSCT	5	2	3	4	**14**
REGION	**20**	**23**	**11**	**22**	**76**

The reported regional pressure ulcer incidence rates for Grade 3 and 4 ranges between 0.6% and 0.15% per 1000 bed days.

There are a number of individual hospital trusts in England report pressure ulcer incidence rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. In March 2016 the reported pressure ulcer incidence rates for these trusts range between 0 - 1.69% per 1000 bed days. It should be noted that this initiative uses incident rates to compare improvement overtime, but not for the purpose of comparison between trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

Falls

The 2015/16 commissioning plan requirement stated: "HSCTs will continue to improve compliance with Part B of the 'Fallsafe' Bundle. HSCTs will spread the regionally agreed elements of Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented. HSCTs will monitor and provide reports on bundle compliance, the number of incidents of falls, those which cause moderate or more severe harm and the rate per 1,000 bed days."

Table 13: Total number of falls recorded, the number resulting in harm of a moderate/ severe nature and the moderate/severe rates per 1,000 occupied bed days

Trust	Measure	Qtr 1	Qtr 2	Qtr 3	Qtr 4	2015/16
BHSCT	No. Falls	566	533	584	646	**2329**
	No. Moderate / Severe Falls	20	23	13	19	**75**
	Moderate / Severe Falls Rate	***0.12***	***0.14***	***0.08***	***0.11***	***0.11***
NHSCT	No. Falls	443	432	424	368	**1667**
	No. Moderate / Severe Falls	18	20	5	8	**51**
	Moderate / Severe Falls Rate	***0.24***	***0.27***	***0.07***	***0.10***	***0.17***
SEHSCT	No. Falls	388	445	403	370	**1606**
	No. Moderate / Severe Falls	15	17	9	5	**46**
	Moderate / Severe Falls Rate	***0.20***	***0.23***	***0.12***	***0.06***	***0.15***
SHSCT	No. Falls	267	251	270	235	**1023**
	No. Moderate / Severe Falls	12	9	16	23	**60**
	Moderate / Severe Falls Rate	***0.18***	***0.14***	***0.24***	***0.33***	***0.22***
WHSCT	No. Falls	328	298	414	388	**1428**
	No. Moderate / Severe Falls	20	17	11	0	**48**
	Moderate / Severe Falls Rate	***0.29***	***0.26***	***0.16***	***0.00***	***0.17***
REGION	No. Falls	1992	1959	2095	2007	**8053**
	No. Moderate / Severe Falls	85	86	54	55	**280**
	Moderate / Severe Falls Rate	***0.19***	***0.20***	***0.12***	***0.12***	***0.16***

For 2015/16 the reported regional outcome measure for rates from falls resulting in moderate to severe harm are 0.11 to 0.22 per 1000 bed days.

There are a number of individual hospital trusts in England report falls resulting in moderate to severe harm rates per 1000 bed days as part of the NHS England Open and Honest Care Driving Improvement initiative. In March 16 the reported moderate to severe harm for falls incidence rates for these HSCTs range between 0.08 – 0.21% per 1000 bed days. It should be noted that this initiative uses incident rates to compare improvement overtime, but not for the purpose of comparison between HSCTs as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

A thematic review of SAIs relating to patients with a fall resulting in moderate to severe harm was carried out in 2015/16. It was evident from the review that there is regional variation in the approach to reporting, investigation, and in identification of learning from these incidents, therefore resulting in potential missed opportunities to prevent harm. In recognition that this is a significant area of risk to patients, there is a recommendation to introduce a different method of reporting which puts in place a consistent regional post falls review evaluation process. This work is being led by the regional falls group which is chaired by the lead nurse for quality and safety and patient experience in the PHA, with a focus on quality improvement, safety and learning.

VTE risk assessment

The 2015/16 commissioning plan states: "HSCTs will sustain 95% compliance with VTE risk assessment across all adult inpatient hospital wards throughout 2015/16." While all HSCTs have reported progress towards the 95% target for compliance of the VTE risk assessment, no HSCT has met this during any quarter of 2015/16. All HSCTs have reported challenges with achieving this target but there has been a small improvement noted since last year.

The compliance with the VTE bundle from April to March 2014/15 was between 77-88% compliance, whereas the regional compliance range for 2015/16 was between 88-92 % with a small but steady progress noted for each HSCT each quarter. Regionally during 2015/16 there were 27,067 audits undertaken with 24,285 compliant – this equates to percentage compliance throughout the year of 90% for the region. All HSCTs have spread the risk assessment to 100% of required areas.

The 'Malnutrition Universal Screening Tool' (MUST)

The 2015/16 commissioning plan requirement states: "% compliance of the completed MUST tool within 24 hours admission to hospital in all adult inpatient wards by March 2016." By quarter 4 in 2015/16 there was a regional percentage compliance of 94% with MUST.

Spread of the MUST tool has been consistent at 100% for each HSCTs during each quarter in 2015/16.

NEWS (National Early Warning Scores)

The 2015/16 Commissioning Plan requirement states: "% compliance with accurately completed NEWS charts." Regionally the % compliance has increased each quarter over the year.

Spread of the NEWS tool has reached 100% for each HSCT at the end of the final quarter for 2015/16.

Measuring improvements from complaints

The Regional Complaints Sub-Group (RCSG) meets on a bi-monthly basis and is chaired by the HSCB Complaints and Litigation Manager. Membership comprises professional representatives from HSCB, the PHA and Patient and Client Council (PCC). Improvements have been made in several areas as a result of complaints.

Do Not Attempt Resuscitation (DNAR)

Complaints relating to DNAR and the communication/lack of communication of such decision(s) to patients and/or families continue to feature in monitoring returns received from the HSCTs. A failure around communication on DNAR decisions has also been the subject of a recent Royal College of Physicians Audit. The relevant professional representative on the RCSG reviewing these complaints has ensured that relevant information from the monitoring returns has contributed to informing the development of the Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Operational Policy, which is currently in draft form.

Enhancement of communication between Allied Health Professionals and parents

Relevant information from complaints is discussed at the Allied Health Professionals (AHP) governance meetings. The need for enhanced communication between the health and education sectors and parents has been identified from complaints and within a review of AHP support for children with statements of special educational needs. A plan is in place to revise the format of how therapy programmes will be provided to children requiring access to occupational therapy services.

Dementia

During 2015/16 complaints relating to patients with a dementia have been shared with relevant professionals. The information and experiences of patients and their families derived from complaints demonstrate initiatives that have been undertaken by some HSCTs in relation to the discharge arrangements for patients with a dementia, and the mechanisms in place to enable families and carers to spend more time with their loved ones in hospital. In addition the information has contributed to the development of the Northern Ireland Dementia Learning & Development Framework. The strategy promotes early assessment and diagnosis; helps to raise awareness in providing information and support to families, and has overseen the introduction of 'navigators' to work with patients and their families.

Family Practitioner Services complaints

General Medical Practice

- Complaints from patients regarding removal from their GP Practice list due to a breakdown in the doctor/patient relationship, as a result of verbal or physical abuse by the patient towards staff, still feature relatively frequently. While the removal has been justified and in accord with the zero tolerance policy, on occasions Practices have been over-reliant on this policy and failed to fully comply with the GMS (NI) contract when removing the patient. Subsequently, this has resulted in findings of maladministration by the Ombudsman.

When presenting at Practice Managers' Forums, Board complaints staff continue to emphasise the importance of compliance with these regulations and on occasions have re-circulated, to individual Practices, anonymised sections of an Ombudsman investigation report concerning this matter; highlighting the failings that were identified and the specific requirements the Practice is required to fulfil when removing a patient under these circumstances.

- As a result of a complaint regarding, amongst other issues, the lack of contact from the GP Practice with the family following the death of patient suffering from cancer, the GP Practice conducted a Significant Event Analysis. The Practice, while cognisant that time constraints prohibited a home visit in every case, agreed in future to review all deaths within the Practice and seek to respond sensitively and sympathetically in all cases, potentially making use of a standardised 'sympathy card'.

Maternity and gynaecology

- A number of complaints regarding pregnant patients presenting at Emergency Departments (ED) with reduced foetal movements were discussed at the RCSG. Following receipt of an SAI investigation into one of these incidents, a reminder of good practice letter was issued to HSCTs to ensure that patients are assessed by obstetrics prior to discharge.

- A patient complained that she and her unborn baby were not treated with dignity and respect within an Early Pregnancy Unit. She felt that there was poor communication with her, no understanding by staff of what was happening, she was not listened to when she indicated she was experiencing labour pains, and was upset by comments made by a nurse.

As a result of this complaint a number of improvements have been made by the HSCT. These include additional training for staff when caring for a patient who has had a miscarriage, including bereavement care. In addition (early pregnancy) baby pouches, blankets and 'Moses' baskets have been introduced within the unit to preserve the dignity of the baby. Arrangements are also in place to ensure that community midwives are aware of circumstances when they receive referrals following miscarriage.

Stroke assessment

A patient was discharged home following attendance at an ED having had a neurological assessment undertaken, which was normal. The patient returned to the ED later that day with similar symptoms. As a result of this complaint, the HSCT has advised ED staff that where a FAST assessment has been undertaken, and a normal neurological assessment presents, should symptoms persist, it is important not to rule out the possibility of a further CVA event by undertaking a repeat FAST assessment.

GP out of hours

A complaint was received from a relative of a patient who attended GP OOHs with cardiac symptoms. The patient was assessed by the doctor but unfortunately died less than two hours later. Guidance was issued to doctors within the OOH Practice to ensure ECG tests are undertaken, when a patient presents with/advises of a history of chest discomfort

Service frameworks

Respiratory

The original respiratory service framework underwent a formal revision process in 2014, and following consultation, the revised version of the framework, which covers the 3-year period 2015/16 – 2017/18, was formally approved by DHSSPS in September 2015.

The revised RSFW recognises that several diseases can co-exist, share common risk factors and can adversely impact on prognosis; therefore the revised service framework includes both standards for specific respiratory conditions, as well as standards relating to all respiratory conditions, and also generic standards relating to a range of conditions. There are a total of 46 standards for the whole care pathway for respiratory diseases from prevention through diagnosis, treatment, ongoing care, rehabilitation to palliative and end of life care. Each standard is supported by a number of key performance indicators (172 in total), which set levels of performance to be achieved over the three-year period.

Implementation of the revised RSFW is overseen by the Regional Respiratory Forum. The membership of the Regional Respiratory Forum and the terms of reference have both been revised to meet the need of the implementation of the revised Respiratory Framework. A detailed implementation plan has been developed which sets out arrangements for how the revised respiratory framework will be implemented across the region.

A baseline assessment exercise has recently been completed, which assessed each HSCT's ability to be able to measure progress and report against the framework standards. This exercise was then followed up with HSCT visits to each of the five HSCTs in May 2016, where key HSCT respiratory clinical and managerial leads were able to meet with PHA/HSCB colleagues to discuss implementation of the framework and any issues and concerns with regards to performance and information systems. The Respiratory Forum in collaboration with HSCTs and all other stakeholders is working to gather information to develop a formal end of

year 1 report which will be submitted to DoH by September 2016.The revised Framework will continue to be subject to regular review and refinement, to ensure it provides a sound basis for continued improvement in the quality of health and social services.

Cancer

The *Service Framework for Cancer Prevention, Treatment and Care* (abbreviated to Cancer Service Framework) was published in 2011. It set out 52 standards for cancer that specifically focussed on prevention, diagnosis, treatment, care, rehabilitation and palliative care and outlined the anticipated levels of performance over a three year period.

The framework standards have been substantially achieved and the framework document is currently being revised to take account of the latest evidence base and advances in diagnostic and treatment technologies.

The revised document will build on the existing draft and will explicitly identify standards and indicators. This amended document will be a 'Cancer Services Indicator Framework' and is expected to be published by the PHA/HSCB by October 2016.

Cardiovascular

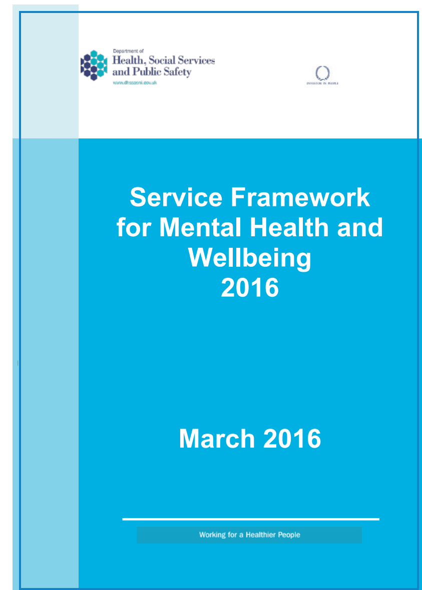
Following an extensive review, a revised Cardiovascular Service Framework was published in 2014. The framework comprises 42 standards and over one hundred key performance indicators, in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of the individuals and communities who currently have, or are at greater risk of developing, cardiovascular disease. A Cardiovascular Service Framework Implementation Group was convened in 2014 and 6 Section Leads appointed for each of the condition-specific sections: vascular; renal; cardiology; stroke; research & development and medicines management. Progress reports are produced annually, with an interim report produced mid-year. The progress report for year 1 of the framework (2014-15) was issued to DoH in autumn 2015. As with many of the frameworks, problems have been encountered with developing data sources, difficulties with IT systems and gaining access to datasets.
Although data could not be provided for all the anticipated indicators, key achievements include:

- Targets were exceeded for the indicators relating to peripheral artery disease in terms of management with anti-plaitlet medication and blood pressure readings and cholesterol levels within acceptable levels.

- An e-alert system is now in place, which flags inpatients at potential risk of acute kidney injury requiring clinical review and intervention as appropriate.

You In Mind mental health services framework

The aim of the revised Service Framework for Mental Health and Wellbeing (draft) is to provide guidance on the steps of mental health care to be delivered by HSCTs. It is designed also to enhance the quality of service experience and promote consistency of service delivery across Northern Ireland. The *"You in Mind Mental Health Service Framework'* was the first framework to be co-produced with people with lived experience alongside carers, professionals, voluntary sector agencies, HSCB, PHA and DoH staff. The new framework sets out the standards of care that individuals, their carers and wider family can expect to receive from the HSC system. It is an agreed way of providing care which enables the development of a whole system model for mental health care delivery across the North of Ireland. The new framework enables mental health services to profile need, sets out the range and scope of evidence based interventions provided across mental health services and facilitate the systematic measurement of clinical and care outcomes of citizen experience.



The revised Service Framework for Mental Health and Wellbeing 2016 reflects the principles and values of the 'You In Mind' Regional Mental Health Care Pathway and contains 10 key standards which are supported by 25 Clinical Care Indicators and 21 Citizen based indicators. The framework not only provides a mechanism to audit the 'You in Mind' care pathway but represents a key reference point for all staff in the implementation and promotion of quality across mental health care services. The framework has also led to the establishment of The You in Mind Mental Health Informatics Project for Northern Ireland. This has resulted in the development of an innovative managed care data framework based on the Institute for Healthcare Improvements' Triple Aim Quality Indicators. The aim of the project is to design and test electronic solutions for mental health care which when implemented will deliver routine evidence for the HSC system in Northern Ireland which will allow us to know how we are doing in delivering mental health care.

Learning disability

The aim of the Learning Disability Service Framework (LDSFW) is to improve the health and wellbeing of people with a learning disability, their carers and their families by promoting social inclusion and reducing inequalities in health and improving the quality of care. There are 34 standards and 85 KPIs in the Service Framework for Learning Disability

Year 1 focused on establishing a baseline for the indictors using a range of audit tools. An excel sheet outlining the baseline position as of 31 March 2015, for each of the five HSCTs, HSCB and PHA is complete. Monitoring templates are currently with the five HSCTs to provide data for 2015-2016. The monitoring data being gathered will allow performance levels for 2016-2017 and 2017-2018 to be agreed and developed with the HSCTs. The monitoring data will also help identify areas where change in practice is required.

Key outcomes to date:

- 77% of the files audited during case note review demonstrated evidence that people with a learning disability, their families/carers have been involved in making choices or decision about their individual health and social care needs.

- 93% of the files audited during case note review were able to demonstrate a preferred form of communication if the service user did not use speech as their main form of communication; this is an improvement from last year.

- There is evidence of transfer to directed enhanced services, where appropriate, for health checks for children on transition to adult services ie all GP practise run a search on date of birth and ensure those eligible are invited for health check.

- Regional guidelines on sexuality and personal relationships have been developed as well as an operational protocol developed by five HSCTs.

- Guiding Principles for Personal Relationships and Sexual Health Training (for Adults with Learning Disability, Parents, Carers and staff working with Adults with Learning Disability) have been developed. The guiding principles define values that underpin relationship and sexuality education, to ensure best practice relationship and sexuality training is being developed and delivered.

- Funding is currently being explored with PHA to facilitate the delivery of appropriate training this year for staff to support the implementation of the personal relationships and sexual health operational protocol.

- The HSC Board and HSCTs have provided evidence that they have plans in place to extend the range and scope of self-directed support including how they will develop skills and expertise in relevant staff.

Older people

Older People Service Framework has benefitted from a range of initiatives in relation to person centred care, safeguarding, carers, transitions of care, re-ablement and self-directed support. These have all lead to the provision of more person centred, individualised support to older people and their carers.

