Belfast Health and Social Care Trust
caring supporting improving together

ANNUAL QUALITY REPORT 2024/25

There is an interactive version of the Report HERE

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1. TRANSFORMING THE CULTURE

Introductory Video from Belfast Trust Medical Director: Mr Chris Hagan

The quality of care that patients, service users and their families receive, and their experiences, are central to all that we do in the Belfast Health & Social Care Trust. Our commitment to improving safety and quality is demonstrated by the following achievements in the year from 1 April 2024 to 31 March 2025.

The successful roll-out and go live of encompass, representing the largest digital transformation in the way we deliver care to patients and service users in the history of Health and Social Care. Through the implementation of encompass, our staff have more time to focus on direct clinical care and less time on administrative tasks, increasing efficiency and improving the quality of care which patients and service users receive

Belfast Health and Social Care Trust were also awarded the prestigious 'Trust of Sanctuary' Award in recognition of its commitment to providing a safe, welcoming environment for everyone, regardless of background, ethnicity, or origin. No other Health Trust in Northern Ireland or the rest of the UK has received this accreditation. The Sanctuary Awards recognise and celebrate organisations who go above and beyond to welcome people seeking sanctuary. This award is recognition of our staff's commitment to deliver inclusive treatment and care across both hospital and community sites, all of which are shared spaces where everyone is welcome and treated with dignity and respect.

We celebrated the opening of an immersive simulation pod in The Royal Belfast Hospital for Sick Children to help staff work with children who have complex medical needs. B-Hive (Belfast Highly Immersive Virtual Environment) is a virtual learning environment and is the first immersive learning environment to be installed in a healthcare suite or facility in Northern Ireland.

It was the result of several years of development and planning by the Simulation Education Team at the hospital. The simulation pod is used for staff and student training, patient and parent involvement, simulation-based education and technology enhanced educational research. This

will not only be used to train our current and future healthcare professionals in a safe, immersive environment, but to provide a sanctuary for our patients and families in the years ahead.

As in previous years we have also been faced with challenges, notably the effect of Storm Éowyn in January which tested our resilience and adaptability. Staff worked tirelessly and collaboratively to ensure continuity of care for all patients and service users and maintained high standards during this period. As with all Trusts in Northern Ireland, the Belfast Trust experienced the impact of winter pressures across all our sites and services. Despite this, most patients received timely, compassionate and professional care, and there are many examples across the organisation which show the hard work, planning and commitment of staff who continued to care for their patients. This represents a continuing challenge, but all teams have continued in their commitment and hard work to mitigate the impact on our patients, service users and their families and carers.

Belfast Trust has contributed to the ‘Big Discussion’, announced by the Health Minister in March 2024 to explore the ongoing challenges we face during annual winter pressures, to examine and address the root causes of these challenges and the impact on our workforce and patients, service users and their families. Several of the regional workstreams that have come from the Big Discussion are being led by staff from the Trust, to improve patient flow through our hospitals and work together as a system to address these challenges as effectively as possible.

