South Eastern Health
and Social Care Trust

ANNUAL QUALITY REPORT 2015/16

Chief Executive's Foreword

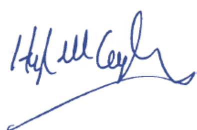
The public deserve assurance that they are receiving the very best quality of care and treatment. The South Eastern Health and Social Care Trust (SEHSCT) employs over 10,000 staff who work tirelessly to deliver safe, high quality and compassionate care for the patients and clients who we are privileged to serve. The purpose of the Annual Quality Report is to detail what we do, how we are performing and provide assurance that our systems assess the quality of our services and drive continuous improvement.

This fourth Annual Quality Report builds on an excellent track record of improvement and I am pleased to report good progress against our quality priorities for last year and share a small selection of our staff achievements over 2015/16. As an organisation we value a culture of learning and on-going improvement therefore our priorities for next year have also been included.

Throughout 2015/16 we have operated in a tough financial climate with continuous growing demand for our services, yet our efforts have allowed us to improve safety, quality and the experience for those who use our services and our staff. However, it is important to say that we are fully aware of the pressure associated with growing demand and the gaps in staffing and that it is a priority for the Trust to address these issues. We continue to face challenges by adopting new ways of working and engaging our staff by actively pursuing a culture of quality improvement. In addition, we are keen to learn from the feedback from our patients/clients and their carers, who provide valuable insight into where our future focus needs to be. It is reassuring that local survey results throughout 2015/16 consistently showed that the majority of our patients and clients were either very satisfied or satisfied with the service they received.

I would like to recognise the contribution of all our staff who are our greatest asset; 24 hours every day, 7 days per week, they display exceptional leadership, professionalism and compassion. During the last twelve months we have continued to encourage more of our staff to be actively involved in identifying local areas of improvement and supported them to lead the required changes, setting the future direction of the organisation. The regional staff survey carried out in 2015 evidenced improved staff satisfaction in a wide range of areas when compared with the 2012 response; a total of 3,459 completed questionnaires giving a response rate of 32%. 79% of SEHSCT staff stated that care of patients is their organisation's top priority, an improvement from 68% in 2012 (compared to the equivalent 66% in England) and 65% of staff stated that they would recommend their organisation as a place to work; an improvement from 60% in 2012 (compared to the equivalent 54% in England). As an organisation we value feedback from our staff and over 2016/17 and beyond we will consider the survey findings and focus improvement in relevant areas.

In summary our priority is to do all we can to continually implement quality improvement that further enhances the safety, quality and experience for all our patients/clients and staff. The Trust recognise the pressures faced through high demand in almost every area. We look forward to the opening of the Phase B Inpatient Ward Block. The seven storey building will provide 12 inpatient wards comprising 288 en-suite bedrooms, a new Day Procedure Unit including 4 state of the art Operating Theatres and an Endoscopy suite where patients will have the opportunity to have a broad range of procedures completed without having to stay in hospital overnight. The building will also have Support Services including a new Pharmacy Department. It is anticipated the new facility will open to Patients early 2017. The next phase will be an Acute Services Block, which will complete the Phase B Redevelopment in 2019. The New Build will provide state of the art facilities, which will add to excellent facilities across the Trust and support our staff to deliver safe, person centred care and treatment.



Hugh McCaughey, Chief Executive

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About The South Eastern Health and Social Care Trust

Facts & Figures

People who used our services during 2015/16:

- 71,524 inpatients
- 301,114 outpatients
- 131,744 Emergency Department attenders
- 19,613 Minor Injuries Unit attenders
- 33,174 day case attenders
- 477 children looked after by the Trust
- 4792 Domiciliary care packages for older people provided in the community

The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approximately 345,000 people with a budget of almost £500 million. The Trust covers the local government districts of Ards, North Down, Down and Lisburn.

The main hospital bases are: Ards Community Hospital, Bangor Community Hospital, Downe Hospital, Downshire Hospital, Lagan Valley Hospital and the Ulster Hospital. Community bases are located in many local towns and villages from Moira in the West to Portaferry in the East and from Bangor in the North to Newcastle in the South.

In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, embracing areas of relative wealth and prosperity as well as pockets of considerable deprivation and need.

The Trust employs in the region of 10,000 staff across a range of disciplines as follows:

- Admin & Clerical
- Maintenance
- Ancillary & General
- Nurses & Midwives
- Social Work
- Professional & Technical
- Medical & Dental

Annual Quality Report

What is the Annual Quality Report?

In 2011, the Department of Health and Social Services and Public Safety (DHSSPS) launched the Quality 2020: A 10 Year Strategy to 'Protect and Improve Quality in Health and Social Care in Northern Ireland'. One of the priority work streams within this strategy was to agree a standard set of indicators for HSC Trusts across the region on safety, quality and experience and detail compliance in an Annual Quality Report. In addition to regionally agreed indicators, each Trust is invited to include a compliance summary against their local priorities for safety, quality and experience, ensuring they reflect staff wellbeing. This is the Trusts fourth quality report.

The Quality Report aims to increase public accountability and drive quality improvement within Health and Social Care (HSC) organisations. It reviews the past annual performance against quality priorities and the goals that were set, identifies areas for further improvement, and includes the commitment to the local community about what activities and ambitions will be undertaken and monitored over the coming year. This report includes feedback from those who use our service and is shared with the local Health and Social Care Organisations and the public. For the purpose of this report the SEHSCT will be referred to as the Trust.

The following table provides an update on the Trust's 'Next Steps' from the 2014/15 Annual Quality Report. A more detailed update can be found at appendix 2.

Annual Quality Report 2014/15 Next Steps Update

Theme	Title	Achieved ✓	On Plan →	Behind Plan △
Theme 1 Effective Health & Social Care	Standardised Mortality Ratio (SMR)	✓		
	Audit	✓		
	Protecting Children at Risk		→	
	Children's Services Family Support Hubs	✓	→	
	Looked After Children		→	
	Ensuring Permanence Plans for Looked After Children	✓		
	Adult Safeguarding	✓	→	
	Carers Assessment		→	
	Re-settlement of Adults with a Learning Disability		→	
Theme 2 Delivering Best Practice in Safe Health & Social Care Settings	Cardiac Arrest		→	
	Reducing Healthcare Associated Infections		→	
	Surgical Site Infection Surveillance	✓		
	Patient Falls	✓	→	
	Pressure Ulcers	✓	→	
	Medication Safety		→	
	Innovative Neuro-modular Treatment for Bladder and Bowel Dysfunction			△
	Direct Payments for Children	✓	→	
	Educate and Training for Young People Leaving Care	✓	→	
	Transition Planning for Children with a Disability	✓	→	
	Direct Payments and Self-Directed Support in Adult Services	✓	→	
	Annual Health Checks for Adults with Learning Disabilities		→	
	Approved Social Work	✓	→	
Theme 3 Protecting People from Avoidable Harm	Adverse Incidents / Serious Adverse Incidents (SAIs)	✓	→	
	Venous Thromboembolism (VTE)	✓	→	
	Surgical Safety Checklist	✓		
	Hand Hygiene		→	
	Malnutrition Universal Screening Tool (MUST)		→	
Theme 4 Ensuring People Have a Positive Experience of Service	Complaints /Lessons Learnt from Complaints / Compliments	✓		
	Patient/Client Satisfaction	✓		
	10,000 Voices Project	✓		
	Emergency Department		→	
	Elective Access		→	
Theme 5 Resilient Staff	Vaccinations			△
	Looking After Your Staff: Stop Smoking Service		→	
	Revalidation of Medical Staff		→	
	Staff Training – Hyponatraemia	✓		
	Infection Prevention & Control Training & Education	✓	→	
	Investors in People	✓	→	
	The Coach Approach		→	
	Leading in Safety, Quality & Experience (SQE) Programme	✓	→	
Community	Telemonitoring		→	
Mental Health	Improving Crises Management		→	
(MHSOP)	Improving the Treatment of Delirium in Nursing Homes		→	

Quality Improvement and Innovation (QII) Approach supporting SQE

Safety, Quality & Experience (SQE)

The focus of the QII Approach is to provide a framework to support staff to continue to provide services that are safe, of a high quality and create a positive experience through improvement, innovation and the growth of knowledge. Through this work it is hoped that we can develop a culture of commitment to continuous improvement at all levels within the organisation.

The QII Approach brings together, and highlights the QII focus and support of four organisational departments through their related strategies to ensure a co-ordinated approach to QII:

- Organisation and Workforce Development
- Safe and Effective Care
- Planning and Service Improvement
- Innovation, Research and Development

There are three main themes within the Approach:

- **Improving Care** - We will commit to work in collaboration to improve safety, quality & experience for service users and staff
- **Increasing Improvement & Innovation Capability** - We will develop all staff to inspire them to continue to think differently & seek opportunities to improve & innovate
- **Improving Organisation Performance** - We will demonstrate evidence of improvement through promoting strategic, planned approaches to service delivery

The associated action plan highlights a range of initiatives both aligned to Trust priorities and regional priorities which will hopefully lead to a greater understanding for staff into how they can continually improve services, but also ensure that they are aware of what support can be provided to them. It is through this work that we hope to embed a range of regional initiatives, such as the quality 2020 attributes framework, into our organisation.

Goal 1: Transforming the Culture

The Trust's Vision

The Trust will be a leading provider of health and social care services for our patients, clients and carers. We will achieve this, in partnership with others, by making sure that our services are safe and effective, improving and provide a positive outcome and experience.

Our Purpose

The Trust will:

- Improve the health and wellbeing of the people in our Trust area in partnership with others
- Provide person-centred, safe and effective care
- Plan for and respond to the changing needs of our patients, clients, carers and staff
- Ensure best value for money

HSC Staff Survey

Facts & Figures

Overall Trust staff are generally positive about their jobs with some significant improvements at or above the average for Northern Ireland.

Q-No	Question	SET 2012	SET 2015	HSCNI 2015
Q29h	Care of patients / clients / service users is my organisation's top priority	68%	79%	73%
Q29j	I would recommend my organisation as a place to work	60%	65%	61%
Q16c	I am able to deliver the standard of care I aspire to	66%	70%	69%
Q3a	My training, learning and development has helped me to do my job effectively	72%	73%	69%

A total of 15 organisations across the HSCNI participated in the survey, using either an all online or mixed mode approach.

The South Eastern Trust opted for a mixed mode approach to ensure that all staff had a mechanism to engage in the survey, particularly staff working in remote locations with no internet access as well as those who do not access IT equipment regularly or at all as part of their role. This was the first year a full census survey was undertaken rather than a stratified sample.

The Trust had the highest return rate of all the HSC Trust at 32% with 60% of questionnaires sent electronically and 40% paper copies.

Next Steps

- The Trust will be conducting an exercise to refresh the values in 2016/17 with all staff
- The Trust will also be producing a new Corporate Plan which will include a new vision statement

Trust Values & Behaviours

	Ensuring safety, quality and improving the experience of our patients and clients by living our Value through the following behaviours	
SET expects me to:	**... and in practice for everyone, this means I need to:**	**... and in practice for managers, this means I need to:**
Treat everyone with dignity and respect	• Respect others and respect differences • Communicate sensitively • Be sincere • Take into account the needs and feelings of others • Show understanding of other's pressures • Congratulate others on achievements and successes • Recognises achievement or effort • Keep confidences	• Thank staff for their work • Recognise both team and individual contribution and performance • Show understanding of staff pressures • Respect people's confidentiality • Communicate honestly • Recognise and challenge inappropriate behaviour
Strive for excellence in all that I do	• Want SET to be the best • Work with passion & enthusiasm • Always do my best • Take ownership for my work • Be willing to go the extra mile • Don't always wait to be told – show initiative • Question why we do things the way we do • Feel free to make suggestions for improvements • Ask for help if I need it	• Encourage creativity and innovation • Actively manage the change process and the impact on people • Use enthusiasm and energy to inspire others • Demonstrate personal commitment to excellence through my day to day actions • Keep momentum alive by reinforcing key messages and putting a real focus on sustainability • Encourage and develop leadership at all levels
Be fair, open and transparent	• Be approachable • Be open and inclusive • Acknowledge my own limitations • Admit when I don't understand or make mistakes.	• Act with probity and integrity • Create an environment where all people can excel • Accept responsibility for my own work and for the performance management of my team • Share my learning and development with others
Listen to and learn from our patients, clients, carers and staff	• Take time to Listen • Learn from my mistakes and shortcomings • Learn from others • Share learning with others • Seek others' input and consider others' views	• Involve people in problem solving and decision making about areas that affect them • Welcome ideas and feedback • Hold regular team meetings
Support and develop our staff to improve services and user experience	• Contribute positively to team working • Help others • Take responsibility for my learning and development and put learning into practice • Work and co-operate with others where it will result in better services • Actively consider own, and others' well-being	• Provide others with clear purpose and direction • Strike the right balance between giving guidance and giving responsibility • Act as a coach when needed • Complete and implement annual appraisals, including a personal development plan • Give clear, evidence-based feedback to help improve and develop performance
	The South Eastern HSC Trust will support everyone to develop the necessary skills and competencies to do their job through learning and development opportunities	

Patient and Client Experience

Patient & Client Satisfaction

Listening to what our patients and clients tell us about our services is a corporate priority, we realise that the experience of the patient is a key measurement of the quality of our services. We have concentrated great effort in developing the most effective methodologies to measure the patient/client experience and to ensure that information is available to staff at all levels from the frontline to the Board. The methodologies include surveys, telephone feedback, focus groups, electronic responses, gathering of patient stories.

Acute Inpatient Care Rolling Programme

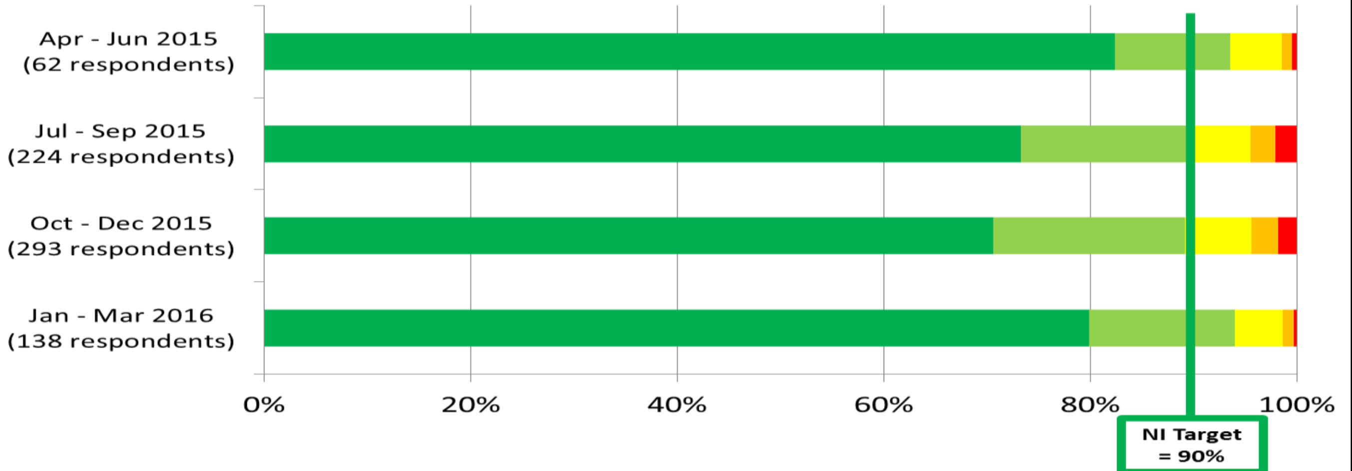
The inpatient survey results show high levels of satisfaction as demonstrated in the graph below. The graph details the aspects of the care and service provided by rating each aspect on a scale of 1 (Least satisfied) to 5 (Most satisfied). Target = 90% satisfaction (rating of 5 or 4)

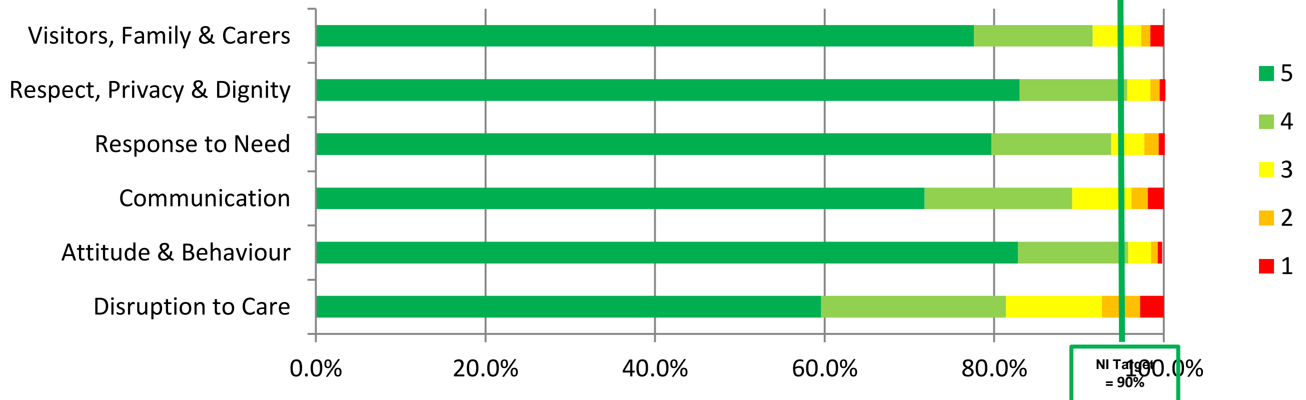
Quarter	Q1		Q2		Q3		Q4		Overall	
	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16
No. of respondents	175	62*	99	224	486	293	111	138	871	717
% of patients rating as 5 or 4 (NI Target = 90.0%)	87.7%	93.7%	88.6%	89.9%	93.5%	89.3%	93.8%	94.1%	90.0%	90.8%

*Post-discharge postal reporting in Quarter 1 was limited to one ward due to an administrative issue

- ***Number of wards included in the inpatient survey has increased from 44 in 2014-15 to 65 during 2015-16***
- ***Overall satisfaction remained above 90.0% and increased by 0.8% during 2015-16***

Goal 1: Transforming the Culture





Through learning from patient/client feedback, the Trust plans to achieve satisfaction levels of > 90% per key theme across all clinical areas.

Goal 1: Transforming the Culture

Primary & Community Care Surveys

The Primary & Community Care Survey measures satisfaction against the five patient/client experience standards.

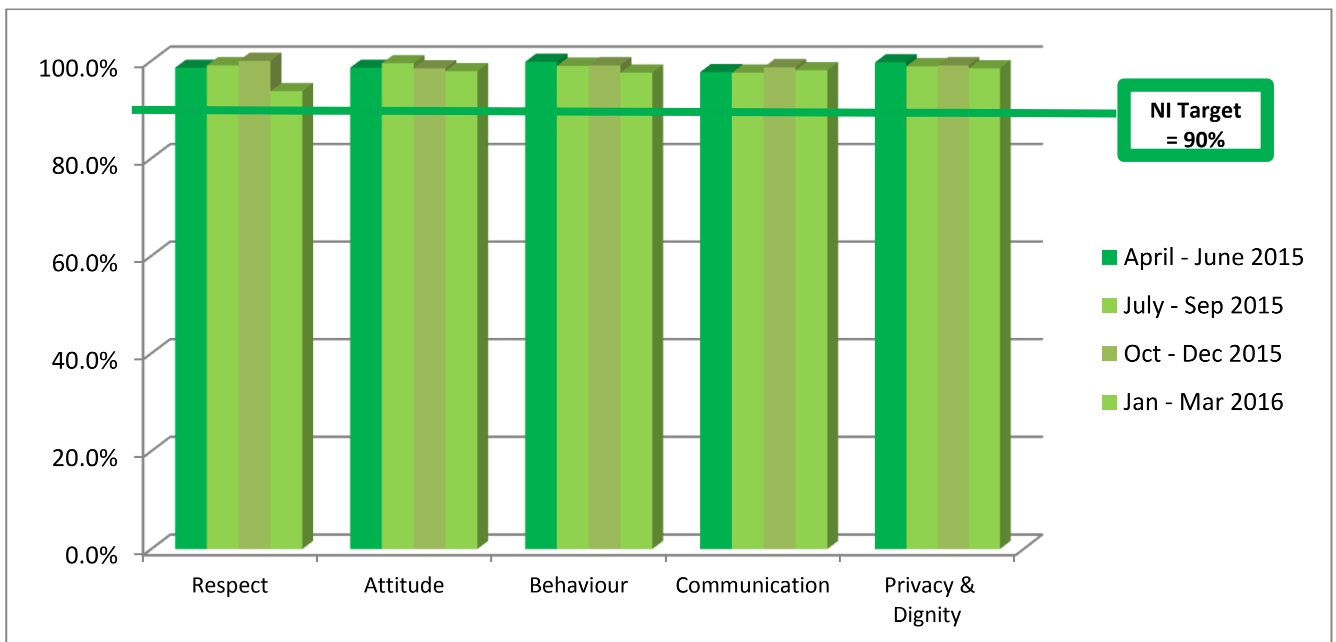
Quarter	Q1		Q2		Q3		Q4		Overall	
	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16
No. of respondents	127	82*	69	102	81	135	97	97	374	416
% of patients rating 'Always'(NI Target = 90.0%)	99.8%	98.9%	99.7%	98.8%	98.7%	99.1%	98.5%	99.6%	99.2%	99.1%

*Post-discharge postal reporting in Quarter 1 was limited to one ward due to an administrative issue

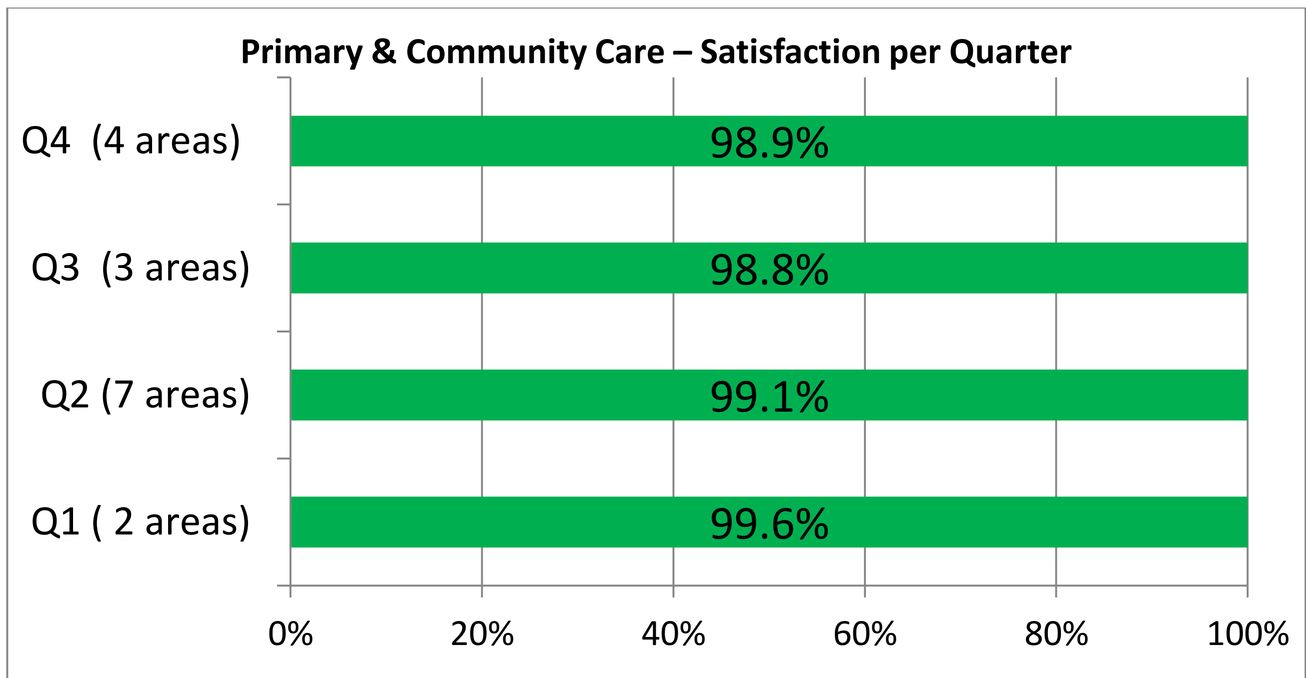
All questions answered, achieved a score of 93.8% or above and all of the standards are therefore fully compliant.

The charts below shows the composite scores for the five Patient & Client Experience Standards demonstrating scores exceeding the Northern Ireland target of 90.0%.

Q1 Range - 97.7% - 99.7%
Q2 Range - 97.6% - 99.5%
Q3 Range – 98.5% - 100%
Q4 Range – 93.8% – 98.5%



Goal 1: Transforming the Culture



Ward and Outpatient Comments Leaflets

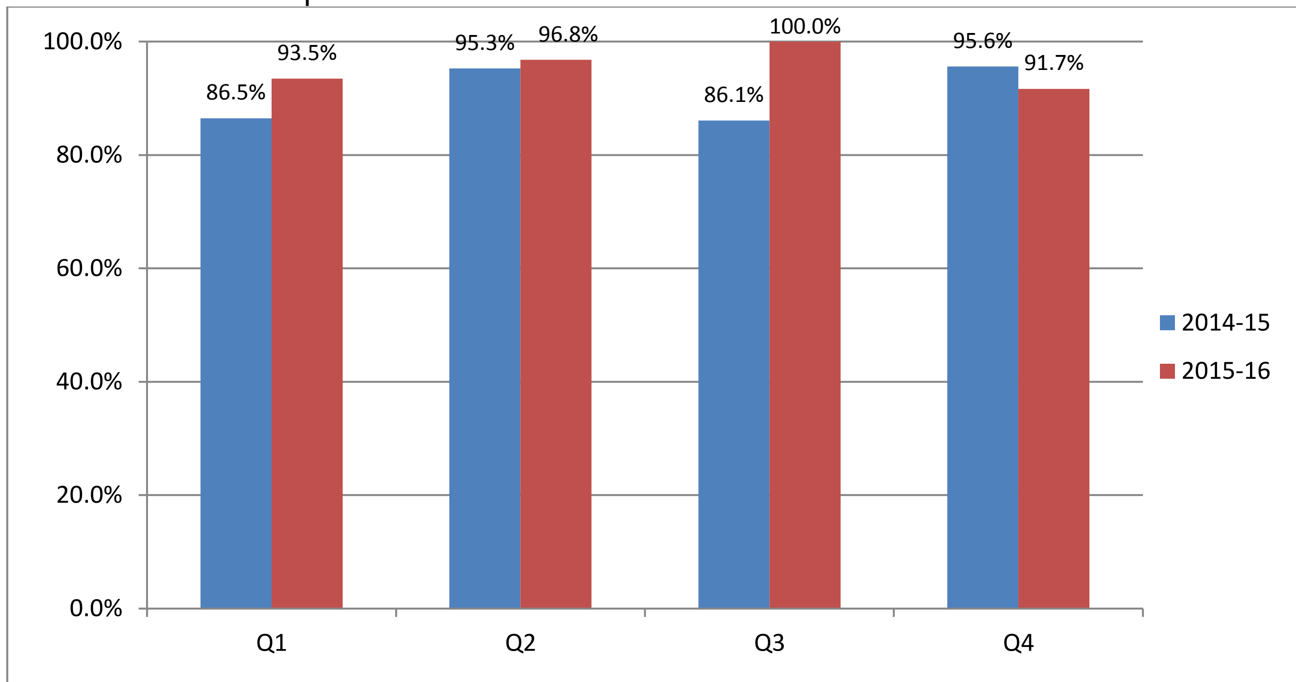
Comments Leaflets are available for patients, clients, relatives and visitors to complete.

Quarter	Number of comment leaflets received		Number of positive comments		Number of negative comments relating to environment		Negative comments relating to treatment and care	
	2014 - 2015	2015 - 2016	2014 - 2015	2015 - 2016	2014 - 2015	2015 - 2016	2014 - 2015	2015 - 2016
1	77	50	128	106	8	17	37	12
2	87	31	167	86	22	5	3	1
3	39	55	77	162	12	15	9	3
4	45	25	121	61	13	7	8	4

- ***The number of negative comment received relating to treatment and care has decreased significantly from 57 to 20, a 65.0% decrease.***

Goal 1: Transforming the Culture

The table and graph below show the % of respondents who stated that overall they were satisfied with their experience.



The negative comments/suggestions include environmental factors (such as noise) and general dissatisfaction of TV systems and food.

Next Steps

Patient & Client Experience Monitoring recently-introduced and planned enhancements include:

- Comprehensive programme across a wide range of services
  - Full integration to co-ordinate Patient & Client Experience Standards monitoring with 10,000 Voices Programme to deliver upon Trust Patient Experience Framework – with appropriate alignment to regional priorities / programme / framework
- Co-production approaches with Users and across teams
  - Planning workshop at 6 monthly CONNECT Event for Users and Staff
  - Experience Book for service users to provide helpful information for staff and patients
  - Expert Patient Support Role through patients who have experienced service / treatment / condition supporting following patients
  - Listening Project for audio collection of patient stories to be reproduced as themed recording sets

10,000 Voices

Facts & Figures

84% of people who accessed our unscheduled care services rated their experience as strongly positive/positive

85% of people found the staff to be respectful

82% of people felt that the department was well managed

"After only a matter of minutes, I was seen by the triage nurse who took a brief medical history. Then I was moved to see the Doctor. I was given pain relief and taken to X-ray. I was checked on regularly by the nursing staff. I am grateful for the care I was given"

"I trust them completely and have total confidence in their care"

The 10,000 Voices initiative continues to provide opportunities for patients, family members, carers and staff to share their experiences across a range of health and social care settings. This initiative asks people to tell us what was important to them in their experience and to describe their overall feelings by "telling their story", using the Sensemaker® methodology. The Trust remains committed to using the information obtained from 10,000 Voices as a reliable indicator of the safety and quality of care from a patient/client perspective. Key to the success of the 10,000 Voices initiative has been the partnership approach whereby service users and staff work together to ensure that positive change can occur.

Unscheduled care

The first phase of 10,000 Voices focussed on the experience of people who use our unscheduled services. Based on the information received a number of areas for local action were identified and progressed. In order to provide ongoing information and to measure the impact of the actions initiated, a second period of story collection commenced in January 2015.

A total of 148 stories were received from patients in relation to experience of unscheduled care services in the Trust from January 2015 to January 2016. It is clear from the analysis of the information that for the majority of patients and their families/carers their experience with using unscheduled care services in the Trust was a positive one. This is evident from many of the stories which describe the efficient and effective care that patients received and how patients felt safe and confident in the care of staff.

Goal 1: Transforming the Culture

The key messages arising from the information are in relation to the following areas:

Evidence of positive patient experience

- Staff provide a high level of care which is very much appreciated by patients
- Staff are professional in their behaviour and are caring and compassionate
- Patients feel very reassured by the staff who deliver their care
- Staff are kind and helpful and patients feel welcome within the department

Communication with patients

- The importance of first impressions when arriving in the department
- Continuing to implement #Hello my name is
- Ensuring all staff have clear name badges
- Ensuring patients are provided with adequate information in relation to their treatment and care
- Ensuring that patients feel involved in decisions about their treatment and care
- Ensuring that as far as possible the privacy of patients is maintained especially when providing personal information
- Continuing to promote the Choose Well campaign

Patient comfort measures while waiting in the department

- Access to seating within waiting areas
- Access to adequate and timely pain relief
- Ensuring patients are kept comfortable during their wait
- Ensuring all staff continue to provide safe and effective, person centred care

Staff have identified a number of areas for action, which include the following:

- **Access to food / drinks in the Emergency Department:** A meal trolley with snacks to be available during the out of hours period
- **Workforce plan:** To ensure that adequate staffing levels are available to provide safe high quality standards of care
- **Increased waiting times:** Self-service Triage kiosks to be piloted
- **Management of patients with dementia:** A working group has been developed and the early objectives of this group include (1) increasing awareness and roll out of the Butterfly Scheme and (2) to develop an action plan with short/medium/long term goals to help improve the experience of those patients / carers attending the Department
- **Management of patients with a pain score >7:** Additional training on the importance of timely re-evaluation of pain has been rolled out across the department. White boards have been amended to include the pain score /time for reassessment. Posters have been developed and displayed around the department and a ‘sticker’ is added to the clinical record as an alert for staff regarding appropriate pain management

- **Management of paediatric patients within the Emergency Department:** In order to ensure that staff have the appropriate skills and competencies to manage

  children within the department, a 4 month training programme has been developed in conjunction with paediatric colleagues. This competency based programme will ensure that staff have the necessary skills to manage children attending the Emergency Department and also improve communication links with the paediatric team

Paediatric Autism and Child and Adolescent Mental Health Services (CAMHS)

The Trust is participating in the 10,000 Voices Paediatric Autism and Child and Adolescent Mental Health Services (CAMHS) phase, which is capturing the experience of children, young people and their parents/carers who use these respective services. Story collection commenced in January 2016 and will conclude on 30 June 2016.

Direct Access (self-referral) to Physiotherapy

The South Eastern Health and Social Care Trust have been the first Trust in Northern Ireland to implement the self-referral process to Physiotherapy. In order to establish a baseline assessment of the direct access to physiotherapy service and to identify recurring themes from personal experience accounts, story collection using the 10,000 Voices model commenced in January 2016 and will conclude on 30 June 2016.