Key areas of progress are:

Person centred care:

- There will be a person centred care module and advocacy awareness in the training programme for the Dementia Champions (currently being recruited). Person centred care is also one of the themes of the Northern Ireland Dementia Learning and Development Framework

- As at April 2016 56, 740 assessments using eNISAT were completed and 3009 staff registered as users on the system. eNISAT has now achieved full technical implementation in older people teams regionally.

Safeguarding:

- NIASP and LASP annual action plans include prevention plans.
- Information cards on how to access safeguarding are being distributed to service users and their carers.
- Provider organisations ensure staff are trained on how to recognise abuse and access safeguarding services.

Conditions more common in older people

- The Northern Ireland Dementia Learning and Development Framework was developed following an extensive regional scoping exercise which collated the type and volume of training currently available to staff in Northern Ireland which included the cost and accessibility of training programmes and existing levels of accreditation. This framework outlines the core themes in terms of the knowledge and skills that health and social care staff require in order to interact and respond sensitively to the needs of people living with a dementia and their carers.
- A delirium best practice bundle has been developed by Dementia Together NI project team. A training programme has been developed and delivered to more than 500 hospital staff.
- A regional tool has been developed to record screening, assessment, diagnosis, prevention and management of delirium. Use of tool began in February 2016 in pilot wards.

NICE

NICE is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
NICE produce different types of guidance, including Technology Appraisals (new drugs, medical treatments and therapies), Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions) and Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB have put in place processes to ensure that all Technology Appraisals, Clinical Guidelines and Public Health Guidance approved by NICE and endorsed by the DHSSPS are implemented within Northern Ireland.

During 2015/16, the HSCB issued 41 Technology Appraisals to HSCTs and continues to monitor the implementation of 130 CGs and which have been issued to the service.The implementation of NICE guidance can often be the driver for changes in service in a wide range of areas, as it provides commissioners, clinicians and health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found on the HSCB NICE webpage. (http://www.hscboard.hscni.net/nice/)

Using data to measure improvements in primary care

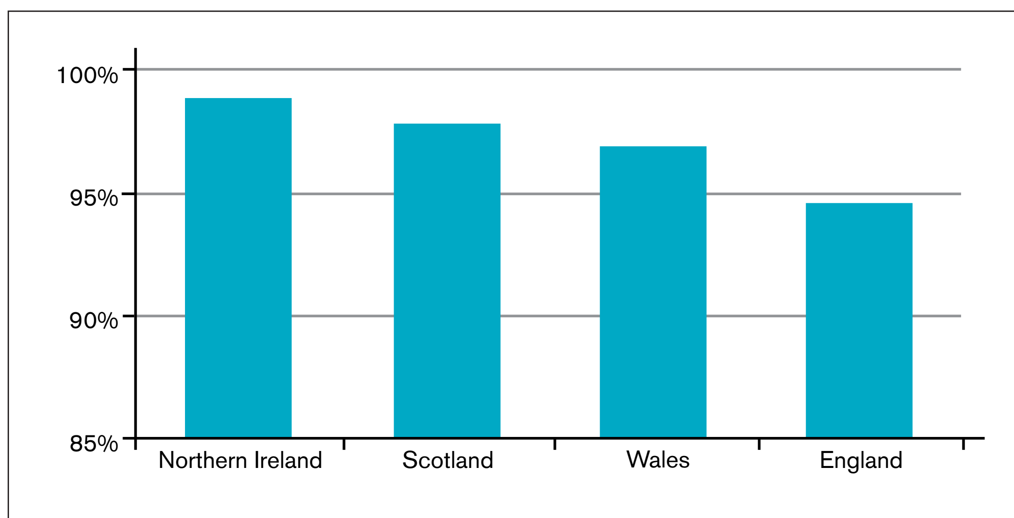
Quality and outcomes framework

There is growing evidence that if people with long term conditions can be supported to manage their condition they will reduce their risk of complications. For example people with high blood pressure (hypertension) who can keep their blood pressure in a safe range through a combination of lifestyle choices and medication are less likely to have strokes and heart attacks.

Based on this evidence, the Quality and Outcomes Framework (QOF) was introduced for GPs across the UK in 2004 to measure achievement against a range of clinical indicators, with points and payments awarded according to the level of achievement. Although participation is voluntary, all 349 practices inNorthern Irelandhave chosen to participate.

GP practices in Northern Ireland have always achieved high QOF Clinical outcomes compared to their colleagues in the other countries. 2014/15 shows that GPs in Northern Ireland achieved 99% of available QOF points.

Figure 6: % QOF achievement 2014/15



Even though our GPs perform well compared to the rest of the UK we are still working hard to improve. Within the HSC Board (Integrated Care), the QOF data is further analysed to provide a picture of the overall clinical outcomes for patients with a range of long term conditions including high blood pressure, diabetes, stroke, asthma, COPD and heart disease.

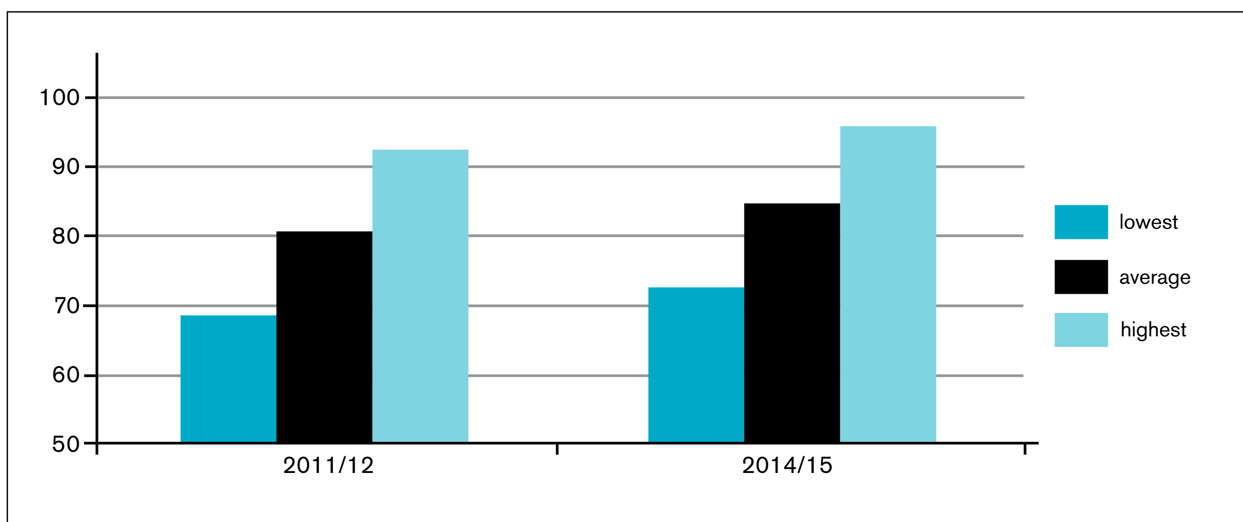
Each practice is provided with an annual report allowing them to compare each clinical outcome with other practices across Northern Ireland. Medical Advisors and practice support staff from the Directorate visit each practice every three years to discuss their achievements and share good practice to improve outcomes.

This focus on measurement and improvement through the combined efforts of individual GP practices and the HSCB has resulted in gradual improvement in the control of some long term conditions, for example in April 2016, 26,058 more people had good control of their blood pressure than in April 2011.

It is really important that everyone has the best possible control of their long term condition, regardless of where they live. If a practice shows lower than average outcomes for management of several conditions they will have a focused visit by Integrated Care (HSCB) staff who will agree an action plan with the practice to improve their outcomes. The practice will then receive annual visits until their outcomes have significantly improved. This focus helps to reduce any inequality between practices.

The graph below shows the indicator for the control of high blood pressure to less than 150/90 (In 2011/12 this was based on QOF indicator BP5, in 2014/15 this was based on QOF indicator HYP002NI). As well as overall improvement, the lowest performing practices have improved the most, therefore reducing the gap between lowest and average performance.

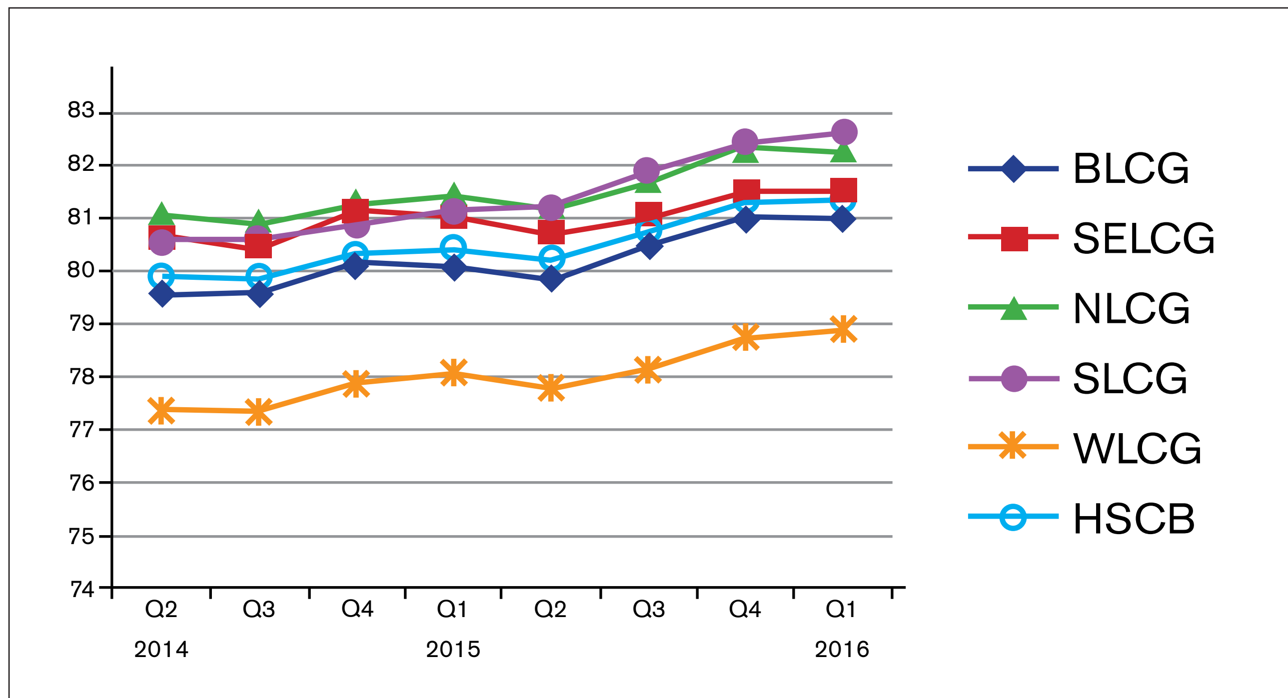
Figure 7: Control of high blood pressure to less than 150/90



Prescribing in primary care

In 2014/15, the Northern Ireland Audit Office published its report on Prescribing in Primary Care. This was followed by a review by the Public Accounts Committee. Later in 2015/16, RQIA published its Review of Medicines Optimisation in Primary Care. In each of these reviews there was recognition of the good work of the HSCB pharmacy and medicines management team. There were also consistent themes in respect of prescribing variation, costs and medicines utilisation in primary care. It was highlighted that in Northern Ireland, we spend comparatively more on medicines in primary care than other countries in the UK. Conclusions based upon comparisons based solely on cost in one sector are not valid given the structural differences in health and social care between countries eg in Great Britain, there is much more dispensing of medicines from hospital outpatients. One of the factors that can be considered is generic prescribing frequency and over the years, primary care prescribers have made steady progress in utilising generic medicines where this is appropriate to do so. The graph below still highlights a degree of variability in certain areas and work is ongoing to maximise the use of generic medicines in order to free funding up for use for patient care in other parts of the HSC.

Figure 8: Generic prescribing rate (%)



Measuring improvements in PPI

The PHA has completed the second annual PPI monitoring process in HSCTs. The PHA has a responsibility for monitoring PPI across the HSC system, but has particular responsibility for providing assurances to the Department of Health (DoH) in relation to the compliance with and progress of PPI in HSCTs. This process was initiated for the first time in 2015.

The monitoring is undertaken using mechanisms and arrangements co-designed with members of the Regional HSC PPI Forum including service users and carers. Service users and carers are also an integral part of the review team. HSCTs are measured against the PPI Standards and associated Key Performance Indicators (KPIs), to help assess progress against compliance with PPI.

In each HSCT there has been considerable progress in many areas while others require additional actions to imbed PPI. All HSCTs have received a PPI Monitoring Report detailing recommendations to support the development of PPI across their organisation

Measuring improvements in social care

The personality disorder regional network audit programme

The personality disorder regional network audit programme team (comprising staff from the HSCB, HSCTs and PBNI staff, service users and family carer representatives) has developed an audit framework to test the implementation of the regional personality disorder care pathway and identify areas for service improvement.

Two service audits have been completed:

- specialist functions for personality disorder services identified in NICE guidelines;
- key performance outcomes identified by service users and family members.

A third audit of triangle of care standards is underway.

Each HSCT service has developed an improvement plan and commissioning/resource priorities have been identified for future service development.

Case note review

The HSCB is responsible for providing updates to the DoH on the performance of the HSCTs against the standards and indicators in the Service Framework for Learning Disability. An objective baseline for the indicators has been established for 2014-2015 in partnership with the HSCTs using a range of audit tools. The main outcomes is to provide robust qualitative measures that can be monitored and reviewed to ensure standards improve over an agreed timescale delivered against key performance indicators. The audits also identify areas where change in practice is required.

A case note review was one of the audit tools completed across the five HSCTs to determine 2014-2015 baseline position for several of the KPIs. Between November 2015 and December 2015 the case note review was repeated to determine performance for several of the KPIs in the Learning Disability Service Framework. The case note review process involved the development of a set of questions in consultation with the HSCTs, which was then transferred onto an excel sheet to allow the audit to be completed electronically. The sample was agreed using the sample calculator tool provided by GAIN. The case note review audit carried out file checks on 450 files across the region, 90 per HSCT, 30 files per locality. The findings of the case note review have determined a series of recommendations for the HSCTs to implement in the next year in order to ensure improved practice and systems of care.

Key observations:

- 77% of the files audited during case note review demonstrated evidence that people with a learning disability, their families / carers have been involved in making choices or decision about their individual health and social care needs.

- 93% of the files audited during case note review were able to demonstrate a preferred form of communication if the service user did not use speech as their main form of communication; this is an improvement from last year.

- The HSC Board and HSCTs have provided evidence that they have plans in place to extend the range and scope of self-directed support including how they will develop skills and expertise in relevant staff.

- There was marked improvement in the presentation of files which included layout and content from last year, as well as evidence of more up to date reviews; service user and carer participation; and carers' needs assessments completed.

Theme four:

Raising the standards

Improvements in patient and client experience

Patient and client experience has been recognised as a key element in the delivery of quality health and social care in a number of high profile reports. The evidence is that organisations that focus on patients have higher quality and efficiency, a safer patient environment, as well as greater employee engagement. Therefore the HSCB and PHA support the HSCTs in their implementation of quality improvements by using use both quantitative and qualitative information to ultimately improve the patient experience.

Implementation of the patient and client experience standards

The PHA in collaboration with the HSCTs have embedded a comprehensive Patient and Client Experience programme which uses a range of methodologies to gain the 'patient' experience of the health and social care to drive quality improvements, enhance the patient and client experience and monitor the implementation of the DoH Patient and Client Experience standards (Respect, Attitude, Communication, Behaviour, Privacy & Dignity).

These include:

- patient stories;
- observations of practice;
- questionnaires;
- 10,000 Voices initiative;
- complaints;
- SAIs.

Through this methodology the PHA gains a comprehensive overview of Patient Client Experience (PCE) in Health and Social Care and this information is used to affect and inform change by driving quality improvements.

During 2015/16 it was agreed that HSCTs would focus on improvement work.
The following four Patient Client Experience Regional Priorities were identified as a result of patient feedback and HSCTs have monitored these in 2015/16:

1. **Develop a process to reduce 'Noise at Night' in hospital;**
2. **Raise the profile of "Hello my Name is…" in community and primary care settings;**
3. **Monitor the availability of meals and drinks in EDs;**
4. **Work with HSC Trusts to implement and sustain improvements in relation to mixed gender accommodation.**

HSCTs have submitted updates to the PHA on each regional priority detailing implementation progress for 2015/16 associated with same and it is recognised there is a considerable amount of work being carried out in relation to these four regional priorities.

In addition HSCTs also agreed to focus on some local improvements based on their individual HSCT feedback and have submitted details of a number of areas they are working on to improve patient experience examples include:

- BHSCT has introduced a 'Ward Entrance Patient Information Notice Board' in (Adult Acute In-patient Wards) – the board highlights key patient experience and safety and quality indicators, 'meet the team' and 'Ward Sisters Commitments'. Post boxes are being added to these to enable patients and carers to 'post' their feedback.

- BHSCT held a 'SAFE-tember 2015'– Programme of events during the month of September which focus on patient, client and staff safety and quality.