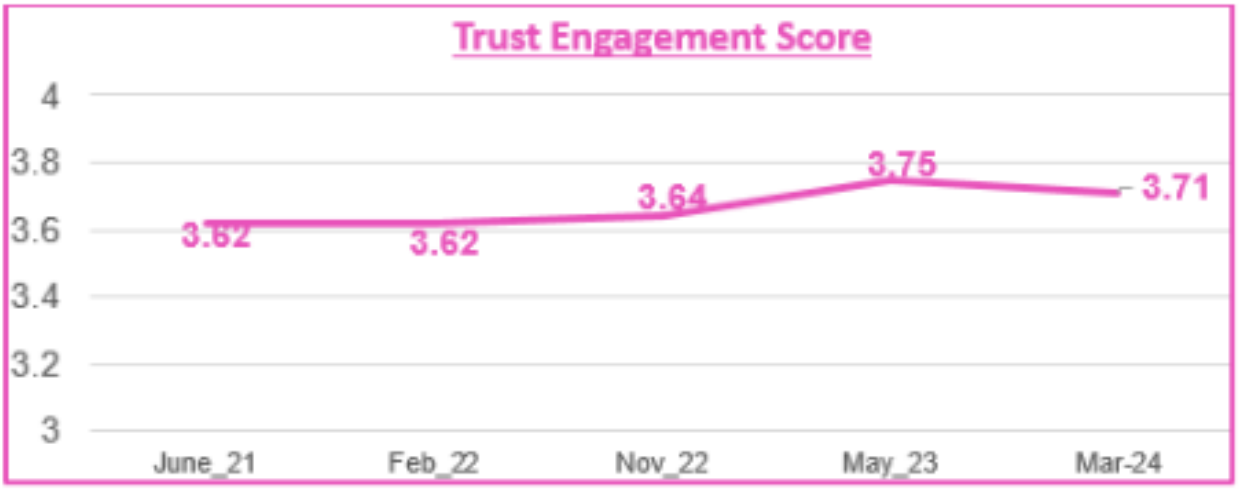
As we look to the future, we remain focussed on the essential values of Health and Social Care; providing safe, effective, equitable and sustainable care for our patients and service users and continuing our commitment to ensuring that we are an organisation which fosters an open, just, learning and restorative culture for all. We’re excited by the opportunities afforded to us in developing new ways of thinking and working including the improvement in efficiency and safety offered by digital innovation and the further integration of the principles of Realistic Medicine into our organisation, which puts patients and services users at the centre of decisions made about their care.

HSC Staff Experience Survey

The Staff Experience Survey is a key tool for understanding how staff feel about working within the Trust. It provides valuable data that helps guide and inform organisational culture initiatives, ensuring efforts are focused where they are most needed and likely to have the greatest impact.

Improving staff experience is not simply a “nice to do”—it is essential. Evidence consistently shows that better staff experience leads to improved patient care, higher attendance, and stronger staff retention.

The survey conducted in 2024 was our fifth to-date and the first fully in-house delivered Staff Experience Survey. The survey continues to measure staff engagement both across the organisation and at a local level. Based on the results from this survey the overall Trust engagement score was 3.71, with a target of 3.80 set for achievement by December 2025.



While the 2024 survey showed a slight decrease in the overall engagement score from the previous survey — from 3.75 to 3.71—there were notable improvements in several other key areas:

- **Reward & Recognition**
  Staff reported feeling more acknowledged for their contributions, indicating progress in how recognition is delivered across the Trust.

- **Wellness & Resilience**
  Initiatives aimed at supporting staff well-being and resilience are beginning to show positive results.
- **Choice & Autonomy**
  Feedback suggests staff are experiencing greater flexibility and control in their roles.

These findings reinforce the importance of staff feedback in shaping a positive workplace culture. Continued focus on these areas will support the Trust's broader goals of improving staff experience and, in turn, enhancing patient outcomes and organisational performance. The next survey is planned for May 2025.