Next Steps

- The Trust will continue its commitment to the 10,000 Voices initiative and will deliver on the areas agreed in the regional work plan
- The Safe and Effective Care team will explore ways to integrate 10,000 Voices with the web based electronic reporting system and other sources of information in relation to patient and client experience

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) describes the process of involving all those who are affected by our services in the development and delivery of these services, whether as a service user, carer, patient, client, staff member or someone from the wider community. PPI is a commitment made by the Trust to ensure that people are involved in the decisions which affect their care.

PPI Leads

The PPI Leads Group promotes PPI activity and shares good practice and learning. This year the PPI Leads Group supported the development of a number of projects to improve involvement in the Trust, including regional e-learning and the creation of stronger links between departments.

PPI Regional Forum

In 2015/16, the Trust contributed actively to the PPI Regional Forum, with Ann Gamble, service user, and Elaine Campbell, Corporate Planning and Consultation Manager, representing the Trust. Ann stepped down from the Forum during the year and Trust User Forum Member Rae Patience took the opportunity to participate in her place.

A number of Trust staff contributed to the production of a new e-learning training package which was launched in February 2016. This will bring training to a wider group of staff and provide an opportunity to learn more about PPI.

Consultation and Engagement

Following a 13 week consultation which ended in February 2015, the Trust presented its proposals for traffic management to the Trust Board meeting in June 2015.

The Trust commenced a consultation on the review of Intermediate Care Services in the North Down and Ards area in January 2015. The consultation concluded in April 2015 and recommendations were subsequently approved by Trust Board. The consultation proposal was endorsed by the Health and Social Care Board and referred to the Minister for Health in October 2015. The Trust is awaiting a decision the Minister on this consultation.

The Trust also consulted on the Review of Statutory Residential Care for older people from 8 September to 21 December 2015. The Trust was requested to hold on producing a recommendation pending a Ministerial Review which commenced in November 2015, and was in relation to other developments in the independent sector. The Trust will await the Health Minister’s decision before presenting recommendations to Trust Board.

Every consultation process includes engagement with staff and users, as well as the wider community and elected representatives and feedback is provided.

The Trust has continued to contribute to the development of community plans through the statutory community planning duty. The Trust is working in partnership with Councils to improve health outcomes. This work will continue with the new Councils to produce Community Plans by March 2017.

Goal 1: Transforming the Culture

The Trust also worked in collaboration with other agencies to carry out engagement, including the South Eastern Trust Local Commissioning Group and the review of Midwifery Led Units.

During this year, the Trust produced a Register of Opportunities which has collated, for the first time, details about opportunities for carers, service users, patients, clients, families and the public on one register, accessible to the public. This register will be updated annually and is on the Trust's website.

Schools Engagement

As part of our commitment to engaging with the wider public, patients, clients and families, the Trust visited six schools within its geographical area in 2015/2016, to talk to pupils about the services we provide, how health and social care is organised and how young people can contribute to their local health service. A key feature of the programme is an interactive exercise to help develop the pupils' understanding of health and social care.

Next Steps

- The Trust will begin rolling out the e-learning training across the Trust
- A revised PPI Strategy will be produced in 2016/17

Complaints & Compliments

Overview

Facts & Figures

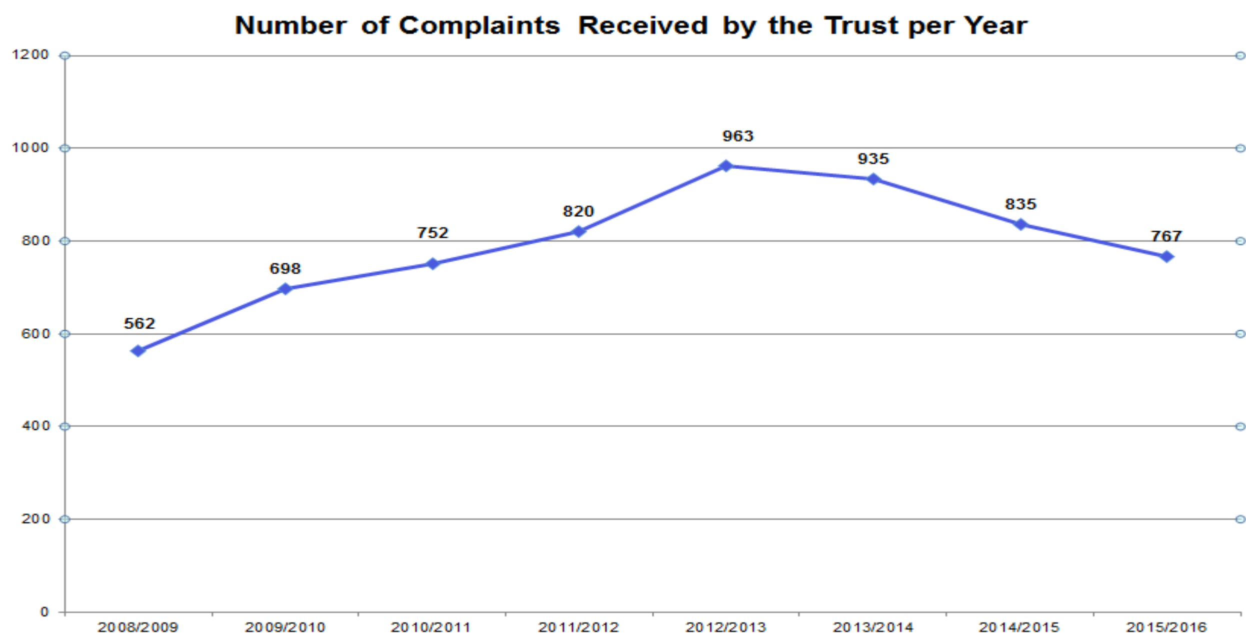
In 2015/16:

- **767** complaints were received, (a decrease of 8% from the previous year)
- **99%** of complaints were acknowledged within 2 working days
- **54%** of complaints were responded to within 20 working days (a 1% improvement from the previous year)
- The top **three** issues of complaint were Quality of Treatment & Care; Staff Attitude / Behaviour; Communication / Information
- **7572** compliments were received

The Trust welcomes complaints and the opportunities they provide to learn lessons and improve services. Whilst we endeavour to ensure that our services fully meet the expectations of users, we wish to know when they do not and in these circumstances complaints enable us to take the appropriate remedial action to prevent a reoccurrence.

Number of Complaints

The overall number of complaints received this year (2015/2016) was 767. This is a reduction of 8% in comparison to last year (835) as shown in the graph below. The number of complaints continues to be low considering the large geographical area the Trust covers and the volume of contacts Trust staff have with patients and clients.

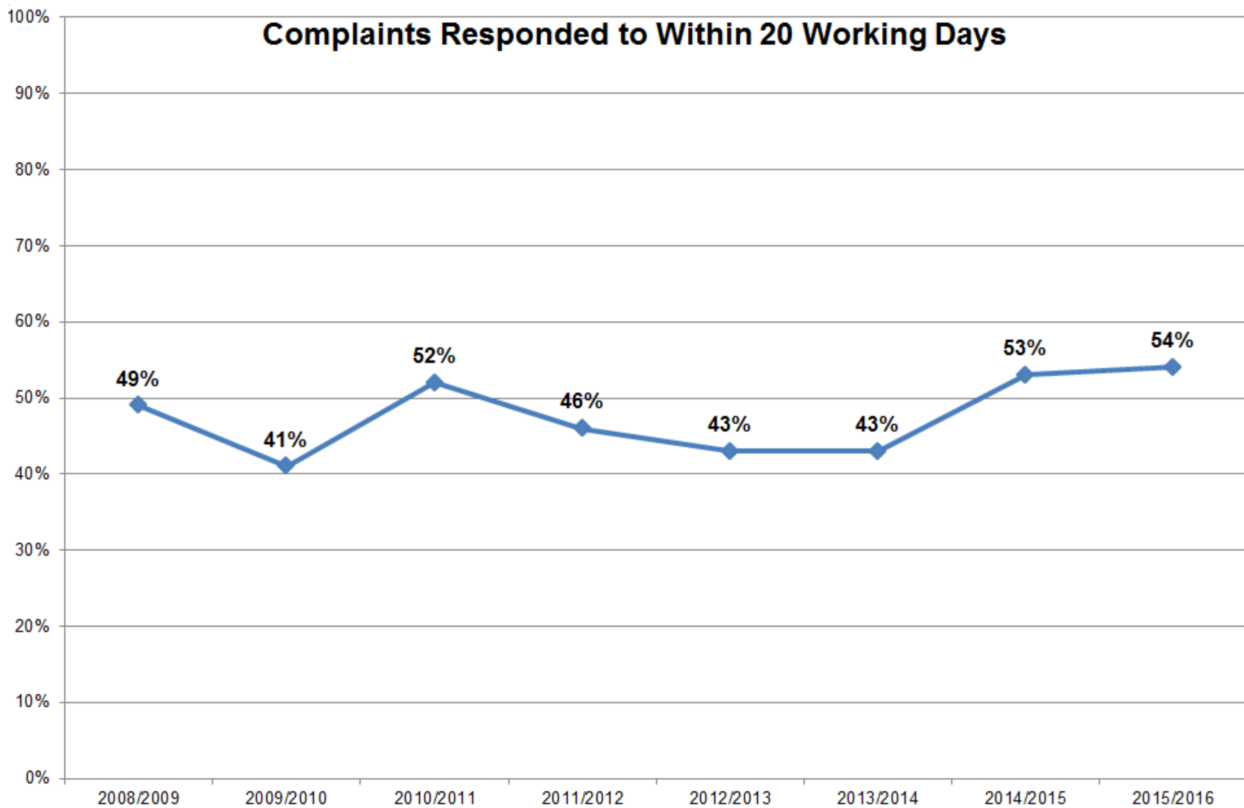


Goal 1: Transforming the Culture

Response Times to Complaints

In the past year 2015/2016, 99% of complaints were acknowledged within a target of 2 working days, and 54% of complaints were responded to within a target of 20 working days, which is an improvement of 1% from the previous year, as shown in the graph below.

The Trust continues to monitor timescales to ensure complainants are provided with timely responses. However, emphasis is on the quality of the response and ensuring resolution for the complainants, relevant to the issues raised.



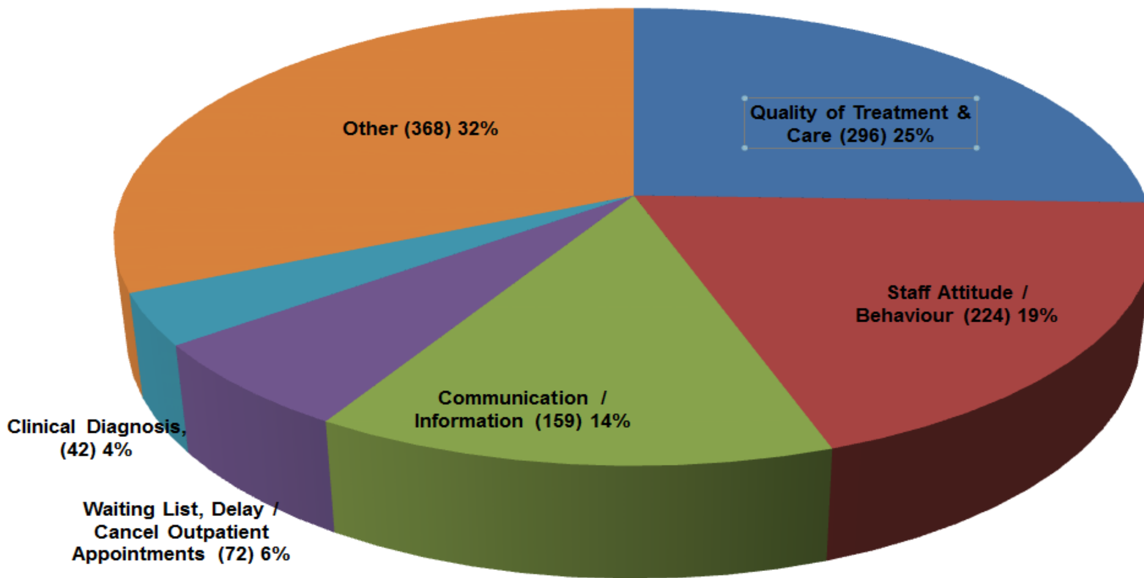
Subjects of Complaints

The chart below shows the top five subjects of complaint received in 2015/2016 were:

1. Quality of Treatment & Care
2. Staff Attitude / Behaviour
3. Communication / Information
4. Waiting List, Delay / Cancel Outpatient Appointments
5. Clinical Diagnosis.

These are the same top five subjects as last year, and this is similar across other Health & Social Care Trusts.

Goal 1: Transforming the Culture

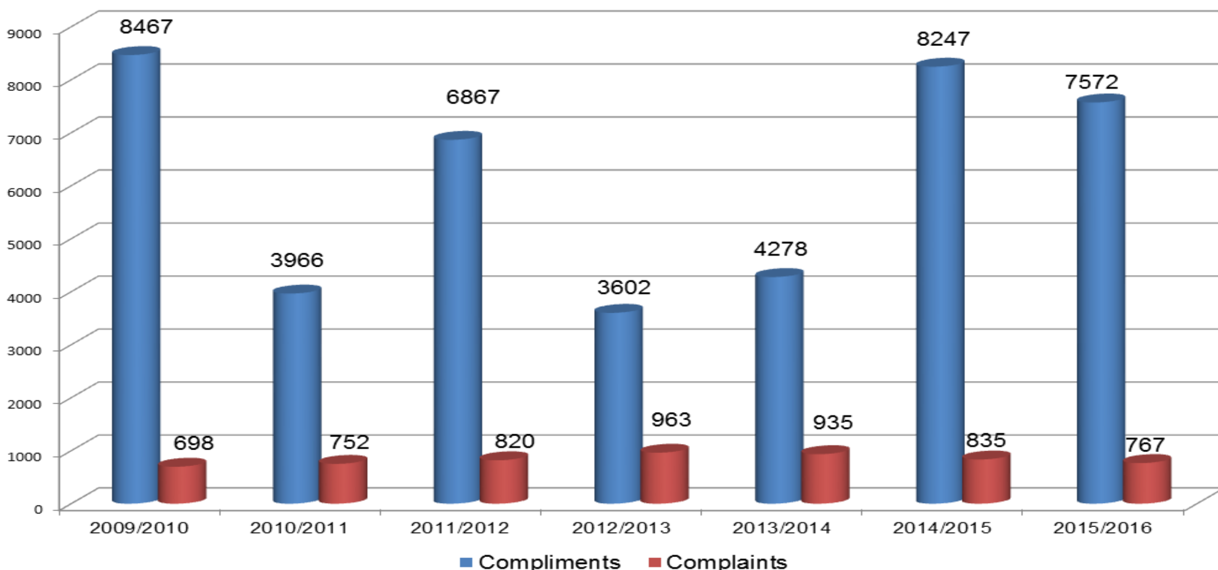


Compliments

Whilst the Trust accepts that sometimes things go wrong and welcomes complaints to enable us to take the appropriate remedial action to prevent a recurrence, each year the Trust receives thousands of letters of appreciation and thanks to acknowledge the excellent services provided.

We are proud of our staff and ensure that positive feedback is shared and celebrated. Our staff certainly appreciate feedback from their patients and clients and knowing when things go well.

In 2015/2016 the Trust received **7572** formal compliments. The graph below shows the number of compliments received per year in comparison to the number of complaints.



Goal 1: Transforming the Culture

Lessons Learnt from Complaints

The Trust is committed to an open and honest culture to ensure that lessons are learnt from issues raised through complaints from those who have used our services.

During the past year, the Trust's Lessons Learnt Sub Committee, which reports to the Corporate Control Committee and is chaired by the Chief Executive, met on a quarterly basis. The role of the Sub Committee is to ensure that the Trust has in place the necessary controls to manage its risk in relation to complaints, incidents and litigation claims. Its role is also to ensure that the lessons learnt have been put into practice on an organisational wide basis.

There are many examples of service improvements put in place throughout the Trust following complaints and a few examples are listed below.

Hospital Services:

- Following a family raising concerns about communication with them regarding their relative's poor prognosis, deteriorating condition and death, we arranged bespoke bereavement training for the staff involved to highlight the importance of timely communication with families and how to deal with these difficult situations and conversations. This training proved to be successful with staff feeling better equipped to deal with bereavement and families.

Adult Services:

- Following concerns about not receiving medication, refresher training on administration of medicines was commissioned and attended by staff. In addition, regular audits will take place on omitted medications across all mental health units.

Primary Care & Older People Services:

- As a result of difficulties experienced in relation to a patient's complex discharge, a flowchart is being developed between the nursing teams on the wards and in community which will prompt nursing staff to ensure the referrals run smoothly and with transfer of patients between hospital and community.

Children's Services:

- After concerns were raised about communication during a child protection investigation, a leaflet for parents is being developed regarding the joint protocol processes and will include information on the right of parents to seek legal advice.

Next Steps

- In the incoming year we plan to run a series of bespoke training days for our staff who investigate complaints in relation to effective complaints response writing
- We have an ongoing survey asking people who have complained to tell us about their experiences of using the complaints process, and we will review the method of collecting this feedback
- We will implement any service improvements / recommendations identified from the planned internal audit

Goal 1: Transforming the Culture

Adverse Incidents and Resulting Reduction in Harm

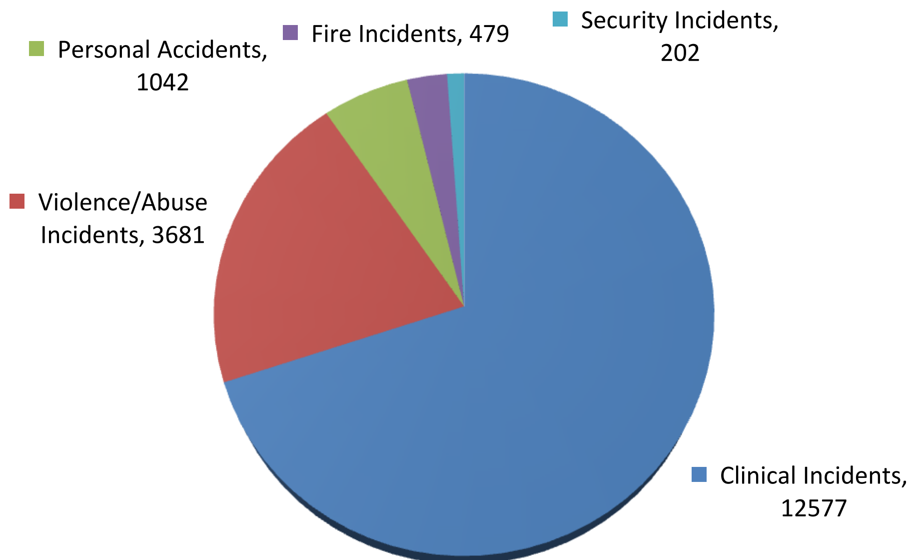
Facts & Figures

- During 2015/16 there were 18,481 incidents reported, 12,577 of which were patient related (Clinical Incidents). The top 5 most reported incident types are shown in the graph below

An Adverse Incident is defined as *“any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation’ arising during the course of the business of a HSC organisation / Special Agency or commissioned service”.*

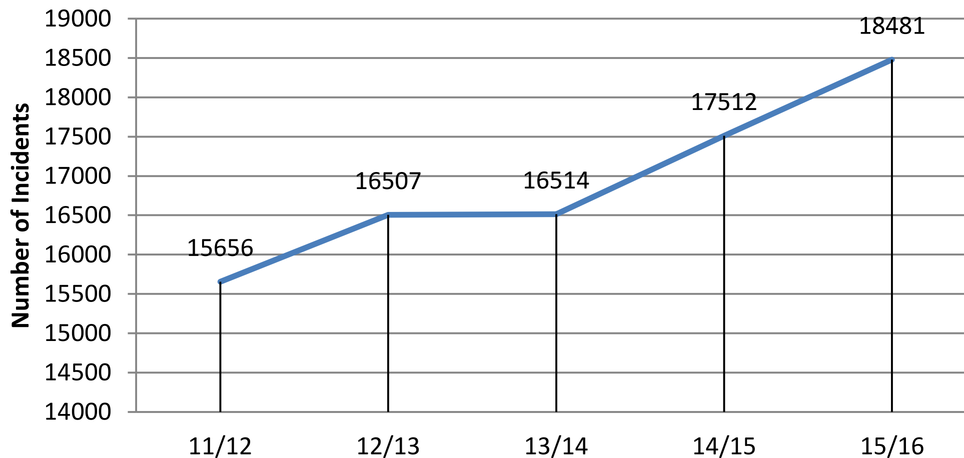
The Trust is committed to providing the best possible services for its patients, clients, visitors and staff. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learnt to prevent recurrence. To this end, it is essential that a responsive and effective incident recording, reporting and management system is in place.

We encourage this by providing an open, no blame, learning culture and where learning from such adverse incidents is identified, the necessary changes are put in place to improve practice. Learning and sharing from adverse incidents can only take place when they are reported and investigated in a positive, open and structured manner, enabling the Trust to reduce risk and proactively improve services.



Goal 1: Transforming the Culture

Staff within the Trust have embraced this ethos as shown by the year on year increase in the number of incidents reported since 2011/12, as evidenced by the following information.



Serious Adverse Incidents (SAIs)

Serious Adverse Incidents are *"an incident where there was risk of serious harm or actual serious harm to one of more service users, the public or to staff"*. These are low in number when compared to the total number of incidents reported annually. Of the 12,577 patient related incidents reported in 2015/16, 112 met the criteria for reporting as serious adverse incidents. This equates to 0.8% of the total incidents reported throughout the Trust. This is a 0.2% increase on last year, but reflects the ethos of the Trust, through its staff, for openness and transparency in a learning environment.

Each SAI is investigated fully at a level commensurate with the assessed level of harm or potential harm. Of the 91 SAI investigations completed during this year, 237 recommendations were made to reduce re-occurrence of similar incidents or to improve patient outcomes. These included:

- revised systems of work or processes/procedures
- re-enforcement or revision of existing policies
- additional and on-going training for staff

An important part of any investigation is the input received from services users, families and carers and where possible their views are sought and the outcome of investigations shared with both the service user and their family, where appropriate.

Our investigations also highlight good practice within the services we provide and these are shared with staff throughout the Trust as an important part of the learning process.

Goal 1: Transforming the Culture

In January 2016 the Risk Management Department, working in partnership with the Health & Social Care Board and a range of other stakeholders across Health & Social Care instigated a pilot of a new process for reviewing and reporting child deaths. This process includes a multidisciplinary review of all child deaths at a Mortality and Morbidity (M&M) meeting as a prime method of scrutiny.

The Trust already reviewed neonatal child deaths through M&M meetings but has commenced the process of setting up a robust internal process to comply with the new requirements to report and review all child deaths whether they occur in hospital or the community, to enhance the culture of learning.

Learning Lessons

Examples of SAIs and the learning from them in 2015/16 are as follows:

- *Patient referred for surgical removal of a tooth when the wrong tooth was removed*

  This incident has resulted in patients being asked when they attend to point out the side of their face that requires the procedure, introduction of a surgical safety checklist for all procedures in the clinic and consideration being given to obtaining written consent at the initial outpatient appointment.

- *A request for a patient to receive an urgent (red flag) procedure was downgraded to routine in error due to several minor oversights resulting in a delayed cancer diagnosis*

Processes have been changed to include copy red flag referral forms to be sent to the Consultant's Secretary; Consultants should include red flag confirmation in their dictation of follow up letter to GPs; Cancer Tracker staff will clarify any discrepancies between referral forms and patient administration systems.

Next Steps

- Continue to promote and further embed an open, no blame, learning culture that supports reporting of adverse incidents including Serious Adverse Incidents to include the implementation of the DatixWeb Incident Module Trust-wide
- Continue to learn from all types of incident and ensure that when changes to policy, procedures and/or practice are recommended following an incident that these are fully implemented within the organisation
- Review on an on-going basis the extant incident policies and procedures in light of reviews of existing systems both internal to the Trust and any new regional guidance

How the Organisation Learns

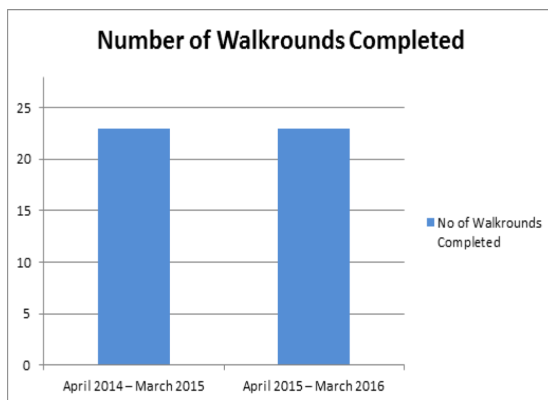
Organisational learning in the South Eastern Trust is developed and delivered using a collaborative approach. The Organisation and Workforce Development (OWD) Strategy provides a strategic framework for the management and co-ordination of organisation and workforce development activities across the Trust through the creation and implementation of an integrated strategy.

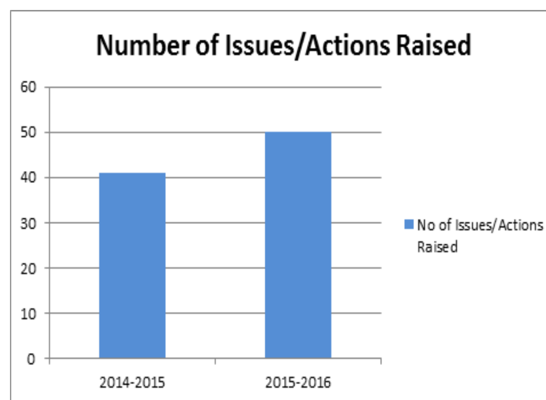
The strategy provides a link between the organisational corporate objectives and the activities required to build the capacity of the organisation and its workforce to deliver against those objectives within a challenging environment. Specifically, the strategy aims to ensure that all staff are equipped with the necessary clinical, social care, technical, managerial and personal skills to enable them to deliver safe and effective care and to contribute to the business of the organisation.

SQE Leadership Walkrounds™

Facts & Figures

- A total of 23 walkrounds took place during 2015/16
- A total of 50 issues were raised during these walkrounds
- The most common issues during 2015/16 were in relation to the environment and equipment





The WalkRounds concept was developed by Allan Frankel, MD, Director of Patient Safety at Partners HealthCare, to accomplish the following objectives:

1. Increase awareness of safety issues
2. Make safety a high priority for senior leadership
3. Educate staff about safety concepts such as a “just culture”
4. Obtain information collected from staff about barriers to safety
5. Act, after careful analysis, on information collected from staff
6. Consistently give feedback to frontline providers and leadership on processes

The Trust have taken this concept and adapted it so that the walkrounds include not only Safety, but Quality and Experience of care as well. SQE Leadership Walkrounds ™

provide the opportunity to connect the executive team to the frontline. Central to the success of these Walkrounds is a collaborative open approach which has been shown to improve the culture of organisations. They provide a venue for discussing concerns and are a means of facilitating finding solutions for everyday issues relating to the Safety, Quality and Experience of our patients and service users without disempowering the line manager. SQE Leadership Walkrounds ™ are conducted across all teams and services across the organisation.

Next Steps:

- Review the documentation to ensure it is relevant
- Follow up with a feedback survey to the walkround participants
- Ensure the cycle for each walkround is completed
- Provide quarterly feedback to the Executive Management Team

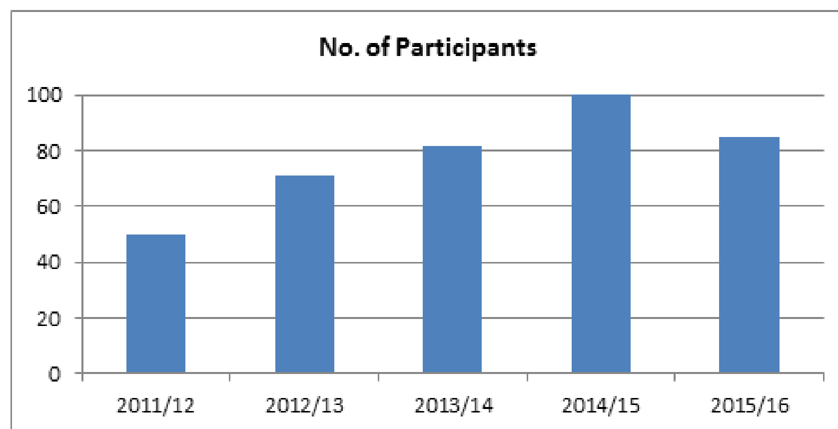
Quality Improvement

Quality Improvement Training

Facts & Figures

- A total of 188 staff applied to undertake the SQE programme in 2015/16 with 85 staff completing the programme.
- A total of 22 participants are undertaking the Regional Social Care programme in 2015/16
- An average of 50 SET mentors support these programmes during the year

Since the development of the SQE Programme in 2011, 153 projects have been undertaken and approximately 426 staff and 129 mentors have been educated in Quality Improvement Methodology. The graph below shows the yearly activity of participants completing the entire programme. We had an overwhelming number of 188 applicants for the 2015/16 programme and were able to signpost a number of these staff to alternative web based programmes that would meet their need.



The project teams, having delivered successful projects, have committed to implementation, spread and embedment of their improvement work through their respective services. A number of the projects undertaken as part of the programme have demonstrated an improvement through service reform that has created efficiencies.

The winning projects from 15/16 were Laura Knott, a speech and language therapist whose project was to improve the referral process for children who stammer under 7 years of age attending the specialist fluency clinic and the Frailty Team from ward 12 in Lagan Valley Hospital who have developed a pathway for frail elderly admissions to the hospital.

Goal 1: Transforming the Culture

During 2015/16 a number of projects were published or presented at conferences both within the UK and Internationally. These are listed in the table below:

International Forum on Quality & Safety in Healthcare 2016 Gothenburg	Evaluation of Communication Huddles in an Aseptic Unit
Publication International Journal of Transfusion	June 2015 “Improving the incidence of missing and illegible wristbands within the Ulster hospital” Vox Sanguinis, 109, (Suppl. 1), p.357-358. ISSN (online) 1423-0410
Gain Conference (Oct 15)	Single Unit Transfusion
Q2020 Task 13 Workshop (Jan 16)	’Alert’ Notice for Outpatient Appointments regarding Anticoagulant Medications
National Association of Prison Dentistry UK (Feb 16)	Oral Health Care for Substance Users and Mental Health Patients in a Prison Setting
NIRAQ (April 16)	Improving Nursing Handovers

The Regional Quality Improvement programme in Social Work and Social Care commenced in December 2015. This programme provides a unique opportunity for social work in Northern Ireland to lead improvement focused practice across the region using a set of techniques based on improvement and implementation science. To support the social work profession to develop skills and knowledge in continuous quality improvement, a regional learning forum was established and a quality improvement programme developed. The programme has been designed to meet the needs of social work professionals committed to leading continual quality improvement and is linked to the Attributes Framework: Supporting Leadership for Quality Improvement and Safety in Health and Social Care, which is informed by the principles and values within the Quality 2020 Strategy (DHSSPS 2011).
The programme has been designed using a similar framework to the SQE Programme and each participant undertakes a quality improvement project within the timeframe of the programme (9 months) enabling them to directly apply the new knowledge and skills acquired in practice as the programme progresses.
On the last day of the programme, Senior Leaders and Managers will be invited to join the final event to hear participants present their projects and share their learning.

Goal 1: Transforming the Culture

Quality Improvement (QI) Clinics

Facts & Figures

- From November 2015 – April 2016 a total of 32 QI clinics (54.5 hours) have been facilitated.
- Fourteen clinics were fully booked with some requiring additional time added
- 5 clinics were partially booked.
- Over the 32 clinics a total of 78 staff/teams have attended for advice or support.

Gaining new knowledge is exciting. Translating into practice can be more of a challenge. At the Quality Improvement (QI) Clinics we support individuals and groups in their improvement efforts by providing ideas and advice about the application of improvement techniques.

At the clinics QI projects are discussed to develop an understanding of processes involved in improving safety, quality and patient experience using skills in Continuous Quality Improvement.

At the clinics we share our knowledge of improvement tools and techniques and provide advice on how to:

- Use the model for improvement
- Develop ideas for change
- Select measures to know the change is an improvement
- Test changes
- Develop run charts
- Help staff reflect on their learning
- Communicate your improvement
- Inspire staff to achieve even more

Quality Improvement (QI) Networks

Ensuring Quality Improvement (QI) is at the heart of health and care is vital to its future sustainability. The Trust is continually striving to build connections both within the organisation and externally. Staff from across the Trust are involved in a number of networks engaging with others working on healthcare transformation and quality improvement to provide opportunities for learning from each other. These networks include:

Goal 1: Transforming the Culture

- The QI Curry Club, which has a focus on building a network to generate and sustain improvement ideas, and an opportunity to reconnect with colleagues who have a strong interest in improving patient/client care through Quality Improvement
- Improvement Network Northern Ireland
- Q Initiative
- UK Improvement Alliance

Next Steps

- To develop a Quality Improvement Academy to support the delivery of training across all levels of the Q2020 Attributes Framework
- To expand the Quality Improvement Clinics to meet the demand
- To build and develop on the existing networks working collaboratively to ensure QI remains a priority for organisations across the UK

Goal 2: Strengthening the Workforce

Induction

Facts & Figures

- In 2015/16 the Trust had 565 new employees with 410 fully completing Corporate Induction. This means 73% of staff completed Corporate Induction
- In 2014/15 the Trust had a 66% completion rate for Corporate Induction. We have had a 9% rise in uptake
- Mandatory training:

Course 15/16	Requirement	Completion
Complaints & Improving Service User Experience	3 Yearly	998
Equality & Human Rights	3 Yearly	1418
Manual Handling	3 Yearly	2356

Corporate Induction & Mandatory Training

The Trust is committed to providing a robust Corporate Induction programme in order to welcome new staff to the organisation and provide an orientation which ensures that individuals feel confident and competent regarding the expectations placed on them in delivering high quality care and experience for patients and clients. As Induction is part of the mandatory training programme an equal aim is to ensure that risk is minimised for all those who come into contact with the Trust.