- The NHSCT has introduced 'Dementia Champions' - Reflective Learning and annual updates in best practice with ward based Dementia Champions and Facilitators. This included the development of reminiscence folders for acute care wards where patients with dementia may be cared for. Work has commenced to re invigorate the 'Butterfly Scheme' with awareness sessions and lunch and learn sessions.

- Within the NHSCT the Macmillan Unit Antrim Hospital, Patient Care Survey has been introduced – findings have been presented to all cancer MGMs and action plans been developed to take forward recommendations for improving patient experience.

- SET Patient & Client Experience Programme has completed analysis of numerous acute wards, community-based services and hospital based services. Reports and posters have been produced and supplied to the local managers for development of action plans designed to make progress against all items rated at <90% compliance.

- SET has a 'Volunteer-Led Survey Programme' – This programme involves volunteers going around the wards to patients and helping them complete surveys. The volunteer-led programme currently has three types of survey running (General inpatient, Night-time, introductions) and recently supported data-gathering regarding the Smoke Free Site initiative.

- The WHSCT has engaged with community activities and minority ethnic groups including hard to reach groups. Member of Chinese Community has agreed to join local HSCT patient and client experience working group. Representatives from RNIB attended HSCT Board to provide experience journeying through the health care system.

- The WHSCT have implemented the award winning purple toolkit on dementia care across the acute hospital sites. A care bundle has been developed and will be used to evidence and determine if the patients with an underlying dementia diagnosis are receiving safe, effective and consistent care.

- Within the SHSCT four Directorates have identified, Top five Patient Client Experience Quality Improvement Initiatives (QIIs)

- Quality Improvement Leadership initiatives specific to PCE activity has been included as part of SHSCT specific leadership programme the 12 participant action learning activities need to include a person-centred focus

10,000 Voices

The PHA and HSCB commissioned the '10,000 Voices' Initiative to provide a vehicle which listens to and acts upon patient and client experience using story methodology to affect, inform and influence rapid changes in the way services are commissioned and delivered. The 10,000 Voices initiative has focused on a range of areas throughout 2015/16 including unplanned care, staff stories, care in the home, care delivered by NIAS and autism and CAMHS services.

During 2015/16, based on feedback from 10,000 Voices a number of tangible improvements to patient experience have been implemented across all HSCTs in Northern Ireland including:

- review of pain pathway for orthopaedic patients;

- provision of timely and appropriate pain relief in EDs;

- review of cleaning regimes;

- review of security arrangements;

- care of babies and young children in EDs;

- information for patients about waiting times and what will happen during their episode of care;

- improved signage to provide information for patients;

- Improvements in the provision of food and drinks in EDs.

Influencing regional policy and strategic direction/commissioning priorities

The patient experience information received through the 10,000 Voices has informed a number of regional work streams, for example:

- patient stories from unscheduled care areas are integrated into the regional unscheduled care programme team;
- regular feedback is presented to the local commissioning groups;
- findings in relation to time allocation and timing of calls for those who receive care in their own home were recognised and will be addressed as part of the review of domiciliary care in Northern Ireland;
- stories which describe the isolation and loneliness experienced by people who live alone will be addressed by working collaboratively with individuals, communities and partner organisations through the implementation of Making Life Better (DHSSPS 2013);
- the 10,000 Voices team is working in collaboration with the Regional Dementia Strategy Implementation Group to address a number of emerging issues in relation to the care of patients with dementia, including support for carers, knowledge and skills of staff and long waits in unscheduled care areas;
- the findings from the experience of women and their partners have been integrated into the regional guidelines for Midwifery Led Units (GAIN 2016);
- through 10,000 Voices, the patient voice is integrated into specific programmes of care and thematic reviews, for example acute oncology care, regional work in relation to long term conditions and thematic reviews on pain and nutrition.

Informing education and training programmes

Patient experience information provides a rich source of evidence on which staff can reflect and learn. Through the 10,000 Voices model opportunities for learning and development have been embraced through a number of ways, including:

- local awareness training in the care of patients with dementia;
- development of a person centred programme for Band 2/3 nursing staff;
- development of a patient experience DVD for staff induction and training, based on patient stories;
- development of a teaching session for undergraduate nurses, doctors and Allied Professionals.

Enabling staff and building capacity

A number of specialist teams are now progressing patient experience programmes by gaining skills in using the 10,000 Voices methodology. Through these programmes, teams are developing and enhancing skills to engage meaningfully with and work in partnership with people to improve experience in specific areas, such as Paediatric Autism and Child and Adolescent Mental Health, eye care services and adult safeguarding.

You in mind - your experience matters. Sensemaker Reaudit December 2015

The report presents analysis of data collected 2015 and offers comparison (where applicable) to data collected in 2012. A total of 665 and 720 narratives and self-signification data were collected in 2015 and 2012 respectively from the users of mental health care services, informal carers, and other respondents in five HSCTs.

There is a comparable data distribution across both capture periods, with 82% of data collected from health care services users, 13-14% - from carers, 1% - from informal carers, and 4% - from other respondents.

In summary, in 2015, compared to 2012:

- There was an increase in the respondents who said that they received the right service at the right time.
- More health service users suggest that the information provided by staff in mental health services was useful and relevant.
- There is no difference in how many respondents said they received no information in both periods.
- The proportion of people reporting that staff in mental services communicated in respectful and considerate manner has increased.
- Fewer respondents felt that they were ignored when their treatment was being planned.
- There was an increase in respondents who said there were fully involved and respected in both treatment processes respectively.
- More respondents reported that mental health services left them feeling stronger.
- Fewer respondents reported that everyday living, social, and leisure facilities were impacted most.
- More people reported that relationships with family and friends, everyday living, or both were impacted most.

- More respondents reported that they had made positive progress and fewer people said that there was no change after using mental health services.

- More respondents suggested that practical support would have made the biggest difference to them.

- Marginally fewer respondents reported that receiving useful information and being treated with compassion and sensitivity would have made the biggest difference to them.

- More respondents (and more users of services) in the current period said that their journey within mental health services was smooth running and the overall number of people reporting that their journeys within mental health services were confusing decreased.

Also, in 2015:

Approximately one third of all respondents say that they are hopeful for the future and a little less than one third are still working with others to plan the future.
To the majority, recovery has been an important part of their treatment.
More than two thirds said that their physical health care needs were discussed in detail

Carers survey

A Carers survey which aimed to capture the experience of informal carers aged 16 years and over of the carer assessment process has been established.To measure if the Carers Support and Needs assessment process introduced as a component of NISAT in 2011 delivered a person centred assessment to carers as was its intent. A number of completed surveys, demographics (age and gender) and location of carers, number of persons they care for, circumstances of person they care for, timeliness of assessment, choice in location and time of assessment, written information/support available to carer. Themed responses on what is important to carers in terms of how assessments are conducted. These included being listened to, recognition of the caring role, receiving support, carers health and flexibility in professional visits/timing of assessments.

Learning from complaints

Health and Social Care learning from complaints annual event

During 2015/16, the HSCB hosted its second annual learning from complaints event in June 2015. The event focused on the theme of 'communication' as this issue features in a significant number of complaints regarding Health and Social Care services. To illustrate this point, from April 2014 to end March 2015, the HSCTs received 7,015 issues of complaint, of these 877 related specifically to communication and information. If complaints regarding staff attitude and behaviour are included, this number rises to 1,989, which is greater than the number of complaints received regarding treatment and care. In addition, of the 230 returns received by the HSC Board regarding Family Practitioner Services (FPS), 59 related to communication. If complaints about staff attitude and behaviour are added to this amounts to 115 complaints of which communication plays a part. Furthermore, the HSC Board has heard directly from service

users of the importance of communication at focus groups, and therefore decided to take the positive step to dedicate its second Learning from Complaints Event to this theme.

Approximately 100 persons were in attendance, with representation across the HSC.
The event had two keynote speakers; Ms Marie Anderson (Deputy Commissioner for Complaints, Northern Ireland) and Mr Hugh McCaughey, (Chief Executive, South Eastern Health and Social Care Trust).

Key messages from the day included, the importance of making an apology; continually learning from mistakes and from patient interactions; the importance of creating a culture within organisations whereby staff identify situations which could have been handled better, thus improving the overall service provided to service users; and barriers to communication and how to overcome these. In addition, the audience heard and reflected on some very powerful messages from two service users who described their complaint and outcome via a pre-recorded video.

Feedback from this event has identified that the quality of communication and information provided to patients and families, is at times sub-optimal, which subsequently leads to further upset and distress of service users.

Service user focus groups

As part of the ongoing evaluation of the effectiveness of the HSC Complaints Procedure, the HSCB also hosted a service user focus group during November 2015, specifically for older persons and carers. This focus group also fulfilled the objectives set out in the 'HSCB Audit of Inequalities Action Plan' (2013 - 2018), which states that work should be conducted to, 'Identify and overcome barriers which prevent service users from making complaints and ensure that the HSC Complaints Procedure is accessible for everyone in Northern Ireland, regardless of characteristic'.

Feedback from this focus group, demonstrated that privacy and dignity, to include communication, remain major issues of concern. It was noted that these issues are embedded within the majority of complaints within primary and secondary care. Therefore to acknowledge and address this issue, these topics will be reviewed in greater detail at a Complaints Learning Event in 2016.
In addition, a further workshop specifically for those persons with a disability will be organised during 2016/17. The outcomes of which will help inform the HSCB, how the public perceive their experiences of health and social care services, how to improve the complaints process and how to address the reluctance on the part of some service users to raise a complaint, possibly due to fear of impact on their, or their relative's on-going treatment and care.

Raising the standards for older people

Building a vision for nursing in older peoples' services

The Northern Ireland Education Commissioning Group for Nursing & Midwifery Education hosted a regional workshop in September 2015 which aimed to review the changing perspectives for older people's services including the impact for nursing workforce within older peoples caring environments; and inform pre and post registration training with models of good practice.

During the discussions at the workshop a set of draft regional and local actions were produced. In addition, a recommendation was to host local engagement events in each HSCT area to further develop local action plans and recommendations for improving services and career pathways for nurses in older people' s services.

The PHA agreed to take this work forward and to provide guidance and assistance to appoint a temporary Band 7 lead nurse. The PHA provided a further funding allocation to each HSCT to engage with Age NI to facilitate an engagement exercise aimed at including the voice of service users, carers and their advocates in the development of a vision for nursing in older people's services

The PHA, HSC and Age NI worked together to co-design a model of engagement to ensure that the expertise, knowledge and experience of staff, service users and carers were captured to inform good practice, improvement and the future development of training and services in care of older people's services. This model has been further developed as a product of the project.

A total of 1100 people responded to the surveys, focus groups, questionnaires and interviews As a result, the older and often frailer people who are predominantly those mostly in receipt of nursing care, were given the opportunity to drive and influence real change, which will benefit not only them, but older people in the future.

The implementation of the Regional Action Plan is being taken forward by the PHA in partnership with other HSC organisations, agencies and the community and voluntary sector. This initiative also promoted a call to action from the HSC, encouraging nurses to actively consider a career in the very rewarding and stimulating area that is Older People's Services. This work will be further progressed with nurse education organisations.

The general workstreams and outcomes of this project will contribute to the enhancement of patient user and carer experience to influence service improvement methods and assist in determining the key areas requiring action to ensure the delivery of high quality services that are safe, person centred and outcome focused.

RQIA review of the care of older people in acute hospitals

Throughout this year the PHA and HSCTs have been progressing work in response to the 14 strategic recommendations for improvement across Northern Ireland from the RQIA Review of the Care of Older People in Acute Hospitals (2015). This is a brief summary of the work being progressed.

In terms of improving person centred care, work is underway, in partnership with Age NI and older adults, to agree what older people value in an acute hospital ward environment and what makes a difference to them in terms of their care. Some suggestions from older people are to follow their usual routines where possible while in hospital, eg having a cup of tea when they wish and reading in bed at night.

In terms of safety and risk management, ward managers are receiving formal reports on incident trends so that learning can be identified and shared

The regional Promoting Good Nutrition (PGN) strategy group has implemented a protected mealtime policy and made improvements relating to the identification of people, who need assistance with eating in the acute settings. This work links with some of the recommendations of the review. Also related to this review, regional work is underway, led by the PHA, to establish normative nursing staffing levels. This includes the agreement and implementation of protected time for management duties. Also relating to the review is the work of the Dementia Together NI project, including the development of a Learning and Development framework targeting HSC staff knowledge and skills in relation to dementia and delirium.

Other progress continues in relation to this RQIA review including, for example, work in relation to accurate completion of fluid balance and prescription charts and work is underway looking at procedures that are put in place if de facto detention is ever used (de facto detention was referenced in the review to describe patients not being able to freely leave the ward without permission). HSCT and PHA colleagues are considering relevant policies and procedures currently in place with the aim of promoting freedom of movement whilst maintaining safety. Some hospitals have a wanderguard technology system in place in appropriate wards, e.g. for use with patients with dementia. The system facilitates freedom of movement whilst providing tracking security to promote safety.

Raising the standards for people with a disability

Regional day opportunities

The vision set out in the Bamford Review and confirmed in Transforming Your Care was to enable people with a learning disability to lead full and meaningful lives in their communities. This ensures that there is a consistent regional framework, and full and meaningful engagement with service users, and their families and carers, and with staff. A group has been established by the HSCB to oversee the coordination and implementation of the regional day opportunities model for people with learning disabilities across Northern Ireland. This group is made up of cross departmental representation, HSCTs, local councils as well as service users and carers. Service users and carers have the opportunity to feed back to local carer's groups in their respective HSCTs as well as critically review the Implementation of the Regional Day Opportunities Model at local trust level citing best practice and making recommendations. Each of the HSCTS have also established Local Day Opportunities Implementation Teams where local service users are involved.

Easy read health booklets

A series of easy read health booklets on AAA screening, menopause and prostate cancer have been developed by health care facilitators in the SHSCT for adults with learning disability. A range of service users inputted into the design as well as providing feedback on final content and layout.

Physical and sensory disability action plan

During 2015/16 the HSCB has continued to lead on the ongoing progression of the physical and sensory disability action plan 2012-2015 through the Strategic Implementation Group and Regional work streams and partnership working with Disabled people, statutory services and community and voluntary groups:

1. Deafblind report- A regional deafblind needs analysis report was completed and key findings of this review were launched at a workshop in autumn 2015

2. Specialist deafblind training for staff commenced in September 2015. Regional Sensory Care Pathways for hearing and sight loss have been developed and implemented by HSCTs

3. A Regional Sensory Training Framework was developed

4. A level 1 e-learning Sensory Awareness raising programme for hearing and sight loss was developed in 2015 and will be launched on 1 July 2016

5. Regional Review of Communication Support Services and an Equality Impact Assessment was completed in 2015-16. The recommendations of this Review and EQIA assessment opened for public consultation on 6 June for 13 weeks

6. My Journey My Voice, a multisensory interactive exhibition highlighting the needs of people with communication impairment was funded by HSCB in partnership with RCSLT and Disability Action

7. Making Communication Accessible - A Guide for all HSC Staff was developed and will be formally launched on 27 June 2016

All of the following were co-designed with service users and community/voluntary sector

1. Deafblind report

2. Regional Sensory Care Pathways

3. Regional Sensory Training Framework

4. Level 1 Sensory awareness e-learning tool

5. My Journey My Voice - a multisensory interactive exhibition highlight the needs of people with communication impairment was funded by HSCB in partnership with RCSLT and Disability Action.

Self-directed support

The self-directed support (SDS) initiative introduces personalisation and co-production across all programmes of care including children with a disability.

SDS requires fundamental culture change in social care assessment, support planning, and practice as this is a strength based/outcomes focused approach working in partnership with Service Users and Carers.

To support the changes to practice and mainstream the ethos of SDS training on three different levels is provided within HSCTs.

These are:

- Level 1: Awareness Raising
- Level 2: Assessment, and
- Level 3: Support Planning.

Training level 2 and 3 are PiP accredited. Training is provided to first-line staff and management levels to embed change in practice and systems.

Currently in HSCTs across the three levels of training over 3,300 staff have been trained.

The SDS initiative introduces the Adult Social Care Outcomes Toolkit (ASCOT) across all adult programmes of care on a phased approach.

The ASCOT measure is designed to capture information about an individual's social care related quality of life (SCRQoL).

The aim is for the measure to be applicable across as wide a range of service user groups, and care and support settings as possible.

Evidence from consultation with Service Users, experts and policy-makers, as well as focus group work and interviews with Service Users, indicated that the measure captures aspects of social care quality of life that are valued by Service Users.

The background work with Kent Innovation & Enterprise (KIE) and the Personal Social Services Research Unit (PSSRU) has taken place, licences agreements have been agreed and signed for the region and training has been provided to HSCT staff. The initial trial of ASCOT's practical use with practitioners and the data capture and reporting mechanisms will begin with SEHSCT in late August/ early September 2016 and other HSCTs will follow soon after.

Work is ongoing to streamline and improve the activity monitoring within SDS.

This is built upon previous data capture tools eliminating fields of data that are no longer required by social care. This new data return has been co-produced in partnership with appropriate HSCB, HSCT and Department of Health staff.

This work is progressing alongside the regional review of information.

Service users and carers are involved in every level of the SDS project from local HSCT levels to regional and strategic level. Good practice examples are shared and podcasts have been recorded with Service Users. Numerous focus groups and events have also taken place to involve and engage service users and carers in the development of SDS and help drive culture change.