Patient and Client Experience

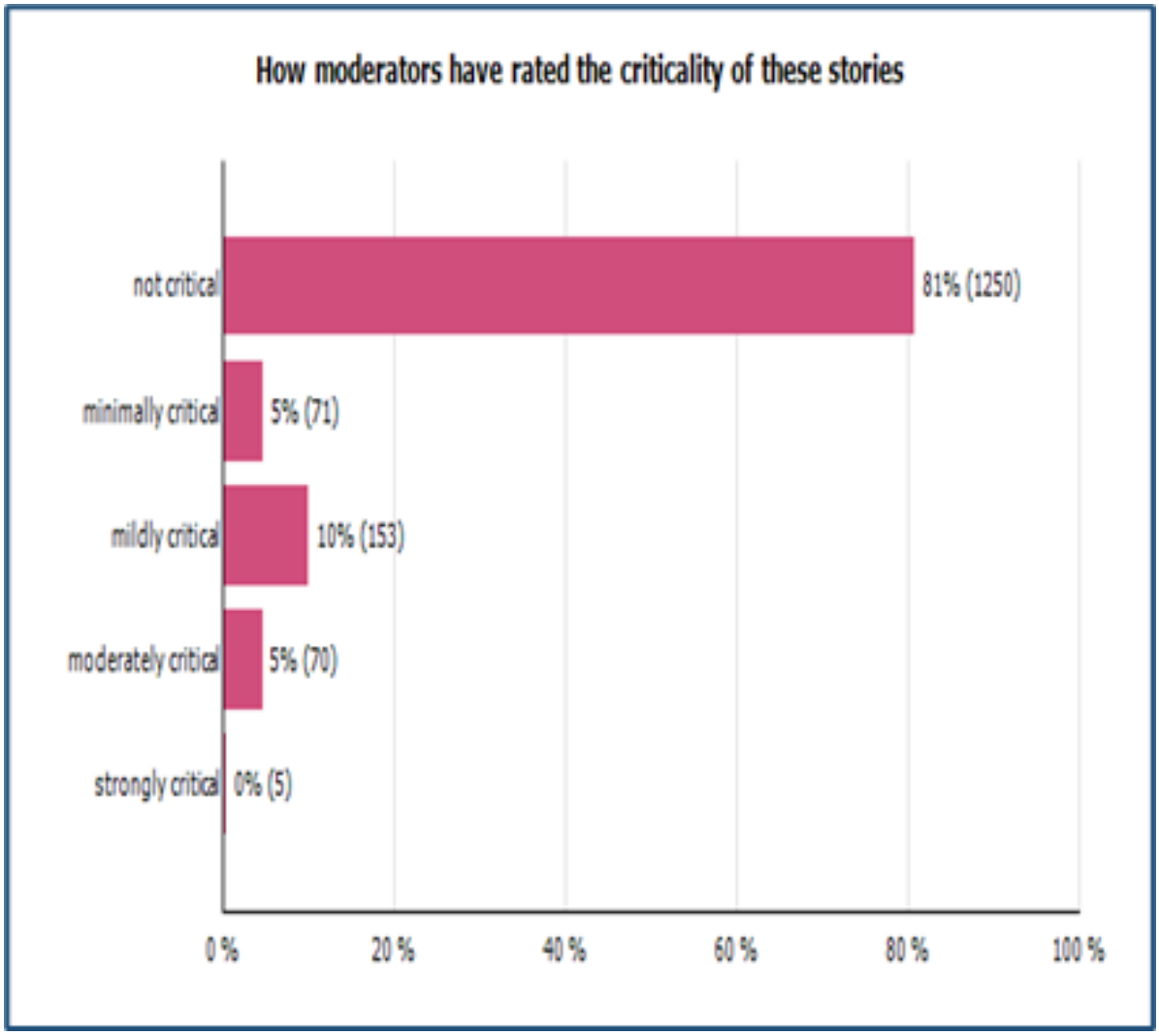
Care Opinion

Patient and Client Experience feedback is important to us within the Belfast Health and Social Care Trust. Care Opinion is an online system used by the Belfast Health and Social Care Trust that allows patients, service users and those who care a mechanism to share their experience at a time that is right for them.

In 2024/25 our main method of gathering feedback on our services was via Care Opinion.