We strive to provide a Corporate Induction to all new staff within 3 months of employment through a blended learning approach. This allows staff to undertake parts of corporate mandatory training through an eLearning followed by face to face training.

Throughout 2015/16 the trust employed 565 staff who required Corporate Induction 510 completing face to face training and 410 completing the eLearning module.

Goal 2: Strenghtening the Workforce

Next Steps

Over the next year the Trust will:

- Review and evaluate the completion of the blended learning approach
- Roll out a new eLearning platform to improve access for the blended learning approach
- Review content delivered through Corporate Induction to ensure it is fit for purpose

Investors in People

The Trust has been recognised as an Investors in People (IiP) organisation since 2011 and is still the only Health & Social Care Trust in Northern Ireland to adopt an Internal Review approach to revalidation against the IiP Standard. Trust-wide recognition was maintained in May 2014 and this innovative approach has enabled the Trust to avail of a rolling programme of assessment against the Standard which reflects the continuous improvement culture within the Organisation.

The Internal Review team was recognised in 2015 as “HR Team of the Year” at the CiPD DMS annual awards ceremony and the team are currently completing the 2nd cycle of post-recognition review assessment.

Some quotes from staff working in the Trust include:

“I feel valued, encouraged to develop”

“No opportunity is ever wasted – we learn from both good and bad situations”

‘My manager actively encourages all of us to put ideas for new ways of working no matter how small’

Next Steps

- The 2014-17 rolling programme will complete with assessments in October 2016 and February 2017
- A revised IiP Framework will be implemented April 2017

Goal 2: Strenghtening the Workforce

Money for Staff Development

The Trust recognises the importance of staff development and demonstrates this through resourcing (people, money, venues, and equipment) and supporting the following teams:

- Trust Professional Learning & Development teams
  - Social services
  - Nursing & midwifery
  - Medical
  - I.T.
  - Patient Experience
- Trust Organisation and Workforce Development team
- Trust Internal Training Providers Group
- HSC Leadership Centre

Learning and development budgets are managed locally and, on occasions, are supplemented by bidding for monies from the DHSSPS for identified development areas and there are dedicated training facilities, including IT suites, across all geographical areas.

Goal 2: Strenghtening the Workforce

Leadership Programmes

Leadership and Management Development

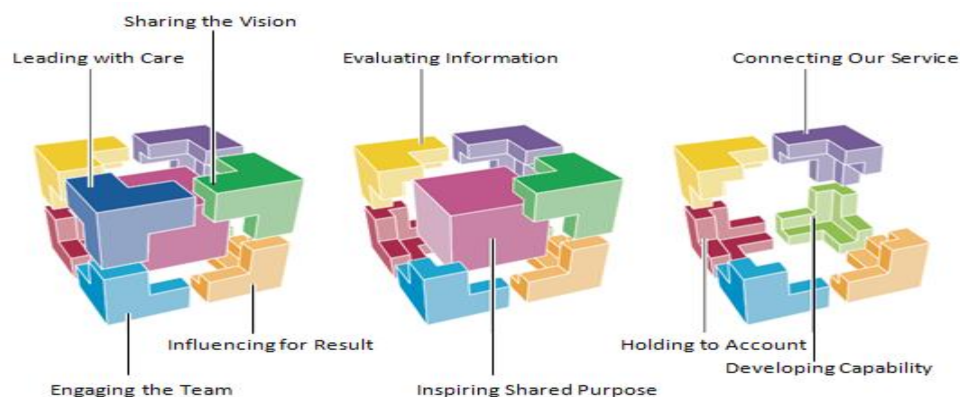
The Organisation and Workforce Development Department offer courses to staff which are part of the Trust's Leadership & Management Development suite of programmes.

During 2015-16, 347 staff completed the below Leadership & Management courses.

Facts & Figures

- ILM Level 5 Effective Manager (Band 6&7) - 35 people
- ILM Level 3 Developing Manager (Band 4&5) - 20 people
- ILM Level 5 Coaching – 5 people
- ILM Level 3 Coaching – 8 people
- Introduction to Coaching –39 people
- ILM Level 2 Team Leading (Band 2&3) – 64 people
- PG Diploma in Health & Social Care Management – 8 people
- Nursing & Midwifery Development Programme – 8 people
- Practical Manager – 126 people
- Medical Leadership Programme – 19 people
- The Training Leader – 3 people
- Essential Skills for Middle Managers – 2 people
- Practical Project Management – 2 people
- Finance for Non-Financial Managers – 4 people
- Managing Effective Practice (NISCC Accredited) – 1 person
- Aspire (Band 7-8b) – 3 people

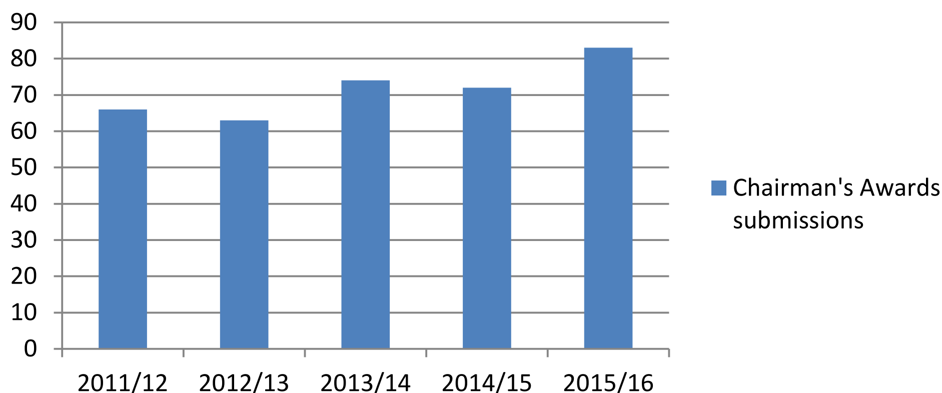
Healthcare Leadership Model



Staff Achievements

Chairman's Recognition Awards 2015

In October 2015 the Trust celebrated the sixth year of the Chairman's Recognition Awards which recognise, reward and celebrate the exceptional achievement of staff, whether as an individual or a team. There were seven categories, six reflecting the Trust corporate themes and one reflecting outstanding commitment of an individual. The standard of all the entries was exceptionally high which demonstrates the commitment to providing quality service for patients and clients. The overall winner was Speech & Language Therapy, Schools Team. The figure below demonstrates the continuous energy for the chairman's awards, with 2015 achieving over 80 applications, a tremendous 15% increase on the previous year.



Category	Winner
Safety, Quality & Experience	Ophthalmic Team, Downe Hospital
Access	Speech & Language Therapy, Schools Team
Health & Wellbeing	Wheelchair Resource Team
Efficiency & Service Reform	Cared for Programme/Strategic & Capital Development
Our Staff	Estates Department
Stakeholder Engagement	Thompson House Hospital – Patient Stories
Going the Extra Mile	Hilary Blakely, Palliative Care, Nursing Auxiliary

Goal 2: Strenghtening the Workforce

Nursing

Accrediting and celebrating practice-based learning: the Developing Practice in HealthCare. There are a number of nurses and midwives registered on both undergraduate and postgraduate programmes of study, with all clearly demonstrating personal, professional and practice development.

Congratulations to two Nurses graduating with their MSc Developing Practice in Healthcare at Ulster University's winter graduations.

Members of staff developing Facilitation and Leadership capacity within nursing and midwifery with another successful module completed in April 2016

A Trust Research Fellow, as part of a research team, successfully attained a HSC R&D office knowledge exchange grant for the iMPAKT project. SEHSCT will be the only UK site in this international research study implementing and measuring person-centeredness using an App based on the Nursing and Midwifery KPI's.

Supporting clinical leaders to prepare for the 100% single room acute ward environment in the new generic ward block (GWB) through learning sets project commenced May 2016.

Next Steps

- Facilitation and Leadership module running again October 2016 – March 2017
- iMPAKT study to commence September 2016 (completing February 2018)
- GWB learning sets project to complete September 2017

Looking After Your Staff

Smoke Free HSC Sites

Facts & Figures

- In 2015/16 Brief Intervention Training was provided to 1029 members of staff compared to 475 in 2014/15
- Four Stop Smoking Clinics were established for South Eastern Trust Staff
- 310 patients enrolled in the Stop Smoking Service with a quit rate of 75% at 4 weeks compared to 246 enrolled in 2014/15
- 119 pregnant women enrolled in the Stop Smoking Service in 2015/16 with a quit rate of 68.8% at 4 weeks

Smoking is the single greatest cause of preventable illness and premature death in Northern Ireland, killing round 2,300 people each year. It is also one of the primary causes of health inequalities, with smoking prevalence rates higher among people living in areas of social and economic deprivation.

Illnesses caused by smoking

Illnesses for which smoking is a major risk factor include cancer, coronary heart disease, strokes and other diseases of the respiratory and circulatory systems.

The harm caused by tobacco smoke also extends to non-smokers through exposure to second hand smoke, with children and unborn babies being particularly vulnerable.

Ten year tobacco control strategy for Northern Ireland

In February 2012, DoH published the '10 Year Tobacco Control Strategy for Northern Ireland' the overall aim of which is to create a tobacco free society. While the strategy targets the entire population, it focuses on three priority groups:

- children and young people
- pregnant women, and their partners, who smoke
- disadvantaged people who smoke

The strategy has three key objectives:

- fewer people smoking
- more smokers quitting
- protection for all from second hand smoke

Goal 2: Strenghtening the Workforce

On the 11th March 2015 the Minister for Health announced smoking will not be permitted in the grounds of any HSC Trust facility from 9th March 2016.

Smoke Free implementation is progressing and there would appear to be good compliance on the Acute Hospital Sites with a marked reduction on patients/ visitors and clients smoking on site.

Next Steps

- Embed the culture of Smoke Free HSC Sites across the organisation and with our users, clients, visitors and volunteers
- Continue to provide Smoke Free Service which is evidence based and accessible to all staff and clients / patients
- Work with Adult Services Directorate to carry out a consultation with Mental Health Clients/ Users to agree the way forward in relation to Smoke Free within Acute Mental Health Settings
- Promote Brief Intervention Training with staff and continue to provide Stop Smoking Clinics which are tailored to the needs of staff

Improving Attendance at Work

The Department of Health (DOH) set the Trust a 2.5% improvement target for absence for 2015/16 (6.5%) In order to help reach the target, the Trust put in place a number of initiatives. These included:

- A Staff Health and Wellbeing Strategy, which was launched at the Chairman's Award Celebrations in October 2015
- A Health and Wellbeing site went live on I connect which signposted staff to access relevant polices and support
- The Cycle to Work Scheme in conjunction with Halfords was re-launched in June 2015 and to date 258 bicycles have been purchased

Goal 2: Strenghtening the Workforce

- Resilience Training for managers and staff was clearly identified as a priority within the Trust during 2014/15. On the back of a successful pilot during 2015/16, the programme was rolled out to 184 managers and 280 staff have attended SMART Resilience Training designed for staff

- A stress tool kit has been developed which has supported staff at work

- A significant staff engagement programme of work was also undertaken in partnership which local Trade Unions

- A Regional Staff Survey was conducted and the results when published during 16/17 will inform an action plan, in response to the findings

- The Trust continued to deliver a bespoke Influenza Vaccination programme for staff. During 15/16. 2135 staff and were vaccinated of which 19.4% (1347) of frontline staff received the vaccine

- A number of staff have accessed the Trust's Alcohol Support Programme

- A Stress Policy has been drafted and it is anticipated it will be launched in Autumn 2016

Next Steps

- The Trust absence figure at the end of March 2016 was 6.77% which fell short of the DOH target. In response, the Trust will continue during 2016/17 to work in partnership with trade union side to improve the Health and Wellbeing of staff which should in turn have a positive impact on attendance.

Building Resilience and Managing Stress in your Team & SMART Training

Facts & Figures

- Comparing 14/15 to 15/16 staff absence due to stress reduced by 14% (includes both stress and work related stress)
- > 96% of managers better understand what their responsibility is in relation to stress
- > 95% of managers feel better equipped to recognise symptoms of stress at an early stage
- 86% feel more/much more confident having a conversation about stress with Their staff

Goal 2: Strenghtening the Workforce

In April 2015 stress accounted for 2282 days absence so it was important that the Trust provided support, information, guidance and "takeaway" tools for both staff and managers. In collaboration, HR, Health Development, Condition Management Programme and Occupational Health co-developed and co-delivered two training programmes utilising the

skills, experience and expertise from several professional areas to ensure the content met the needs of our staff. The programmes were:

"Stress Managing and Resilience Training" (SMART) aimed at all staff;
"Build Resilience and Manage Work-Related Stress in your Team" for Managers

In addition to the resources staff and managers receive at training, a dedicated i-connect page has been developed which is currently being accessed by over 150 staff per month.

To date 280 staff have attended SMART and 184 have attended the Manager programme with all levels of staff participating. Early returns show that over 80% of staff attending SMART have shown a positive improvement in their perceived stress score when a self-assessed questionnaire was revisited 3 months after attending the training.

The volume of positive feedback from both programmes is encouraging and the comments below are a small example from staff who feel the training has benefited them immensely:

- "Fantastic that SET is supporting staff through SMART training"
- "Very enjoyable course – much needed!"
- "Feel uplifted and positive…thank you so much"
- "Very beneficial and I appreciate the Trust investing in staff wellbeing"
- "Felt like you cared about how we felt"

Next Steps

Continuing to use a collaborative approach the Trust will:

- Evaluate the effectiveness of SMART training
- Continue to roll out both programmes over all Trust sites ensuring as many staff as possible can avail of the training
- Develop additional resources to support staff and managers e.g. mobile phone app

Revalidation

Medical Staff

Facts & Figures

- In 2014/15 the Trust submitted 100 positive recommendations to the GMC for doctors to revalidate.
- Approximately 9.9% of those due to revalidate were deferred for 6 to 12 months.
- There were no doctors reported to the GMC for non-engagement.
- The Trust Clinical Appraisal rates during 2015 were 96.26%.

The Trust continues to work closely with the General Medical Council to ensure it has robust systems in place with regards to Medical Revalidation. This will ensure patients, the public and other healthcare professionals that our doctors are licensed, up to date, and practicing to the appropriate professional standard. The Trust received positive feedback from the RQIA following a review in February 2016 of all internal governance procedures relating to revalidation and appraisal.

During the last 12 months, the Trust worked in conjunction with the HSC Leadership Centre to deliver two Appraisal training sessions for new Clinical Appraisers.

Next Steps

- During the next year, the Office of the Medical Director will conduct several quality assurance mechanisms. This will include issuing Appraisal Feedback Questionnaires. Responses will be analysed and a report will be compiled which will be used to further inform appraiser up-date training
- The Trust will closely monitor reasons for revalidation deferral requests from all doctors and take appropriate action to ensure these are minimised. This will include more detailed provision of information to Clinical Leaders in relation to doctors due to revalidate within the next 12 months

Goal 2: Strenghtening the Workforce

Nursing Staff

In October 2015 the Nursing and Midwifery Council introduced Revalidation, a new process which would be used by registered nurses and midwives to demonstrate that they remain fit to practice.

There was widespread engagement with nurses and midwives across the Trust and over 1500 attended a face to face information session with others accessing information via iConnect, Facebook and Twitter.

Support and training was given for those line managers who would act as 'confirmers' for registrants, assessing their compliance with NMC requirements. In April 2016 the first nurses and midwives successfully revalidated with the Nursing and Midwifery Council.

Next Steps – 2016/17

- On-going support for registrants approaching revalidation and those line managers acting as confirmers, to ensure 100% compliance with NMC requirements

Goal 2: Strenghtening the Workforce

Staff Support and Development

Making Communication Accessible for All

The Making Communication Accessible for All guide was produced for Health and Social Care staff so that they can communicate more effectively with people who may have a disability or a communication support need. This resource has been greatly informed by the input and quality assurance from disability representative organisations.

The guide looks at people with a range of disabilities and offers Trust staff advice to improve:

- Face to Face Communication
- Telephone Communication
- Written Communication
- Information on the Web

This document is available on the Equality and Human Rights Intranet pages and can be made available in alternative formats upon request to the Equality and Human Rights Department.

A Making Communication Accessible event was organised for Monday 27th June 2016 in Knockbracken Healthcare Park where we:

- Launched the Guide
- Shared examples of Good Practice in Communication
- Showcased some of the innovative work by HSC staff to include SET Teams to improve communication

Goal 2: Strenghtening the Workforce

Reducing the Risk of Hyponatraemia

Facts & Figures

During the period 15/16 SET commissioned further Fluid Balance Chart training:

- Fluid Management in Children & Young People: 7 sessions
- Fluid Management Refresher Training: 4 sessions
- Skills Refresher for Community Child Health Care Assistants: 1 session

SET identified a number cohort wards as well as the Paediatric wards for the admission of children up to their 16th birthday; this was agreed to aid compliance with the competency framework for reducing the risk of hyponatraemia when administering intravenous infusions to children and young people. A group meets quarterly to discuss good practice and any issues or areas of concern.

Next Steps

- CEC continue to roll out IV Fluid training for nursing staff
- CEC commissioned to roll out Fluid Balance Chart completion for HCA's
- Fluid Balance Chart Audit planned for November 2016

Goal 3: Measuring the Improvement

Reducing Healthcare Associated Infection

Urinary Catheter Management

Facts & Figures

- 71 urinary catheters were audited
- Patient Assessments (for the requirement of the device) had been undertaken
- The number of patients who had a urinary catheter in place was low
- The number of catheter- associated urinary tract infection (CAUTI) reported was also low
- Patients being treated for a catheter-related infection had been prescribed antibiotics in accordance with Trust guidelines
- The implementation and compliance with the Trust evidence-based guidelines was of a high standard

Across the Trust urinary catheter bundles had been introduced to improve care. These are "check lists" which when implemented contribute towards a reduction in urinary catheter-related infection. During the year the IPCT undertook an audit to establish whether evidence based practice was consistently applied in the management of urinary catheters within the Trust's acute hospitals. The findings were presented in poster format at the Trust's Annual Multi-professional Audit Conference and the team was awarded first prize.

Infection Prevention & Control Nurses receiving first prize at the Audit Conference for their poster

Goal 3: Measuring the Improvement

Care of peripheral cannulae (PVCs)

Facts & Figures

- 221 PVCs were observed for signs of phlebitis/infection (136 patients)
- No infections were reported during the survey
- In cases where there was moderate phlebitis the PVC was removed promptly
- In 89% had appropriate documentation in place.
- In some instances there was a delay in removing a PVC when no longer required

One of the initiatives implemented to reduce healthcare-associated infection has been training/awareness in the management of PVCs. A recent audit was undertaken (over two weeks) to measure observations of phlebitis and infection rates in PVCs in four wards. 221 PVCs were surveyed. No line infections occurred during the time of study. A small number of patients who had developed phlebitis had their line promptly removed. Further improvement work is required to ensure that the patient is assessed for the most suitable type of line for intravenous medication. A re-audit will be carried out and findings shared in order to support good practice and shape future training needs.

Next Steps:

Urinary Catheter care

- Review methodology and re-audit urinary catheter device management

Peripheral cannula care

- Undertake further work to ensure the most suitable access device is chosen for individual patient's needs
- Raise awareness to ensure a review and prompt removal of devices that are no longer required
- Undertake a review of blood sampling practice

MRSA Bacteraemia cases

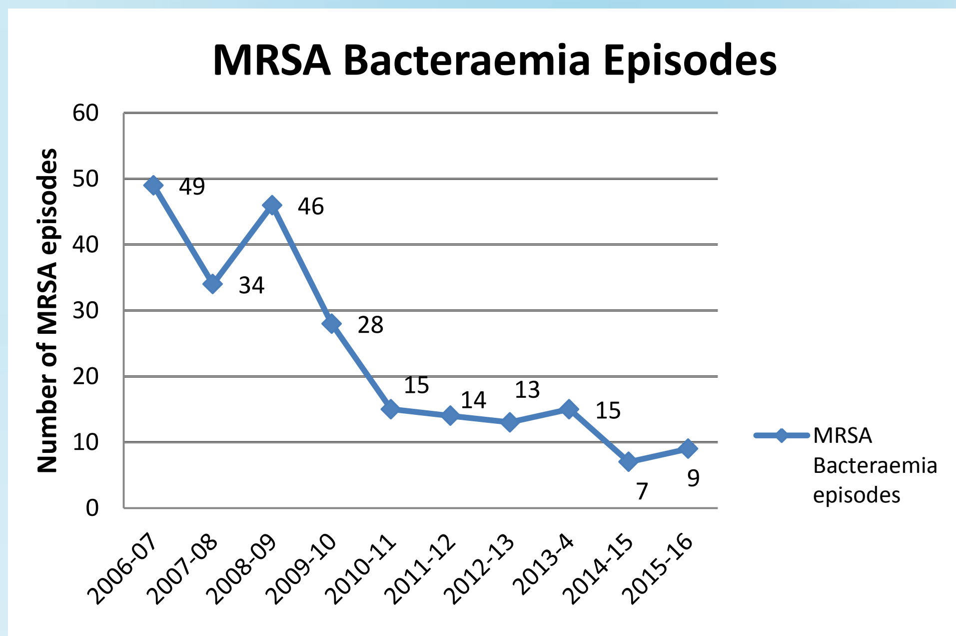
The Healthcare-associated Infection (HCAI) targets set by the DHSSPSNI for the year 2015-16 were to report no more cases than the previous year (2014-15) namely not more than 7 cases, with the sub-objective of reducing by two the cases associated with invasive devices. In total the Trust reported 9 MRSA bacteraemia (blood stream) infections in 2015-16, but two have been considered false positives due to contaminated samples as the patients did not present with full sepsis.

Goal 3: Measuring the Improvement

Post-infection Root Cause Analysis (RCA) case reviews were undertaken for all nine MRSA bacteraemia cases this year (2015-16).

Facts & Figures

This table shows the continuous reduction in the number of MRSA bloodstream infections within South Eastern Trust over the past nine years
(note also that the nine in 2015-16 represents laboratory results but only 7 were deemed to be true infections).



In each of the seven MRSA blood stream infections, the case review and root cause analysis involved the patient's consultant, the ward manager and the infection control team. Learning included raising the awareness of risks associated with invasive devices within the care of confused patients, management of MRSA carriage in patients with complex urological conditions and the overall awareness of screening those at risk of MRSA carriage as set out within Trust Policy.

Clostridium difficile Toxin Positive cases

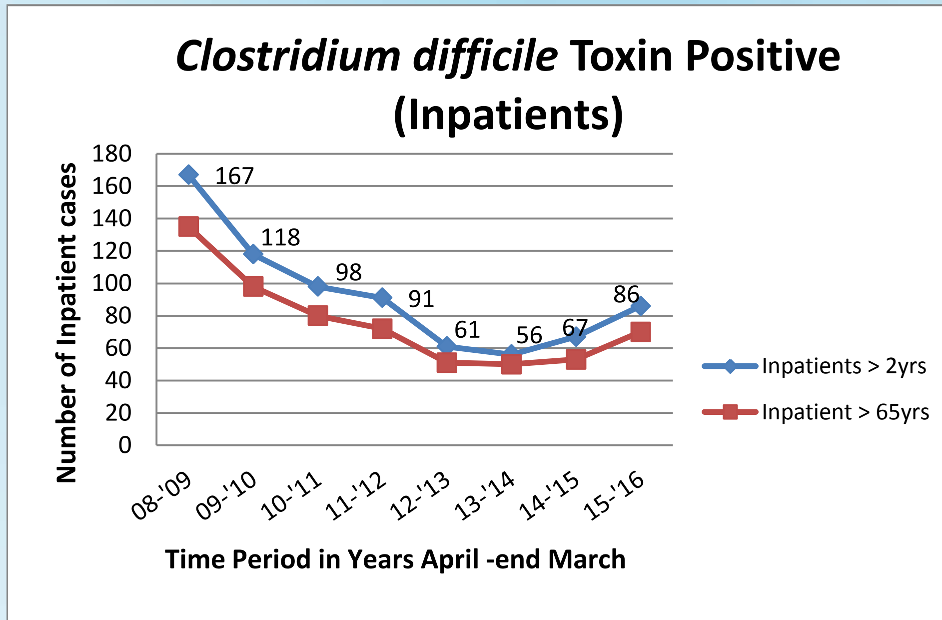
The *Clostridium difficile* target set by the DHSSPSNI for the year 2015-16 was to have no more than 55 *Clostridium difficile* toxin positive cases in patients of 2years or above.

In 2015-16 the Trust reported 86 *Clostridium difficile* infection (CDI) cases, thirty over target and nineteen cases more than last year. This is the second consecutive year that there has been a rise in cases since the establishment of South Eastern Trust in 2007.

Goal 3: Measuring the Improvement

Facts & Figures

This graph shows that after a five year reduction in *Clostridium difficile* infection over the last two years there has been an increase in cases.



Root Cause Analysis (RCA) case reviews are undertaken for all *Clostridium difficile* toxin positive cases that have had recent healthcare.

In this year case reviews have provided assurance that there is a high level of compliance with the Trust's first line empirical antibiotic prescribing guidelines for hospital patients. There is also a high level of compliance with implementing Infection prevention and control practices including the prompt isolation of patients with diarrhoea who are suspected to have *Clostridium difficile*.

In some case reviews this year there has been insufficient information to understand what antibiotics the patient has been prescribed in the community prior to admission to hospital. To aid understanding, links are being forged with our local GPs to share more information regarding local *Clostridium difficile* infection (CDI) trends, aiming to increase awareness with GPs of the primary care influence on CDI cases. The Trust has also discussed this evolving trend in a rise of the number of cases arising within 48hrs of admission to hospital with the PHA (Public Health Agency) to seek a more focused communication with GPs on CDI epidemiology and help where possible to reduce infections.

Goal 3: Measuring the Improvement

Next Steps

Clostridium difficile

- Continue detailed review of CDI cases
- To work with PHA and improve liaison with GPs on CDI trends and antimicrobial prescribing.
- Continue work to optimise hospital antimicrobial prescribing and minimise the impact on CDI

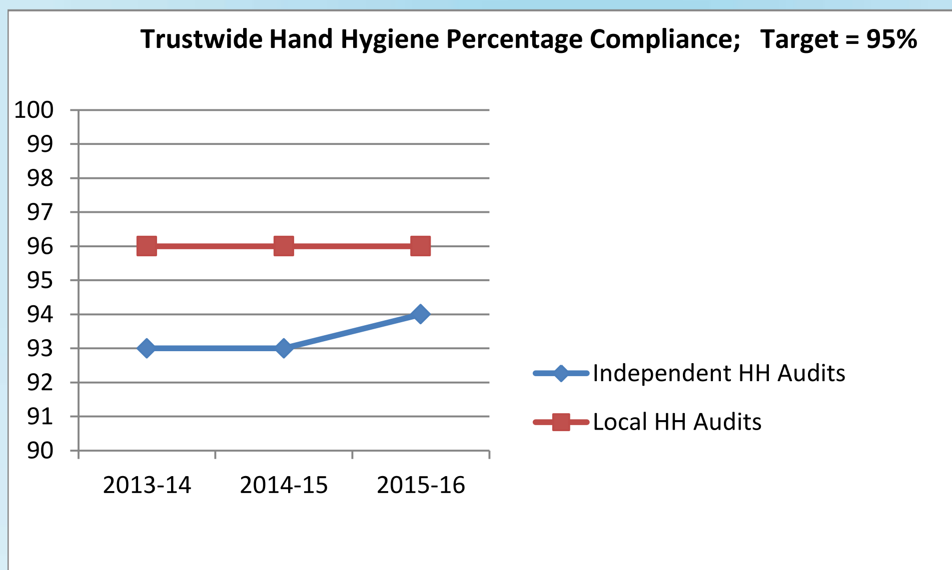
MRSA bacteraemia

- Continue to support the work of healthcare staff in the management of invasive devices
- Continue to identify and manage patients 'at risk' of MRSA to avoid bacteraemia

Hand Hygiene

Facts & Figures

The Trust's average Hand Hygiene compliance scores over the last year are shown below. The data below relating to this year (2015-16) is based on 27,425 local observations of hand hygiene practice ad 5,227 independent observations of practice.



Goal 3: Measuring the Improvement

The infection prevention and control team undertake independent validation audits of hand hygiene in practice in all inpatient wards as a means of validating local audits untaken by Clinical Teams.

Hand hygiene data is processed through computer software which easily facilitates review of findings and comparison of scores by ward sisters, clinical managers etc. to give assurance of practice, and undertake remedial action where required.

The scores below show a consistent compliance over the past three years with hand hygiene across the Trust hospital wards and departments.

Independent auditing of hand hygiene compliance is a way of validating the accuracy of local audits within clinical teams. It also provides opportunities to reflect on practice with staff if hand hygiene is being under taken at appropriate times. All disciplines are included in the hand hygiene audits.

Next Steps

- Continue validation audits and work with staff to maintain attention on good hand hygiene in the care of our patients
- To maintain a focused interest in hand hygiene compliance amidst other service pressures
- Reinforce to staff that differences of more than -5% need to be addressed.
- To update computer systems and provide a reporting template which communicates the improvement plan to staff

Hospital Services: Monitoring Surgical Site infection & Surveillance of Critical Care Infections

Facts & Figures

Caesarean Section Wound Infection surveillance

From 1st January 2015- 31st December 2016 the number of caesarean section wound infectior occurring during inpatient stay was 0.1% compared with the NI average 0.2%. The rate occurrir post-discharge was 7.5% (compared with 9.7% in 2015).

Investigation has shown that some of the infections developing in the community were due to reporting of wounds which were inflamed (as part of the normal healing process), but did not meet the Public Health Agency’s and National standard definition of wound infection.

Work was introduced to support/update midwives this has included provision of a checklist of the standard definition of wound infection, advice on methods of managing patients with wounc problems and reviewing the information given to women on the best method of managing their wounds post-delivery. It was positive to note that the number of post-discharge caesarean sect wound infections reported in 2015 has fallen.

Goal 3: Measuring the Improvement

As part of a regional Infection programme Orthopaedic and Caesarean section surgical wound infection is monitored in the Trust. In addition within the Critical Care Unit the incidence of ventilator-associated pneumonia; central venous and urinary catheter device-related infections are kept under review. Collected data is sent to the Public Health Agency for analysis. This enables clinical teams to monitor progress and benchmark against other centres across the region.

Next Steps:

Caesarean Section Wound Infection surveillance

- Review and publish a leaflet for women on the management of their wound post C-section in order to reduce infection
- Continue with an education programme for midwives to maintain awareness of the definitions of wound infection and ensure accurate reporting
- Work regionally with colleagues and the Public Health Agency to introduce electronic methods of collecting information relating to C-section wound infection.

Orthopaedic Wound Infection Surveillance

Facts & Figures

Orthopaedic Wound Infection Surveillance

The overall average surgical site infection average rate from January 2015- 31st December 2016 was 0.65%. An in-depth review of each infection was undertaken and none were thought to be linked by transmission. We will continue to monitor this closely in the future.

This year the Trust worked with the Public Health Agency to introduce a surveillance method whereby much of the information required to monitor orthopaedic surgical site infection (SSI) is taken electronically from the theatre system and sent for analysis. This has resulted in a reduced work load for staff. They now no longer complete surveillance procedure details manually onto a paper form. Additional information is only required if a post-operative wound infection develops.

Next Steps

Orthopaedic Wound Infection Surveillance

- Continue to monitor infections and feedback findings to surgeons and clinical teams in order to share learning

Goal 3: Measuring the Improvement

Surveillance of Critical Care Unit Infection

Facts & Figures

Surveillance of Critical Care Unit Infection

- No urinary catheter or central line infections have been reported since the monitoring programme started in 2011
- There has been no Ventilator-associated pneumonia reported since November 2012. (this equates to one ventilator infection since the programme started in 2011)
- The Critical Care Unit staff celebrated 1000 days without a ventilator-associated Infection in August 2015

The Critical Care Unit at the Ulster Hospital provides intensive nursing and medical care for patients requiring essential lifesaving support. Lots of skill is required and the multidisciplinary team (including support, physiotherapy and dietetics staff) strive to work to very high standards. Many of the patients being managed within the unit have multiple tubes and lines going into their body which are an essential part of their treatment. Unfortunately sometimes with all the best care and attention infection can develop and this can require additional intervention.