To date in excess of 120 people were involved in the EQIA and approximately another 120 at various events across the province. Service users and carers have been involved in developing other resources such as the SDS user guide, practitioner guide and the revised direct payments guide.

Work is currently on-going regarding the development of an easy read service user guide and a specific guide directed at carers.

Allied health professional care pathways

The PHA has been working with AHPs across Northern Ireland to agree AHP Professional Care Pathways. The Care Pathways clearly outline the approaches professional staff take when working with service users and carers. This work, across 6 of the AHP Professions and 5 HSCTs, will work to reduce variation in elective AHP Pathways and deliver consistency of approach across those areas that constitute their greatest areas of demand within elective. This work is unique to Northern Ireland and supports improvements in the quality and consistency of services for service users and carers.

Choose Well campaign

This Northern Ireland-wide public awareness campaign was developed to inform the public on the range of healthcare services available from self-care, pharmacy, GP and GP out of hours services, Minor Injury Units, Emergency Departments and 999 services as well as providing information on mental health support.

The campaign aims to empower the public and to encourage people to think about the service that best meets their healthcare needs and to choose appropriately. By choosing the most appropriate service, people will be seen in a timelier manner and this will also help ensure emergency services are available for those patients who need to use these services.

The campaign, now in its third year, is led by the HSCB in partnership with the DoH, PHA, HSCTs, British Medical Association, Community Pharmacy NI and the Patient Client Council.

The Choose Well campaign was shortlisted in the Chartered Institute of Public Relation Pride Awards, 2014.

New services procured

Drugs and alcohol

The PHA, in collaboration with the HSCB, drew up a framework for commissioning alcohol and drug services in response to the New Strategic Direction (NSD) Phase 2 – 2011/16. The framework aimed to provide clarity and direction on the commissioning of the NSD resource allocation post March 2014 and identified the need for a regional Drug and Alcohol Commissioning Strategy. In line with this guidance and with the support from colleagues, the PHA Health and Social Wellbeing Improvement Division developed a Strategy for the procurement of Drug and Alcohol Services.

Business cases on each of the seven service areas identified within the commissioning framework were developed. In April 2014, PHA issued a formal notice informing the drug and alcohol sector that seven services to support the implementation of the NSD 2011-16 would be subject to public procurement. Total contract value was approximately £5.5m per annum. Seven separate public procurement tenders for services to support the implementation of the NSD 2011-16 were issued during 2014/15.

A number of measures were taken in order to enhance the procurement processes including:

- assessment of need and budget allocation;
- researching the evidence;
- consultation with the market/stakeholders;
- development of service specifications/contract adjudication groups;
- links across the PHA and HSC.

Quality improvement is a common goal and is central to the development of health and social care services. The procurement process has significantly addressed three main areas integral to the modernisation and reform agenda:

- setting of minimum standards;
- improved governance arrangements;
- improved accountability.

Also, as a result of the work in developing the regional Drug and Alcohol Commissioning Framework, drug and alcohol service provision across Northern Ireland has significantly changed. Regionally consistent services and models of delivery are now in place across the seven service contract areas. This has made a significant improvement to the range of services available to the population and has responded to the previous perception of a "postcode lottery" landscape of drug and alcohol service provision.

Seven drug and alcohol services are now available in each locality and/or regionally delivering consistent services and models of delivery to agreed standards including:

1. Drug and Alcohol Co-Ordination Team Connection Services

2. Prevention and Harm Reduction life-skills programmes for vulnerable young people

3. Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services)

4. Regional Workforce Development Programmes

5. Community-based services for young people who are identified as having substance misuse difficulties

6. Community based intervention services for adults and family members affected by substance misuse.

7. Therapeutic services for children, young people and families affected by parental substance misuse

Self-harm Intervention Programme (SHIP)

A new service for people who self-harm has been commissioned by the PHA following open tender. The service is referred to as the Self-harm Intervention Programme (SHIP).

SHIP offers counselling services in line with NICE guidance to those who self-harm. It has been available to people aged over 18 years from Oct 2015 and is expanding to provide service to under 18 year olds during 2016 . The service is provided by community and voluntary sector providers and operates in partnership with the mental health services offered by HSCTs in order to provide a more joined-up service for people who self-harm. There is regional branding and patient literature for consistency. The service is provided in non-stigmatising community setting to maximise engagement and uptake, as it is well recognised that people who engage in self-harm often experience barriers to engaging with services.

SHIP is a Tier 2 level intervention aimed at those who may be at risk of further self-harm in the context of personal and social problems but without major psychiatric morbidity. An assessment by

HSCT mental health practitioners is required to ensure suitability and that any serious mental health issues have been excluded before stepping down into this service. If more serious mental health issues are identified, on-going care is provided by the local HSCT. SHIP can also provide support to people who self-harm who have some issues with alcohol or drug misuse if it is deemed appropriate and more intensive services are not required. The assessment in some cases can involve a telephone call with the patient and GP to confirm eligibility in order to prevent lengthy waits for HSCT assessment.

Self-harm within a family context can be very stressful for the entirely family. Taking a preventative and upstream approach SHIP, also offers a parent/carer a short period of education and support regarding how to support someone who self-harms and how to take care of their own mental wellbeing. This element of the service can be provided to parents/carers even if the client does not wish to engage with the service as people who self-harm can sometimes be reluctant to engage in services.

Outcomes are being monitored using the CORE Outcome Measure which scores clients pre and post involvement with the service. Pilot work with this client group has demonstrated significant clinical improvements in CORE Outcome Measures however outcome data is not yet available for the SHIP service. Early indications are that the service is becoming well established but it has been slow to get off the ground in some HSCT areas. It is a good example of collaborative working and development of formal cross-sectoral care pathways.

Raising the standards in primary care

Enhanced services

The HSCB also commissions enhanced services which are elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services which are designed around the needs of the local population. Enhanced services provide the HSCB with opportunities to develop more local and integrated services across primary and secondary care.

Provision of enhanced services is optional and those GP practices which agree to provide each enhanced service contract individually with HSCB.
Below is an example of an enhanced service which has been well received by patients, their carers and GPs in 2015/16.

Medical care planning for patients with long term conditions

The increasing number of patients living with long term conditions is one of the biggest challenges facing Health and Social Care and represents over 50% of the current GP workload. As people live longer the incidence and prevalence of long term conditions will increase. Many elderly patients live with more than one long term condition adding to the complexity of management.

This enhanced service aimed to target groups of patients with long term conditions and complex care needs including multiple sclerosis, Parkinson's disease, stroke, nursing and residential home patients and patients with multiple co-morbidities. This enabled an annual planned comprehensive

medical review of these patients in order to agree an individual medical care plan and allowed early diagnosis, problem recognition and appropriate referral as well as adequate social support to be put in place. It also facilitated early identification of palliative care needs for some patients and appropriate management. Proactive management of long term conditions can help to ease the burden on primary care. It can also improve the patient's quality of life and reduce the number of unplanned hospital admissions.

Improving patient information returns from the community dental services

An analysis by the HSCB of the information returns by the Community Dental Service (CDS) from the five HSCTs revealed significant inconsistencies as to how patient contacts are recorded against some of the programmes of care, particularly POCs 3 and 8. The lack of comparability of patient contacts across the POCs has implications for accurately measuring clinical activity and financial expenditure and needed to be addressed.

Dental staff from the HSCB led on the project to develop a standardised community dental return for the CDS and agree common definitions across the five HSCT CDS teams. This work was completed in April 2015 and signed off by the Central Returns Group DHSSPS in May 2015. The new information returns commenced in 2015/16 and now provide standardised data on:

- **Oral health improvement programmes and disease prevention**
  An important metric to inform key policy documents such as the Programme for Government and Bamford Learning Disability Action Plan and address enquiries such as Assembly questions, Assembly correspondence and media queries.

- **General anaesthetic dental extractions in young children**
  An important measure of oral health in one of the most vulnerable patient groups.

- **New and review patient contacts against relevant POCs**
  Provides standardised activity information for patients with special care needs as defined in the Department's CDS Scope of Practice (March 2011).

Developing eyecare partnerships

Through the collaborative work of Developing eyecare partnerships the HSCB has raised the standards in eyecare through investment in enhanced training for primary care optometrists to enable the provision of enhanced services by optometrists. Work across two eyecare pathways, the acute eyecare pathway and glaucoma care pathway, has resulted in significant service developments supported and underpinned by optometric workforce training and development.

1. Acute eyecare pathway

Optometrists were supported with additional training in acute eye conditions to allow patients in the Armagh/Dungannon locality of the Southern Local Commissioning Group area to access an enhanced optometry service in the community for the management of acute eye conditions. The Southern Primary Eyecare Assessment and Referral Service 2 (SPEARS) has provided patients with prompt, safe and appropriate eyecare, tailored to their needs closer to home.

This innovative service has meant that patients with sudden onset/acute eye conditions can be assessed, examined and managed by optometrists without the need to access hospital based eye services. In the small number of instances where patients do need to be referred to hospital for treatment the optometrist can arrange for this to happen. Patient experience reports over 80% of patients describing their experience as excellent. The SPEARS service will be extended to the entire Southern LCG area during 2016/17 with additional investment in training and extension of the service provision.

Patient A . . .

"It's good to know if you have an eye problem that you can get it sorted straight away rather than having to wait maybe two weeks to see your doctor"

Patient B . . .

"This is an excellent service. The optician had removed the foreign body in minutes and relief was immediate. If she was unable to help me I would have had to attend the Royal Hospital in Belfast almost an hour away"

Patient C . . .

"It's brilliant. Advice and re-assurance (and treatment if necessary) provided right away- no waiting and wondering and worrying about the condition"

2. Glaucoma eyecare pathway

The HSCB has invested in training for optometrists working in the community in the detection and case finding for glaucoma and ocular hypertension. These conditions in combination are estimated to affect 5-6% of the population and detection of the condition requires specific clinical tests and skilled examination of the eyes and visual fields. Over 380 optometrists in the community already provide a service to reliably measure the intra ocular pressure (pressure within the eyes) which is one indicator for glaucoma and ocular hypertension. In addition in 2016/17 HSCB will implement plans to support enhanced higher training for optometrists for a further enhanced service. The enhanced service will enable more detailed and repeated testing of the eye and visual fields for patients who may show some initial signs of glaucoma and ocular hypertension.

This advanced case-finding training will help and support community optometrists in service provision, and in deciding if a patient does require referral to the hospital eye service. The impact will be a reduction in unnecessary referrals, reduced patient worry and anxiety and optimum patient experience.

Antimicrobial stewardship

Resistance to antibiotics has been recognised as the most significant public health challenge facing our generation. The fact that there is increasing resistance to common antibiotics, with few if any new antibiotics coming to market means that without a change in the way that antibiotics are prescribed, we may see illnesses re-emerge that will not be amenable to treatment and the

delivery of health services will have to be radically changed as common surgical procedures may not be possible.

HSCB and PHA have been working jointly throughout the year to support the changes required to antimicrobial prescribing. Aligned with European Antibiotic Awareness Day in November, the revised Antimicrobial Guidelines for Primary Care were published. For the first time, these guidelines were made available in App form and prescribers have provided positive feedback. It is recognised that concerted work in this area is required in 2016/17 and beyond.

The quantum of prescribing per weighted head of population (NIPU) shows that the overall volume has not changed markedly despite rising demand. On a positive note, there have been changes to the types of antibiotics in use with a decrease in the broader spectrum antibiotics (eg cephalosporins, co-amoxiclav and quinolones) often associated with healthcare associated infections such as C.difficile.

Figure 9: Antibiotics, items/1000 NIPUs

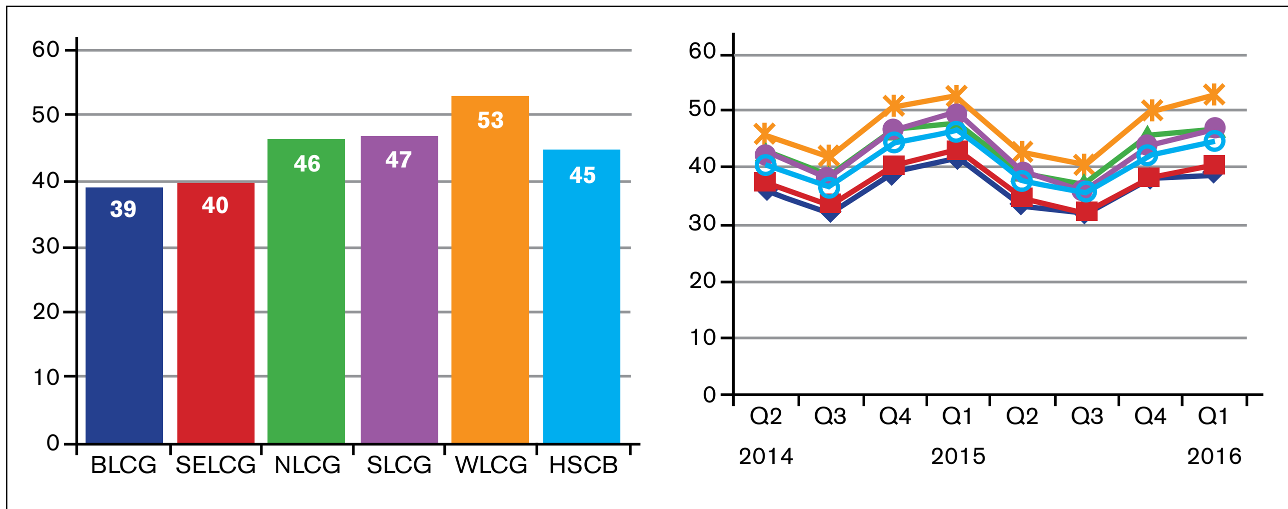


Figure 10: Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin and clarithromycin, % items