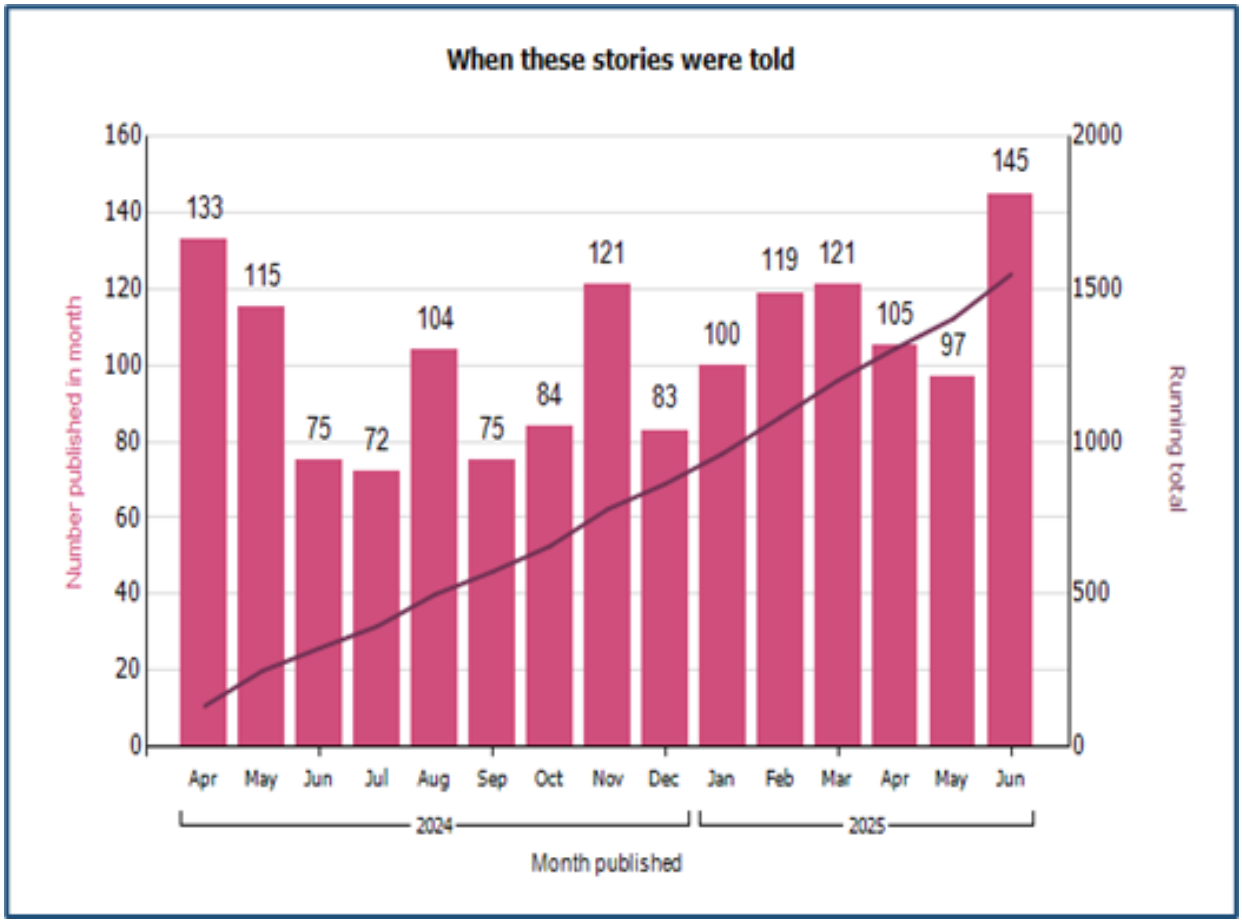
Care Opinion Stories

In 2024/25 our service users shared 1202 stories about their experience of care in the Belfast Trust through Care Opinion. These stories have been heard 140,244 times.