Within this demanding environment, efforts have been focused on ensuring that good practice is maintained to prevent avoidable central venous line and urinary catheter device infections and ventilator-associated pneumonia. This work has included the introduction of Care bundles (check lists which assist healthcare staff to focus on the key measures necessary to manage these devices effectively and reduce infection).

Critical care staff celebrates success

Critical Care Unit staff celebrated 1000 days without a ventilator-associated Infection August 2015

Goal 3: Measuring the Improvement

Next Steps

Surveillance of Critical Care Unit Infection

- Continue to maintain all good practice within the unit and ensure compliance with the implementation of “care bundles” (check lists which help focus adherence on ensuring that practices linked to reducing infection are in place) are maintained.

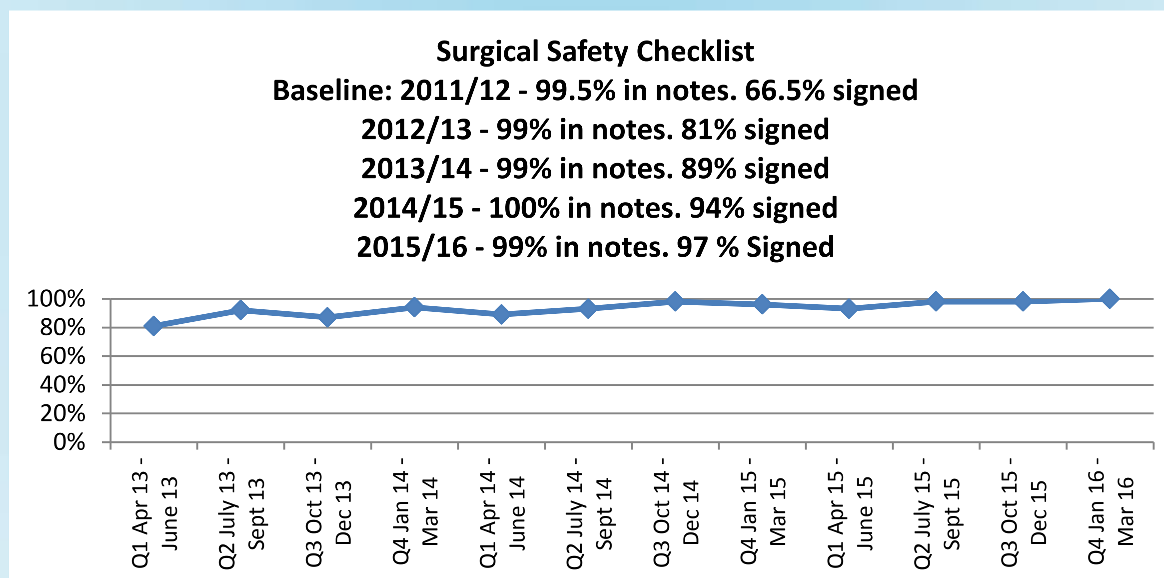
Goal 3: Measuring the Improvement

Surgical Safety Checklist

Facts & Figures

Monthly data is collected from each theatre specialty and facility, including endoscopy procedures and day case surgery. Checklist compliance is determined by the completion of the final signature box on each sampled checklist.

Following baseline data in 2011/12 an increase of 14.5% was achieved in 2012/13. Further improvement was seen in 2013/14 with a mean compliance of 89% and a further increase of 5% achieved in 2014/15. In 2015/16, compliance has universally exceeded the 95% target.



Many studies from around the world have confirmed that the use of a surgical checklist improves safety for patients undergoing surgery. The Trust's Surgical Safety Checklist (SSC) was launched in June 2009 and has three main goals:

- To capture common or serious preventable errors within the operating theatre
- To encourage and improve communication and team working amongst all members of the theatre team
- To increase team vigilance and awareness of patient safety issues.

The Trust SSC is applied at three points during an operation:

- The first check is completed just before the patient is anaesthetized
- The second check is performed immediately prior to the start of the procedure
- The final check is conducted on completion of surgery and prior to the patient leaving the theatre.

Goal 3: Measuring the Improvement

The Trust has been committed to the goal of achieving 95% checklist completion for all surgical procedures in Trust theatre areas since March 2014. The excellent progress of previous years continued in 2015/16 with audit results universally exceeding the 95% target throughout the year. These results confirm that the checklist is now firmly embedded in operating theatre practice within the Trust.

With the routine of the checklist firmly established our efforts are now directed at ensuring excellence in SSC performance:

- A new policy detailing standard behaviours in SSC performance was written in 2015 and is currently in the final stages of sign-off and publication
- Several SET checklists were re-designed (as per World Health Organisation guidance) and piloted in 2015. These new checklists were successfully launched in early 2016
- Two SET SQE projects were initiated in 2015/16 to audit and improve the performance of the SSC – the projects are looking at checklist performance within Ulster Hospital Main Theatres and Labour Ward Theatres respectively. The Labour Ward project has been a particular success to date and has recently won through to the SQE Final Event

Next Steps

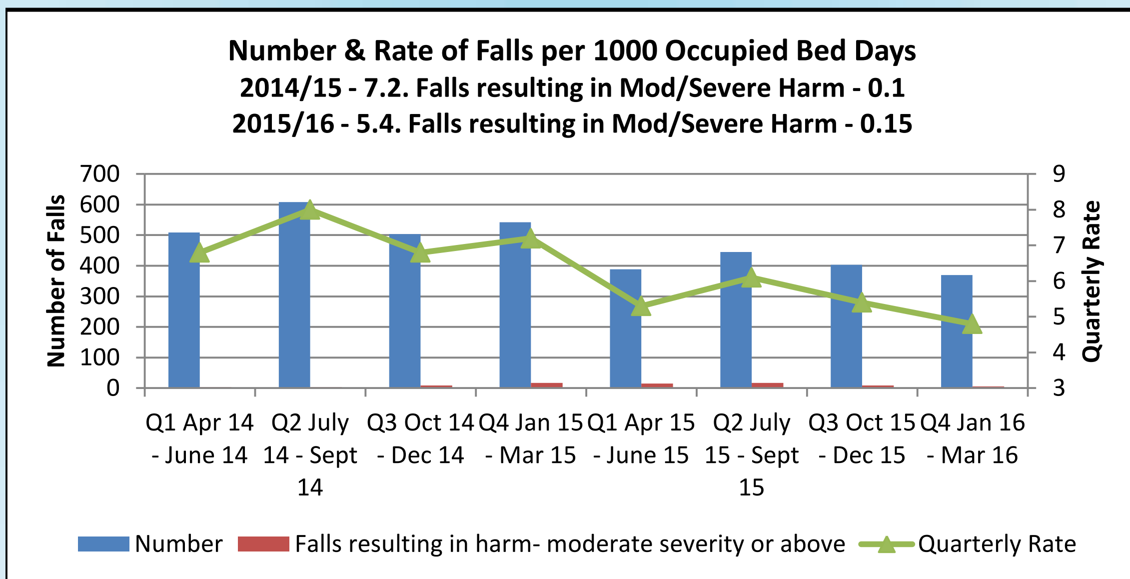
- Move to Theatre Management System (from paper) for recording checklist completion
- Formal launch of SSC policy
- Ongoing SQE projects to audit and improve standards of checklist performance

Goal 3: Measuring the Improvement

Patient Falls

Facts & Figures

The mean falls rate across all adult inpatient areas is 5.4 over the period April 2015 – March 2016 with a mean falls rate for moderate to severe harm of 0.15. The use of the falls prevention bundle of care aims to continue to reduce the risk of inpatient falls across the adult inpatient wards.



Falls in hospital are one of the most reported incidents consequently falls prevention continues to be an aim for the Trust. 'FallSafe', the evidence-based falls prevention bundle of care has been included in the Regional Nursing Assessment and Plan of Care document and is in place within all the adult acute inpatient wards throughout the Trust. All adult inpatients are assessed for the risk of falls and those who are found to be 'at risk' have a personalised plan of care developed.

Next Steps

- The use of the falls prevention bundle of care aims to continue to reduce the risk of inpatient falls across the adult inpatient wards
- The Trust will continue to share learning and provide awareness for staff to reduce the number of inpatient falls
- The Trust will continue to focus on monitoring and measurement of the FallSafe Bundle in all Adult Inpatient Wards

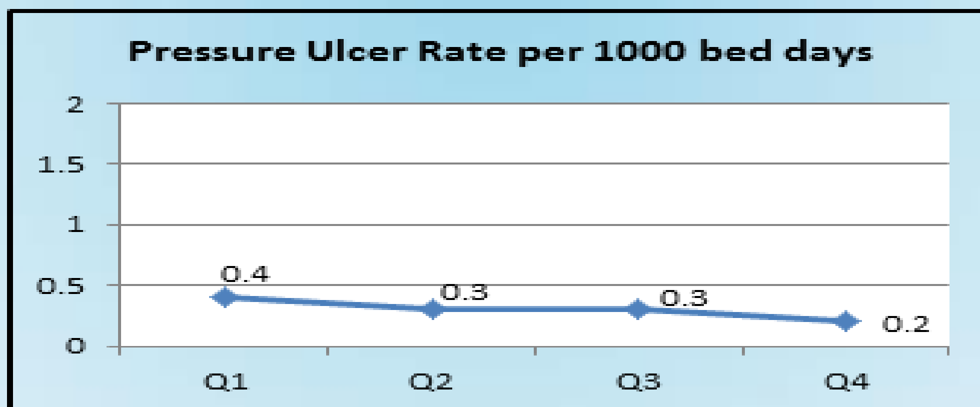
Pressure Ulcers

Facts & Figures

The Trust uses the European Pressure Ulcer Advisory Panel (EPUAP) staging system to describe the severity of pressure ulcers. Staging is from one to four, the higher the stage, the more severe the pressure damage.

In 2015/16 there were 107 incidents of pressure ulcers reported within the Trust. This equates to 0.35% incidence rate per 1000 Occupied Bed Days. The Trust is proud to report that this is a reduction in the number of patients developing pressure ulcers from the previous year. This is the second consecutive year South Eastern HSC Trust have reduced the number of hospital acquired pressure ulcers:

2012/13 N = 87, Stage 3 / 4 = 21 (24%)
2013/14 N = 118, Stage 3 / 4 = 29 (25%)
2014/15 N= 111, Stage 3 / 4 = 35 (32%)
2015/16 N = 107, Stage 3 / 4 = 35 (32%)



A pressure ulcer is damage that occurs on the skin and underlying tissues due to lack of blood and oxygen supply resulting from sustained pressure. A number of contributing factors are also associated with the development of pressure ulcers; the primary of which are impaired mobility and impaired sensory perception. Typically they occur in a person confined to bed or chair by an illness. Pressure ulcers often result in significant pain and distress and can lead to other complications. (NICE 2014)

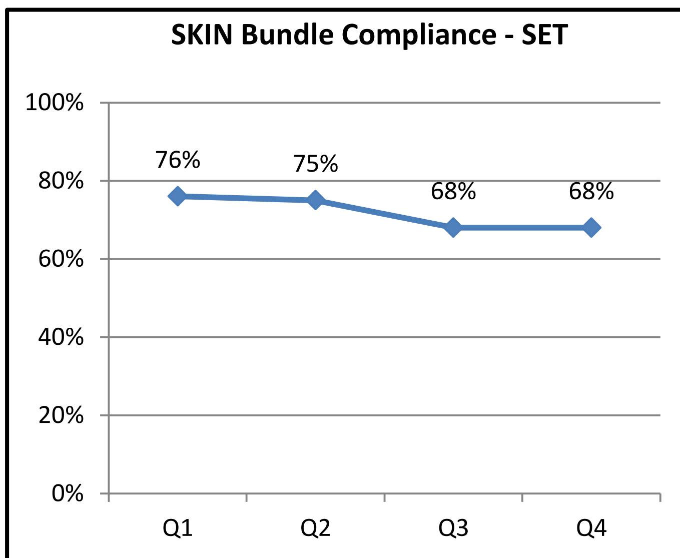
Incidence of Pressure Ulcers is considered to be an indicator of safety and quality and as such is a Key priority for the HSCB and PHA. In 2015/16 each acute health and social care Trust was required to:

'Establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable & monitor and provide reports on SKIN Bundle compliance and the rate of pressure ulcers per 1,000 bed days'.

Goal 3: Measuring the Improvement

Monitoring Standards in Pressure Ulcer Prevention

The Trust aims to ensure that all acute adult inpatients have a pressure ulcer risk assessment and an individualised management plan including implementation of the SKIN bundle, which incorporates preventative measures. To monitor consistency in standards and support improvement, 30 charts/ Quarter per ward are audited against compliance with the SKIN Bundle. The following chart demonstrates compliance over the reporting period 2015/16:



The **SKIN Bundle** is an evidence based collection of interventions proven to prevent pressure ulcers:

Significant work has been undertaken within the Trust to further improve SKIN Bundle compliance including; revision of the audit format and SKIN Bundle/ care rounding bed end documentation from which the data is collected, monthly feedback of data analysis to frontline staff as well as a series of workshops to raise awareness and provide practical assistance to nursing staff delivering care.

Maximising opportunities for learning

Not all pressure ulcers are avoidable. Many patients have co existing conditions and factors that increase their risk and despite best care, pressure damage cannot be prevented. There are however many pressure ulcers that are preventable. The Trust has developed processes to determine how and why pressure damage occurs in every hospital acquired incident. In instances of severe pressure damage (grade 3 and above) a review (Root Cause Analysis) is undertaken and regional guidance is followed to determine if it was avoidable or unavoidable. This level of review provides opportunity to identify learning which is shared with clinical Teams, across Directorates, at mandatory pressure ulcer training, Governance meetings and via newsletters to further enhance practice and patient care.

Goal 3: Measuring the Improvement

Rate of Stage 3 & 4 Pressure Ulcers per 1,000 Occupied Bed days	0.12
Number of Stage 3 & 4 Pressure Ulcers	**35**
No. of AVOIDABLE Grade 3 & 4 Pressure Ulcers	**7**

The table above shows rate and numbers of grade 3 & 4 pressure ulcers, alongside the number of **avoidable** pressure ulcers (grade 3 & 4) in 2015/16:

Collaborating to Improve Preventative Strategies

In sharing a common goal for their patients, the Medical Assessment Unit (MAU) and Emergency Department (ED) in the Ulster hospital worked together to develop a strategy for providing a high standard of pressure ulcer prevention at the very onset of care in ED that perpetuated throughout their stay in MAU.

An ED specific SKIN Bundle was developed and implemented which highlighted risk factors in this patient population and acted as a trigger to introduce patient specific preventative measures e.g. provision of pressure reliving mattresses, hospital beds and skin checks. The positive outcomes on patient care were:

- Significant increase in the number of 'at risk' patients with an individualised preventative care plan implemented & documented in ED
- 66% increase in the number of 'at risk' patients nursed on pressure relieving mattresses in ED.
- Implementation of a food trolley in ED, ensuring patients' access to nutrition after 6pm.
- 50% reduction in pressure ulcer incidents in MAU.

SEHSCT reach a milestone in pressure ulcer prevention

All facilities openly display their individual standard of pressure ulcer prevention in the form of a safety cross and the number of days between the development of pressure ulcers. These tools enable each ward to benchmark their own progress and provide easy access of this information to all staff, patients and the public. In the reporting time period, three wards across two hospital sites have reached **1000 plus pressure ulcer free days**.

Goal 3: Measuring the Improvement

1000+ Pressure Ulcer Free Days
Ward 20, Cardiology, UHD

1000+ Pressure Ulcer Free Days
Ward 11, Old Age Psychiatry, LVH

1500+ Pressure Ulcer Free Days
Ward 4, Oncology/ Haematology, UHD

Next Steps

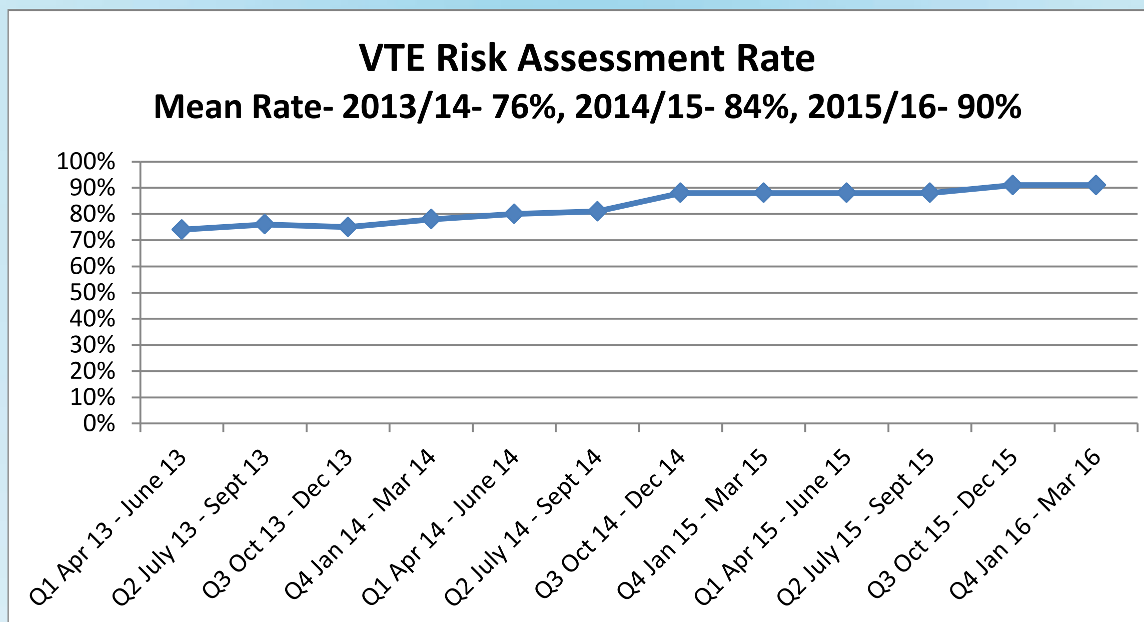
- Work towards obtaining consistency in compliance with the 'SKIN Bundle'
- Continue to monitor and report the number of pressure ulcer incidents, including the number of severe pressure ulcers (grade 3 & 4) which were considered unavoidable
- Work towards reducing the number of severe facility acquired pressure ulcers.
- Maximize learning from each incident of severe pressure damage
- Continue to provide mandatory pressure ulcer education and bespoke training in specific clinical areas as determined through analysis of incident reports and KPI data
- Continue to monitor the impact of ED specific SKIN bundle in UHD & Downe hospital & implement in LVH ED
- Complete pilot of primary care SKIN Bundle & collaborate on regional KPI for this patient population
- Continue to recognise ward staff for their achievements in providing pressure ulcer free care

Venous Thromboembolism (VTE)

Facts & Figures

The Trust continues to aim to achieve 95% compliance with VTE Risk Assessment across all adult inpatients and where appropriate prescribe prophylaxis treatment to prevent blood clots from developing. Alongside staff training patient awareness is high on the agenda to tackle the risk of DVTs.

A review of 10 patients across each ward takes place every month and the graph below illustrates quarterly compliance with risk assessment for April 2015-March 2016

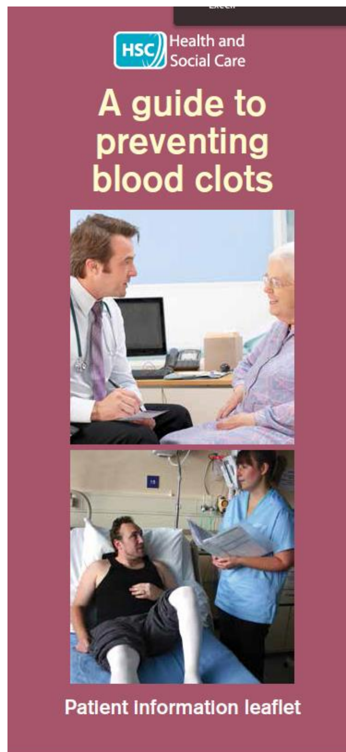


Venous thromboembolism' (VTE) is a collective term for both 'deep vein thrombosis' (DVT) and 'pulmonary embolism' (PE). A DVT is a blood clot in the deep veins of the leg. A PE is when all or part of the DVT breaks off, travels through the body and blocks the pulmonary arteries in the lungs.

Every year, an estimated 25,000 people in the UK could die from VTE associated with hospitalisation (www.rcn.org.uk). VTE is the single, most common, preventable cause of death in hospital patients (Lifeblood - The Thrombosis Charity; NICE) and VTE risk assessment and appropriate preventative measures (thromboprophylaxis) can reduce this risk. 'Pharmacological prophylaxis' refers to a drug-related preventative measure, whereas 'mechanical prophylaxis' refers to a preventative measure that involves a physical device.

Goal 3: Measuring the Improvement

Patients who are at risk of bleeding, are unlikely to be prescribed anticoagulants but instead, alternative preventative measures such as anti-embolism stockings will be prescribed in addition to keeping well hydrated and being as mobile as possible.



Next Steps

- Work bespoke to LVH/Downe hospital commencing soon to improve compliance with VTE risk assessment
- Compliance results forwarded for discussion at monthly audit/SQE meetings to encourage action planning to improve and sustain compliance

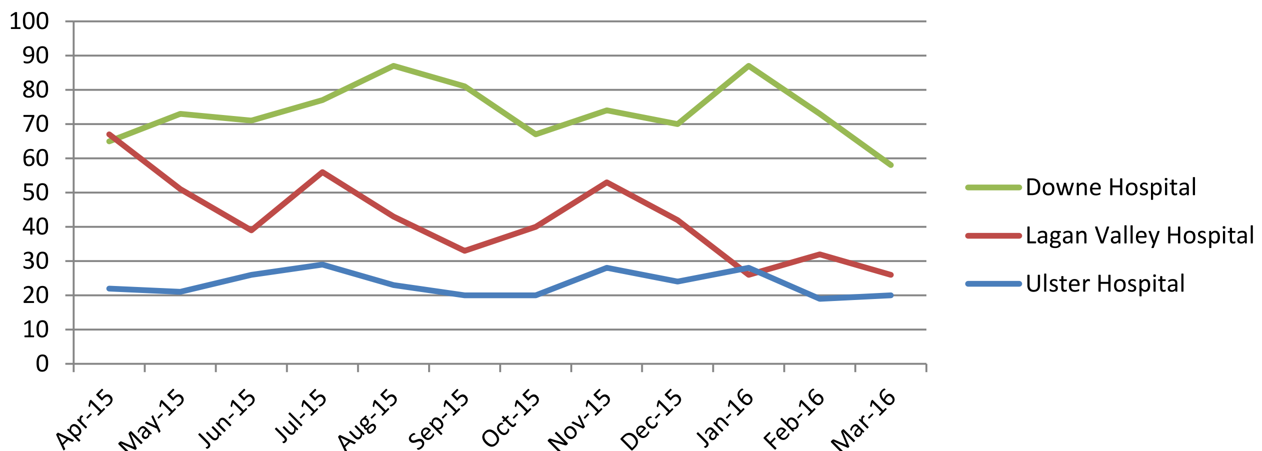
Medication Safety

Medicines Reconciliation

When a patient is admitted to hospital it is vital that an accurate medication history is obtained. Research has shown that when patients move between care settings unintentional changes to medication may cause patient harm.

Pharmacists work alongside medical staff on the wards to ensure accurate medicines reconciliation at admission and also at discharge. Undertaking medicines reconciliation within 24 hours of admission to an acute setting (or sooner if clinically necessary) enables early action to be taken when discrepancies between lists of medicines are identified.

Reconciliation within 24 hours is a key performance indicator for Pharmacists. Dashboards containing monthly figures track performance and are reported on a monthly basis to the Head of Pharmacy and Medicines Management at HSC Board NI.



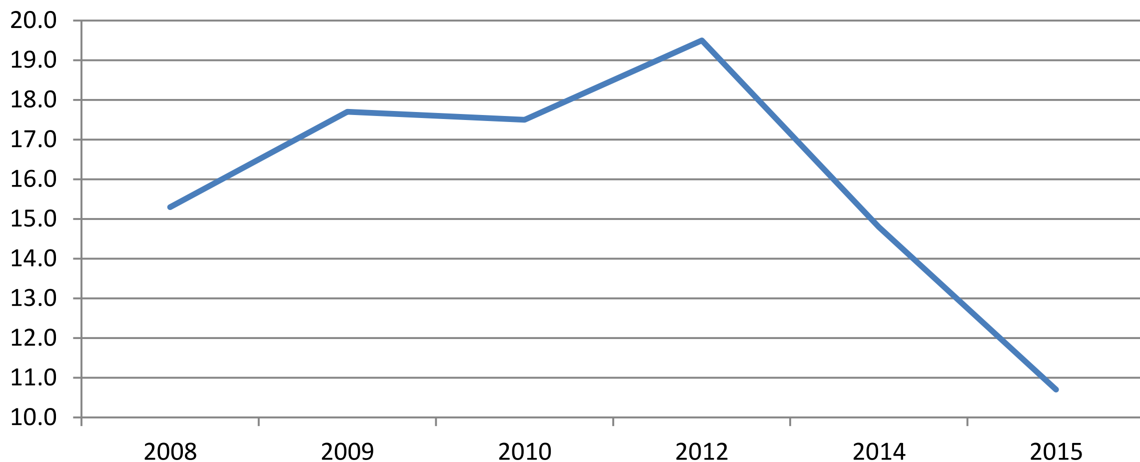
Next Steps

- Electronic whiteboards will allow tracking of medicines reconciliation in real time. This will help improve the efficiency of the service by allowing us to better prioritise patients on the basis of need
- 7 day working is being piloted in the admission team
- Pilot of pharmacist on post-take ward rounds is planned
- Increasing the use of non-medical prescribing continues
- Work with commissioners to ensure all ward areas are funded to provide a clinical pharmacy service

Goal 3: Measuring the Improvement

Omitted Doses

Patients in hospital should receive their medicines on time and if a medication cannot be given to a patient a reason should be recorded on their medication chart. Reduction of medicines that are inappropriately omitted or delayed has been a priority for South Eastern Trust and audit data confirms that the number of omitted and delayed medicines on our wards continues to fall.



Nursing KPI (Key Performance Indicator)

Sometimes the reason for the omission or delay is not recorded and it is therefore difficult to assess the impact of this failure to record on the health and recovery of the patient or whether any omission or delay caused actual harm to the patient. Further analysis of the data collected to date will help us gain more understanding of the type and number of dose omissions that occur.

Prison Healthcare

An audit tool based on the work in the acute setting was developed to examine the number and type of omitted doses in Prison Healthcare. This work commenced early in 2016 and the results will be available later in the year.

Next Steps

- The next Trust-wide omitted doses audit is due before the end of 2016
- Further analysis of the nursing key performance indicator results
- Roll out of Pharmacy LEAN project
- Report on Omitted Doses in Prison Healthcare and identification of quality improvement opportunities

Goal 3: Measuring the Improvement

Medication Safety - Anticoagulants

All medication incidents reported are reviewed by the Medicines Governance Pharmacist. All incidents are included in a quarterly medication incident report which is reviewed by the SET Medication Incident Review Group.

Medication incidents involving anticoagulants were noted to be increasing and work was undertaken to examine why this was happening. It was noted that a group of medicines called NOACs (new oral anticoagulants) also known as DOACs (direct oral anticoagulants) were often reported. As a result a number of initiatives were introduced:

- Education of staff to raise awareness of the new oral anticoagulants
- Stickers were attached to boxes of the medicines to alert staff that the medicines were an anticoagulant
- Development of a bespoke prescription chart to help prescribe and administer these medicines safely
- Collaboration with regional colleagues to prompt safer prescribing of anticoagulants within the regional acute medicine prescription and administration chart.

Emergency Department Initiatives

A number of service improvements have been identified within the Emergency Department to enhance the safe prescribing of medicines, reduce missed doses and obtain faster turnaround times on discharge.

These initiatives have included:

- Pharmacist prescribing project funded by HSCB which showed great benefits for patients and medicines management practices within the department
- Investment in further Pharmacists and Pharmacy technical staff within the Department
- Development of a Pharmacy seven-day a week service
- Introduction of a mobile dispensing unit to reduce waiting times for discharge prescriptions and promote better patient flow throughout the department.

Malnutrition Universal Screening Tool (MUST)

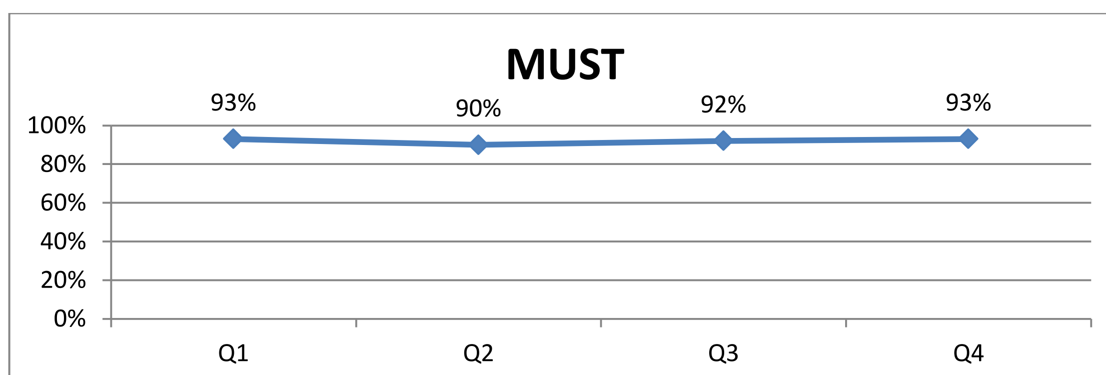
The overall vision of the regional 'Promoting Good Nutrition' strategy (DHSSPSNI 2011) is to improve the quality of nutritional care of adults in Northern Ireland, in all Health and Social Care settings. This can be achieved through the prevention, identification, and management of malnutrition in all Health and Social Care settings including peoples own homes.

The adverse effects of malnutrition are well documented – it can increase hospital stays, delay healing and reduce strength and mobility.

MUST is a five step screening tool which is used to help to identify adults who are malnourished or at risk of malnutrition, allowing Healthcare Staff to put in place a plan of care to promote their nutritional wellbeing.

The Trust has set a target that all inpatients are screened for malnutrition on admission and throughout their stay.

The graph illustrates compliance with the elements of the MUST across all ward areas. In 2015/16 the average trustwide compliance was 92%.



Our progress

Through the work of the Clinical Nutrition Sub-committee, chaired by the Director of Nursing, work has continued in conjunction with Dietetic, Speech and Language, Pharmacy, Catering Staff and User Representatives to monitor and improve all aspects of nutrition.

The PAAT (Prevent, Anticipate, Avoid and Treat) model continues to roll out to care homes across the SET. This model is to manage the nutritional needs of large numbers of patients using a 'virtual ward round' based on data gathered in the care homes and supported by Dietitians and nutrition assistants. Implementation is complete in the Ards area with 406 residents being managed within the model. Roll out in the Lisburn area has commenced along with MUST screening training to assist in the identification of patients at risk of malnutrition.

Goal 3: Measuring the Improvement

Speech and Language therapy and catering continue to work together to ensure that patients who have swallowing difficulties and are at risk of choking receive the appropriate type and consistency of food to ensure safe optimum nutrition.

Awareness training around promoting good nutrition and risk of malnutrition is being delivered to frontline care workers to ensure that patients who are at risk of malnutrition have timely recognition and treatment.

Next Steps In 2016/17:

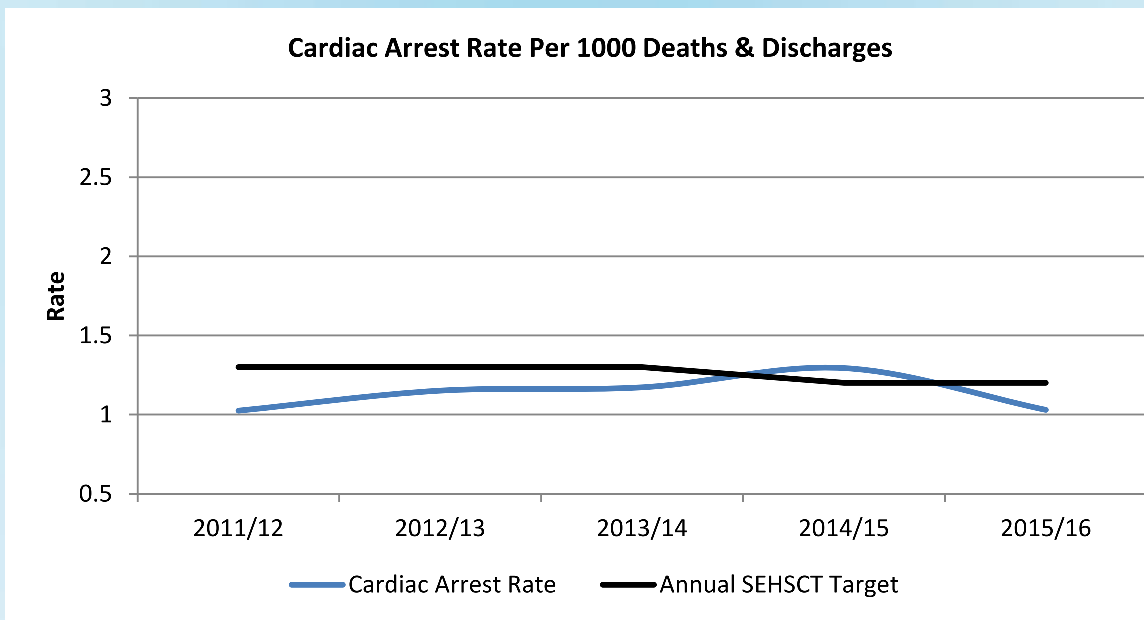
- Continued emphasis on protecting each individual's mealtime, especially in terms of assistance with eating and mealtime interruptions
- Observational mealtime audit in line with RQIA requirements
- Medical student training – dietetics are in discussions to ensure that training to raise awareness of risk of malnutrition and other nutritional issues among medical staff
- Pilot of an internal volunteer system for mealtime assistance with eating to be piloted in Care of the Elderly

Cardiac Arrest

Reducing Hospital Cardiac Arrests

Facts & Figures

The chart below shows the yearly average of reported cardiac arrests per 1000 deaths and discharges. The Trust set an aim to maintain the crash call rate at 1.2 or less by March 2016. On-going work has seen an overall reduction in cardiac arrests in the Trust since 2007/08; however the mean crash call rate at the end of March 2016 is 1.03 which is below the target for the Trust.