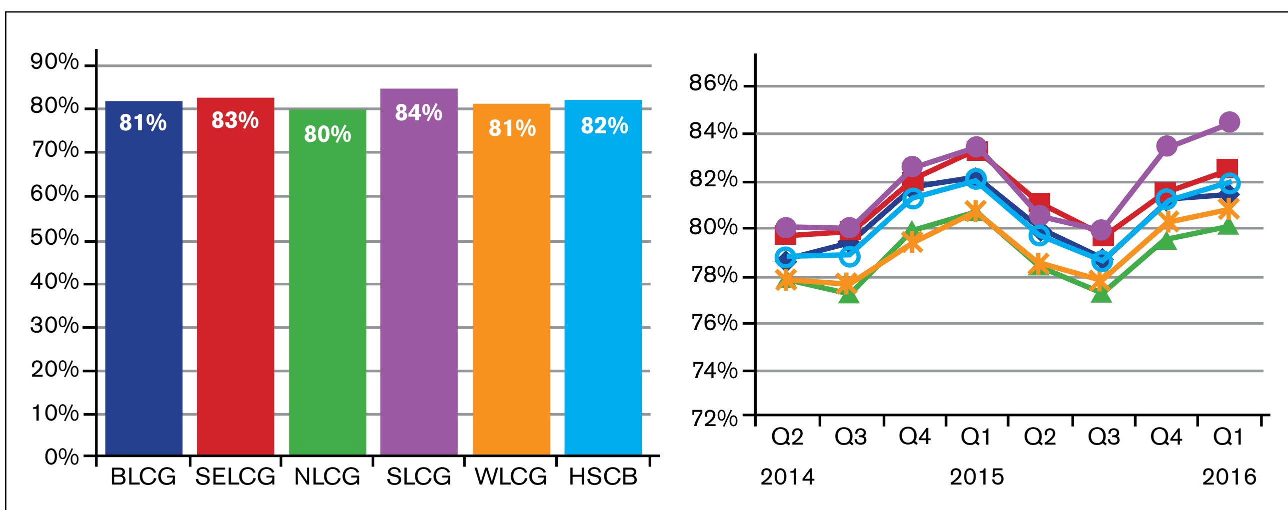


Figure 11: Cephalosporins and other beta-lactams, items/1000 NIPUs

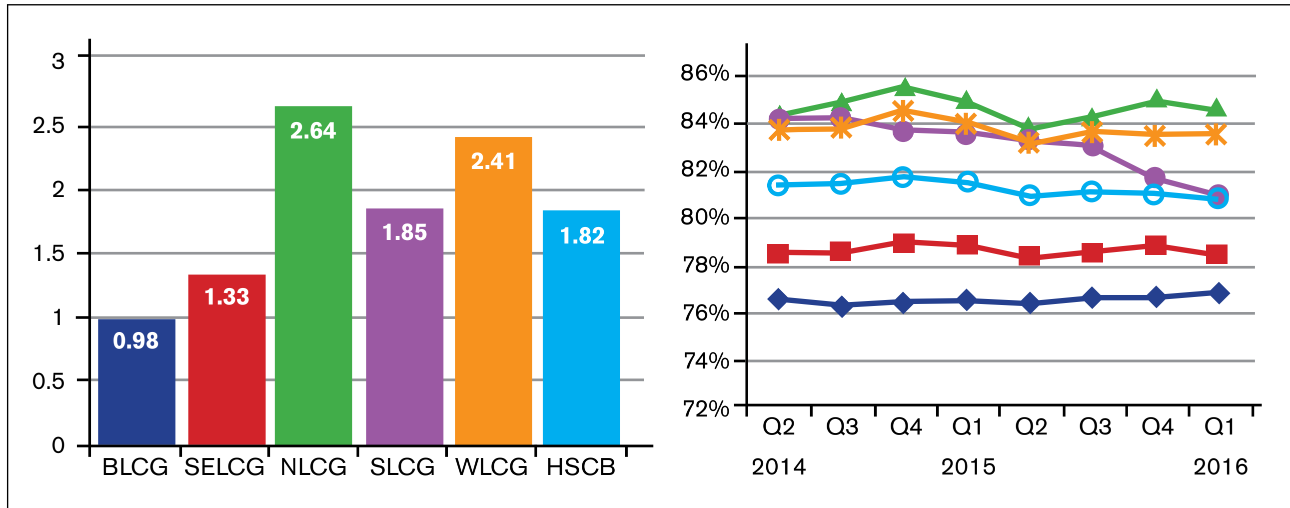


Figure 12: Quinolones, items/1000 NIPUs

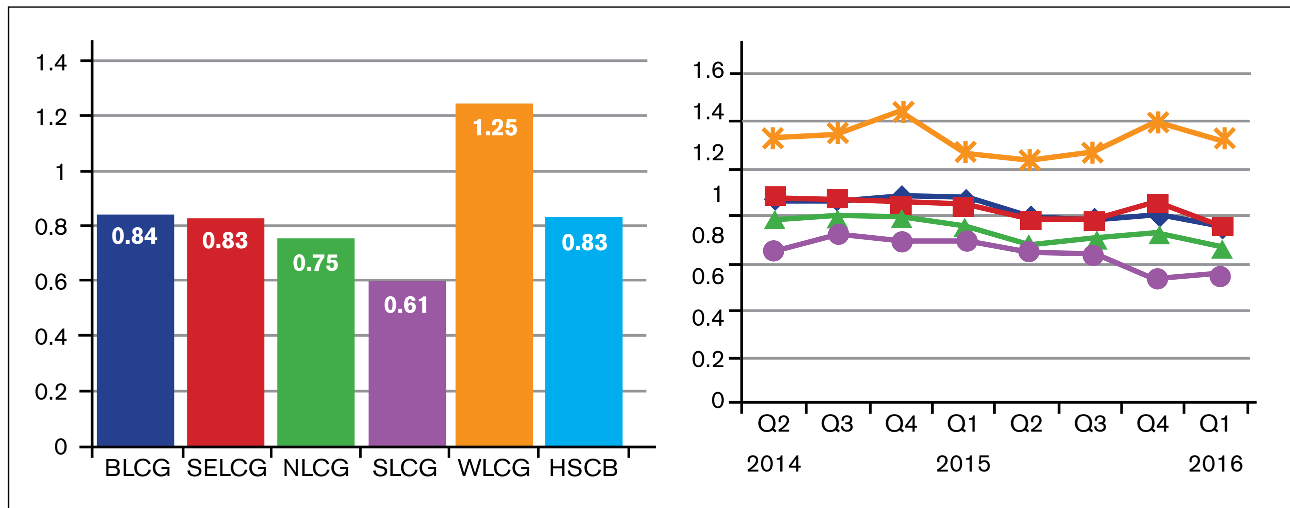
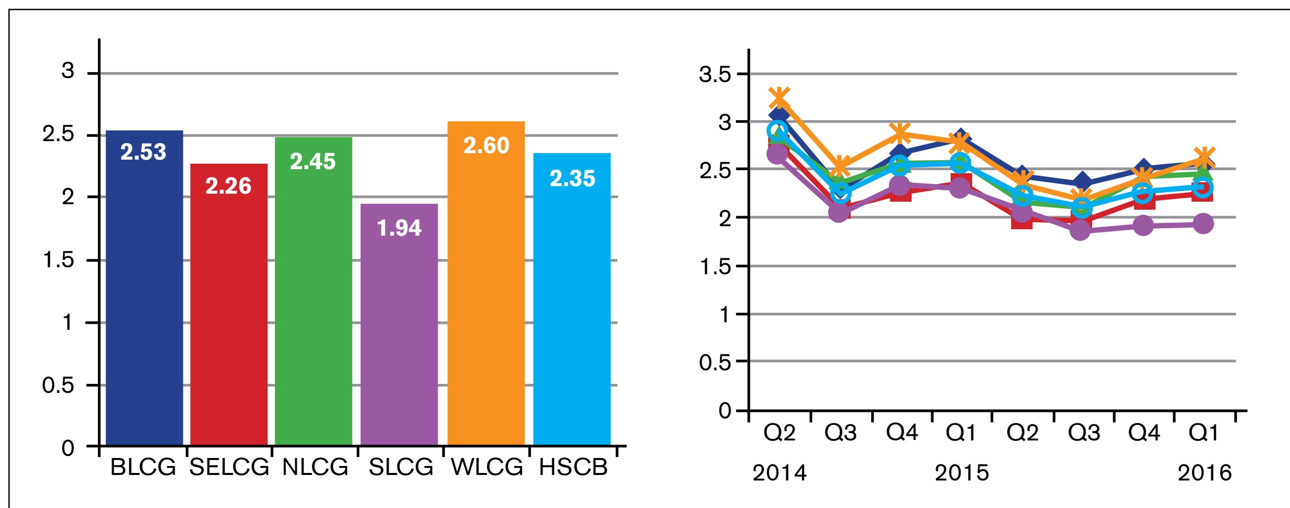


Figure 13: Co-amoxiclav, items/1000 NIPUs



Controlled drugs

Controlled drugs are designated under Misuse of Drugs legislation and due to their nature have specific requirements associated with their possession and supply. Following the Shipman Review, legislation has been enacted throughout the UK to increase the governance associated with the

management of controlled drugs. Designated bodies must have nominated Accountable Officers to ensure appropriate governance arrangements are in place. Since 2015, HSCB has been tasked with an additional legislative responsibility in convening the Local Intelligence Network (LIN) of Accountable Officers for Northern Ireland. During 2015/16, under the chairmanship of the HSCB, the LIN has provided a unique forum for sharing intelligence around the use of controlled drugs in Northern Ireland. One specific project that has been referenced at the LIN has been the development of a controlled drugs supply chain database. This has provided the facility for reporting of 'leakage' from the controlled drugs supply chain and highlighted areas where inspection and enforcement activities are needed in order to prevent diversion for illicit means.

Improving dementia services in Northern Ireland

Delivering social change project

During 2015/16 the Delivering Social Change Project team developed a Northern Ireland Dementia Learning and Development Framework, steered by an expert group.

A series of regional workshops were held to identify the thematic subject areas which were considered to be central to the content of this Framework.

This Framework presents an illustrative model which encapsulates the value base for all encounters with people living with a dementia, their families and carers. It is based on the concept that living with a dementia is not a linear journey nor indeed one where people fit into clinical categories such as early, middle or late stages of dementia and in fact people will enter the journey at different stages.

At the centre of the model is the key objective that the framework strives to ensure that the person living with a dementia, their family and carers, can live well with dementia. The key points in a person's journey pertains to finding out it's dementia, making changes and planning for the future.

There has been wide engagement across a number of organisations and a formal launch by the Health Minister is planned for autumn 2016.

Dementia Together NI delirium workstream

'For every 48 hours delirium remains undetected, mortality increases by 11%'

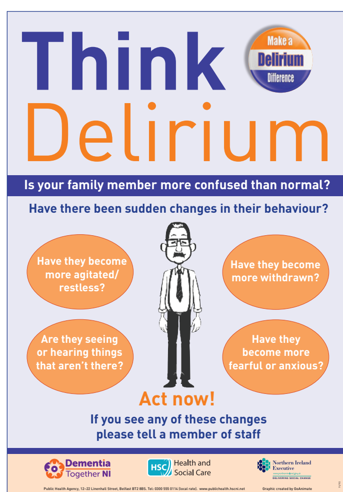
Delirium is an independent risk factor for poor outcome - increased mortality and increased risk of adverse incidents such as falls and prolonged length of hospital stay. It is commonest in those over 65 years, with conditions such as acute infection, hip fracture or pre-existing dementia.

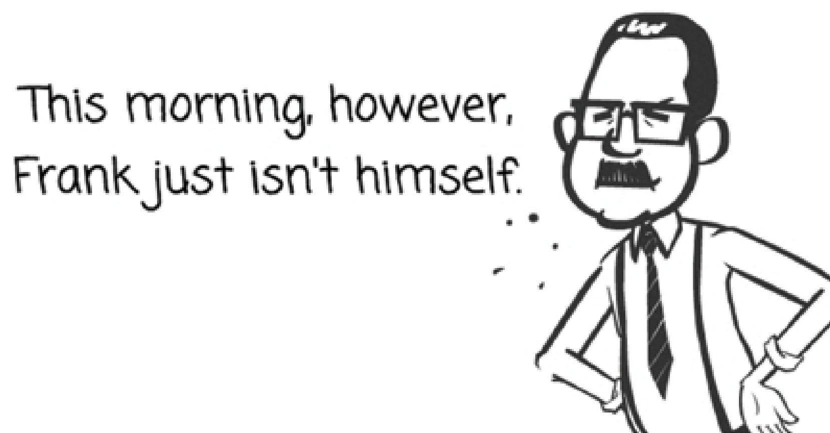
In order to address difficulties in prevention, recognition and management of delirium within the acute setting, the HSC Safety Forum facilitated a regional quality improvement collaborative. In support of the regional dementia strategy, the collaborative, working with front line staff, patients

and their families/carers explored ways to improve care for those suffering from (or at risk of developing) delirium.

The work of the collaborative involved development of a screening tool and care bundle designed to embed best care, based on NICE guidance, for people who are at risk of developing delirium.

It was also imperative to (i) highlight the increased risk for certain populations of patients and (ii) improve communication between staff and those who are at risk, their families and carers. Materials were developed to engage with these groups and emphasise the importance of improved engagement; posters for use in public areas, under the theme 'Think Delirium' outlining signs and symptoms; information leaflets to reassure family/carers in relation to delirium experience; staff posters to re-enforce care pathway and use of tool. A delirium awareness animation was developed to share information on delirium far beyond HSC organisations.





Tailored delirium training was developed to provide staff with additional knowledge in relation to identifying, preventing and managing delirium. This training module has been provided to over 700 staff on site, and will be available on the HSC eLearning platform to ensure spread and sustainability of best practice.

Saving babies' lives campaign

Saving babies' lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

These elements were identified as such by experts through a process of engagement and consensus building over a 12 month period since 2014. Each HSCT in Northern Ireland has mapped their current work against all four elements and have plans to take forward improvements in each area in collaboration with each other in order to reduce stillbirth rates in Northern Ireland.

Family nurse partnership programme

Quality is at the heart of the Family Nurse Partnership Programme. The Family Nurses aim to provide the highest quality service for our young people's wellbeing. Following the publication of the Building Block Randomised Controlled Trial, the Family Nurse Partnership Programme in Northern Ireland has embarked on a Quality Improvement programme focusing on five key areas:

- smoking cessation in pregnancy and parenthood;
- improving breastfeeding in initiation rates;
- improving access to a flexible sexual health and fill planning services for teen parents;
- initiation of the revised perinatal mental health pathway;
- improved access to home safety equipment.

A service improvement methodology will drive this quality improvement bundle. The regional database will inform whether the programme adaptions are improving the outcomes for young parents on the programme

Service developments

Early pregnancy assessment services

Early pregnancy assessment services (EPAS) play a crucial role in treating and supporting women and their families during what can be a very distressing and frightening time in their lives. In 2012, NICE published guidance on ectopic pregnancy and miscarriage, including a specific recommendation on seven day access.

Over the last year, the PHA has worked with HSCTs and patient groups to consider issues of variation across early pregnancy services in Northern Ireland. In November 2015, the PHA hosted a regional multi-professional workshop examining criteria for referral, models of service delivery, links with bereavement services and seven day access. Following further engagement, including the Maternity Strategy Implementation Group and Emergency Department Clinical Engagement Group, a common direct referral pathway and commissioning intention for early pregnancy assessment services were developed and shared with HSCTs and primary care in June 2016. The common referral pathway specifies when women who experience vaginal bleeding/pain in early pregnancy should be referred from community or emergency department triage settings directly to early pregnancy assessment services. The commissioning intention also outlines the regional approach to referral, access, models of care,
ultrasound scanning and bereavement care within early pregnancy assessment services.

These will be implemented by the HSCTs and primary care sending a consistent message to referrers and aiming to improve experience for patients their families and staff. This is an

important area for the Maternity Strategy Implementation Group and updates on progress within HSCTs will be sought in six months.

Acute oncology service

An acute oncology service (AOS) was created and introduced to improve the care of people with acute cancer-related symptoms requiring hospital care. This innovative development led by the HSCB, working with the PHA and Macmillan means that Northern Ireland leads the way in the UK in introducing services on a regional basis.

AOS will ensure that people requiring unscheduled hospital admissions with complications of cancer will have improved access to oncology support. Northern Ireland patients receive excellent cancer care, but when requiring unscheduled admissions they do not necessarily have access to oncology advice. A bed census, undertaken in autumn 2013, identified an unmet need for AOS with 368 people in hospital with acute cancer-related complications.

The introduction of acute oncology services is a response to national advice. The service was developed drawing on this advice and bringing together local expertise from many disciplines to ensure a rigorous and consistent patient centred care. Importantly, we developed an integrated approach across all HSCTs, across clinical disciplines and across the statutory and voluntary sector.

Through collaboration with HSCT clinicians and managers, service users and Macmillan Cancer Support, a service model was developed, patient pathways mapped and a service specification developed. Subsequently an evaluation framework was created and tested against the specification, and a database developed to ensure consistency in monitoring across all HSCTs. Quarterly reports are shared at the steering group at which the service impact can be assessed. The development of a mobile APP provided access to the guidelines for all health care professionals. Guidelines and APP details were disseminated through HSCTs, made available on HSCT intranets and shared through social media channels.

The service commenced in 2016 and outcomes are assessed utilising the evaluation framework (table 2). Early results have shown services provide rapid access to the service which often negates the need to attend ED, reduces 30 day mortality and length of stay, all improving patient safety and quality of care for people with acute cancer related complications.

Developing the acute oncology service through a collaborative approach with primary, secondary and community care, service users and the voluntary sector representation meant that engagement and commitment of stakeholders was secured.

With limited funding, by necessity the service will develop in a phased manner, an approach instrumental in developing key priorities and securing agreement for a robust evaluation which will help provide the evidence of effectiveness and facilitate service expansion.

Recruitment has been slower than anticipated and on reflection, we could have potentially utilised a central recruitment process which may have expedited the appointment of medical and nursing staff.

Improvements in reducing health care associated infections

During 2016 the PHA Heath Care Associated Infection team carried out two pilot projects focused on care home settings. These projects aimed to improve the knowledge of MRSA colonisation; and improve the diagnosis and management of urinary tract infections in these settings. Improvements in the management of these issues have the potential to reduce the burden of resistant bacteria in the community and contribute to the reduction in health care associated infections.

1) Educational intervention to improve knowledge and management of MRSA in a sample of care homes in Northern Ireland

MRSA carriage in care home residents has been found to be disproportionately high in admissions to acute HSCTs. It has been reported that MRSA colonisation levels among residents in care homes in the UK were >20%.

Given the disproportionate incidence of MRSA colonisation in care home settings, the team identified one care home in each of the five HSCTs in Northern Ireland and arranged three visits to each selected home in order to ascertain the knowledge and management of MRSA/ antimicrobial stewardship before and after an educational intervention. The visits consisted of a range of methodologies including audits, feedback and improvement techniques.

First visit

- Hand hygiene audit
- Personal protective PPE audit
- MRSA questionnaire
- Antimicrobial stewardship
- Questionnaire

Second visit - the intervention

- Presentation on general IPC (with HH glow machine)
- Presentation on MRSA and management (with scenarios)
- Presentation on PPE (with practical donning and removal)
- Presentation on Antimicrobial stewardship
- Questionnaire

Third visit

- Re-audit hand hygiene
- Re-audit PPE
- Repeat MRSA questionnaire
- Repeat antimicrobial stewardship questionnaire
- questionnaire

Following the intervention, hand hygiene practice improved for all members of staff. With hand hygiene being the single most important factor in the onward spread of most infections, not just MRSA, it is hoped that the quality of care and safety of residents improves also.

PPE usage is an important factor in infection prevention control practices. It is, however, only effective if used properly. The practice of donning, removal and disposing of PPE improved in all the homes participating.

Antimicrobial resistance is a major treat to everyone especially the elderly and infirm. The knowledge of virus/bacteria, first and second line antibiotics for specific infections, dangers of prescribing without examination or lab result and Kardex review all improved following the intervention for each participating home.

MRSA knowledge improves the management of residents either colonised or infected within the care home environment. Subjects covered included isolation, decolonisation, outbreak management, transfer to other healthcare facilities and terminology. In all participating homes the repeat questionnaire proved that knowledge levels had increased.