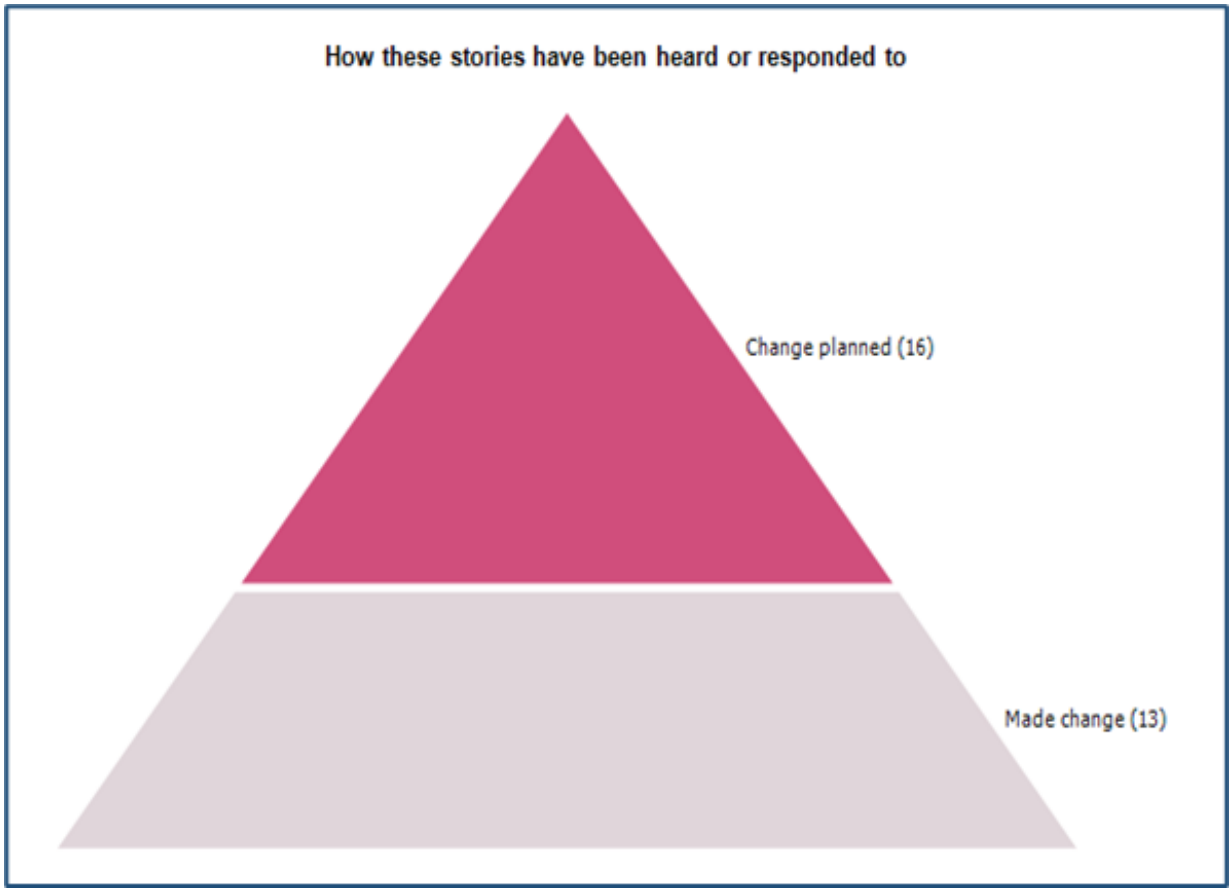
Achievements

- **14%** increase in published stories for
- 2024/25 in comparison to 2023/24
- **81%** of stories were completely positive
- Strengthened partnerships with Trust services
- **96%** Responsiveness to stories in BHSCT
- Highly positive feedback regarding **Quality of Care** and **Staff.**



Impact and change through Care Opinion

- A new initiative within our acute wards and departments called 'Cognitive Champions'. Each area will have staff identified to help support patients who may have cognitive issues like dementia.
- The introduction of digital signage at RVH reception through stories regarding poor signage.
- A range of Gluten free products added in the Coffee Doc and a request to vending contractor to increase the Gluten Free selection in all vending on the hospital site.
- The introduction of site maps of RVH for patients, services users and carers.
- The updating of information boards.
- Introduction of stylists across Ophthalmology to make it easier for consent boxes being completed.



Priorities for 2024/25

- Continue engagement with services to embed Care Opinion through the Trust.
- Continue to forge and strengthen partnership working with teams.
- Work closely with the Engagement Team to promote CO with the public.
- Strive to have 100% responsiveness