This measure is important because it reflects the effectiveness of the organisation in managing patients in hospital whose condition is deteriorating. It also helps us measure how we recognise those patients who are at the end of their natural lives. Current evidence suggests that effective recognition and management of the acutely unwell patient will reduce cardiac arrests and subsequent deaths in hospital wards.

We recognise that engaging and empowering frontline staff to take appropriate action is known to be an influential way of generating long term improvement.

Next Steps

Timely recognition of the deteriorating patient remains a priority for Trust staff.

During 2016/17 the Trust will continue to:

- enhance staff skills in recognising the deteriorating patient
- promote the importance of effective communication
- promote the importance of escalating concerns appropriately

We will do this by providing Sharing and Learning sessions, Improvement Workshops and bespoke initiatives and training for specific wards and departments.

The Trust will continue to focus on monitoring and measurement of the Regional National Early Warning Scoring system (NEWS) Key Performance Indicator (KPI) in all Adult Inpatient Wards.

Goal 4: Raising the Standards

Standardised Mortality Ratio (SMR)

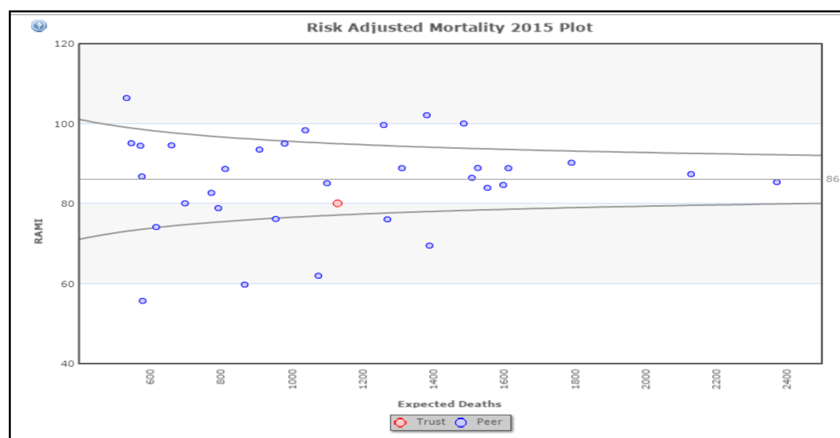
The Standardised Mortality Ratio (SMR) is an indicator of healthcare quality that measures whether the death rate is higher or lower than you would expect. Like all statistics, SMRs are not a perfect indicator of safety; if a hospital has a high SMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign (smoke alarm) that things are going wrong and an indicator for further investigation.

The Risk Adjusted Mortality Index (RAMI) is an SMR which takes case complexity into account, by comparing the actual number of deaths, with the predicted number, based on outcomes with similar characteristics, i.e. age, sex, primary diagnosis, procedures performed, and comorbid conditions. A RAMI index value of 100 means that the number of patients who actually died in hospital matches the number predicted. A RAMI value lower than 100 means fewer people than expected died. It is useful to compare the trust mortality rate against a selection of UK peer top hospitals and against other Northern Ireland Trusts.

Facts & Figures

- The monthly RAMI for the Trust remained lower than both the UK and NI peer for nine out of the 12 months shown. The lowest RAMI value was recorded in July 2015 (71) and the highest value was recorded for December 2016 (96) but this was only 2 points higher than the NI peer for that month.

The following funnel plot (RAMI 2015) show the trust position in relation to the individual UK peer sites and shows that the Trust with an average of 80 is within the confidence limits of the peer population.



Next Steps

- Over the period 2016/17 the Trust will continue to monitor the monthly RAMI and undertake a case note review on any patient deaths that are identified as unexplained or unexpected.

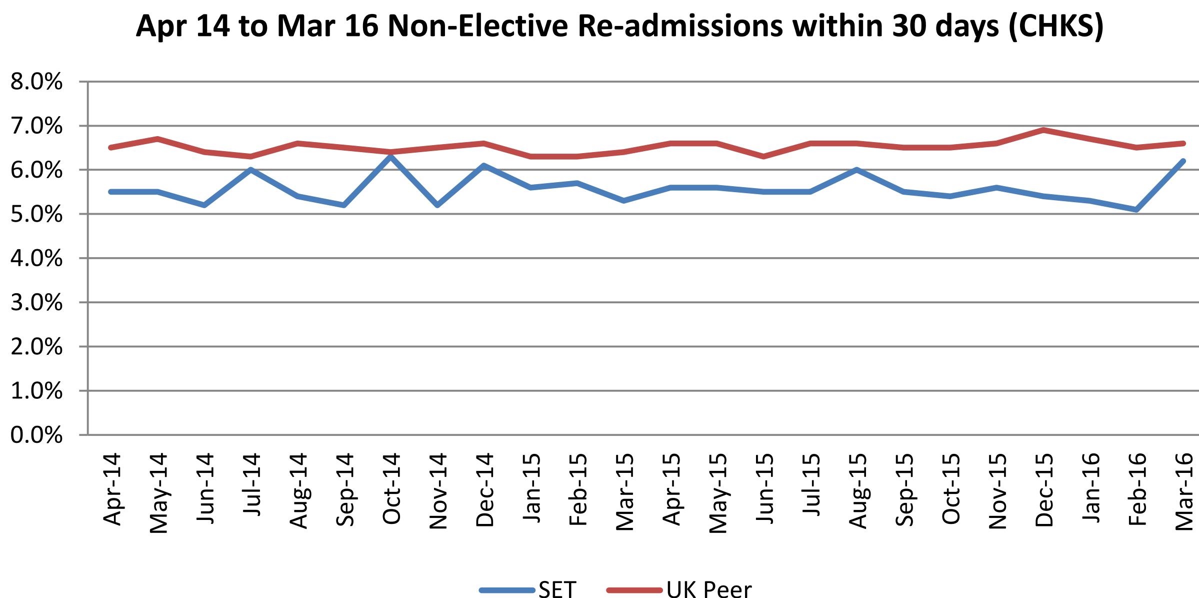
Rate of Emergency Readmission within 30 Days of Discharge

Facts & Figures

- To ensure we measure as appropriately as possible, readmissions are counted as those patients readmitted as an emergency within 30 days of any previous admission to the Trust. The Trust readmission rate has remained unchanged in 2015/16 in comparison with 2014/15 at 5.6% overall. In 2015/16, 6.6% of all UK peer group admissions were emergency readmissions within 30 days. Throughout 2015/16 the Trust readmission rate was lower than the UK peer

Readmission rates can provide an indicator of quality of care, but must be interpreted carefully and in the context of other activity. There is no specific recommended rate of readmissions however observation of our hospital rates against similar hospitals can be useful in providing an indication of performance. It is also helpful to look at readmission rates over time to assess changes. Reasons for readmission can be due to many factors and hospital care and treatment is only one, e.g. other factors include the patient's home environment and access to community services.

The graph below shows the recorded readmissions to the Trust but does not include readmissions to other hospitals outside the Trust geographical boundary.



Goal 4: Raising the Standards

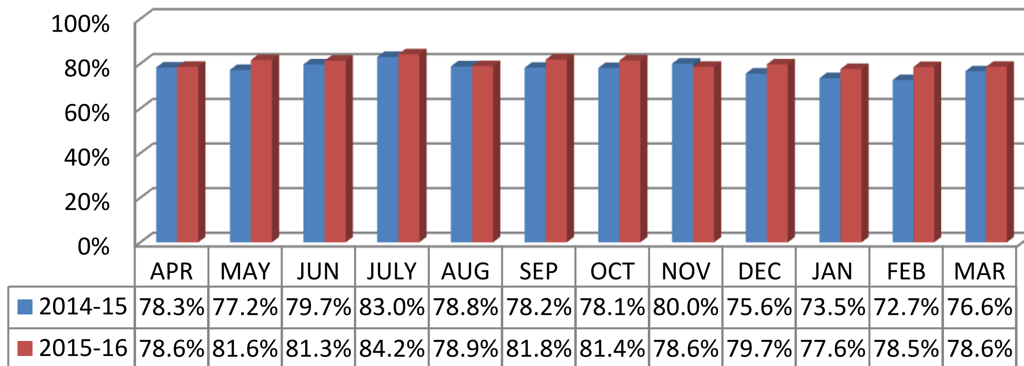
Emergency Department

4 &12 Hour Standard

Facts & Figures

In 2015-16 81.5% of patients were admitted or discharged home in less than four hours compared to 77.6% in 2014-15

% of ED patients admitted or discharged home in less than 4 hours
(Downe, Lagan Valley and Ulster Hospitals)



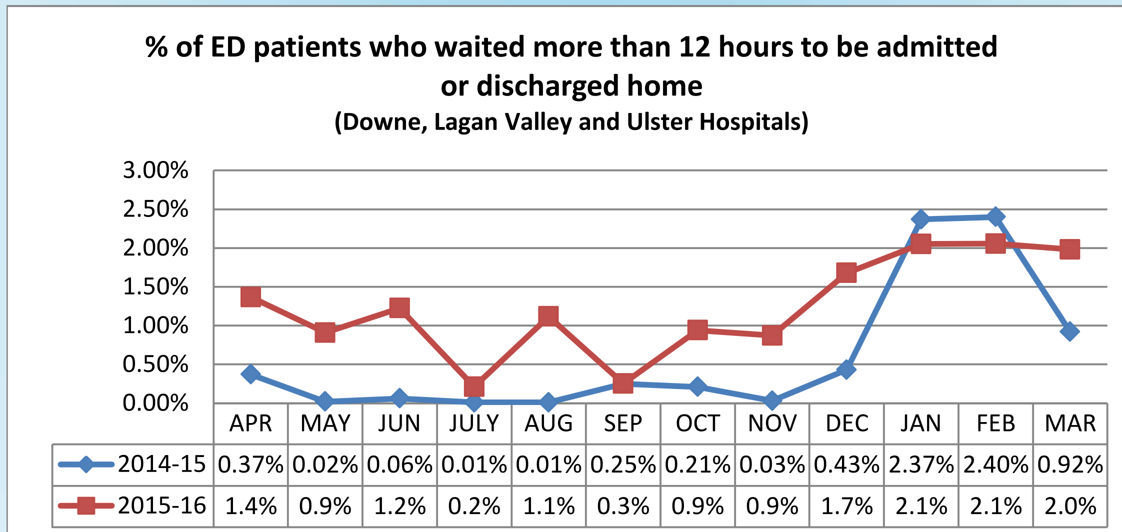
	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2014-15	78.3%	77.2%	79.7%	83.0%	78.8%	78.2%	78.1%	80.0%	75.6%	73.5%	72.7%	76.6%
2015-16	78.6%	81.6%	81.3%	84.2%	78.9%	81.8%	81.4%	78.6%	79.7%	77.6%	78.5%	78.6%

Demand for emergency care continues to grow and people should only attend an Emergency Department (ED) when they have a condition which requires immediate urgent care so that staff are able to use their time to treat those who are most ill. Emergency Care reform targets introduced in 2008 included the target that 95% of patients attending an ED should either be treated and admitted or discharged home within four hours of their arrival time.

Goal 4: Raising the Standards

Facts & Figures

In 2015-16 1.2% of patients waited more than 12 hours compared to 0.6% in 2014-15.

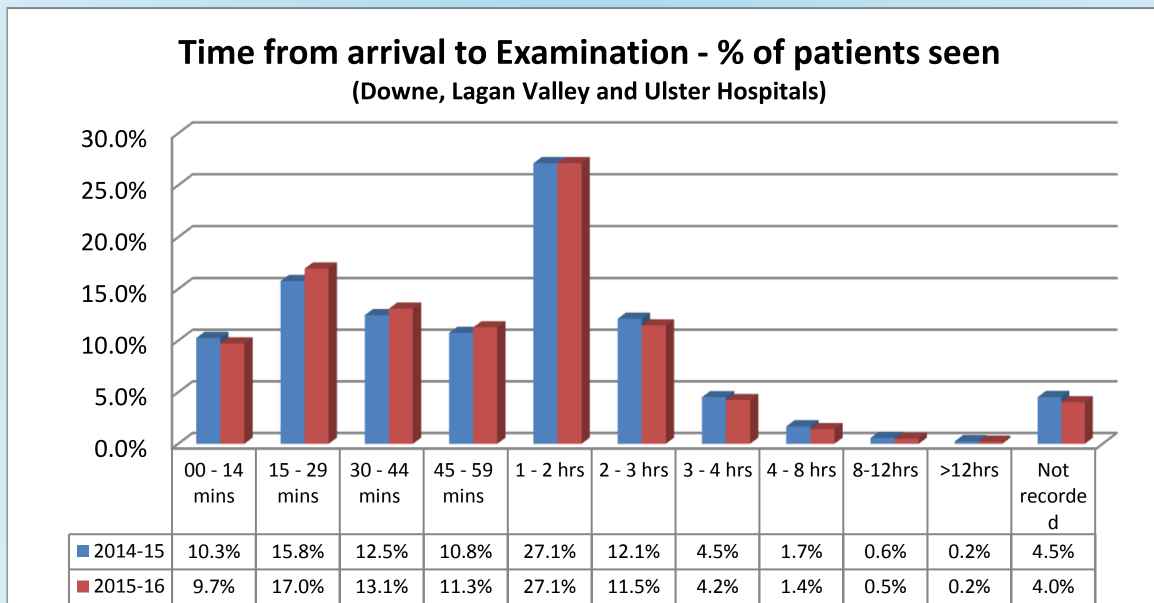


	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2014-15	0.37%	0.02%	0.06%	0.01%	0.01%	0.25%	0.21%	0.03%	0.43%	2.37%	2.40%	0.92%
2015-16	1.4%	0.9%	1.2%	0.2%	1.1%	0.3%	0.9%	0.9%	1.7%	2.1%	2.1%	2.0%

Time to be seen by Emergency Department (ED) Doctor/Emergency Nurse Practitioner (ENP)

Facts & Figures

In 2015-16 51% of patients were seen by a clinician within the standard of 60 minutes. This is an improvement from year 2014-15 when 49.4% of patients were seen within 60 minutes.



	00 - 14 mins	15 - 29 mins	30 - 44 mins	45 - 59 mins	1 - 2 hrs	2 - 3 hrs	3 - 4 hrs	4 - 8 hrs	8-12hrs	>12hrs	Not recorded
2014-15	10.3%	15.8%	12.5%	10.8%	27.1%	12.1%	4.5%	1.7%	0.6%	0.2%	4.5%
2015-16	9.7%	17.0%	13.1%	11.3%	27.1%	11.5%	4.2%	1.4%	0.5%	0.2%	4.0%

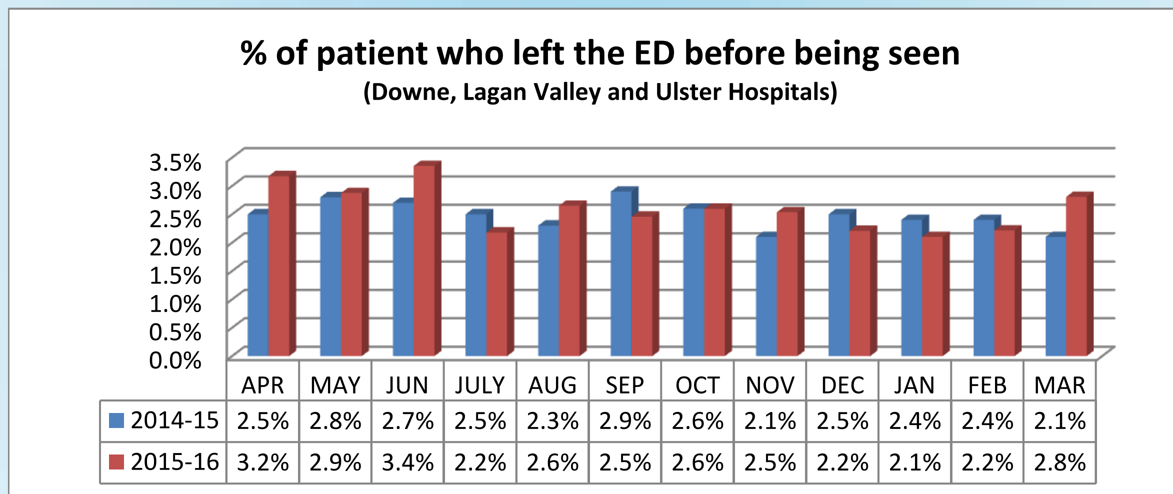
Goal 4: Raising the Standards

This quality indicator records the time between arrival in the ED and the time when the patient is seen by a decision making clinician, and defines that 50% of patient will be seen by a clinician within 60 minutes. This indicator reflects that earlier intervention improves clinical outcomes and patient experience.

Patients Who Leave before Being Seen

Facts & Figures

In 2015-16 2.6% of patients left the Department before being seen by a clinician, compared with 2.4% in year 2014-15



	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2014-15	2.5%	2.8%	2.7%	2.5%	2.3%	2.9%	2.6%	2.1%	2.5%	2.4%	2.4%	2.1%
2015-16	3.2%	2.9%	3.4%	2.2%	2.6%	2.5%	2.6%	2.5%	2.2%	2.1%	2.2%	2.8%

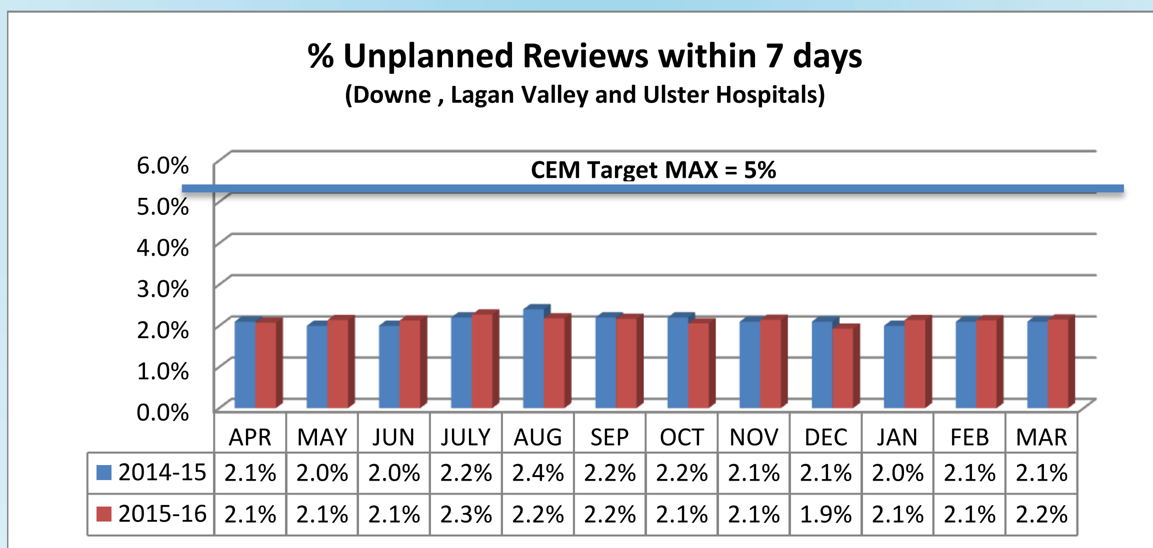
This measure is designed to capture the number of patients who leave the Emergency Department (ED) before a proper and thorough clinical assessment has been undertaken. In principle, a rate greater than 5% of ED attendances leaving before full clinical assessment should be considered to be an area of risk.

Goal 4: Raising the Standards

Unscheduled re-attendance rate within 7 days

Facts & Figures

The unscheduled re-attendance percentage remains consistently within the quality indicator target range of 5%. Overall 2.2% of patients re-attended within seven days as an unscheduled review which is a slight increase compared to the previous year 2014-15 (2.1%).
The graph below shows the percentage of patients who re-attended as an unplanned review in less than seven days of the initial attendance by arrival month.



	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2014-15	2.1%	2.0%	2.0%	2.2%	2.4%	2.2%	2.2%	2.1%	2.1%	2.0%	2.1%	2.1%
2015-16	2.1%	2.1%	2.1%	2.3%	2.2%	2.2%	2.1%	2.1%	1.9%	2.1%	2.1%	2.2%

One of the College of Emergency Medicine (CEM) quality indicators is that unscheduled re-attendances should lie between 1% and 5% of all new ED attendances. This indicator is aimed at reducing the number of avoidable re-attendances at the Emergency Department by improving the care and communication delivered at the original attendance.

This indicator reflects the care delivered by the Emergency Departments in the Trust, but it can also be affected by the provision and use of other emergency and urgent care services, and the incidence, case mix and severity of presenting conditions in the local population. These factors should be noted when comparisons are made across different Emergency Departments.

Next Steps

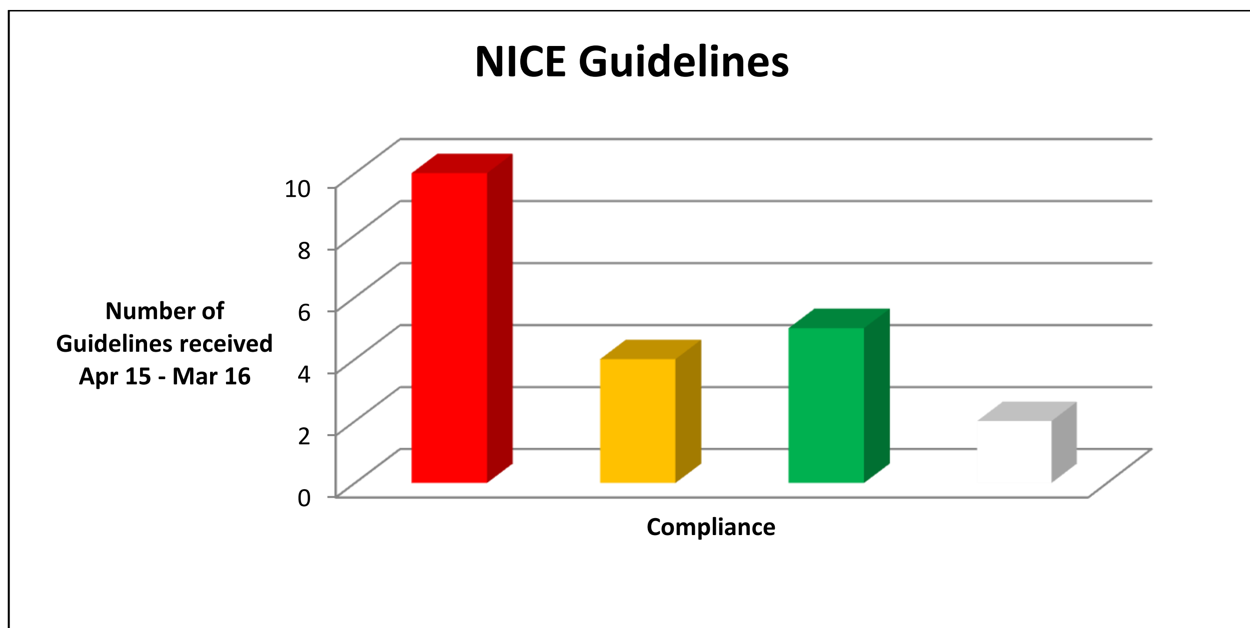
- Further development of the Urgent Care Work stream to improve 4 hour performance; improve patient experience and clinical outcomes
- Further explore the development of work around the Frail Elderly work stream

NICE Guidelines

NICE National Institute for Health and Care Excellence

Clinical Guidelines (CG's) can cover broad aspects of clinical practice and service delivery and, as such, application can often be complex and have financial and wider strategic implications, where non-compliance is indicated in the chart below risks associated have been considered and addressed with through action or escalation. Work continues to achieve compliance. It is recommended that HSC Trusts have a 3 month planning period from the date the DHSSPS issue the guideline and then implement the Clinical Guideline within a further 9 months. The Trust is continuing a programme of activity to ensure compliance as far as possible with all by the target dates, those not on target have been reported to the board at the bi-monthly reviews.

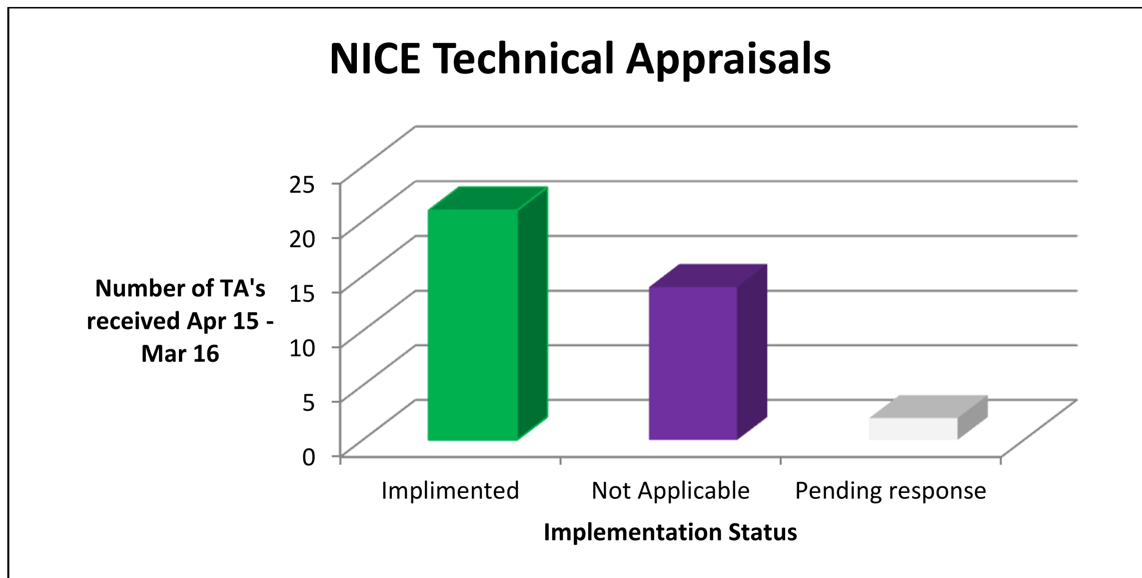
Red: Not compliant
Amber: On target for compliance
Green: Compliant
White: Pending response



Technology Appraisals

It is expected that HSC Trusts will have plans in place to implement Technology Appraisals within 3 months of receiving the Service Notification from the HSC Board and that these plans are fully implemented within a further 6 months in the vast majority of cases. The precise timescale, which may be shorter, or longer in exceptional cases, will be specified in the Service Notification. The HSC Board will seek positive assurance that the required timescales have been met at bi-monthly director level meetings with HSC Trusts.

Goal 4: Raising the Standards



Next Steps

- Continue to submit all reports as requested
- Audit guidance that is compliant for more than six months
- Continue to actively participate in the NICE managers forum

Goal 4: Raising the Standards

Audit

The Trust continues to strive towards a position of guaranteed Safety, high Quality service and a positive Patient Experience at local level. In the quest to achieve this, it is important that staff are enabled to demonstrate their impact and outcomes through audit.

The development of KPI's (Key Performance Indicators) across the Trust has been one way of demonstrating the standard of care we are achieving and the elements of care we need to focus on. Staff have fully embraced the online electronic data entry tool and appreciate being able to access results via the Qlikview system in a timely fashion enabling real-time improvements to be identified.

Another process of ensuring that key goals are achieved is the development of an audit programme within the Trust against NICE guidelines. This programme provides the Trust with a mechanism of assurance that key guidance is embedded within departments and effectively implemented.

During the period 2014-2015 the Trust contributed to the National Audit of Inpatient Falls Moreover the Trust undertook their own analysis and completed a comparison of local findings against National results.

The Trust also contributed to a GAIN funded audit looking at the Appropriate use of AntiD Immunoglobulin in Pregnant Mothers. This audit, which was coordinated by the Northern Ireland Transfusion Committee (NITC), was undertaken to ascertain whether anti-D Ig was administered appropriately to RhD negative mothers in Northern Ireland.

Next Steps

National Inpatient Falls Report

Key Recommendations:

- All Trusts and Health Boards should have a board-level falls steering group and a falls multidisciplinary working
- Trusts and Health Boards should regularly audit the use of bed rails against their policy and embed changes to ensure appropriate use. *SETrust have undertaken a Bedrails audit in 2013 and again in 2015*
- Trusts and Health Boards should review their MFRA and associated interventions to include all domains in this audit

Key Indicator Recommendations

- All Trusts and Health Boards should review their dementia and delirium policies to embed the use of standardised tools and documented relevant care plans. *The Trust is participating in a general ward collaborative that is developing guidance around delirium, a delirium tool and awareness campaign.*

Key Indicator Recommendations continued:

- All patients aged over 65 years should have a lying and standing blood pressure performed as soon as practicable, be assessed for visual impairment, have a medication review and have a continence care plan developed if there are continence issues
- Trusts and Health Boards should develop a workable policy to ensure that all patients who need walking aids have access to the most important walking aid from the time of admission
  - All Trust and Health Boards should regularly audit whether the call bell is within reach of the patient

GAIN: Appropriate use of AntiD Immunoglobulin in Pregnant Mothers

Key Recommendations:

- All qualifying women who undergo surgical or medical management of early pregnancy loss or who suffer pregnancy loss after 12+0 weeks of gestation should be administered an appropriate dose of anti-D Ig.
- 1500 IU of anti-D Ig should be offered to all qualifying RhD negative women between 28+0 and 31+0 weeks gestation.
- Potentially sensitizing events should be managed by prompt administration of anti-D Ig at an appropriate dose for gestational age.
- The correct dose of anti-D Ig should be given to all qualifying women within 72 hours of delivery. Anti-D Ig should not be given to RhD negative women when it is confirmed that they have delivered only RhD negative babies.
- A Kleihauer test is required when a potentially sensitizing event has been identified in a RhD negative woman at 20+0 weeks of gestation or later. A maternal blood sample for this test should also be taken 30 to 120 minutes following delivery in a RhD negative woman.
- Consent must be obtained from all women for the administration of anti-D Ig and evidence of this process must be documented in the clinical notes. The batch number of all doses administered must also be recorded.