2) Educational intervention to improve the diagnosis and management of urinary tract infections (UTIs) in a sample of care homes in Northern Ireland

HALT (2013) raised concerns about the diagnosis and management of UTIs in care homes in Northern Ireland. The aim of the pilot was to review the impact of a decision aid (adapted from Scottish Consortium's decision aid) and educational package in improving the diagnosis and management of UTIs in care homes. The team took a range of steps to assess the impact including:

- adopting the Scottish Consortium's decision aid for use in Northern Ireland following consultation with a wide range of experts and clinical staff;
- developing an educational package for both care homes and GPs;
- selecting five care homes (one from each of HSCTs) and invited them to take part in the pilot;
- carrying out semi-structured interviews with staff in care homes to determine how UTIs were diagnosed and managed prior to the pilot;
- providing care home based training on UTI diagnosis and management in each of care homes and provided GPs with hard copies of training packs and decision aids;
- asking care homes to collect information on residents receiving antimicrobials for UTIs/ uroprophylaxis for a two month period following the educational intervention;
- collecting feedback from care homes and GPs on training and decision aid.

The information collected during the semi-structured interviews confirmed the findings of HALT (2013). Signs and symptoms of infection were not used appropriately to diagnose UTIs and dipstick urinalysis was often used as a diagnostic tool for UTIs in the absence of signs and symptoms of infection. This resulted in inappropriate antimicrobial prescribing. In addition to this most of the care homes referred to feeling pressured to initiate treatment for UTI because of requests from relatives, even in the absence of clear signs and symptoms of infection. The G.P. often initiated treatment based on a laboratory result and relied on the care home to send samples at appropriate times.

The feedback from the educational intervention and decision aid was positive and both care homes and GPs agreed that they were easy to understand and improved diagnosis and management of UTIs. The care homes reported that antimicrobial prescribing was reduced during the two month period of the pilot.

The pilot highlighted that more work is required in educating the general public on the need to treat UTIs in > 65 year olds based on signs and symptoms of infection. This may require PPI work to ensure effective communication. In addition to this the pilot highlighted the need for training to be rolled out to staff outside of the care home setting, including community psychiatric nurses, district nurses and out-of-hours staff.

Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC) continue to work in partnership with HSCTs and HSCB to participate in EU initiatives. The European Innovation Partnership on Active and Healthy Ageing aims to achieve its overarching target to increase the average healthy lifespan by two years by 2020.

By bringing together key stakeholders (end users, public authorities, industry); all actors in the innovation cycle, along with those engaged in standardisation and regulation the partnership provides a forum in which they can cooperate, united around a common vision that values older people and their contribution to society, identify and overcome potential innovations barriers and mobilise instruments. Currently the PHA and HSCB participate in the work of Action Groups. Action Groups formulate collective plans to take forward work in their respective areas such as Personalised health management, starting with a falls prevention initiative; prevention of functional decline and frailty; Integrated care for chronic diseases, including remote monitoring at regional level; development of interoperable independent living solutions, including guidance for business models; innovation for age friendly buildings, cities and environments and prescription and adherence to treatment. Participation in the action groups raises the profile of Northern Ireland and the many excellent initiatives and models of service that we have in place; provides a means to benchmark against other European regions and to discuss, explore and learn from the experience of others. Participation also allows for relationships to be formed that may lead to consortia that would be well placed to bid against future calls for EU funding.

Theme five:

Integrating the care

Integrated care partnerships (ICPS) in primary care

Seventeen Integrated Care Partnerships (ICPs) were established in June 2013 as collaborative partnerships of providers tasked with designing, implementing and monitoring services within their locality. Each ICP Partnership Committee has representation from primary care, secondary care, community pharmacy, NIAS, voluntary and community sectors, local council officers as well as service users and carers. The initial clinical priority areas that ICPs have been asked to focus on are frail elderly, respiratory disease, diabetes, stroke and end of life care as it applies to those clinical areas.

Through the collaborative work of ICPs, services are now planned and delivered in partnership between all providers involved in the frontline delivery of care. This has created a shift in culture from providers working in relative isolation of each other to an open and transparent partnership to deliver patient centred services. New models of care have been developed across the region that have driven integration amongst providers and have also brought a focus to establishing the promotion of wellness and use of community and voluntary services as a core part of new models of care. Belfast ICPs are working to implement a chronic disease prevention hub as an integral part of all redesigned care pathways and South Eastern ICPs are currently developing a proposal for a similar service, both commissioned by the respective Local Commissioning Group.

Western ICPs have successfully implemented a social prescribing pilot to help older people to address social, emotional or practical needs by linking them to sources of support and activities within their local community. The pilot involved Aberfoyle Medical Practice and Eglinton Medical Practice and was delivered by Bogside & Brandywell Health Forum, in conjunction with Rural Area Partnership in Derry (RAPID).

Older people referred to the service by their GP were visited by a social prescribing coordinator to discuss suitable options including: social clubs, physical activity, self-help groups, and volunteering, learning, counselling, and advice and guidance services. The coordinator then supports the older person to access the necessary services and remains in contact with the client to review progress. The majority of people referred were for long term physical conditions, emotional resilience and social isolation. Most referrals were made to exercise opportunities or older people's social clubs.

From April 2015 to May 2016 106 people were referred to the programme with 66 people going on to participate in social activities delivered by the community and voluntary sector. Feedback from patients shows that the programme has had a positive impact in changing health behaviours through losing weight or stopping smoking, in integrating the new activities into their daily routine, increased confidence and willingness to try other activities, and fewer visits to their GP.

Since their establishment in June 2013, ICPs have been focusing on delivering integrated care pathways with providers working in partnership to deliver the right care, in the right place, at the right time. Belfast ICP, Southern and South Eastern ICPs have developed or helped refine acute/enhanced care at home models aimed at treating elderly patients in their own home for certain conditions where they would previously have presented at ED or been admitted to hospital.

The average length of stay in the acute care at home service is six days, compared to an average 11 day stay in hospital for older people in Belfast.

In 2015/16 274 elderly people were provided with care in their place of residence and therefore avoided a hospital admission, saving 3014 bed days. All patients have reported 100% satisfaction with the service.

Each ICP Partnership Committee is responsible for service redesign and implementation, the monitoring of services across the clinical priority areas and demonstrating the improvement they have made. ICPs are held to account by their respective Local Commissioning Group for the services they deliver, against a range of regional and local metrics set out in a formal Local Accountability Agreement (LAA). The LAA is in place to demonstrate value for money and facilitate ongoing improvement by facilitating evidenced based rapid cycles of change.
The Northern ICPs' 'Nursing home in-reach' project focuses on very frail older people living in nursing homes, who commonly experience a high level of attendance at EDs.

The aim is to develop and deliver a specialist education, training and development programme for staff working in nursing homes in the Antrim/Ballymena area to enable them to provide care for their residents in the home, rather than in hospital.

Two staff from each of the 20 participating nursing homes took part in training including: long term conditions management; dementia care; recognising/managing the deteriorating patient; medicines optimisation; end of life care; catheter management; PEG tube management; syringe driver management and venepuncture. The staff then cascade this learning to their colleagues. A practice development facilitator provides a 'case finder' function to track patients who do attend ED, to determine the appropriateness of that attendance, and then to provide follow up support to the home, such as additional staff training, to avoid a re-attendance.

The increased knowledge and skills of nursing home staff in the pilot has resulted in a 25% reduction in the number of visits from Marie Curie staff out of hours; a 21% reduction in the number of calls made to district nursing services compared to the same period in the previous year; a 48% reduction in the number of calls to the hospital diversion nursing team relating to PEG tube issues.

The numbers of elderly people attending the ED from nursing homes in the NHSCT area has reduced by a third due to the enhanced skills of nursing home staff, down from 1016

attendances in 2014/15 to 706 in 2015/16, and avoiding 1624 acute bed days. Unfortunately, the further roll-out of schemes, even where the emerging evidence of improvement is strong, is often impeded by a lack of ring-fenced funding for reform projects.

A number of initiatives aimed at allowing patients to be cared for in their own home by appropriate specialists were developed in 2015/16. Examples of two such initiatives are described below.

The enhanced care at home service – South Eastern HSCT

In 2015 the enhanced care at home service was commissioned by the South East LCG and launched in a locality (North Down and Ards) of the South Eastern LCG area. Patients age 65 and over could be referred by their GP or district nurse to the Enhanced Care at Home service. This service allowed these patients to receive, within their own home environment, assessment and treatment from a team of specialist professionals coordinated through their own GP and District Nurse. This service, an excellent example of joined up and innovative working, is designed to enable health and social care providers to work more closely together. Enhanced care at home delivers seamless care, providing a better experience for patients, their families and carers whilst reducing pressure on hospital services. This initiative keeps people well in local communities while responding to each individual's needs.

Between September 2015 and April 2016, fifty patients were admitted to the service with conditions such as COPD, cellulitis, congestive cardiac failure, UTI, dehydration and asthma. As the service rolls out across the SE LCG area, numbers are anticipated to rise significantly.

The acute care at home team – BHSCT

This is an innovative new service which was commissioned by the Belfast LCG and launched in Belfast in October 2015. It provides older people with expert medical and social care in their own home. GPs can refer older people living within BHSCT Community team catchment area whether they are living in their own home or in residential or nursing homes. The 'acute care at home' team is led by a consultant geriatrician and includes nurses, pharmacists, social workers, occupational therapists, physiotherapists and community psychiatric nurses. GPs are an integral part of the team, provided through a local enhanced srvice with Belfast practices working together through GP Federations to provide 20 GP sessions per week to the team.

Since the service was officially launched in October the team have treated 260 older people with conditions such as chest infections, urinary tract infections, cellulitis and dehydration who would previously been referred either to ED or admitted to hospital. The average length of care with the acute care at home team is one week, and around 75% are managed without the need to be admitted to hospital.

Developing eyecare partnerships

A core tenet of developing eyecare partnerships (DEP) is the integration of eyecare services across primary and secondary care through a pathway approach to service provision. Eye conditions are sometimes life-long but can also be of sudden onset with rapid resolution;

however, irrespective of how quickly they take to present or how long they are present, it is important that the management of the condition and the outcomes are consistently good. Patients with eye problems often attend both optometrists in the community and doctors and other ophthalmic professionals in the hospital eye services. It is essential for good patient outcomes that primary and secondary eyecare services are integrated and connected. Through DEP the HSCB has introduced several initiatives to allow better integration of care.

How we did this, what did we do and what difference has this made and will continue to make to patients?

1. **Project ECHO for optometry/ophthalmology**
   During 2015/16 Optometry services in HSCB established a 'world first' Project ECHO® 3 Ophthalmic Knowledge Network supported by the Northern Ireland Hospice. Project ECHO is an innovative tool using interactive digital communications to facilitate engagement between ophthalmic specialists and optometrists in the community. Through regular ECHO sessions, knowledge is shared and clinical experience and skills are enhanced. ECHO has enabled the establishment of a culture of engagement and support for learning and a mutual understanding of the challenges faced in care provision across primary and secondary care. In 2016/17 the HSCB plans to establish a second ophthalmic knowledge network. Patients will benefit from Project ECHO in that the clinicians who engage will have direct access to expertise and peer support resulting in enhanced knowledge and skills to support their provision of generalist clinical care.

2. **Electronic referrals**
   In 2015/16 the HSCB has established the mechanisms and infrastructure to enable optometrists in the community to refer patients to secondary care using electronic referral via the HSC Clinical Communications Gateway. This significant project will ensure that patient referrals are sent directly to secondary care in a timely and direct manner and that feedback directly to the optometrist is enabled. Electronic referrals will ensure that the patient journey 'in' to secondary care is efficient and safe and that the essential feedback on the patient outcome, that is the journey 'out', and is advised to the primary care professional who will provide ongoing care in the community. 3 Project ECHO® (Extension for Community Health Outcomes) Northern Ireland http://echonorthernireland.co.uk

Building the community pharmacy partnership

The Building the Community-Pharmacy Partnership (BCPP) is a partnership between the Community Development and Health Network (CDHN) and the HSCB
with strategic direction offered by a multi-agency steering group.

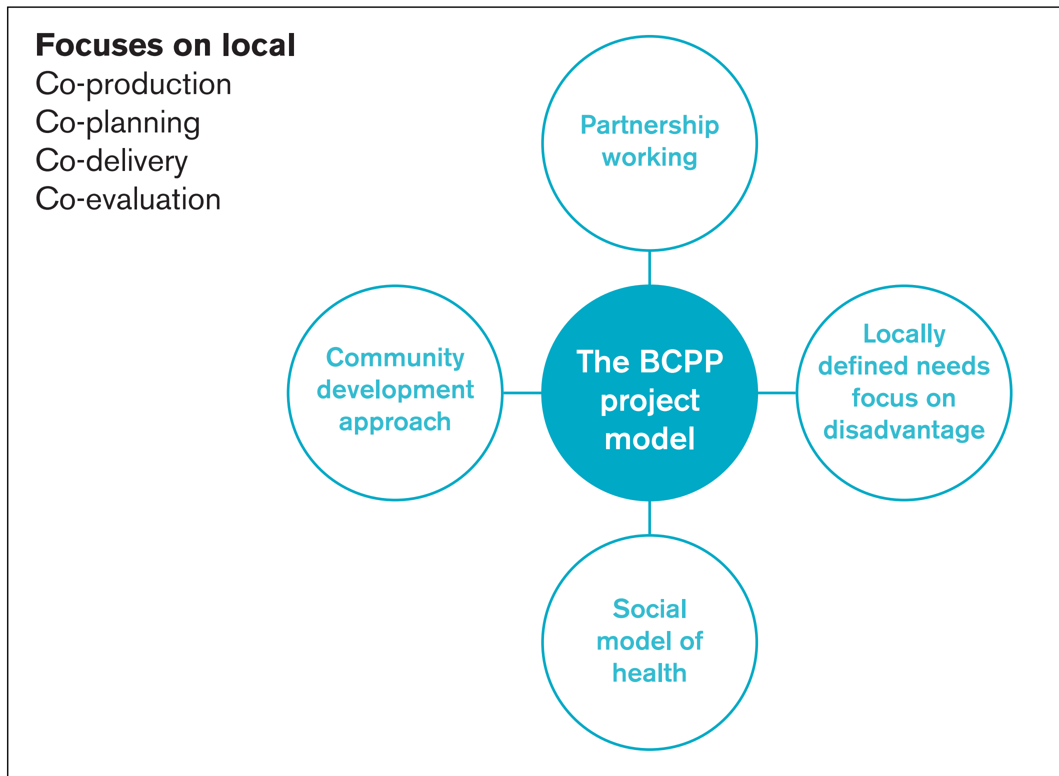
The programme aims to promote and support local communities to work in partnership with community pharmacists to address local health and social wellbeing needs using a community development approach.

The programme works towards:

- increasing local people's skills, encouraging community activity and self help;
- increasing local people's understanding of health issues;
- encouraging local people to play a role in promoting health.

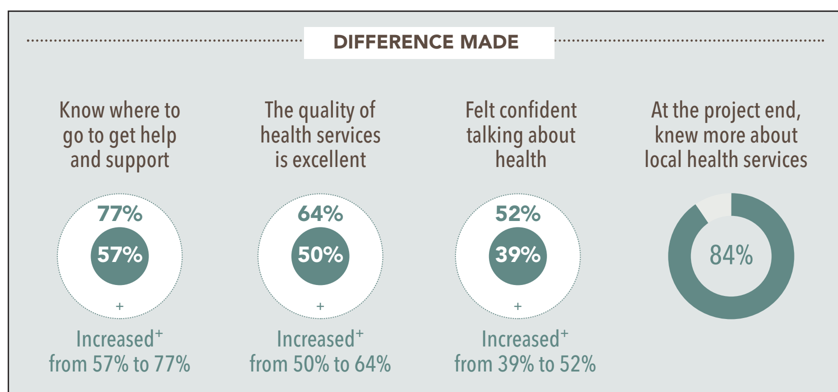
The project model is summarised as follows:

Project model

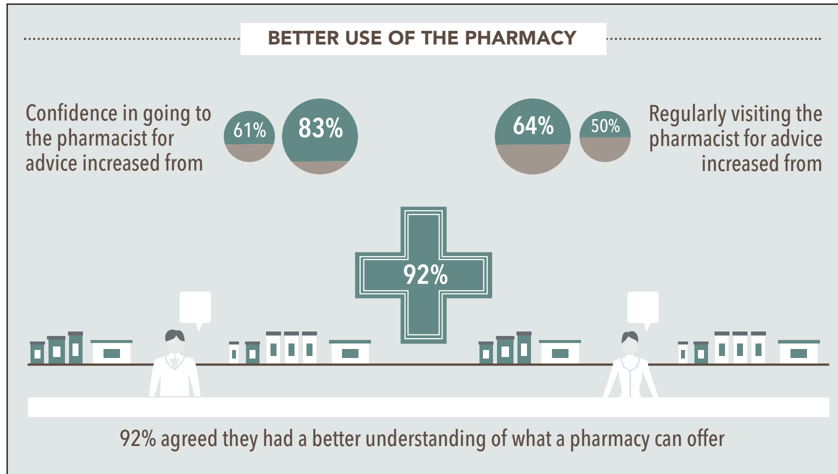


ADDED EXTRAS

Over the course of the year £360,000 funding is typically invested into over 60 projects which engage over 1600 core participants. Projects are delivered to some of the most deprived communities in Northern Ireland and cover a broad range of health and social care issues as well as wider determinants of health eg housing, poverty, employment. The programme is continually being evaluated and details of the impact of the project are given on the CDHN website: http://www.cdhn.org/bcpp-resources In summary there has been an improvement in confidence and knowledge in participants in relation to healthcare:



There have been improvements in the utilisation of pharmacies:



There have been improvements in self-reported health status of participants:

The HSCB will continue to commission CDHN to deliver this programme in 2016/17 and seek ways to build on what is a very positive programme.