Goal 4: Raising the Standards

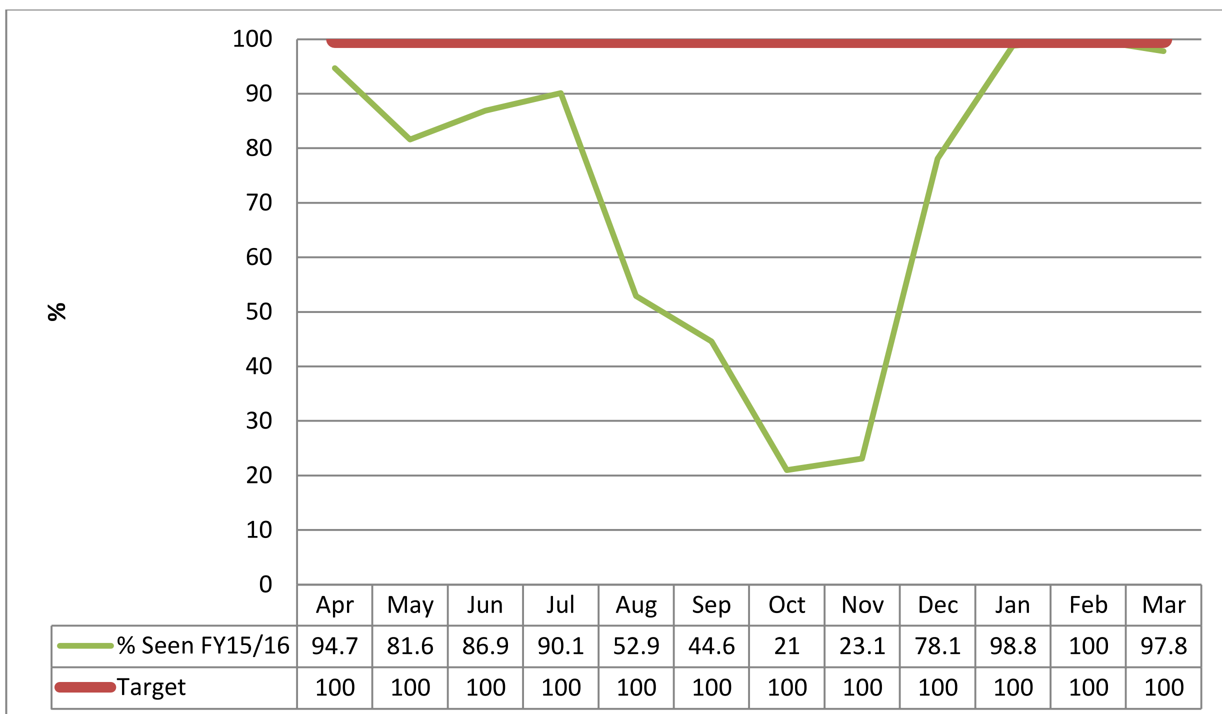
Cancer Access

From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

14 Day Breast Cancer Referrals

The number of referrals to the Symptomatic Breast Service has continued to increase throughout 2015/16. The average number of referrals received each month rose from 84 in 2014/15 to 121 in 2015/16. This represents a 44% increase in monthly referrals. It is anticipated that the increase in referrals will continue into 2016/17. This will cause significant problems in achieving and maintaining 100% of referrals being seen within 14 days. Routine slots have been converted to red flag until the end of May 16 initially and this may have to be extended. Current actions include:

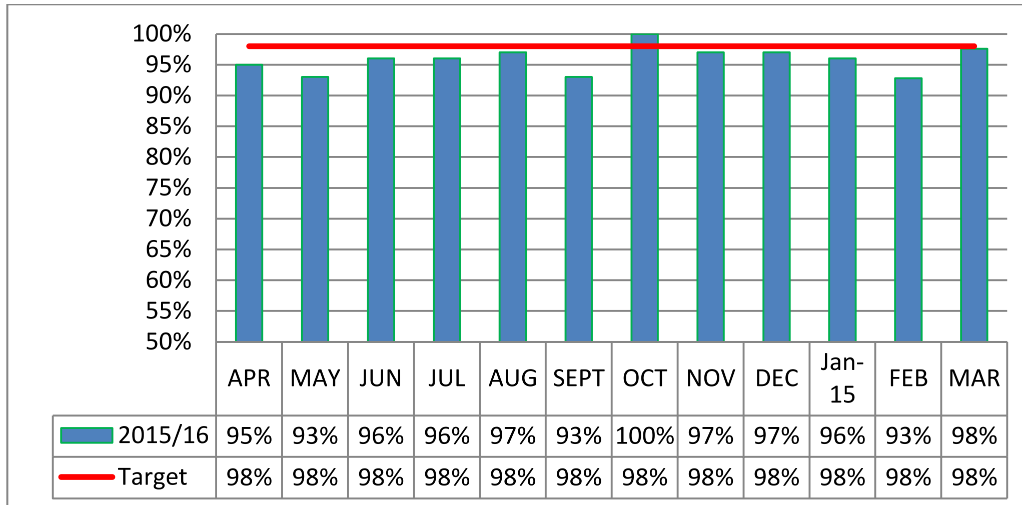
- Weekly monitoring of the number of patients on the waiting list
- Weekly monitoring of the longest wait
- Monitoring of the number of slots available each week.



31 Day Target

The overall position for 2015/16 was 96%. The majority of breaches were caused by insufficient theatre capacity for Urology and Skin. Performance against this target will remain challenging in 2016/17. Current actions include:

- Additional lap nephrectomy lists using BHSCT surgeon
- Additional consultant urologist to be advertised
- Increasing plastic see and treat capacity



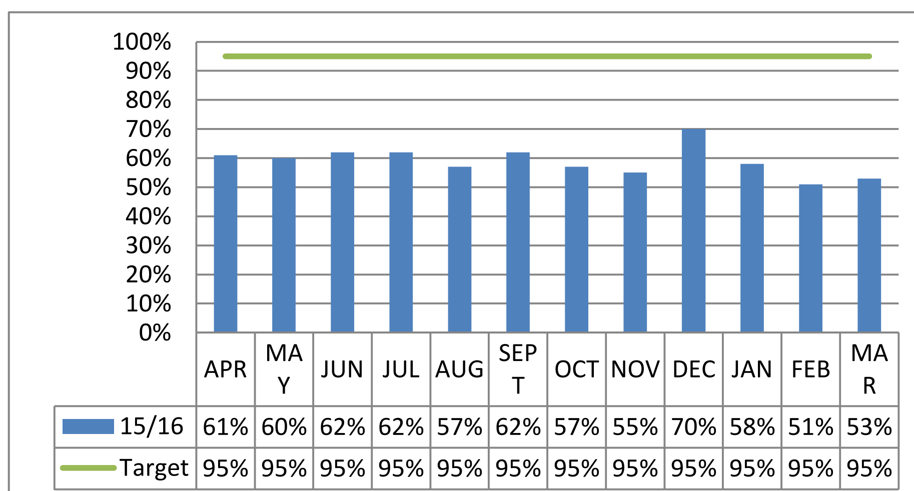
	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	Jan-15	FEB	MAR
2015/16	95%	93%	96%	96%	97%	93%	100%	97%	97%	96%	93%	98%
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

62 Day Target

The Trust continues to aim to treat 95% of GP Suspect Cancer Referrals and Consultant upgrades within 62 days. However, the volume of GP Red Flag referrals continues to increase significantly on an annual basis. The trust received 10,057 GP Red Flag referrals in 2015/16. This was an increase of 1697 compared with the previous financial year and represents a 20% increase. The growth rate in referrals is expected to remain at around 20% for 2016/16 and will have a significant impact on the number of patients on the suspect cancer pathway.

Current actions include:

- Further expansion of the telederm pilot into primary care
- Additional See and Treat Plastic Surgery Clinic (Skin) to commence in 2016.
- On-going implementation of the principles of Transforming Cancer Follow Up in a number of tumour sites with the aim of releasing review appointments to create capacity for new referrals.
- Weekly performance teleconference with the board
- Additional cystoscopy lists
- Additional TURP lists



	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
15/16	61%	60%	62%	62%	57%	62%	57%	55%	70%	58%	51%	53%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Goal 5: Integrating the Care

Community Care

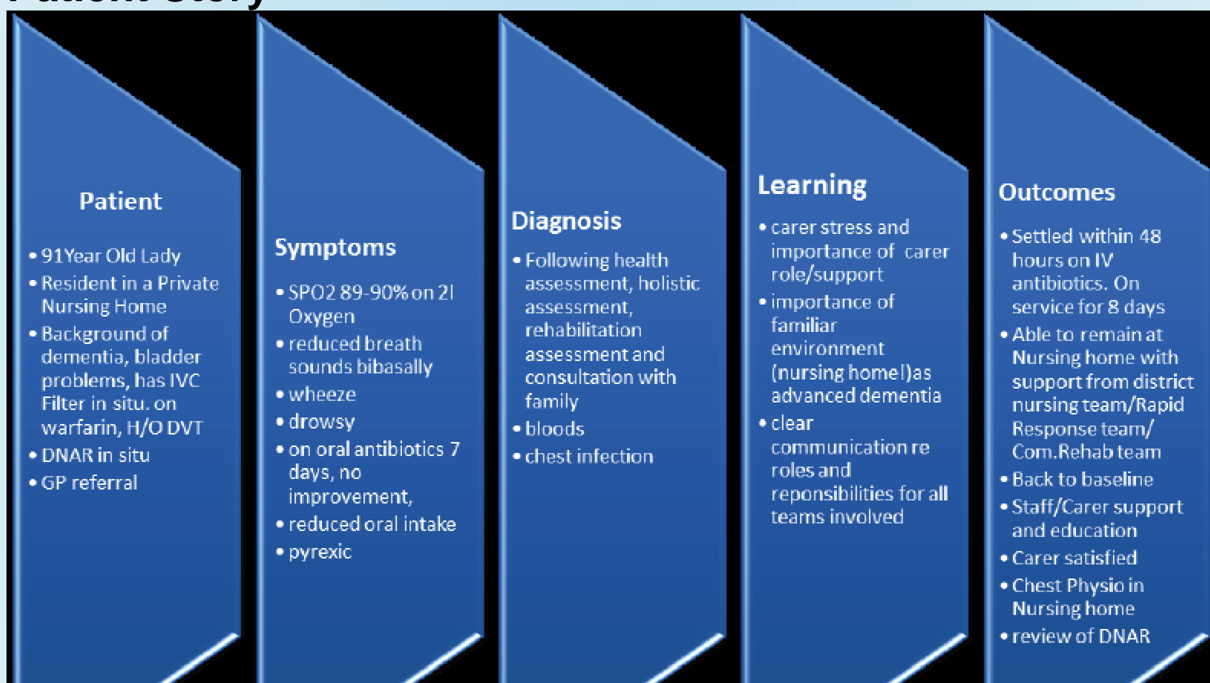
Enhanced Care At Home

The Enhanced Care At Home (ECAH) service has been developed through Integrated Care Partnership (ICP) working and commenced in Ards and North Down in September 2015. The service provides co-ordinated multi-disciplinary care and treatment for the more ill older person in their own home. It is a short term scheme to support people mainly over 65 years and aims to appropriately avoid a hospital admission through intensified care at home and to support individuals to be as safe and independent as possible. As well as providing an alternative to an acute hospital admission, ECAH also facilitates an earlier discharge from hospital whereby a patient can complete their treatment at home. The multi-disciplinary team consists of GPs, Consultant Geriatrician, community nursing, AHP and social services professionals. People can be referred to ECAH by the primary and secondary care teams or other health care professionals. Conditions treatable at home include community acquired pneumonia, heart failure, COPD, chest infections, urinary tract infections and cellulitis. The ECAH service was officially launched in March 2016 by the then Health Minister Mr Simon Hamilton.

ECAH is a 7 day service, presently available in Ards and North Down. Nursing recruitment has been a challenge, however all district nursing posts have now been appointed.

- Up to the end of March there were 157 referrals
- Referral pathways have been developed with Northern Ireland Service, hospital services, Care of Elderly Wards
- There has been very positive user feed back

Patient Story



Next Steps

- Continue to raise awareness and promote ECAH service both internal & external to Trust to increase referrals
- Targeted approach to Nursing / Care Homes for ECAH case management / referrals for specific high users of Emergency Department / acute admissions.
- Develop referral pathway for GPOOHs service to ensure 7 day week referrals
- Continue to raise awareness with GPs using practice based learning days
- Increase capacity within community nursing service to administer increased intravenous anti-biotics
- Liaise closely with hospital colleagues to create a seamless service of case finding both to prevent admission and facilitate early discharge

Home Oxygen Service Assessment & Review

Facts & Figures

- All staff have been in post since September 2015 (Nurse & Physiotherapist)
- Oxygen Assessment & Review clinics have been established on 3 sites across the Trust – Ards, Downe and Lisburn
- A standardised oxygen data base has been established on each site
- Regional work continues regarding metrics, data collection & evaluation for HOSAR
- Domiciliary assessment & review visits are provided as clinically indicated
- There is an on-going structured education programme for Primary & Secondary care staff
- Positive feedback received from service users.

The Home Oxygen Service Assessment and Review (HOSAR) is an Integrated Care Pathway (ICP) developed to provide a clear structured process for accurate assessment and review of people on home oxygen. Evidence has shown that Long Term Oxygen therapy (LTOT) reduces admissions to hospital, reduces mortality and improves quality of life.

Prior to the development of this pathway, some people (particularly non-respiratory patients) were at best reviewed on an ad hoc basis and it is estimated that 30% of patients on home oxygen get no benefit whilst another 20% of patients with COPD who would benefit, have not been assessed. HOSAR aims to ensure all patients on home oxygen are assessed appropriately and reviewed within a structured designated service and that oxygen equipment will also be removed at the appropriate time. Patients can be reviewed at clinic or at home depending on their needs and individual circumstances.

Goal 5: Integrating the Care

The HOSAR service will facilitate:

- A clearly structure process for referral, assessment & review
- Improved review post discharge from hospital so that oxygen therapy can be removed if / when appropriate
- Review ambulatory prescriptions
- Reduce the number of patients on dual supply
- Enhance quality, governance & risk management processes with home oxygen use.
- Reduce waiting times for assessment & review
- Optimisation of quality of life for each individual patient
- Provide on-going education in Primary & Secondary Care regarding the use of & prescription of home oxygen therapy

Next Steps

- As the service progresses comment cards will be given to patients attending the home oxygen clinic to complete. Responses will be collated to obtain feedback on the new service & identify opportunities for improvement. Patient stories will be sought at agreed intervals.
- Patient satisfaction surveys and patient stories will also be completed for the year end evaluation.
- A patient has consented to sharing their oxygen story and details have been forwarded to the ICP project lead to consider filming a user experience video “Living Life with Oxygen”

Mental Health

Recovery College

The SET Recovery College is a place where people from all over the Trust come to learn and educate themselves about mental health and recovery. There are over 20 campuses across the Trust in a mixture of Trust and community venues.

The College offers educational courses about mental health and recovery which are designed to increase knowledge and skills and promote self-management. Each course is co-produced and co-facilitated by Recovery College Tutors. At least one Tutor will have lived experience of mental health recovery and the other will have worked in the subject area. Both Tutors have a special interest in mental health recovery. There are three themes inherent in the Recovery College: Hope, Control and Opportunity - Hope for the future; Control over choices and Opportunities to achieve meaningful goals.

Co-production in the Recovery College involves the design and delivery of educational recovery-focused programmes that aim to increase knowledge and skills and promote self-management. The College place's a high value and regard for lived experience and we are passionate about involving service users and Peers in the design and delivery of the College business

There are currently 35 Recovery College Tutors in SET Recovery College and they are a mixture of people with lived and learned experience. Over half of the trainers have their own lived experience of mental health. All tutors are extremely committed to recovery and value coproduction.

- 51 courses have been delivered
- 22 courses have been co-produced
- 347 people have attended a course
- 156 students are registered on the database

Volunteer Role

Over the past year the SET Recovery College and the SET Volunteer Services have been working closely together to co-develop, approve and promote the Recovery College Volunteer role within the Trust.

The Recovery College Volunteer code of conduct has also been developed in line with the Royal College of Psychiatry's Volunteer Code of Conduct and is important for ensuring that Volunteers have a clear role in the Recovery College and that their well-being and safety is always a primary concern.

The Recovery College Wellness Plan has also been developed and is now a standing item during each volunteer and trainer supervision session.

Goal 5: Integrating the Care

Improving Access to Psychological Therapies in an Acute Ward Setting

SQE Project LVH Ward 12 2015-2016. Behavioral Activation (BA) seeks to help people understand environmental sources of their depression, and seeks to target behaviors that might maintain or worsen the depression. BA targets inertia. When depression zaps motivation, the BA approach is to work from the "outside-in", scheduling activities and using graded task assignments to allow the client to slowly begin to increase their chance of having activity positively reinforced. To date the project in Ward 12 Lagan Valley

Hospital has demonstrated BA has improved self-reported and observed mood, motivation and participation in Occupational Therapy and Nursing treatment. Initial outcomes demonstrated a reduced length of stay in hospital, as patients are able to access treatment earlier in their stay and this aims to set a culture of active participation in the available treatments within the inpatient environment. The 2015-2016 SQE project has demonstrated initial positive outcomes and future developments include the use of a self-management behavioural activation booklet which will support patients to address symptoms of low mood and low motivation and enable them to participate actively in the treatments options available within the acute inpatient environment from the multi-disciplinary team. Low level evidence based psychological interventions within acute services are an empowering and hope building treatment strategy that supports patient's recovery.

Next Steps:

- Provision of low intensity psychological therapies throughout acute mental health services the three inpatient wards, three crisis resolution home treatment teams (CRHT) and the three mental health day hospitals (MHDH) The effective treatment intervention is now being spread to the other inpatient wards through the training and recruitment of a full time Psychological Wellbeing Practitioner. As well the training and provision of evidence based low intensity psychological interventions throughout acute community services (CRHT and MHDH)

Outcomes in Adult Mental Health:

The Mental Health Quality Outcomes and Evaluation group have undertaken:

- Completion of the benchmarking for Implementing Recovery Through Organisation Change (ImROC) within SEHSCT
- Developed Driver Diagram and change package for ImROC using QI methods this has been presented to the HSCB at the regional ImROC Business Meeting and is currently being cross referenced with the work of the Regional Mental Health Safety Collaborative to ensure connection with the work on positive risk taking
- Ongoing exploration to use a computer system for analysing our data at an individual patient level as well as at service and directorate level to enable us to evidence how the people that use our services are better off from the provision. This will enable ongoing review and improvement to ensure services meet our user's needs.

Goal 5: Integrating the Care

- Outcomes based accountability is being used to address the high level of bed occupancy and the current planning of the development of effective Acute Community Services (Crisis Resolution and Home treatment and Acute Support Services).
- The outcomes group links with all the ImROC groups to ensure they are measuring their outcomes this is evidenced in the Recovery College evaluation.
- PHd secured to research the outcomes of peer support workers on the service provision and on patient outcomes within SEHSCT.

Goal 5: Integrating the Care

Crisis Planning-forward planning

Building on last year's Safety Collaborative project, outcomes based accountability has been introduced within mental health services to address the people within the trust who repeatedly self-harm and present to the Emergency Department. Mental Health services have joined with stakeholders including the Emergency Department, voluntary sector, ambulance and the PSNI with the planned outcome that people who self-harm are able to access alternative strategies to cope with self-harm.

The numbers of people presenting to ED have reduced with the increased range of services within mental health including the provision of the SHIP counselling provision, Dialectical Behaviour Therapy Service, Just Right State Protocol and the Crisis Resolution Home Treatment Service

- Training on use of the risk management tool via maxims has been provided to staff
- Further improvement work has been undertaken from Serious Adverse Incidents/ Serious Early Alerts

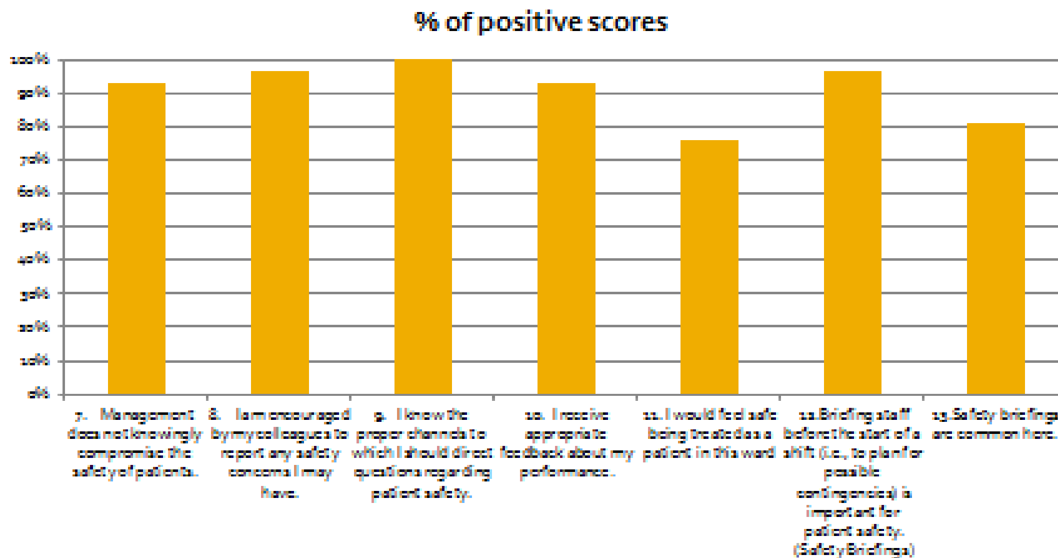
Mental Health Safety Collaborative

The Regional Mental Health Safety Collaborative aims to improve the quality of Acute Mental Health Services by encouraging a culture of learning and reflective practice throughout the region. This has led to further development of the Quality Improvement culture within acute mental health services in the trust, with 62% of the Acute Community staff having completed Level 1 training. Within the trust this has led to the development of reflective practice groups, the creation of a dashboard of accidents and complaints ensuring learning and actions are undertaken to improve safety for both patients and staff. Quality Improvement Projects are currently ongoing regarding learning from incidents and complaints, building a resilient workforce and acute community services through developing Home Treatment as an alternative to hospital admission or to support a shorter length of stay enabling people during periods of acute mental illness to remain within their home and community.

A staff safety survey was undertaken within the Acute Mental Health Services (Inpatient, Crisis Resolution and Home Treatment, MH Day Hospital) and an action plan has been created including the provision of reflective practice groups and learning from incidents and complaint.

Goal 5: Integrating the Care

Staff Safety Climate Survey



Acute community services have further developed to provide a recovery focused alternative to admission enabling people to remain at home while experiencing a mental health crisis or period of acute illness. An SQE Project was completed in the Downpatrick Mental Health Day Hospital by clinical staff which addressed the poor access to the day hospital from ward patients as a means of supporting their transition to the community and reducing length of stay in hospital. As part of the acute community service provision, day hospital when used effectively can provide a step down period from the ward when required.

The project included the provision of information sessions and the development of a leaflet for the inpatient staff and patients, MHDH staff attended the ward huddles to identify who would be appropriate to access the MHDH. This has led to a significant increase in referrals and it is planned that long term this will reduce length of stay as instead of protracted periods of patients on pass, they would be discharged and attend the MHDH supporting their return to home and community living.

Physical Health Monitoring

There is an increased prevalence of physical health problems in people who have a mental illness. For example, people with a psychosis aged 25 to 44 years have 6.6 times higher cardiovascular mortality and die up to 25 years earlier; the highest being in the most developed countries" (Parks et al 2006; Saha et al 2007).

The work of the original 2014 SQE Project has been sustained and developed including an increase in patients' awareness of health and wellbeing through groups provided at the

Mental Health Day Hospitals and practice has improved as demonstrated in the recording of physical health checks throughout the multidisciplinary team.

Goal 5: Integrating the Care

The Mental Health Day Hospital has made significant improvement with over 85% of physical health checks being undertaken as documented in the 2015-2016 audits. Effective processes have been embedded increasing accessibility for patients through the provision of a planned appointment. The physical health monitoring is now in place through the development of the Physical Health Proforma which enables consistency of process and provision throughout the acute services. The template was developed from the Schizophrenia Health Study 2012 and adheres to the associated NICE guidance.

The Lithium pathway is in place with weekly clinics running throughout the trust with nursing, Specialist Doctor and Psychiatric Consultant involvement including the provision of cardiac screening.

Condition Management Programme

SQE Project 2015-2016 CMP/ Introduction of a telephones screening for the Condition Management Programme. The Condition Management Programme is a work focused programme which aims to help clients better manage their health conditions, particularly in relation to entering or returning work. The project tested whether a telephone screening prior to meeting clients for an initial assessment would increase the percentage of clients accepted onto CMP. The telephone screening had a positive impact by:

- Reducing staff and client travel time
- Increasing staff capacity
- Reducing time and cost of organizing appointments
- Reducing room rental costs
- Quicker contact with clients when compared to posting an appointment letter
- More personable service provision through initial phone contact with clients. This supported greater engagement and improved attendance.

Childrens Social Care Services

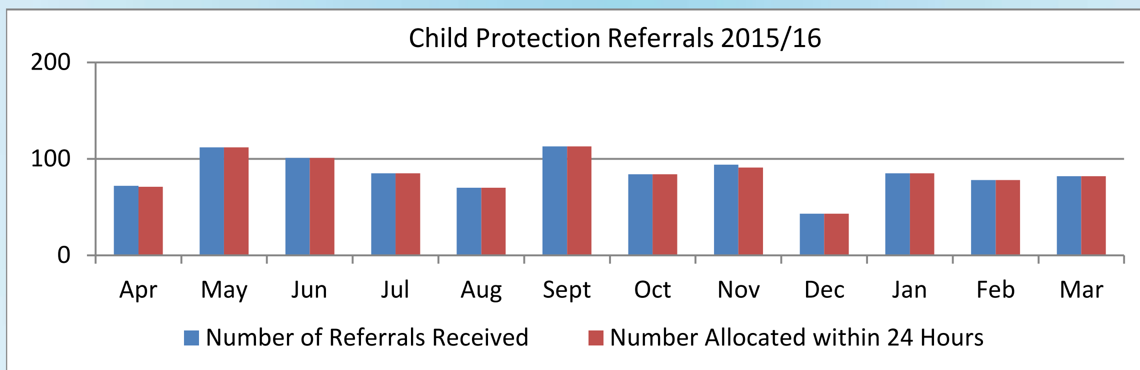
Theme 1: Effective Health and Social

Children's Social Care Indicators

Protecting Children at Risk

Facts & Figures

During this year 99.6% of children or young people were seen within 24 hours of a child protection referral being made. The four children not seen within this period, were unavailable when the social work visit was made, all were seen and spoken to at the first available opportunity.



It is essential that children and young people identified as 'potentially at risk' are seen by a Social Worker and receive a timely response for assessment. Regional child protection procedures require that children identified as being at risk are seen within 24 hours. All child protection referrals are made to the Trust Gateway Team. This is the single point of contact which makes it easy for other professionals and members of the public to make direct contact with skilled staff who assess risk to children.

The Trust, in partnership with Queens University, is currently piloting a Service User App to test the use of technology to understand family's experiences of child protection gateway services.

Next Steps

- Develop innovative approaches to hear the experiences of children and families

Children's Services Family Support Hubs

Often family members find themselves under stress as a result of life's events and are in need of support to help them cope. The Family Support Hub provides early intervention family support services to vulnerable families and children/young persons aged up to 18 years. This year the Trust provided support to 921 families through this hub.

Next Steps

- Continue promoting the benefits of this service with professionals across the Trust.
- Produce improved promotional materials.
- Continue to develop outcome measures

Looked After Children

Facts & Figures

During 2015/16, there were 477 children in the care of the Trust. 97.4% of the looked after children had reviews of their care undertaken within regionally agreed timescales, which is a slight increase on last year's figure of 97%. The timing of these reviews is closely monitored to ensure the care meets the needs of the child or young person.

Children who become looked after by Health and Social Care Trust's must have their living arrangements and care plans reviewed within agreed timescales. The Trust must ensure that the care they are receiving is safe, effective and tailored to meet their individual needs and requirements.

Social workers engage with children and young people prior to their review meeting to ensure that their views are sought and presented. The use of the MOMO (Mind of My Own) App has continued to encourage the young people's engagement in discussions about their care and continues to be consolidated across teams that provide support to looked after children and other teams in children's services.

This year service user stories have been gathered from ten young people, with a focus on their experience of family contact as young people in care. Key themes identified emphasise how much young people value contact with their families and that in most cases it works well. Areas for improvement include young people being more involved in the planning of contact and improvement of practicalities, such as the provision of more family friendly facilities where contact can take place, with more activities available.

Work is progressing with the young people to address these identified improvement areas.

Next Steps

- To continue to improve children's' participation in their looked after reviews. A dashboard of key elements has been agreed and is being tested in preparation for each child's review
- To progress improvements on contact arrangements for children in care

Ensuring Permanence Plans for Looked after Children

Every looked after child needs certainty about their future living arrangements. Trusts are required to ensure that plans for the child's permanent long term care are in place at the earliest point following a child's reception into care which is called 'Permanency Planning'.

This Trust aims to provide every looked after child with a safe, stable environment in which to grow up. A sense of urgency should exist for every child who is not in a permanent home.

Permanency planning starts at first admission to care and continues throughout the lifetime of the child or young person's care until permanency is achieved.

Facts & Figures

In this reporting period 95% of all looked after children in care for more than 3 months after children had a permanency plan in place. The Trust will continue to focus on ensuring all children have a permanency plan

Next Steps

From January – December 2016 the Trust is involved in a Care Proceedings Pilot which aims to achieve permanence for children at the earliest point. An evaluation will be undertaken in 2017

"Home on Time" Project

The "Home on Time" project aims to improve the process for young looked after children to either return home to their parents or be adopted by their carers.

The project offers a range of options for young children to achieve an early permanence plan. These include:

- Children placed with foster carers who are approved to adopt while options for return to birth parents are explored. If rehabilitation to birth family cannot be achieved, the child is adopted by the foster carers.
- Ensuring the child has a single placement while care planning is determined.

The programme has now successfully progressed its first placement and the child involved will now have permanence through adoption by the carers with whom it was placed at birth. For this child, the project has resulted in a single placement from birth.

Next Steps

The project will be promoted and shared across all social work teams in the Trust

Childrens Social Care Services Theme 2: Delivering Best Practice in Safe Health

Direct Payments for Children

Facts & Figures

In 2015/16, 37% (200) of the total number of direct payments (541) within the Trust is made in respect of children (particularly children with disabilities).

Direct payments are cash payments given to families who have been assessed as needing personal social services. Families use the payments to arrange the service they require for themselves.

Direct payments now form part of a new initiative from the Health and Social Care Board, known as Self Directed Support (SDS). This will offer more control, flexibility and independence to families as they choose the support they want to meet their assessed need and agreed outcomes.

It is excellent to record an increase in the uptake of direct payments for children, which is now further enhanced through the roll out of Self Directed Support (SDS) in the Trust this year. SDS enables families to locally source the care they require, allowing the individual to choose how they are supported within their community.

Your Name: My name is and I am 10 years old

What People like about you

What is important to you?

What do you want to change or improve in your life?

Next Steps

The process of implementing SDS is well underway in children's services and all plans are currently under review with the intention of moving towards the SDS model. This will be well embedded by 2017

Education and Training for Young People Leaving Care

Facts & Figures

The average for 2015/6 of care leavers in education, training and employment was 67% compared to the average of 75.5% in 2014/15. This reduction is due a number of complex issues for this group of young people and also changes in government and European funding. This year we have increased number of young people who have apprenticeships and employment within the Trust.

Research tells us that young people who leave care do not always achieve the same levels in education, training, and employment as other young people in the community. The Trust has established an employment scheme to support the training and employment for these young people, coordinating services for them and ensuring they have a personal education plan.

In 2015/16, the majority of young people known to the Trust's leaving and aftercare service were engaged in education, training, and employment, as demonstrated in the table below. A number of young people are sometimes are unable or unwilling to participate or engage in education, training and employment.

Care Leavers Aged 19. Source: Monthly Children's Return to HSCB

No. of Care Leavers who are in Education, Training or Employment on Last Day of Month
(Performance against Target of 75%)

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total No. of Care Leavers who are aged 19 at month end;	40	54	54	55	55	50	42	42	46	41	41	44
Total No. of these Care Leavers who are in education, training or employment	30	38	38	41	39	38	30	29	33	31	31	34
Performance against target	75%	70%	70%	75%	71%	76%	71%	69%	72%	76%	76%	77%

The Trust continues to provide a range of support for young people leaving care to reach their full potential. This year we have created six employment opportunities through the inclusion of a social clause in the new Ulster Hospital build.

Next Steps

- The Trust will continue to provide a comprehensive person-centred Employability Service offering opportunities in traineeships, apprenticeships, work placements and in-education work experience schemes
- Young people will be supported by specialist mentors and 16 plus teams to progress into a range of employability programmes and to attain the appropriate support as and when required
- To use film with the Educational Shakespeare Company to engage young people in preparation for adulthood and independence

Transition for Children with a Disability

Facts & Figures

In the year 2015/16 100% of young people with a disability, who were in receipt of special education, had a transition plan in place when they leave school within the Trust.

Effective planning at an early stage is vital if young people are to move successfully from school towards fuller adult lives.

This is a statutory requirement under special education legislation and a recommendation of the Bamford Review. These arrangements should be made in partnership with the young person, their family/carers and adult learning disability services for transition to appropriate adult services. The objective of this transition planning is to support people into the same life chances as other non-disabled young people e.g. a job, relevant education, positive relationships and the start of living independently.

Planning for transition is a complex process that can cause additional stress for families. A Trust working group was established in 2014/2015 to consider the needs of young people going through the transition process and this group have successfully matched the needs of all young people into adult facilities. This monthly group is well attended by all professionals who have a role with the young person and this early planning helps smooth the process and identifies options and any arising needs in a timely way for all concerned.

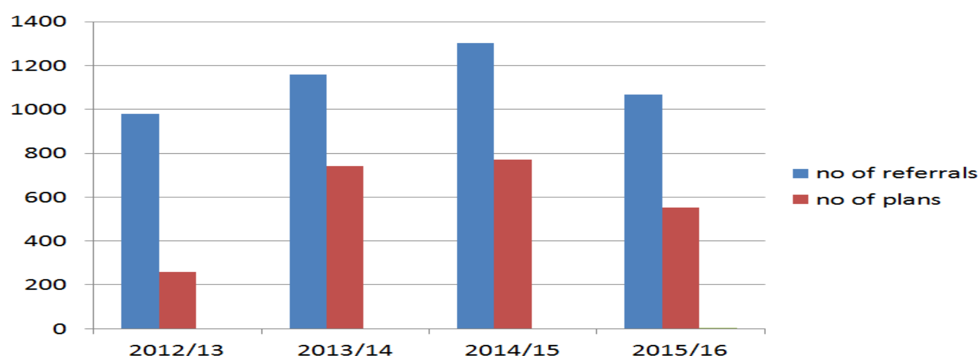
Next Steps

- The Trust continues to work in partnership with parents, carers, schools and specialist voluntary sector organisations to enhance transition planning and opportunities for meaningful engagement in their communities and workplace
- A Trust working group has been established to improve early identification and information sharing to enable a creative transition process for young people. A children's school liaison social worker and an adult transition social worker will be identified
- A working group is in place to identify the needs of children with a challenging behaviour and it is envisaged that a seamless intensive support service between children and adults will be established into 2017

Adult Social Care Services Theme 1: Effective Health and Social Care

Adult Safeguarding

Facts & Figures



The Trust has a lead role in adult safeguarding and has seen a 234% increase in the number of adult safeguarding referrals in the last 5 years. This is due to a better understanding and awareness of adult safeguarding accompanied by a greater willingness of professionals and the public to report concerns.

Adult protection plans are important in that they help eliminate or significantly reduce the likelihood of abuse occurring again. This year 1069 referrals were received; 52% (553) resulted in protection plans being agreed.

The Trust adopted the 10,000 Voices project to seek feedback on service user's experiences and help identify better ways of working. The importance of this has been acknowledged and has now been taken on regionally.

A review of Trust facilities is ongoing with the use of a checklist of items to alert staff to the potential of risk or abuse with intervention before any harm or further abuse occurs.

The newly developed adult safeguarding training programme, developed by the Trust in partnership with other trusts has completed its first year and has been nominated as a finalist in the Social Work Awards this year.

Next Steps

- Recruitment to a specialist Gateway team will be progressed this year
- Adult safeguarding information will be included in talking newspapers
- Collaborative working with the Ulster Bank and other financial agencies to increase detection of financial abuse

Carer Support

There is a significant population of carers within the region providing an invaluable service for relatives and their loved ones needing care and support. The Trust is committed to supporting carers through carer assessments as well as other support services including wellbeing events and personal development programmes.

During the period 2015-16, 2,739 adult carers were offered individual carer assessments. 803 carers engaged with Trust staff in this process, compared to 1,919 and 628 respectively in 2014-15. Work was undertaken to understand the reason why many carers do not wish to have an assessment. Reasons included that carer's report they did not require additional service and were too involved in the caring role.

Carers And Direct Payments Act 2002	Mental Health	Learning Disability	Physical Disability	Older People	Children Family & Child Care Disability	Total 2015-16
Number of adult carers offered individual carers assessments during the year	359	103	245	1,917	115	2,739
Number of adult carers assessments undertaken during the year	104	71	138	385	105	803

The Trust's Carers Development Officer continues to promote awareness of the needs of carers across the Trust and works alongside teams across children's and adults services to support carers.

In 2015/16 after carers assessments were completed, 608 individual payments were made to carers across all programmes of care to promote the carers' own health and wellbeing by getting a short break from caring.

Wellbeing events for carers were held during June and October 2015 and March 2016. In addition, a range of personal development programmes for carers were held across the Trust during Autumn 2015 and Spring 2016.

Carer Feedback on Personal Development Programme

"*I was offered the opportunity to take part in a programme for carers. I was unsure what to expect but decided to give it a go as I was feeling under pressure. It helped me develop confidence and look at how I was managing all the responsibilities I had. I met new fiends with whom I still keep in contact. This just came at the right time for me and has really turned my life around*"

Next Steps

- Trust staff to continue to continue to promote the benefits of carer assessment
- Consult with carers on their views of the support offered to them
- Continue to extend the Short Breaks Initiative developed in partnership with local community pharmacists across the Trust

Adult Social Care Services Theme 1: Effective Health and Social Care

Re-settlement of Adults with a Learning Disability

Facts & Figures

- The Trust has continued to focus on resettlement of people from Muckamore Abbey Hospital.
- Only 4 people remain to be resettled, all of whom have plans in place for discharge.

The goal of the Trust is to improve the quality of life for those with learning disabilities. This is achieved by providing a range of services that will support personal choice, moving away from a service-led to needs-led approach, challenging and changing mind-sets that may affect the individual's potential to become an integral and valued member of their community.

Small scale supported living arrangements have been shown to offer a better quality of life as compared to congregated living arrangements for people with learning disabilities. Each person to be resettled has an individual person centred support plan developed, identifying the person's preferred living arrangements.

While some families and carers expressed concern about moving their family member from a hospital setting where they felt safe, interim evaluation reports indicate that the overall feeling now from individuals and their families is that betterment has been met through the move to the community and there are vast improvements in their loved one's quality of life.

Findings also indicate that people experience more choice in the community and much more opportunity to socialise, pursue interests and activities.

Next Steps

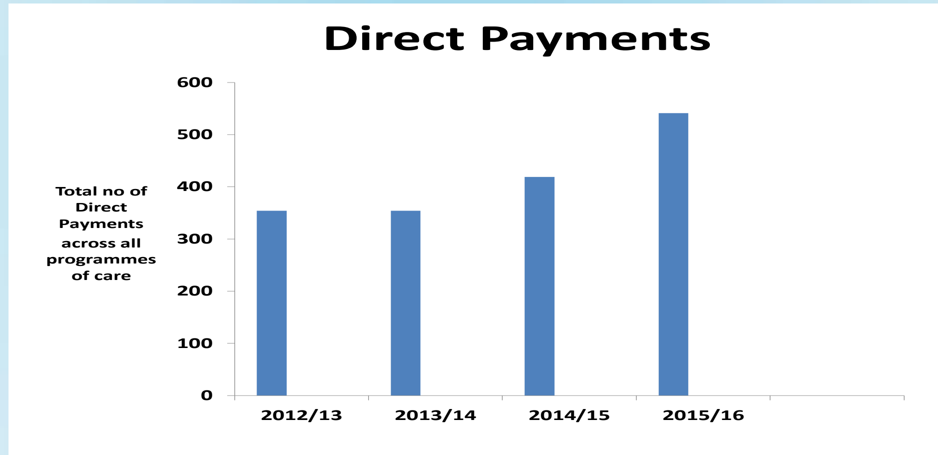
- The Trust will continue to focus on the resettlement of the remaining four people in hospital who will require bespoke services in the community
- We will continue to extend living options and schemes based on identified needs in partnership with other private and voluntary providers, housing associations, the Housing Executive and Supporting People to meet these challenges

Adult Social Care Services Theme 2:
Delivering Best Practice in Safe Health and Social Care

Direct Payments and Self-Directed Support in Adult Services

Facts & Figures

The last year has seen a 22.5% increase in the number of people who received Direct Payments from the Trust.



Changes to the way people receive social care support have been introduced from June 2015 Self Directed Support (SDS) offers more control, flexibility and independence to people as they choose the support they want to meet their assessed need and agreed outcomes.

A Direct Payment is one of four options of managing a personal budget under the umbrella of Self Directed Support. This option offers individuals the greatest control over how their budget is spent. In 2015/16 in the Trust over 541 individuals utilised Direct Payments. As expected with the introduction of SDS, there has been an increased uptake in Direct Payments.

In March 2016 the Trust launched the Self Directed Support Provider Toolkit. This toolkit was co-produced with providers form the community, voluntary and private sectors and is available on the Trust Internet site.

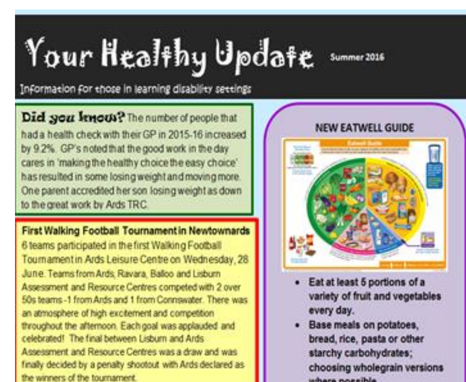
Next Steps

- The Trust is committed to increasing the flexibility of social care support through embedding Self Directed Support across all programmes of care

Annual Health Checks for Adults with Learning Disabilities

Facts & Figures

- 98% of GP's in the Trust continue to be engaged in the health check process.
- Over the past year, there has been a steady increase of 9.2% to 73.1% of people with learning disabilities accessing GP practices and receiving an annual health check.



Your Healthy Update Summer 2016

Information for those in learning disability settings

Did you know? The number of people that had a health check with their GP in 2015-16 increased by 9.2%. GP's noted that the good work in the day cares in 'making the healthy choice the easy choice' has resulted in some losing weight and moving more. One parent accredited her son losing weight as down to the great work by Ards TRC.

First Walking Football Tournament in Newtownards

6 teams participated in the first Walking Football Tournament in Ards Leisure Centre on Wednesday, 28 June. Teams from Ards, Ravara, Balloo and Lisburn Assessment and Resource Centres competed with 2 over 50s teams - 1 from Ards and 1 from Connswater. There was an atmosphere of high excitement and competition throughout the afternoon. Each goal was applauded and celebrated! The final between Lisburn and Ards Assessment and Resource Centres was a draw and was finally decided by a penalty shootout with Ards declared as the winners of the tournament.

NEW EATWELL GUIDE

- Eat at least 5 portions of a variety of fruit and vegetables every day.
- Base meals on potatoes, bread, rice, pasta or other starchy carbohydrates; choosing wholegrain versions where possible.

People with learning disabilities are more likely to experience major illnesses and develop them younger than the population as a whole. Research shows people with learning disability are less likely to access health checks and treatments they need and continue to face significant barriers within health services.

Effective screening and regular health checks help to identify unmet need and prevent health problems arising but people with learning disabilities participate less in regular health checks than the rest of the population. To improve the uptake for people with learning disabilities, the Trust employs a Health Facilitator to encourage health promotion, promote health screening and the uptake of annual health checks.

The Direct Enhanced Services (DES) for providing an annual health checks for people with learning disabilities has continued to develop over the past year. The Trust Health Facilitator has worked with GP's across the Trust to encourage attendance at health screening.

Next Steps

- The Trust will continue to work with health development agencies to encourage health promotion for people with learning disabilities
- The Trust will continue to provide training for staff and carers on healthy options for people with learning disabilities
- The Trust plans to increase the number of health action plans for people who have been health screened

Social Care Indicators

Approved Social Work

Facts & Figures

- In 2015/16 the number of applications for assessments made by an ASW in the Trust in 97.4% (311) occasion.
- Only 1.3% (4) of all admissions were noted following an application by the nearest relative.

Sometimes it is necessary, for the protection of an individual and to prevent harm to themselves or others, to detain people in hospital for assessment under the Mental Health Order.

Applications can be made by an Approved Social Worker (ASW) or by the persons nearest relative. Although this year there is an increase in the number of assessments by an ASW, there is a reduction in the number of applications for assessment and detentions in hospital.

We have been successful in ensuring there is not unnecessary delay in completing the ASW assessment process.

A regional GAIN audit was undertaken in 2015 and has identified areas for improvement which the Trust will be working on during the incoming year:

Next Steps

- Develop and co-ordinate inter-agency training resources
- Develop a process for identifying beds used by service users outside South Eastern Trust
- South Eastern Trust ASW report format to be adopted regionally
- Explore the implications for the nearest relative being involved in the detention process

Promoting Continuous Professional Development in Social Work Practitioners

SOCIAL WORK LEADERSHIP

The Trust strategy for professional social work *Pride in Practice 2012–15* has been reviewed. Priorities for the social work profession are being developed for 2016-2019 linked to the regional Social Work Strategy "Improving and Safeguarding Social Wellbeing" 2012-2022.

Professional Social Work – Staff Support and Development

Professional Supervision

During this reporting year 74% of social workers received professional supervision within their work place. In those areas where regularity of supervision was not to the standard required, local improvement plans are implemented and are subject to monitoring by the Executive Director of Social Work.

In March 2015 a study entitled "What is Excellent Supervision" was undertaken with Queens University and residential child care social work staff in the Trust. The findings have informed the development of a supervision model and supporting documentation for residential child care staff which will be tested during 2016/17.

Assessed Year in Employment

Facts & Figures

- 94% received full induction.
- 94% received regular professional supervision
- 100% managers discuss AYE procedures in supervision.

Newly qualified social workers spend their first year in an "Assessed Year in Employment" (AYE). The 2015/16 AYE audit of the Trust's compliance with the Northern Ireland Social Care Council (NISCC) standards highlighted that social workers in their assessed year in employment within the Trust are well supported.

Continuous Professional Development

When Social Workers have completed their Assessed Year in Employment, they are required to complete further professional development achieving two requirements of the "Social Work Consolidation Award". The Trust continues to support social workers to complete the Initial Professional Development programme and other approved programmes. Social workers are achieving their consolidation award within three years and so achieving 100% compliance with the NISCC standard for professional development.

During 2015, Professionals in Practice (PiP) was introduced by NISCC with a wide range of programmes to enhance social work professional practice and competence. A total of eighteen successful social workers from the Trust achieved their Professional in Practice Social Work Awards.

Implementing Quality Improvement

Social work staff continue to engage in quality improvement through skilling its workforce in the use of a range of improvements tools which are applicable to social care settings and contribute to the effectiveness of social work services.

An exciting new development this year has been the introduction of a new regional quality improvement programme funded by the Social Work Strategy, which has been co-ordinated and delivered by South Eastern Trust staff.

The Quality Improvement in Social Work programme commenced in January 2016 and will finish in October 2016. The programme, with twenty-two participants from all five Trusts and a voluntary organisation is focused on skilling front line practitioners to make improvements on the care they deliver. Improvement initiatives have included improving experience of young people in their review meetings, improving the experience of care planning in a day care setting, and co-production of a carer assessment tool within a voluntary sector setting.

Course participants attend teaching on Human Factors with Phil Higton

Adult Social Care Services Theme 2:
Delivering Best Practice in Health and Social Care

The Trust look forward to the final award event in October when all participants will share their improvement initiatives and their learning in quality improvement across all the Trusts.

Social Work Research

The Trust continues to support staff in line with the regional ***Social Work Research and Continuous Improvement Strategy*** and its own ***Research in Practice 2014 – 2017*** strategy.

The Trust is keen to promote practice that is informed by the best evidence currently available and is pleased that three candidates have recently completed the Evidence Informed
Practitioner and Organisation module at the University of Ulster.

We are also delighted that Susan Ritchie from the Social Services Learning and Development team was awarded the Dr Diana R. Jones Memorial Bursary from Queens University for her final year dissertation, which examined the impact of bureaucracy on the social work profession.

The Trust is a key partner in the bi-annual DARE international conference that promotes research relating to decision making, assessment, risk and evidence based practice in social work. The conference was held in July 2016 and a number of seminars were facilitated to promote the DARE themes.

In addition, the bi-monthly Lessons Learned bulletin provides staff in children's services with key messages from audit findings, complaints, judicial reviews, case management reviews and research findings.

Social Work Finalists in Regional Social Work Awards

During 2016 a number of social workers have been short-listed in the Regional Social Work Awards which will be held in November 2016. The Trust nominations are:

- The Regional Adult Safeguarding Training Programme - Team Award
- Jane McCullogh – Learning & Development Individual Award
- Pauline Thompson - Learning & Development Individual Award
- Rosalyn Anderson – Lifetime Achievement Award

APPENDICES

ANNUAL QUALITY REPORT 2015/16 NEXT STEPS SUMMARY

Theme	Title	Next Steps
Goal 1: Transforming the Culture	Vision of the Trust	• The Trust will be conducting an exercise to refresh the values in 2016/17 with all staff • The Trust will also be producing a new Corporate Plan which will include a new vision statement

	Patient & Client Experience	**Patient & Client Experience Monitoring**
		Recently-introduced and planned enhancements include:
		- Comprehensive programme across a wide range of services
		  • Full integration to co-ordinate Patient & Client Experience Standards monitoring with 10,000 Voices Programme to deliver upon Trust Patient Experience Framework – with appropriate alignment to regional priorities / programme / framework
		- Co-production approaches with Users and across teams
		  • Planning workshop at 6 monthly CONNECT Event for Users and Staff
		  • Experience Book for service users to provide helpful information for staff and patients
		  • Expert Patient Support Role through patients who have experienced service / treatment / condition supporting following patients
		  • Listening Project for audio collection of patient stories to be reproduced as themed recording sets
		
		10,000 Voices:
		• The Trust will continue its commitment to the 10,000 Voices initiative and will deliver on the areas agreed in the regional work plan
		• The Safe and Effective Care team will explore ways to integrate 10,000 Voices with the web based electronic reporting system and other sources of information in relation to patient and client experience
		
		PPI:
		• The Trust will begin rolling out the e-learning training across the Trust
		• A revised PPI Strategy will be produced in 2016/17

	Complaints & Compliments	• In the incoming year we plan to run a series of bespoke training days for our staff who investigate complaints in relation to effective complaints response writing • We have an ongoing survey asking people who have complained to tell us about their experiences of using the complaints process, and we will review the method of collecting this feedback • We will implement any service improvements / recommendations identified from the planned internal audit
	Incidents/SAI's	• Continue to promote and further embed an open, no blame, learning culture that supports reporting of adverse incidents including Serious Adverse Incidents to include the implementation of the DatixWeb Incident Module Trust-wide • Continue to learn from all types of incident and ensure that when changes to policy, procedures and/or practice are recommended following an incident that these are fully implemented within the organisation; • Review on an on-going basis the extant incident policies and procedures in light of reviews of existing systems

		both internal to the Trust and any new regional guidance
	How the Organisation Learns	SQE Leadership WalkroundsTM • Review the documentation to ensure it is relevant • Follow up with a feedback survey to the walkround participants • Ensure the cycle for each walkround is completed • Provide quarterly feedback to the Executive Management Team
	Quality Improvement	• To develop a Quality Improvement Academy to support the delivery of training across all levels of the Q2020 Attributes Framework • To expand the Quality Improvement Clinics to meet the demand • To build and develop on the existing networks working collaboratively to ensure QI remains a priority for organisations across the UK
Goal 2 **Strengthening the Workforce**	Induction	Over the next year the Trust will: • Review and evaluate the completion of the blended learning approach • Roll out a new eLearning platform to improve access for the blended learning approach • Review content delivered through Corporate Induction to ensure it is fit for purpose
	IIP	• The 2014-17 rolling programme will complete with assessments in October 2016 and February 2017 • A revised IiP Framework will be implemented April 2017
	Mandatory Training	• The 2014-17 rolling programme will complete with assessments in October 2016 and February 2017 • A revised IiP Framework will be implemented April 2017
	Staff Achievements	Nursing: • Facilitation and Leadership module running again October 2016 – March 2017 • iMPAKT study to commence September 2016 (completing February 2018) • GWB learning sets project to complete September 2017
	Looking After Your Staff	**Smoke Free Sites** • Embed the culture of Smoke Free HSC Sites across the organisation and with our users, clients, visitors and volunteers • Continue to provide Smoke Free Service which is evidence based and accessible to all staff and clients / patients • Work with Adult Services Directorate to carry out a consultation with Mental Health Clients/ Users to agree the way forward in relation to Smoke Free within Acute Mental Health Settings • Promote Brief Intervention Training with staff and continue to provide Stop Smoking Clinics which are tailored to the needs of staff **Building resistance and managing stress** Continuing to use a collaborative approach the Trust will: • Evaluate the effectiveness of SMART training • Continue to roll out both programmes over all Trust sites ensuring as many staff as possible can avail of the training • Develop additional resources to support staff and managers e.g. mobile phone app
	Revalidation	**Medical Staff:** • During the next year, the Office of the Medical Director will conduct several quality assurance mechanisms.

		This will include issuing Appraisal Feedback Questionnaires. Responses will be analysed and a report will be compiled which will be used to further inform appraiser up-date training • The Trust will closely monitor reasons for revalidation deferral requests from all doctors and take appropriate action to ensure these are minimised. This will include more detailed provision of information to Clinical Leaders in relation to doctors due to revalidate within the next 12 months **Nursing Staff** • On-going support for registrants approaching revalidation and those line managers acting as confirmers, to ensure 100% compliance with NMC requirements
	Staff Support and Development	Reducing the Risk of Hyponatraemia • CEC continue to roll out IV Fluid training for nursing staff • CEC commissioned to roll out Fluid Balance Chart completion for HCA's • Fluid Balance Chart Audit planned for November 2016
	Improving Attendance at Work	• The Trust absence figure at the end of March 2016 was 6.77% which fell short of the DOH target. In response, the Trust will continue during 2016/17 to work in partnership with trade union side to improve the Health and Wellbeing of staff which should in turn have a positive impact on attendance.
Goal 3 **Measuring the Improvement**	Infection Rates	**Urinary Catheter Management** • Review methodology and re-audit urinary catheter device management **Peripheral cannula care** • Undertake further work to ensure the most suitable access device is chosen for individual patient's needs • Raise awareness to ensure a review and prompt removal of devices that are no longer required • Undertake a review of blood sampling practice **Reducing Healthcare Acquired Infections:** • Clostridium difficile • Continue detailed review of CDI cases • To work with PHA and improve liaison with GPs on CDI trends and antimicrobial prescribing • Continue work to optimise hospital antimicrobial prescribing and minimise the impact on CDI **MRSA bacteraemia** • Continue to support the work of healthcare staff in the management of invasive devices • Continue to identify and manage patients 'at risk' of MRSA to avoid bacteraemia **Hand Hygiene**: • Continue validation audits and work with staff to maintain attention on good hand hygiene in the care of our patients. • To maintain a focused interest in hand hygiene compliance amidst other service pressures. • Reinforce to staff that differences of more than -5% need to be addressed. • To update computer systems and provide a reporting template which communicates the improvement plan to staff.

		Hospital Services:- Monitoring Surgical Site infection & Surveillance of Critical Care Infections **Orthopaedic Wound Infection Surveillance** • Continue to monitor infections and feedback findings to surgeons and clinical teams in order to share learning **Caesarean Section Wound Infection surveillance** • Review and publish a leaflet for women on the management of their wound post C-section in order to reduce infection • Continue with an education programme for midwives to maintain awareness of the definitions of wound infection and ensure accurate reporting • Work regionally with colleagues and the Public Health Agency to introduce electronic methods of collecting information relating to C-section wound infection. **Surveillance of Critical Care Unit Infection** Continue to maintain all good practice within the unit and ensure compliance with the implementation of "care bundles" (check lists which help focus adherence on ensuring that practices linked to reducing infection are in place) are maintained
	Safer Surgery / WHO Checklist	• Move to Theatre Management System (from paper) for recording checklist completion • Formal launch of SSC policy Ongoing SQE projects to audit and improve standards of checklist performance
	Falls	• The use of the falls prevention bundle of care aims to continue to reduce the risk of inpatient falls across the adult inpatient wards • The Trust will continue to share learning and provide awareness for staff to reduce the number of inpatient falls • The Trust will continue to focus on monitoring and measurement of the FallSafe Bundle in all Adult Inpatient Wards
	Pressure Ulcers	• Work towards obtaining consistency in compliance with the 'SKIN Bundle' • Continue to monitor and report the number of pressure ulcer incidents, including the number of severe pressure ulcers (grade 3 & 4) which were considered unavoidable. • Work towards reducing the number of severe facility acquired pressure ulcers. • Maximize learning from each incident of severe pressure damage. • Continue to provide mandatory pressure ulcer education and bespoke training in specific clinical areas as determined through analysis of incident reports and KPI data. • Continue to monitor the impact of ED specific SKIN bundle in UHD & Downe hospital & implement in LVH ED. • Complete pilot of primary care SKIN Bundle & collaborate on regional KPI for this patient population. • Continue to recognise ward staff for their achievements in providing pressure ulcer free care.
	VTE	• Work bespoke to LVH/Downe hospital commencing soon to improve compliance with VTE risk assessment • Compliance results forwarded for discussion at monthly audit/SQE meetings to encourage action planning to improve and sustain compliance
	Medicines Management	**Medication Safety** • Electronic whiteboards will allow tracking of medicines reconciliation in real time. This will help improve the

		efficiency of the service by allowing us to better prioritise patients on the basis of need. • 7 day working is being piloted in the admission team. • Pilot of pharmacist on post-take ward rounds is planned. • Increasing the use of non-medical prescribing continues. • Work with commissioners to ensure all ward areas are funded to provide a clinical pharmacy service. **Omitted Doses:** • The next Trust-wide omitted doses audit is due before the end of 2016 • Further analysis of the nursing key performance indicator results. • Roll out of Pharmacy LEAN project • Report on Omitted Doses in Prison healthcare and identification of quality improvement opportunities.
	MUST	• Continued emphasis on protecting each individual's mealtime, especially in terms of assistance with eating and mealtime interruptions • Observational mealtime audit in line with RQIA requirements • Medical student training – dietetics are in discussions to ensure that training to raise awareness of risk of malnutrition and other nutritional issues among medical staff • Pilot of an internal volunteer system for mealtime assistance with eating to be piloted in Care of the Elderly
	Cardiac Arrest Rates	Timely recognition of the deteriorating patient remains a priority for Trust staff. During 2016/17 the Trust will continue to: • enhance staff skills in recognising the deteriorating patient • promote the importance of effective communication • promote the importance of escalating concerns appropriately We will do this by providing Sharing and Learning sessions, Improvement Workshops and bespoke initiatives and training for specific wards and departments. The Trust will continue to focus on monitoring and measurement of the Regional National Early Warning Scoring system (NEWS) Key Performance Indicator (KPI) in all Adult Inpatient Wards.
Goal 4 **Raising the Standards**	Standardised Mortality Ratio	• Over the period 2016/17 the Trust will continue to monitor the monthly RAMI and undertake a case note review on any patient deaths that are identified as unexplained or unexpected
	Emergency Department	• Further development of the Urgent Care Work stream to improve 4 hour performance • Improve patient experience and clinical outcomes • Further explore the development of work around the Frail Elderly work stream
	NICE Guidelines	• Continue to submit all reports as requested • Audit guidance that is compliant for more than six months • Continue to actively participate in the NICE managers forum

	National Audits	**National Inpatient Falls Report** ***Key Recommendations:*** • All Trusts and Health Boards should have a board-level falls steering group and a falls multidisciplinary working • Trusts and Health Boards should regularly audit the use of bed rails against their policy and embed changes to ensure appropriate use. *SETrust have undertaken a Bedrails audit in 2013 and again in 2015* • Trusts and Health Boards should review their MFRA and associated interventions to include all domains in this audit ***Key Indicator Recommendations*** • All Trusts and Health Boards should review their dementia and delirium policies to embed the use of standardised tools and documented relevant care plans. *The Trust is participating in a general ward collaborative that is developing guidance around delirium, a delirium tool and awareness campaign.* • All patients aged over 65 years should have a lying and standing blood pressure performed as soon as practicable, be assessed for visual impairment, have a medication review and have a continence care plan developed if there are continence issues • Trusts and Health Boards should develop a workable policy to ensure that all patients who need walking aids have access to the most important walking aid from the time of admission • All Trust and Health Boards should regularly audit whether the call bell is within reach of the patient **GAIN: Appropriate use of AntiD Immunoglobulin in Pregnant Mothers** • All qualifying women who undergo surgical or medical management of early pregnancy loss or who suffer pregnancy loss after 12+0 weeks of gestation should be administered an appropriate dose of anti-D Ig. • 1500 IU of anti-D Ig should be offered to all qualifying RhD negative women between 28+0 and 31+0 weeks gestation. • Potentially sensitizing events should be managed by prompt administration of anti-D Ig at an appropriate dose for gestational age. • The correct dose of anti-D Ig should be given to all qualifying women within 72 hours of delivery. Anti-D Ig should not be given to RhD negative women when it is confirmed that they have delivered only RhD negative babies. • A Kleihauer test is required when a potentially sensitizing event has been identified in a RhD negative woman at 20+0 weeks of gestation or later. A maternal blood sample for this test should also be taken 30 to 120 minutes following delivery in a RhD negative woman. • Consent must be obtained from all women for the administration of anti-D Ig and evidence of this process must be documented in the clinical notes. The batch number of all doses administered must also be recorded.
Goal 5 **Integrating the Care**	Community Care	**Enhanced Care At Home** • Continue to raise awareness and promote ECAH service both internal & external to Trust to increase referrals • Targeted approach to Nursing / Care Homes for ECAH case management / referrals for specific high users of Emergency Department / acute admissions.

		• Develop referral pathway for GPOOHs service to ensure 7 day week referrals • Continue to raise awareness with GPs using practice based learning days • Increase capacity within community nursing service to administer increased intravenous anti-biotics • Liaise closely with hospital colleagues to create a seamless service of case finding both to prevent admission and facilitate early discharge **Home Oxygen Service Assessment & Review** • As the service progresses comment cards will be given to patients attending the home oxygen clinic to complete. Responses will be collated to obtain feedback on the new service & identify opportunities for improvement. Patient stories will be sought at agreed intervals. • Patient satisfaction surveys and patient stories will also be completed for the year end evaluation. • A patient has consented to sharing their oxygen story and details have been forwarded to the ICP project lead to consider filming a user experience video "Living Life with Oxygen"
	Mental Health	• Provision of low intensity psychological therapies throughout acute mental health services the three inpatient wards, three crisis resolution home treatment teams (CRHT) and the three mental health day hospitals (MHDH) The effective treatment intervention is now being spread to the other inpatient wards through the training and recruitment of a full time Psychological Wellbeing Practitioner. As well the training and provision of evidence based low intensity psychological interventions throughout acute community services (CRHT and MHDH)
Children's Social Care Theme 1 **Effective Health & Care**		**Protecting Children at Risk** • Develop innovative approaches to hear the experiences of children and families Children's Services Family Support Hubs • Continue promoting the benefits of this service with professionals across the Trust. • Produce improved promotional materials. • Continue to develop outcome measures **Looked After Children** • To continue to improve children's' participation in their looked after reviews. A dashboard of key elements has been agreed and is being tested in preparation for each child's review • To progress improvements on contact arrangements for children in care **Ensuring Permanence Plans for Looked after Children** • From January – December 2016 the Trust is involved in a Care Proceedings Pilot which aims to achieve permanence for children at the earliest point. An evaluation will be undertaken in 2017 **"Home on Time" Project** • The project will be promoted and shared across all social work teams in the Trust
Children's Social Care Theme 2 **Delivering Best**		**Direct Payments for Children** • The process of implementing SDS is well underway in children's services and all plans are currently under review with the intention of moving towards the SDS model. This will be well embedded by 2017

Practice in Safe Health & Social Care		**Education and Training for Young People Leaving Care** • The Trust will continue to provide a comprehensive person-centred Employability Service offering opportunities in traineeships, apprenticeships, work placements and in-education work experience schemes • Young people will be supported by specialist mentors and 16 plus teams to progress into a range of employability programmes and to attain the appropriate support as and when required • To use film with the Educational Shakespeare Company to engage young people in preparation for adulthood and independence **Transition for Children with a Disability** • The Trust continues to work in partnership with parents, carers, schools and specialist voluntary sector organisations to enhance transition planning and opportunities for meaningful engagement in their communities and workplace • A Trust working group has been established to improve early identification and information sharing to enable a creative transition process for young people. A children's school liaison social worker and an adult transition social worker will be identified • A working group is in place to identify the needs of children with a challenging behaviour and it is envisaged that a seamless intensive support service between children and adults will be established into 2017
Adult Social Care Theme 1 Effective Health & Care		**Adult Safeguarding** • Recruitment to a specialist Gateway team will be progressed this year • Adult safeguarding information will be included in talking newspapers • Collaborative working with the Ulster Bank and other financial agencies to increase detection of financial abuse **Carer Support** • Trust staff to continue to continue to promote the benefits of carer assessment • Consult with carers on their views of the support offered to them • Continue to extend the Short Breaks Initiative developed in partnership with local community pharmacists across the Trust **Re-settlement of Adults with a Learning Disability** • The Trust will continue to focus on the resettlement of the remaining four people in hospital who will require bespoke services in the community • We will continue to extend living options and schemes based on identified needs in partnership with other private and voluntary providers, housing associations, the Housing Executive and Supporting People to meet these challenges

Adult Social Care Theme 2 **Delivering Best Practice in Safe Health & Social Care**		**Direct Payments and Self-Directed Support in Adult Services** • The Trust is committed to increasing the flexibility of social care support through embedding Self Directed Support across all programmes of care **Annual Health Checks for Adults with Learning Disabilities** • The Trust will continue to work with health development agencies to encourage health promotion for people with learning disabilities • The Trust will continue to provide training for staff and carers on healthy options for people with learning disabilities • The Trust plans to increase the number of health action plans for people who have been health screened
Social Care Indicators		Approved Social Work • Develop and co-ordinate inter-agency training resources • Develop a process for identifying beds used by service users outside South Eastern Trust • South Eastern Trust ASW report format to be adopted regionally • Explore the implications for the nearest relative being involved in the detention process