Wasted medicines in primary care

In 2014/15, the Northern Ireland Audit Office published its report on Prescribing in Primary Care. This was followed by a review by the Public Accounts Committee. Later in 2015/16, RQIA published its Review of Medicines Optimisation in Primary Care. In each of these reviews there was recognition of the good work of the HSCB Pharmacy and Medicines Management Team. There were also consistent themes in respect of prescribing variation, costs and medicines utilisation in primary care.

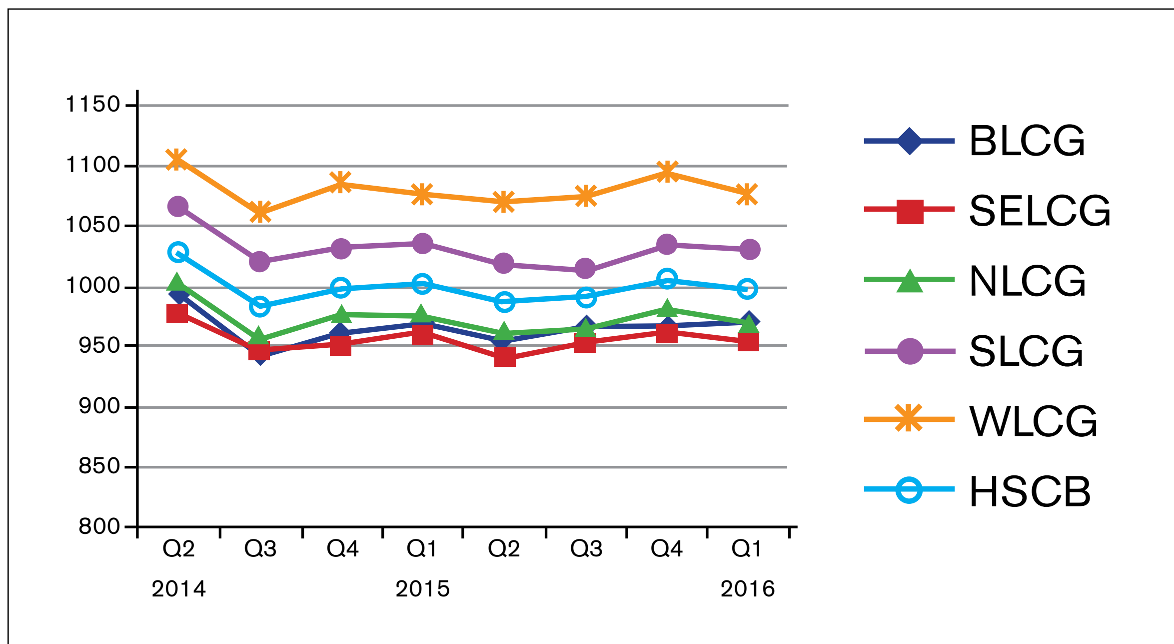
With respect to the demand for prescriptions and use of medicines, HSCB has embarked on a social media campaign which highlighted that:

- Medicines wasted in Northern Ireland have an estimated value of £18m each year;
- Over 70 tonnes of medicines are returned to community pharmacies each year with an estimated value of £6.5m each year.

The target group for the campaign was women aged over 40. The campaign was supported by LCGs and had good reach on social media with 34000 people in the target group on Facebook, 53000 people on Twitter with a total exposure of over 100,000 impressions.

The direct impact of this campaign is difficult to measure. It is noticeable that the overall prescribing frequency as measured by the number of prescriptions per weighted head of population (NIPU) has shown a slight decrease. This is against an increasing demand for health and social care services.

Figure 14: Items/1000 NIPUs



Pharmaceutical clinical effectiveness (PCE)

Each year, the HSCB is tasked with delivering the PCE programme. The ethos for PCE is that by focusing on quality and safety in prescribing and use of medicines, we can derive efficiency and health gain. While there is a financial target for PCE, and in 15/16, this was £20m which will ensure budgetary breakeven, it is of critical importance that this drive for efficiency does not supersede quality and safety. In 2015/16 there was work undertaken in all therapeutic areas and integration of work in primary care with secondary care and with the community and voluntary sector has been and continues to be important. By way of example, in Northern Ireland we issued **4,201,874** prescriptions for analgesics (pain killers) costing **£36,089,876**. We have recognised that simply issuing guidance to general practice in relation to the best medicines to prescribe simply does not address the underlying issues with management of pain. There is a requirement for a whole systems approach:

- prescribing guidance that is jointly owned by practitioners in primary and secondary care;
- support for patients and carers in respect of how they manage chronic pain;
- access to specialist advice and support;
- access to therapists such as physiotherapy.

In 2015/16 chronic pain was recognised as a Long Term Condition and further work is underway to consolidate the actions that have been undertaken thus far. HSCB continues to monitor progress in this area through a range of prescribing indicators which shows progress is being made:

Figure 15: NSAIDs DDs/1000 NIPUs

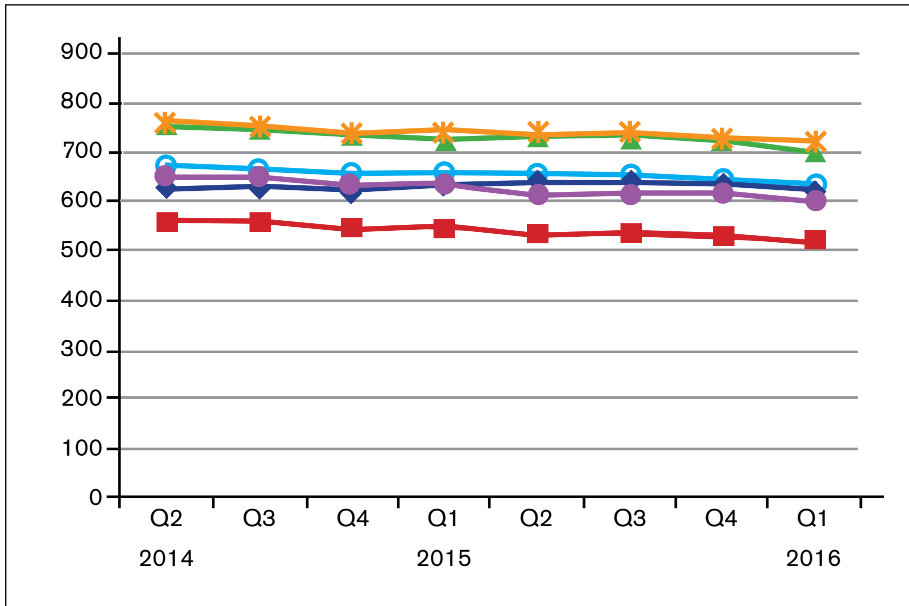


Figure 16: % ibuprofen and naproxen of all NSAID items

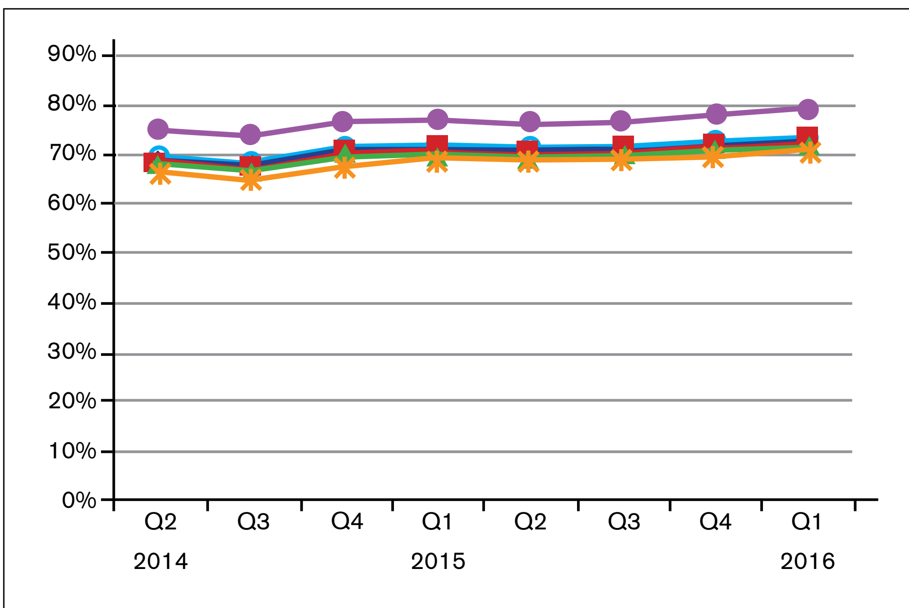


Figure 17: Diclofenac, DDDs/1000 NIPUs

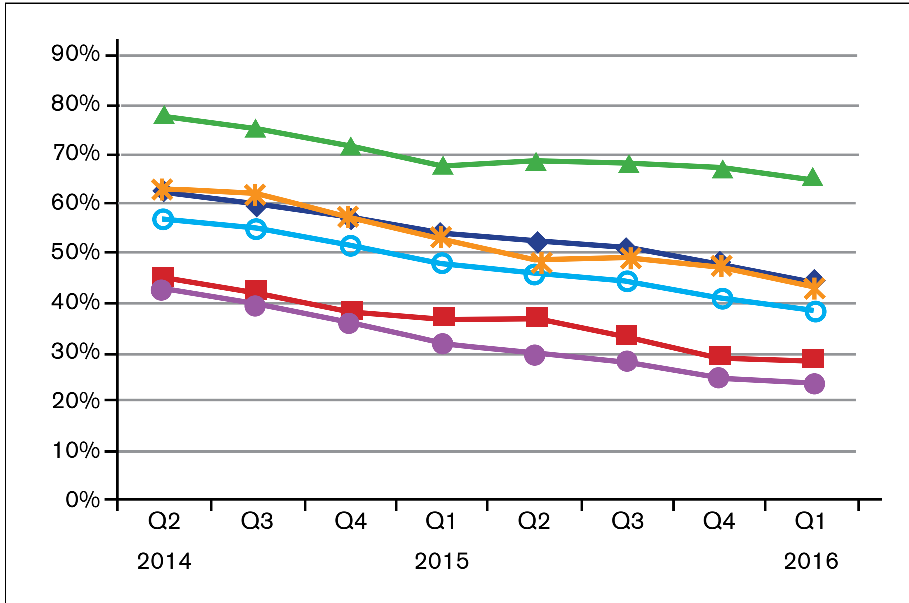


Figure 18: Cox IIs, DDDs/1000 NIPUs

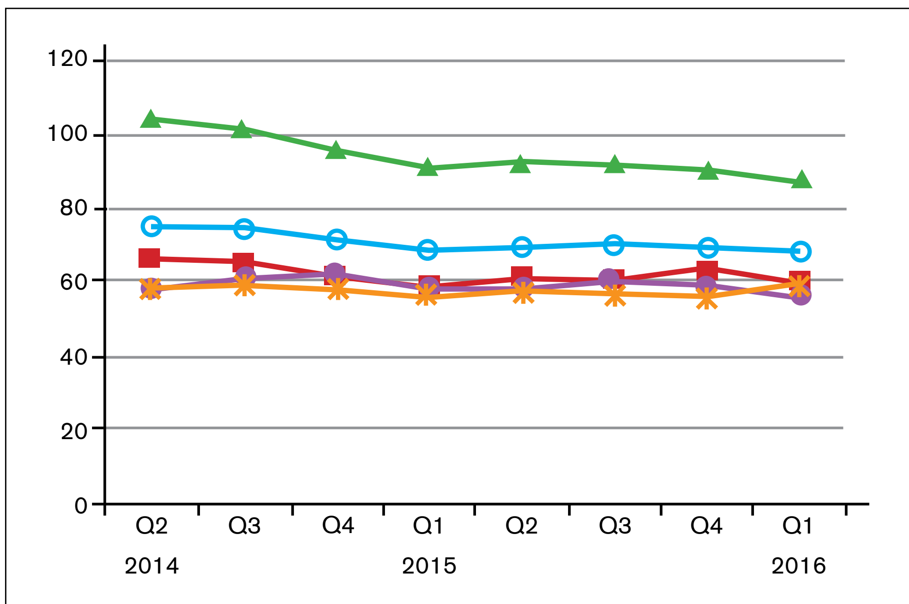


Figure 19: Pregabalin, DDDs/1000 NIPUs

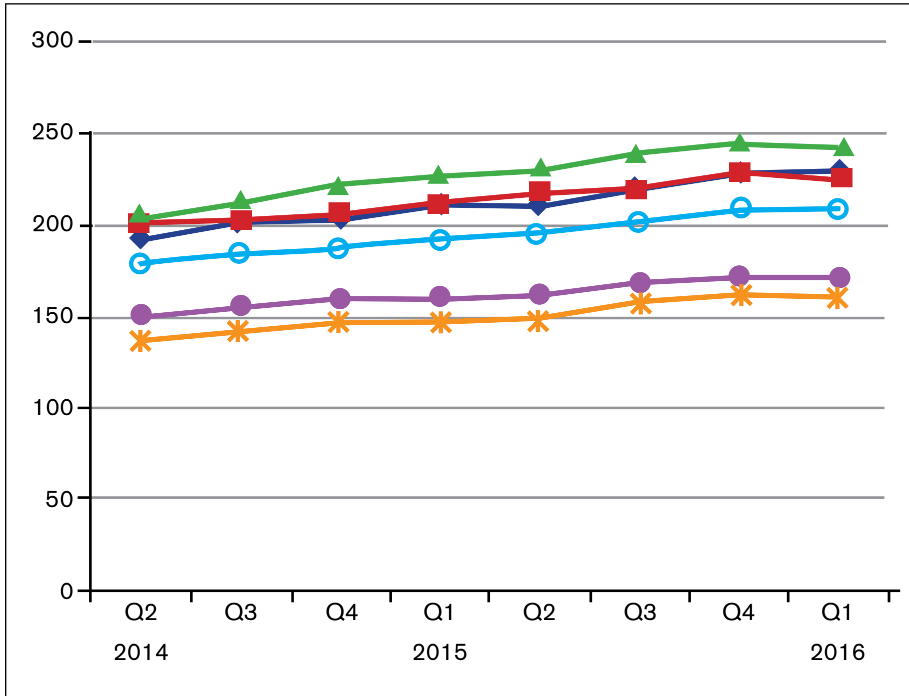


Figure 20: Paracetamol-opioid compound analgesics, DDDs/1000 NIPUs

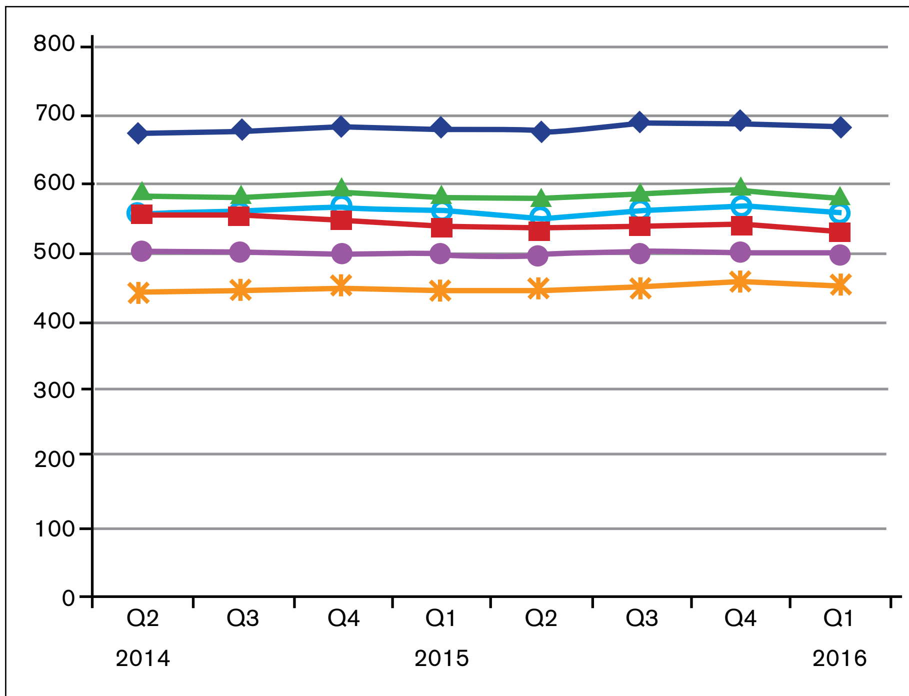


Figure 21: Co-codamol 8/500 DDDs/1000 NIPUs

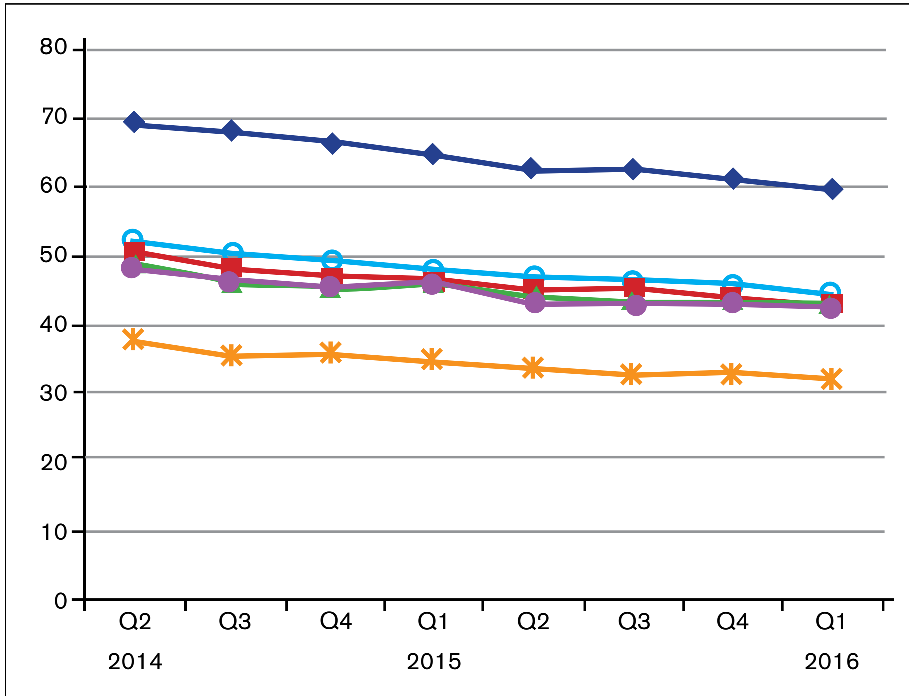


Figure 22: Co-codamol 15/500, DDDs/1000 NIPUs

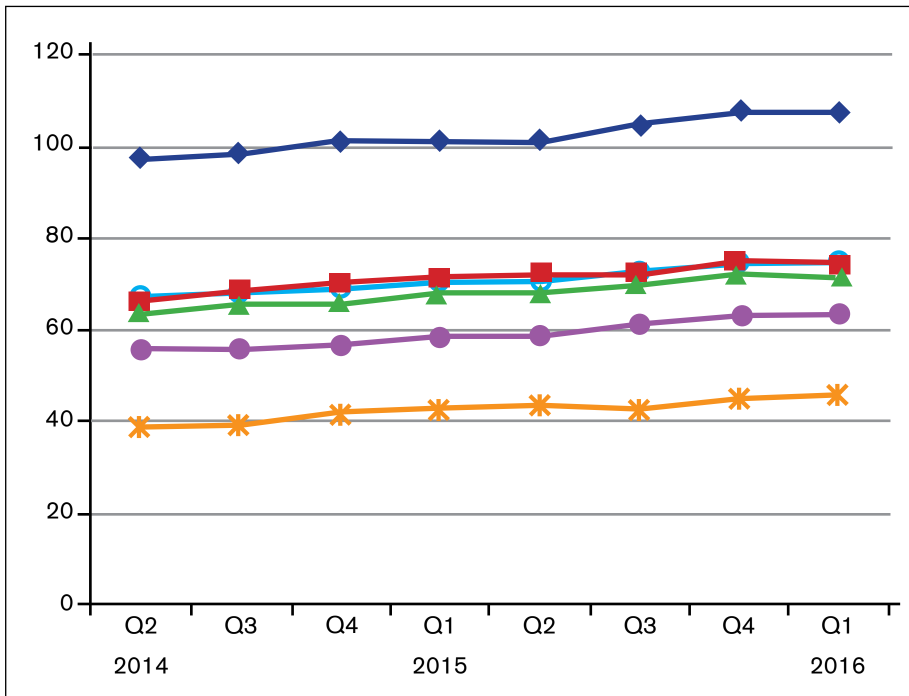
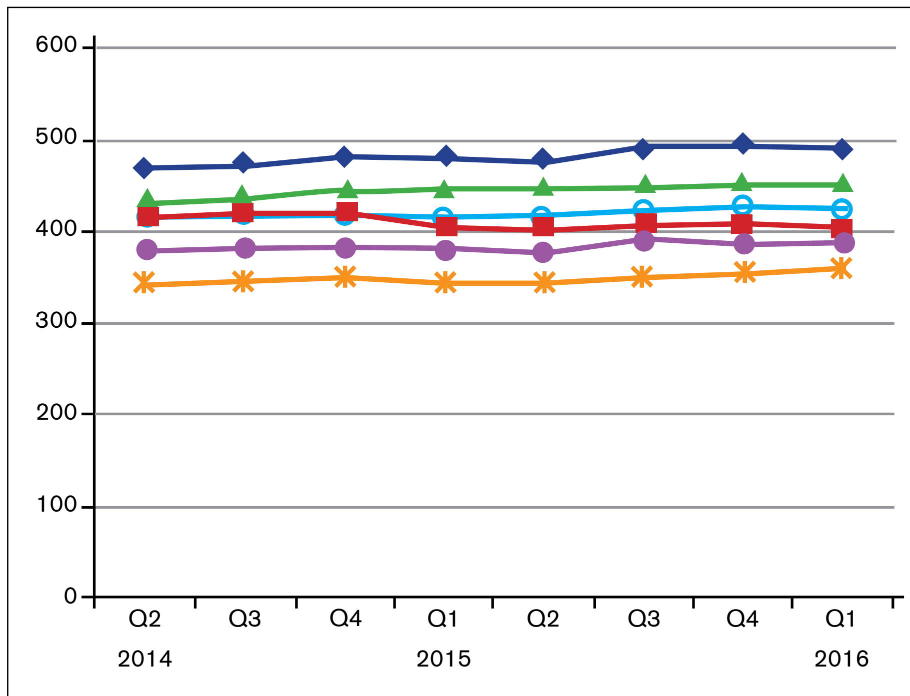


Figure 23: Co-codamol 30/500, DDDs/1000 NIPUs



Integration of quality improvement

Improved care for children in hospital

In 2015/16, the HSC Safety Forum's paediatric quality improvement collaborative completed the introduction of age-adjusted early warning scores for all children in hospital to facilitate the early detection of deterioration and timely intervention. This was achieved by evaluating a prototype system in pilot areas and making further minor changes before full introduction – which in turn will be re-evaluated after 12 months.

Medication errors are a significant but preventable cause of harm to children and young people. The HSC Safety Forum in partnership with the Royal College of Paediatrics and Child Health have joined the UK Meds IQ network to bring together tools and improvement projects to address this problem. The vision of the network is that child health professionals will be able to use this resource to support their own improvement work and learn from the experiences of others. Each HSCT has identified champions whose role is to (i) promote the use of Meds IQ in their HSCT and professional groups (ii) share local and regional resources on medication safety and contribute to the content of the website.

In parallel with the above, working in partnership with Northern Ireland Medical & Dental Training Agency, paediatric medical trainee programme, the HSC Safety Forum designed and delivered an introduction to Quality Improvement training package for child health professionals covering basic QI methodologies including the IHI Model for Improvement, PDSA cycles, stakeholder engagement and measuring for improvement. We also shared experiences of successes and failures and look at how we can share good practice. It is anticipated that this will become a standard element of future training programmes.

Beyond pills - living better with persistent pain

It is challenging for people living and often struggling with persistent and disabling pain to become involved in Health and Social Care service improvements. In 2014 the Patient Client Council published 'The Painful Truth' report based on the personal accounts of 2500 people in Northern Ireland and their experience of living with persistent pain. The majority of the report's ten recommendations were accepted by the health minister, the HSCB and PHA. This led to the establishment of the Northern Ireland Pain Forum in 2015; a collaborative network of voluntary and statutory service providers and service users. The forum seeks to drive pain management service improvements through co design and co delivery, set priorities and influence policy decisions for the estimated 400,000 people, who have persistent pain in Northern Ireland. The forum is built around a service user reference group and has participation from voluntary agencies, community and primary care professionals and all HSCTs. It is supported by the Patient Client Council and the HSCB and convened and chaired by the PHA.

During 2015/16 a number of key service improvements relating to pain management were introduced including:

- development of the first comprehensive five year plan for much needed pain management service improvements;
- participation in the Northern Ireland Pain summit in November 2015;
- development of a Northern Ireland web portal for pain management;
- introduction of a menu for self-management interventions for patients in pain;
- identification of options for improving community and GP services;
- development of a patient pathway for fibromyalgia – a debilitating condition that is difficult to diagnose and treat.

Integrating the care with AHPs

Allied Health Professional support in neonatology

Recent regional investment has been secured for children with complex healthcare needs to appoint AHP practitioners to work within Neonatal care across the region. This investment ensures standards set within the British Association of Perinatal Medicine is met (BAPM) based on the current cot figuration in Northern Ireland.

The AHP staffing resource appointed within this investment for neonatal care includes Dietetics, Occupational Therapy, Physiotherapy and Speech and Language Therapy. These practitioners will work as part of the wider multi-disciplinary team of medical and nursing staff to strengthen the workforce and professional expertise in neonatal care, which will enhance outcomes for children and their families.

This investment will support the baby's short and long term neurodevelopmental, growth, nutrition, physical, respiratory and bonding with parents in line with the growing evidence of the complex needs of this vulnerable group.
Support provided will include a comprehensive assessment and provision of a developmental focused model of intervention to meet the identified babies and families'.

Neuro-disability

Occupational therapy and physiotherapy support has been integrated within neuro-disability services in both a tertiary and local HSCT basis to address the complex movement disorders associated with Cerebral Palsy and other acquired Neurological conditions.

This integrated model of care with specialised medical support has provided comprehensive innovative interventions to meet the needs of children and young people with a range of neuro-disability disorders. This service model provide intervention to address the difficulties experienced by children within complex movement disorders from a neuro-disability base, eg increased spasticity, muscle stiffness and variable muscle tone.

This model delivers medical intervention such as Botulinum Toxin with intensive therapy to enhance children's independence and performance, ease their management and reduce pain in the following areas:

- children who are GMFCS 4 or 5 and who are experiencing discomfort for dressing and changing due to adductor and hamstring spasticity;
- ambulant children who have diplegia;
- children with upper limb spasticity.

The integrated Medical and AHP model of care has had positive outcomes for children and young people, parents/carers, school staff and clinicians and facilitates early intervention for children of varying levels of spasticity, meeting NICE guidelines. This team was recently runner up at the UK Neurology Team of the year and was a finalist at the 2016 AHP Award for Children's Services.

Integrating the care with social care services

Adult safeguarding - new procedures including adults at risk

Adults in need of protection, Joint Protocol for Working Adult safeguarding is a complex task involving a range of skills and expertise. This is reflected in the wide range of organisations who are members of NIASP. This allows NIASP access to an equally broad range of initiatives and developments across government departments which, in turn, significantly increases opportunities to raise awareness of adult safeguarding. Adult Safeguarding is a key service regionally, both for individual users/carers, but also strategically. Developed to standardise and streamline response to allegations of abuse, neglect and exploitation and improve outcomes for service users. Making Communication Accessible - A Guide for all HSC Staff was developed and will be formally launched on 27 June 2016

Regional review of domiciliary care

Domiciliary Care is a key service regionally, both for individual users/carers, but also strategically. Information flows about the service and marketplace were poor and contradictory, the service user experience not consistently captured. Improved financial and activity information; better understanding of HSCT operating models, workforce pressures and the market regionally; improvement in data definitions. Establishment of a set of recommendations to inform future development of the service, including learning from user/carer experience, improved service interfaces and learning from national/international experiences.

Self-directed support initiative

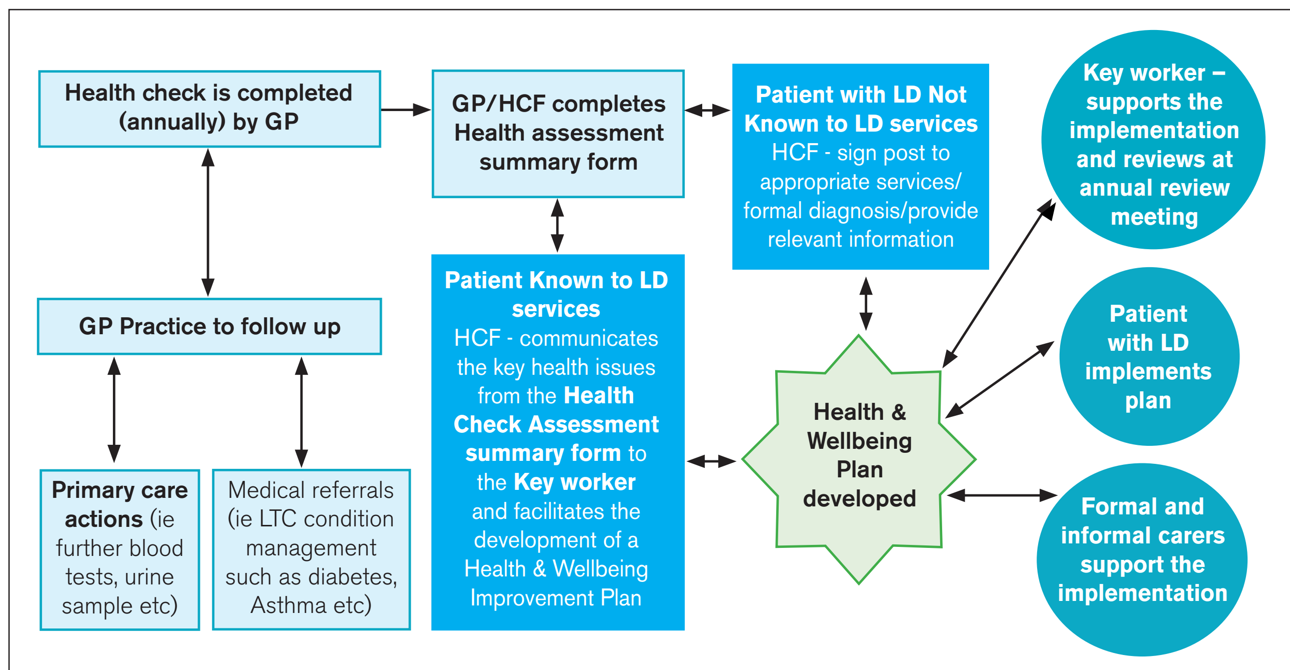
Introduces personalisation and co-production across all programmes of care including children with disability. Requires fundamental culture change in social care assessment, support planning, and practice as this is a strength based/outcomes focused approach working in partnership with service users and carers. The development of SDS initiative is a key component in personalisation and coproduction. The SDS initiative introduces the ASCOT Adult Social Care Outcomes Toolkit across all programmes of care on a phased approach. The background work with Kent University has taken place, licences are agreed and signed for the region and training has been provided to HSCT staff. The initial trialling will begin with SEHSCT in late August/ early September and other HSCTs will follow soon after.

Annual health check: patient pathway to support the development of a health and wellbeing plan

Within the Learning Disability Services Framework standard 21 indicates that people with a learning disability should be supported to achieve optimum physical and mental health. The key performance indicator linked to the standard specifies that each person with a learning disability who receives an annual health check should have a health and wellbeing plan in place. Health and wellbeing plans simply identify the personal health and wellbeing needs of individuals and describe the actions to empower individuals to make healthy choices to improve their health. They will also identify any help and support that might be needed to achieve and maintain good health and prevent ill health.

A patient Pathway has been developed (see below) as well as guidance in order to assist the HSCTs with the implementation of individual Health and Wellbeing plans for adults with a learning disability. The pathway and guidance will facilitate a consistent regional introduction to the development and implementation of Health and Wellbeing Plans by describing roles and responsibilities and will ensure that these plans become integral and routine to existing assessment, care planning and review processes.

Annual Health Check: Patient pathway to support the development of a health and wellbeing plan

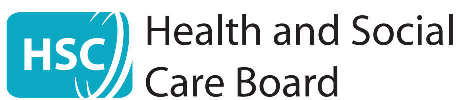


Beyond silos: learning from integrated eCare practice and promoting deployment in European regions

CCHSC are currently leading a three year EU project in partnership with HSCTs, primary care, HSCB and BSO. Although the provision of collaborative service models bringing together the usual silos of social care, health care and informal support have started to emerge much remains to be done to deliver truly integrated care which meets people's needs.
The project is called 'Beyond silos: learning from integrated eCare practice and promoting deployment in European regions'. The overall aims of the project are to enable delivery of integrated care to older people to support them to live independently within the community by providing the ICT tools necessary to join up care pathways across organisations, in particular between social and health service providers.

HSC are using the Beyond silos project to better integrate the care of older people in Northern Ireland. We are building on the Telemonitoring Northern Ireland service by integrating it with the NIECR thereby providing health and social care teams with common access to patient and client data. While interfacing elements of eNISAT with the NIECR will enable the transfer of information, including risk assessments, between professionals and will facilitate a smoother journey for the service user along the care pathway.

Additionally, we are piloting the inclusion of a shared care summary within the NIECR. Care professionals will be able to create and update service user information using a dynamic, interactive and integrated shared care plan. The Beyond silos project will use NIECR dynamic forms and pathway creation technologies to develop a shared care plan reusing information gathered from the community, eNISAT, TNI, and social care integrations, as well as information already known to NIECR.



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