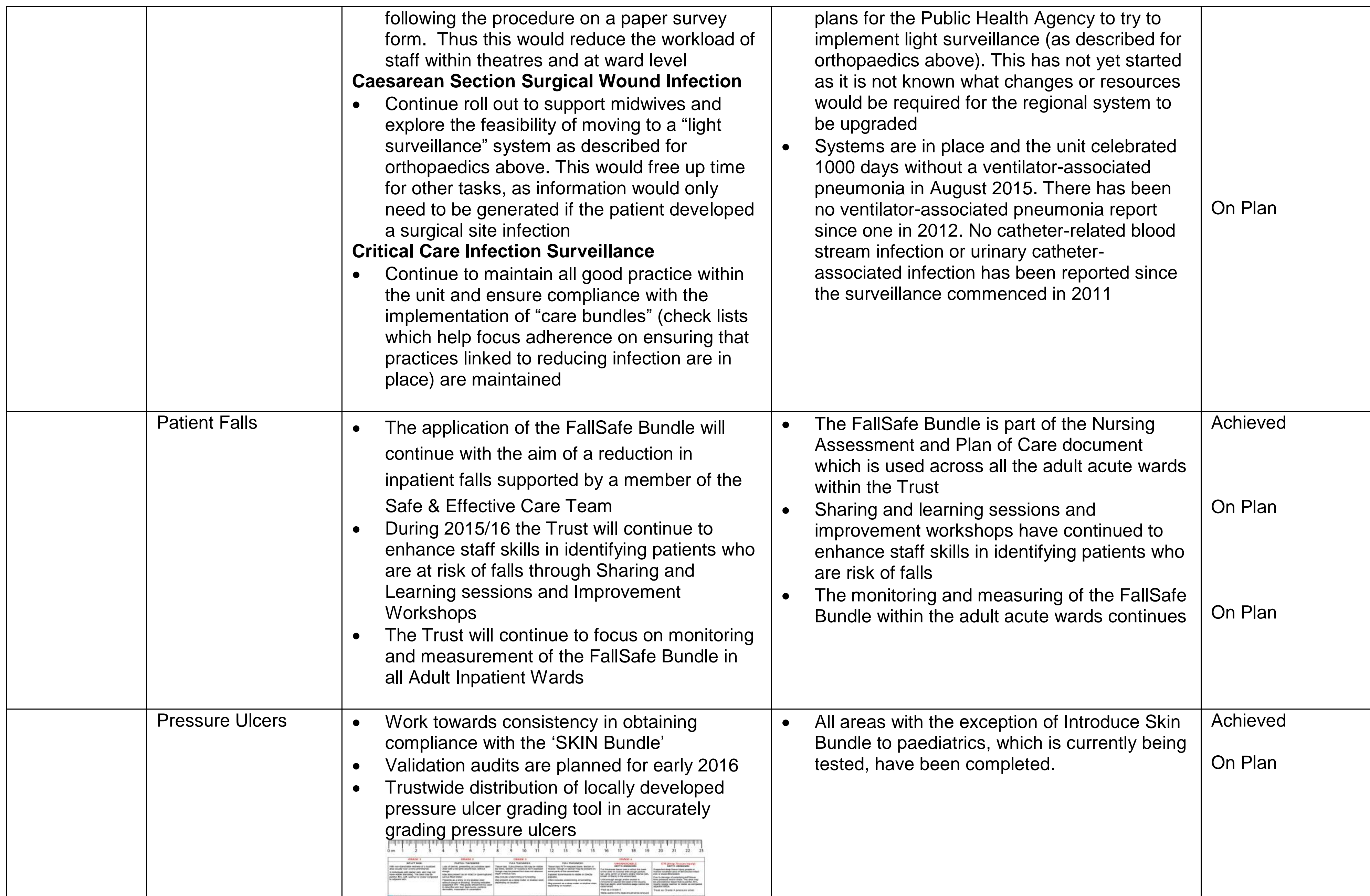
ANNUAL QUALITY REPORT 2014/15 NEXT STEPS UPDATE

Theme	Title	Next Steps AS AGREED NOVEMBER 2015	UPDATE POSITION AS OF NOVEMBER 2016	STATUS ACHIEVED/ON PLAN/ CLOSE TO TARGET/ BEHIND PLAN
Theme 1 **Effective Health & Social Care**	Standardised Mortality Ratio (SMR)	• Over the period 2015/16 the Trust will continue the process of validation to review cases which would indicate an unexpected death based on diagnosis or prognosis. This information is considered at Governance Committees and investigated further or learning shared as appropriate	• Over the period 2015/16 the Trust continued to validate cases which indicated an unexpected death based on diagnosis or prognosis. This information was considered at Governance Committees no further investigations were required over this period	Achieved
	Audit	• Building on the success of previous years, the Trust plan to hold the 3rd Annual Multiprofessional Audit Conference in May 2015 in the Quality Improvement & Innovation Centre (QIIC) • The Trust participated in the data collection phase of the Northern Ireland Audit of Dementia led by University College Cork. The anticipated report from this audit is due to be published early in the 2015/2016 year • Work will continue in the development of Trustwide and bespoke KPIs. For example, the KPI looking at Omitted Medications currently in its pilot phase will be rolled out to all Trust wards in September 2015 • Audit staff will support Audit Convenors to develop and maintain their bespoke audit plans for their area of work to support SQE plans through QI approach	• The Trust held a very successful Annual Multiprofessional Audit Conference in May 2015 in QIIC. The plan is to hold/participate in a similar event within the Trust during the 2016/17 year • The overall Northern Ireland Audit of Dementia report, along with Trust specific audit results, was received in July 2015 • The Omitted Meds KPI was successfully rolled out to all Trust wards during September 2015. New and existing KPIs continue to be developed across the Trust • Audit staff have developed electronic audit plans alongside the Audit Convenors that are bespoke to their areas of work and are easily updated and maintained	Achieved Achieved Achieved Achieved

	Social Care Indicators Protecting Children at Risk	• The Trust would like to develop opportunities to hear from children and their parents about their experiences of working with child protection professionals. In this forthcoming year the Trust is collecting data from service users on their experience of the child protection processes in which they were involved	• The Trust is working in partnership with QUB to test an app to collate the experiences of service users using child protection services. Two teams are currently taking this forward • Service user story on video completed of their experience of child protection services – improvement action plan developed	Behind plan On plan
	Children's Services Family Support Hubs	• Promoting the benefits of this service with professionals across the Trust • During this year outcome measures will be developed.	• Co-ordinator attends team meetings and events in the • Hub leaflet has been produced and is in the process of being circulated across the Trust • Information on the Hub is on www.familysupportni.gov.uk and regularly updated for families to access • New terms within service level agreements for Hub providers will require them to use a specific suite of outcome measurements and submit the information regularly on their outcomes. To be advertised in 2017. • Service user feedback family sample questionnaires now completed – 6 • Discussion ongoing about increasing service user feedback	Achieved Achieved On plan
	Looked After Children	• The use of the Momo App will be extended to other teams within the Trust. This will ensure that review meetings listen to the voice of the child An improved format of review meetings will be tested to encourage attendance and participation of young people.	• An improvement group has been established to focus on improvements to the LAC review process for children and young people	On plan
	Ensuring Permanence Plans for Looked After Children	• Staff have been appointed to lead this project • Information on this new project will be shared across all Social Work teams in the Trust	• All teams have been informed and APSW emailed every month to ensure they invite to all pre-birth planning and pre-birth conferences • Senior practitioner also visits staff teams on regular basis across the Trust	Achieved

	Adult Safeguarding	• The Trust has developed a checklist to alert staff and services to potential increased risk of abuse among vulnerable adults. This is being evaluated and it is hoped to be shared regionally • The Trust is exploring the use of 10,000 Voices Project to seek service user feedback through their stories. A questionnaire is being developed in consultation with service users which will be tested • The Trust has developed an accredited training programme on Adult Safeguarding for social workers which will be piloted in 2015/16.	• Checklist is now regional checklist • 10,000 voices project for older people is now a regional priority • Adult safeguarding programme developed and in use regionally. This programme has been short-listed for a social work award	Achieved On plan Achieved
	Carers Assessment	• Trust staff to continue to promote the benefits of carer assessment • Continue to raise awareness of the needs of carers from black and minority ethnic groups • Extend the Short Breaks Initiative piloted by Mental Health in partnership with local community pharmacists across the Trust.	• Trust staff continue to promote benefits of carers assessments, with an electronic system monitoring reasons for decline • Regional group established and needs of carers from black and minority ethnic groups promoted at all professional forums in the Trust and included in carer assessment training • Rolled out across all pharmacy's across the Trust • Business cards in all Pharmacy's to promote carer needs, their health and wellbeing, and short break initiative	On plan On plan On plan
	Re-settlement of Adults with a Learning Disability	• The Trust will continue to focus on the resettlement of the remaining six people in hospital who will require bespoke services in the community. We will develop and extend living options and schemes based on identified needs in partnership with other providers and housing bodies to meet these challenges	• Resettlement officer continues to focus on developing bespoke community living options; two people have been re-settled and four remain to be resettled	On plan
Theme 2 **Delivering Best Practice in Safe Health &**	Cardiac Arrest	• Timely recognition of the deteriorating patient remains a priority for Trust staff. During 2015/16 the Trust will continue to enhance staff skills in the recognition of the deteriorating patient and effective	• Timely recognition of the deteriorating patient continues to form an important competency of Immediate Life Support courses, where all registered nurses are formally assessed. Discussion based sessions are included in	On Plan

Social Care Settings		communication in escalating concerns appropriately through Sharing and Learning sessions, Improvement Workshops and bespoke initiatives with identified wards • The Trust will continue to focus on monitoring and measurement of the Regional National Early Warning Scoring system (NEWS) Key Performance Indicator (KPI) in all Adult Inpatient Wards	BLS classes and as part of the e-BLS programme on i-connect, available to all grades of staff. Presentations on the deteriorating patient take place at QI workshops through-out the year and bespoke sessions have been delivered to our colleagues in Prison Healthcare through lunch and learn afternoons • Regular audits measuring compliance in NEWS continue to be fed back to SEC and measuring of Cardiac Arrests/1000 discharge are currently 1.2% • NEWS and Cardiac Arrest KPI continues to be measured and identified learning actioned	On Plan On Plan
	Reducing Healthcare Associated Infections	A post-infection review (Root Cause Analysis) is carried out following *Staphylococcus aureus* bloodstream and *Clostridium difficile* infections to identify any areas for learning. The outcome of the investigation is shared with Clinical Teams, across Directorates at Governance meetings and via newsletters to further enhance practice and patient care: • To further embed the care management of vascular access and invasive devices and reduce the incidences of false-positive blood cultures • To measure compliance with MRSA screening guidelines.	• Root cause analysis case reviews have continued through the year and learning identified for relevant clinical teams and shared through directorate newsletters and comprehensive annual reports on Clostridium difficile and MRSA bacteraemia have been shared with clinical teams • Work has continued to reduce the contamination rates (false positives) in blood cultures. The accumulative contamination rate (for all wards/depts.) has dropped from that of 5.1% in Dec 2014 to 3.1% in May 2016 with 27 areas having a contamination rate of 0% from the start 2016 to end of May 2016 • MRSA screen compliance has been monitored as part of a regional PHA lead survey and will be reviewed again this year by the Trust's IPC team	On Plan On Plan On Plan
	Surgical Site Infection Surveillance	**Orthopaedic Surgical Site Infection** • The plan is to introduce a "light surveillance" system whereby much of the data is extrapolated from the Trust electronic theatre management system. Hence staff will no longer have to collect the data on each orthopaedic procedure in theatre and	• A light surveillance system has been implemented into orthopaedics. Much of the detail is now taken from the Theatre Management system. This has reduced the work load of staff in theatres and at ward level • Work continues. The number of post discharge infections has reduced. There are	Achieved On Plan

		following the procedure on a paper survey form. Thus this would reduce the workload of staff within theatres and at ward level **Caesarean Section Surgical Wound Infection** • Continue roll out to support midwives and explore the feasibility of moving to a “light surveillance” system as described for orthopaedics above. This would free up time for other tasks, as information would only need to be generated if the patient developed a surgical site infection **Critical Care Infection Surveillance** • Continue to maintain all good practice within the unit and ensure compliance with the implementation of “care bundles” (check lists which help focus adherence on ensuring that practices linked to reducing infection are in place) are maintained	plans for the Public Health Agency to try to implement light surveillance (as described for orthopaedics above). This has not yet started as it is not known what changes or resources would be required for the regional system to be upgraded • Systems are in place and the unit celebrated 1000 days without a ventilator-associated pneumonia in August 2015. There has been no ventilator-associated pneumonia report since one in 2012. No catheter-related blood stream infection or urinary catheter-associated infection has been reported since the surveillance commenced in 2011	On Plan
	Patient Falls	• The application of the FallSafe Bundle will continue with the aim of a reduction in inpatient falls supported by a member of the Safe & Effective Care Team • During 2015/16 the Trust will continue to enhance staff skills in identifying patients who are at risk of falls through Sharing and Learning sessions and Improvement Workshops • The Trust will continue to focus on monitoring and measurement of the FallSafe Bundle in all Adult Inpatient Wards	• The FallSafe Bundle is part of the Nursing Assessment and Plan of Care document which is used across all the adult acute wards within the Trust • Sharing and learning sessions and improvement workshops have continued to enhance staff skills in identifying patients who are risk of falls • The monitoring and measuring of the FallSafe Bundle within the adult acute wards continues	Achieved On Plan On Plan
	Pressure Ulcers	• Work towards consistency in obtaining compliance with the ‘SKIN Bundle’ • Validation audits are planned for early 2016 • Trustwide distribution of locally developed pressure ulcer grading tool in accurately grading pressure ulcers 	• All areas with the exception of Introduce Skin Bundle to paediatrics, which is currently being tested, have been completed.	Achieved On Plan

		• Trustwide questionnaire designed to evaluate the effectiveness of the pressure ulcer grading tool • Evaluation of pilot • Collaborate regionally to address pressure ulcer prevention in hospital Emergency Departments • Introduce Skin Bundle to paediatrics		
	Medication Safety	• Further work to spread the use of the nursing tool to measure omitted doses • Collaboration with the regional IT team at BSO to improve communication around patients medicines between primary and secondary care • New projects on improving the use of high risk medicines such as insulin and anti-coagulants	• The Omitted medication KPI has been spread to all wards, results are monitored and shared with staff on a monthly basis. Next steps: Work on providing further guidance for staff re the KPI; add updated critical medications to the KPI • Work progressing with BSO to tag red list drugs on ECR • Work progressing	On Plan On Plan On Plan
	Innovative Neuro-modular Treatment for Bladder and Bowel Dysfunction	• Although still in its infancy, this pilot study has shown some exciting results for patients who otherwise would have required more expensive and invasive options • All patients found the treatment to be a pleasant experience; and no patients dropped out of the pilot once treatment was initiated • However, to continue with this project, the Continence Service would require to attract recurrent funding to ensure more patients have the opportunity to access this new treatment option	• We have been unable to take on a any new patients for this treatment unless they have been able to self fund, as we have been unable to attract recurrent funding. • The patients who are currently receiving PTNS are those patients who have completed their 12 weeks treatment, and attend 6 - 8 weekly for a "top-up" session to keep them symptom free • We have created a waiting list for those patients unable to self fund	Behind plan
	Social Care Indicators • Direct Payments for Children	• The Trust continues to promote direct payments in lieu of direct service delivery to develop sustainable flexible supports to carers. This will be further enhanced through the Trusts commitment to the development and roll out of Self Directed Support (SDS) in 2015/16 • The Trust has appointed an Implementation Officer and Practice Development Officers to promote and embed Self Directed Support • Staff training and implementation will be a	• Direct payments for children have increased and continue to be promoted with teams and at professional forums • The role of the implementation officer is well established • Staff training on implementing Self – directed support has been carried out across children's services • Implementation of an SDS support plan has commenced	On plan Achieved Achieved On plan

		focus in 2015/16		
	• Educate and Training for Young People Leaving Care	• The Trust will continue to provide a comprehensive person-centred Employability Service offering opportunities in traineeships, apprenticeships, work placements and in-education work experience schemes • Staff will continue to work on an outreach basis and deliver a structured personal development and employability scheme in the community • Young people will be supported by specialist mentors and 16 plus teams to progress into a range of employability programmes and to attain the appropriate support as and when required	• The number of young people in care in apprenticeships and employment has increased • New employment opportunities have been secured • Creative methods of engaging young people have been developed • Specialist mentors in place	On plan On plan Achieved
	• Transition Planning for Children with a Disability	• The Trust continues to work in partnership with parents, carers, schools and through service level agreements with specialist voluntary sector organisations to enhance transition planning and opportunities for meaningful engagement in their communities and workplace • A Trust working group has been established to improve early identification and information sharing to enable a creative transition process for young people. A children's school liaison social worker and an adult transition social worker will be identified • An evaluation of families' experience of transition will be undertaken in 2016	• Monthly working group in place to match children to appropriate options for young people leaving school • Evaluation underway to be completed by November	Achieved On plan
	• Direct Payments and Self-Directed Support in Adult Services	• The Trust is committed to increasing the flexibility of Social Care Support to ensure that every person has choice and control of how their support is provided • The Trust has appointed an Implementation Officer and Practice Development Officers to promote and embed Self Directed Support across all programmes of care • To support staff teams, awareness sessions are on-going and regional training programs are being established to ensure a consistent	• The role of the implementation officer is well established • Extensive training has been delivered across all programmes of care • Practitioner forum well established to develop expertise in implementation of SDS	Achieved On plan Achieved

		training program across all Trusts • Management and practitioner forums have been established with representatives from all programmes of care in attendance to lead Self Directed Support		
	• Annual Health Checks for Adults with Learning Disabilities	• The Trust plans to continue to work with Health Development Agencies to encourage health promotion for people with learning disabilities • The Trust plans to provide training for staff and carers on healthy options for people with learning disabilities • The Trust plans to increase the number of health action plans for people who have been health screened	• The Trust health facilitator has worked with GP'S across Trust to encourage people with learning disabilities to receive an annual health check- 73% achieved • Training has been carried out with staff and carers • A number of health action plans in place	On plan On plan On Plan
	• Approved Social Work	• The Trust will participate in a Regional GAIN audit from August – October 2015 to identify and examine any possible sources of delay in the process of assessment for compulsory admission under the Mental Health (Northern Ireland) Order 1986 • The Trust will implement any necessary actions from the audit findings to ensure that any delay in the assessment process is minimised and any other issues identified in the audit are addressed	• Gain audit completed and recommendations made • Continued close monitoring of response times through ongoing monitoring of ASW Risk Assessment Reports + Liaison meetings with PSNI • Trust liaison meetings with PSNI established to promote better interagency working and clarity provided for Trust staff around designated "Place of Safety" within the Trust	Achieved On plan
Theme 3 **Protecting People from Avoidable Harm**	Adverse Incidents / Serious Adverse Incidents (SAIs)	• Continue to promote and further embed an open, no blame, learning culture that supports reporting of adverse incidents including Serious Adverse Incidents • Continue to learn from all types of incidents and ensure that when changes to policy, procedures and/or practice are recommended following an incident that these are fully implemented within the organisation; and • Review, revise and update the extant incident policies and procedures in the light of the Donaldson Report, The Right Time, The Right Place (December 2014) and any subsequent DHSSPS and/or HSCB directives and/or guidance	• Risk Management & Governance staff continue to promote and embed an open, no blame, learning culture that supports the reporting of adverse incidents including SAIs via various training sessions such as induction, practical manager, incident reporting training sessions. • Lessons learned from incidents are reported on a quarterly basis to the Lessons Learnt Sub Committee. Recommendations in respect of SAIs, in particular, are tracked until completed by the Risk Management & Governance Directorate. Directorates are responsible for implementing learning at local Directorate level	Achieved Achieved

			• The suite of incident policies and procedures are currently being revised and should be ready for consultation at end of Sept/early October 2016	Close to target
	Venous Thromboembolism (VTE)	• The Trust will continue to focus on monitoring and measurement of VTE in all Adult Inpatient Wards • Regular audit schedule for compliance of risk assessment for Day Cases • Development of Patient Education and Information Leaflet for use in Day Cases	• The Trust monitors results monthly and shares with audit convenors for discussion as applicable • The VTE risk assessment form has been amended recently and is in another pilot stage. We hope to have this finalised and shared with all DPUs by end Dec. the PHA VTE leaflet is in use in all DPUs. Audit of the VTE risk assessment will take place once the pilots have completed	Achieved Close to target
	Surgical Safety Checklist	• Launch of new policy and updated checklist in mid-2015	• New policy published - June 2016 • Updated checklists published and in use - March 2016	Achieved Achieved
	Hand Hygiene	• To update the Qlikview systems to make this information readily available to ward and clinical managers as well as the IPC team • To create a renewed interest in hand hygiene compliance and by default the dress code compliance. • Reinforce to staff that differences of more than -5% need to be addressed. • Update Qlikview to include correct directorates and be inclusive of all inpatient wards across the Trust	• The Qlikview HCAI Dashboard review and update work commenced July 2016 reporting has been aligned to directorates and through line management reporting rather than by hospital and location. Portions of this work should be complete before end of March 2017 • Hand Hygiene re-focus will commence with a 'hand on heart' approach to the uptake of hand hygiene opportunities in the third and fourth quarter of the year • IPCN access to comparison of independent scores against local ward audit scores is now attainable and this will also be made available to Ward managers as part of the re-configuration	On Plan On Plan On Plan
	Malnutrition Universal Screening Tool (MUST)	• Continue to train staff in the community, including domiciliary care staff and care managers to screen patients for malnutrition • Continued emphasis on ensuring that patients receive all assistance required at mealtimes, without interruptions • Ensuring that information about patients' nutritional care is shared with everyone	• Training in the community settings continues with nursing home staff and front line care workers. • Recent observational audit across sites and mealtimes showed that patients are receiving assistance as appropriate. In some areas there are still interruptions to the patients' meals and staff are working to keep these to a	On Plan On Plan

		involved in their care, whatever the setting	minimum. • Work continues to share nutritional care about patients, especially on discharge with district nursing and community care staff	On Plan
Theme 4 **Ensuring People Have a Positive Experience of Service**	Complaints /Lessons Learnt from Complaints / Compliments	• In the incoming year we plan to run a survey to ask our staff their views of our complaints process and how we may improve this service • We also have an on-going user survey asking complainants to tell us about their experiences of using the complaints process. The results will be analysed to see where improvements can be made • The Lessons Learnt Sub Committee will continue to meet quarterly to monitor learning from complaints	• •A staff survey showed our staff have a moderate knowledge of our complaints process. However, actions have been taken to improve staff support and training • Our online user survey asked complainants to tell us about their experiences of using the complaints process. The number of respondents was disappointing but we intend to review the methods used in an attempt to receive sufficient feedback to help improve our service • The Lessons Learnt Sub Committee met quarterly to proactively review and monitor learning from complaints	Achieved Achieved Achieved

	Patient Client Experience Standards
	• Patient/Client Satisfaction
		Patient & Client Experience Monitoring enhancements currently under consideration and/or development include:
		• Electronic bedside feedback facility
		• Development of patient experience app with three key feedback options
		  • Your Important Patient Experience Message
		  • Targeted Survey tailored to your current ward or service
		  • Set of mini question sets (Mixed Gender, Night-time, Introductions)
		• Partnership Approaches to Patient & Client Experience Monitoring (Patients, Service User Forum, Service Leads) – to commence with:
		  • Meals Focus
		  • Out of Hours Focus
		• New Primary Care Approach to include:
		  • Telesurvey
		  • Focus Group.
			• Electronic bedside feedback was successfully piloted over the first 2 quarters of 2015/16. The evaluation of the pilot have been presented at the regional Patient/Client Experience steering group led by the PHA. The development of the app has progressed but is currently on hold awaiting further decision
			• Throughout the year there were a number of successful inititives to ensure partnership working with User Groups and the Trust staff. These resulted in changes to how we provide our services.
			• Telesurveys were completed within Primary Care
				Achieved

	• 10,000 Voices Project	• The Trust remains committed to and will continue to participate in the 10,000 Voices Initiative	The 2016/2017 work plan for 10,000 Voices has been agreed by the regional Patient and Client Experience Steering group. Story collection is	Achieved

		• The areas for inclusion in the regional work plan for 10,000 Voices will be confirmed during Autumn 2015	ongoing in the following areas: • Unscheduled care • Experience of the Northern Ireland Ambulance Service • A generic story template (Health and Social Care in Northern Ireland) is also available Analysis of information received in relation to experience in the following areas is currently being undertaken: • Direct Access to Physiotherapy • Experience of children/young people/parents/carers who have accessed Paediatric Autism and Child and Adolescent Mental Health services The following projects are in the planning/pilot phase: • Eyecare services • Process of Adult Safeguarding • Experience of discharge from hospital • Experience of people with dementia	Achieved
	Emergency Department • Four/Twelve Hour Standard • Time from Arrival to Examination • Left before Treatment • Unplanned Re-attenders in the Emergency Department	• Further development of the Urgent Care Work stream to improve 4 hour performance; improve patient experience and clinical outcomes • Further explore the development of work around the Frail Elderly work stream.	• There is no change to the improvement plans / position for Nov 16. Work continues on these workstreams	On Plan
	Elective Access	Unfortunately due to an increase in cancer and urgent referrals the waiting time for routine referrals has increased substantially in the last year. The Trust continues to experience an increased demand for service and continue to	• Referrals continue to increase and therefore waiting times in all areas continue to increase • HSCB advise currently no money for elective	On Plan

		work closely with the Health and Social Care Board to: • Understand the increased demand • Plan for funding – both recurrent and non-recurrent to address the gaps • Use of the Independent Sector where appropriate	• IS resource ceases Sept 16	
Theme 5 **Resilient Staff**	Vaccinations	Staff attitude influences the uptake of Influenza vaccination. Education and encouragement regarding this subject needs to continue if Public Health targets for future winter Influenza vaccination programmes are to be met. We continue to strive to drive improvement in this area of Public Health	• Public Health Agency (PHA) set a target of 30% uptake of the flu vaccine among frontline healthcare workers (HCWs) for last year's winter season October 15 – March 16. The uptake for this Group of HCWs was 19.4%. • The planning for this season's flu vaccination programme is well underway and will commence week beginning 3rd October • PHA have set the target this year as 40% uptake	Not achieved
	Looking After Your Staff: Stop Smoking Service	The South Eastern H&SC Trust is committed to positively influencing the health and wellbeing of our own staff, patients and visitors. The Trust is committed to eliminating smoking on Trust premises and grounds to assist staff, patients and visitors in order to improve their health and wellbeing. The Smoke Free HSC Site objectives are to: • Save lives over the next decade by reducing exposure to hazardous second-hand smoke • Protect and improve the health of staff, patients/clients, visitors and contractor's by countering the health risks caused by tobacco smoke • Assist both patients and staff who wish to stop smoking by ensuring Stop Smoking Services are widely available to staff, patients and clients • Set an example of best practice • Reduce the risks to health from exposure to second-hand smoke • Increase the benefits of Smoke Free enclosed public places and workplaces for people trying	• The Stop Smoking Service is providing assistance and support to patients, clients ,users and staff to stop smoking. The service is delivered on 1:1 or in group sessions with follow up telephone / text support to clients. A variety Nicotine Replacement Therapy products are available to suit individual needs of the client • Staff wishing to quit can self-refer using a number of different referral methods and support is given in a location and time that is convenient for the staff member. • Smoke Free Sites • Much progress has been made towards Smoke Free Status. recently there has been a slight increase in the number of recorded challenges to persons smoking on the Ulster site which need to be addressed. This is a similar experience observed in other Trust • Directorates continue to take responsibility to ensure their staff, patient & clients in their care and their visitors are compliant with the statutory requirements and Trust Policy.	On Plan

		to give up smoking so that they can succeed in an environment where social pressures to smoke are reduced recognise a person's right to be protected from harm and to enjoy smoke free air.	Monitoring takes place by Directorates with follow up non-compliance when appropriate. Key Points • Wd11, Dementia Ward on the Downe Site, Wd 12, Wd 27, UHD, MH Inpatients (Downe), Wd 27 Downshire and Thompson House have been acknowledged as having an exemption from the Smoke Free Policy. A risk assessment is required to be completed for these areas • A group has been established in Adult Services to look at the implications and actions required as a result of the recent legal case taken against the Trust. • Each Directorate reviews its implementation plan • Smoking Warden post has been advertised but this is proving difficult to recruit to • Trust working with PHA regarding ongoing public communication • Cardiac Ambulance bay doors at the Ulster will have access control restrictions applied to prevent use by unauthorised persons; a risk assessment has been completed and ADs concerns were taken into consideration when developing control measures • The Stop Smoking Team supports the implementation of Smoke Free HSC Sites by providing Brief Intervention Training to all staff, working with PR / Communications to deliver effective messages to promote the service and improve the health and wellbeing of those working in and using South Eastern H&SC Trust • The team coordinate and deliver local community campaigns such as "Smoke Free Homes" in the Colin Area , this is a	

			partnership approach with Community, Voluntary and Statutory Organisations • Health Improvement Midwives deliver a stop smoking service to pregnant women and have designed, implemented and coordinated training, community initiatives and referral systems and as a result of these and the strong partnership working our smoking in pregnancy rates at booking has reduced from 15.4% to 12% (2105/16)	
	Revalidation of Medical Staff	• During the next year the Trust will continue to use a number of mechanisms to assure the quality of the revalidation process. These will include the random selection of a proportion of revalidation portfolios from each clinical leader, which will be audited by the Responsible Officer. In addition the Trust in conjunction with the HSC Leadership Centre, will deliver appraisal update training to ensure nominated appraisers remain suitably skilled and cognizant of their obligations	• Medical staff have been formally advised and a random selection of portfolio's identified for audit. • Two training sessions for new appraisers were delivered during April 2016 in conjunction with the HSC Leadership Centre • Feedback questionnaires will be issued following completion of the 2016 appraisals for the appraisal year Jan to December 2016	Close to target
	Staff Support and Development • Staff Training – Hyponatraemia	• CEC continue to roll out IV Fluid training for nursing staff.	To date there have been: • Fluid Management in Children & Young People : 7 sessions • Fluid Management Refresher Training: 4 sessions • Skills Refresher for Community Child Health Care Assistants: 1 session	Achieved
	• Infection Prevention & Control Training & Education	• Continue steps in the conversion from Training Administration Information System (TAS) to the new Learning Solution (LSO) • Aim is to have a completely paper free system by the end of 2015 • Managers will be able to track and report on the grade and number of staff who have attended IPC training • Reinforce that IPC training attendance need to be maintained	• Conversion to the Learning solution system (LSO) has been completed. • The system is completely "paper free" as there is still a requirement to complete "sign in" sheets (evidence of attendance). Course attendance certificates are now available on line • Managers can approve the courses staff request to attend on the system. • Attendance at training is good	Achieved On plan
	• Investors in People	• The 2014-17 rolling programme will continue with two Directorates being assessed in May	• May and October 2015 IiP assessments completed using an Internal Review	Achieved

		and October 2015 • A revised IiP Framework is being launched September 2015 and will be adopted by the Trust following completion of the 2014-17 assessment period.	approach. • Discussions scheduled with UKCES re transition to IiP Generation 6 from April 2017.	On Plan
	• The Coach Approach	• To increase the internal capacity for coaching by continuing to offer the current range of courses and by creating the opportunity to upgrade current qualifications to Diploma level.	• Current courses continue and coaching offered across a range of individuals, teams and within the Recovery College	On Plan
	• Leading in Safety, Quality & Experience (SQE) Programme	• As the programme has demonstrated the ability to address local needs in terms of development of improved service delivery and creation of efficiencies the Trust will continue to deliver this programme annually • Regional Social Work Quality Improvement Training Programme commencing January 2016 • Linkage of the SQE Programme to the Quality Improvement Academy.	• The 5th cohort of SQE participants completed the Leading in SQE Programme in June 2016. We are currently over subscribed for the 2016/17 training programme. In addition we have commenced our SQE Lite training, offering 2 Quality Improvement workshops for clinical and non-clinical teams • The Regional Social Work Improvement Training Programme has concluded with extremely positive feedback. Funding has been secured for a 2nd. • The Trust Quality Improvement Academy has been established and offers a comprehensive programme of QI training and support services including the SQE Programme and the development of a new internal QI programme- SQE lite.	Achieved Achieved On plan
Community: Supporting People in the Community	Telemonitoring	In 2015/16, it is the Trust's intention to: • Increase the usage of telehealth to reach the 78,000 MPD target and to increase the number of clinical staff currently utilising telehealth in supporting their patients managing this condition • Increase the usage of telecare as a means of supporting clients in their own homes across Primary Care and Older People, and Adult Services (Learning Disability and Physical Disability), which will also enhance the support available to carers	• The Trust continues to monitor usage on a monthly basis with a balanced scorecard. There was a slight dip in usage over the summer, but staff continue to be encouraged to meet targets. • The annual contract was renewed and sits at the same level of 78000 MPD.	On Plan On Plan

		• Populate a suite of case studies to illustrate the benefits of telemonitoring to both professional staff and patients		
Mental Health	Improving Crises Management	• Community Link Worker – Partnering with Pharmacy aimed to work with hidden respite • Improve systems in Down sector to support the project and data collection/ analysis • Training on use of the risk management tool via MAXIMS • Further improvement work taken from Serious Adverse Incidents/ Serious Early Alerts has been identified.	• Community Link Worker position under review • Work ongoing in the Regional Mental Health Informatics Group and within trust with Outcomes Based Accountability to ensure data collection demonstrates how patients are better off from using our services. Mental health and IT working together to ensure efficient systems are in place for analysing data. • MAXIMS training including risk assessment now provided to all staff at induction and as part of ongoing training • SAI Recommendations Group established using Electronic Project management (EPM) to ensure that recommendations are achieved and communicated effectively to staff ensuring learning is implemented.	Behind plan On Plan Achieved Achieved
Mental Health Services for Older People (MHSOP)	Improving the Treatment of Delirium in Nursing Homes	• Next step is to submit an Investment Proposal Template (IPT) to enhance the MHSOP teams to enable this in-reach service to care homes to be extended to all localities across the Trust.	Within the submission of IPT for Lisburn locality delirium training as been provided within a number of targeted nursing homes. The purpose -to increase awareness of delirium for staff and identify strategies that decrease the risk delirium in residents . A short presentation with information leaflets are provided with additional follow up support from CPNs aligned to each nursing home. Further resources will be required to provide across all other areas.	On Plan