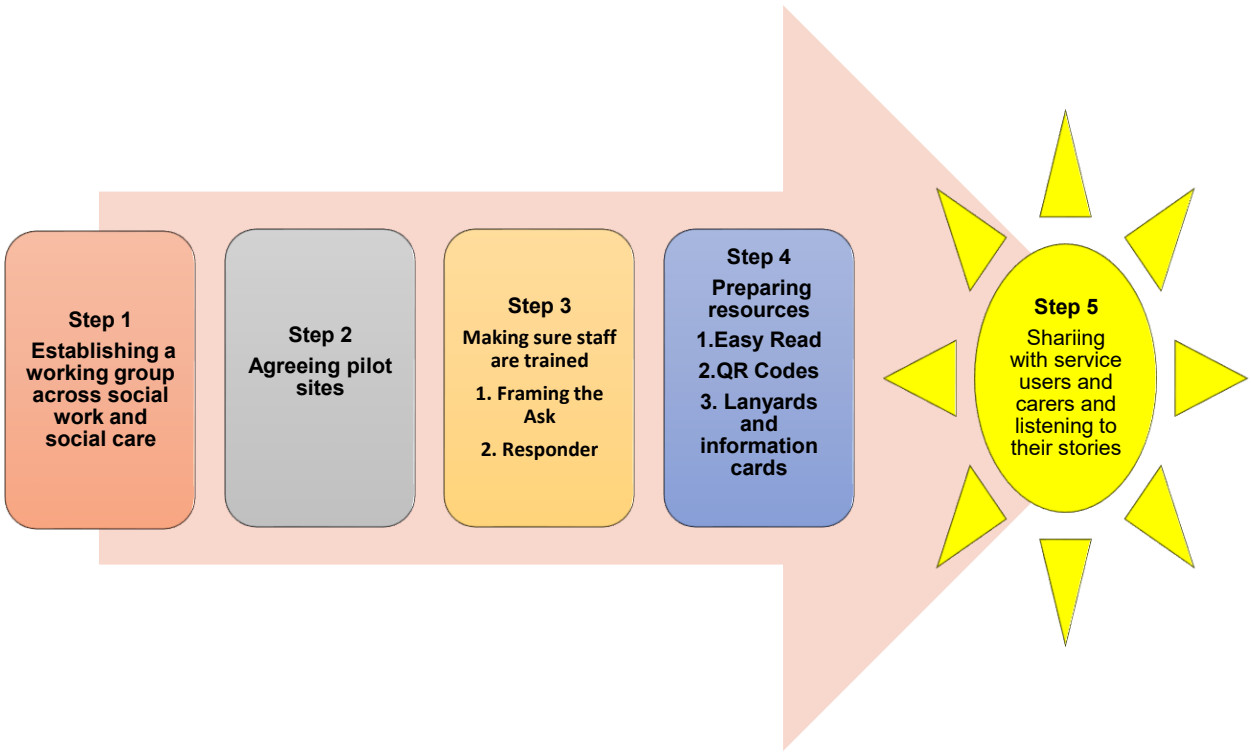
Patient and Client Experience: 10,000 Voices Survey

The 10,000 Voices survey report was published in September 2023, and the action plan recommended the Trust find a way to capture the ongoing experience of people who use social work services. Social work has been busy in this reporting period making it easier

for people who use services to share what has gone well and how social work in the Trust can improve.

The Trust have worked in partnership with regional colleagues and the Public Health Agency to plan how Care Opinion can be used in social work and social care, to ensure the voices of people who have experience of services are heard. There is currently a Care Opinion pilot across adult and children's services and colleagues in patient experience have provided training for social work staff, as well as working in accessible literature for sharing with children and adults with additional communication needs. Care Opinion will be rolled out across social work within the next reporting period.

Action Plan



Hearing from the people we work alongside

"Our family would like to thank all the staff who attended dad until recently …The service they gave was fantastic and they all treated dad as an individual person… They are a credit to the Homecare service"

"Me and my support worker went to the Christmas market…we had hamburgers looks around the stalls…the first support worker that has done that for me she is the best support

"Lovely helpful person who explained the purpose of her visit. Felt emotional at the reality of the situation"

What Matters to You

During 09th-13th September 2024 we engaged at the bedside with patients across our services asking, 'What Matters To You?'

Face to face listening engagement during a patient stay can highlight areas of quality and areas for improvement, providing insight to patient journeys and evidencing positive cultures. Across the Trust 399 surveys were completed, thanks are extended to all staff groupings supporting engagement. Thanks also to our patients who were happy to participate, shining a light on what matters to them.

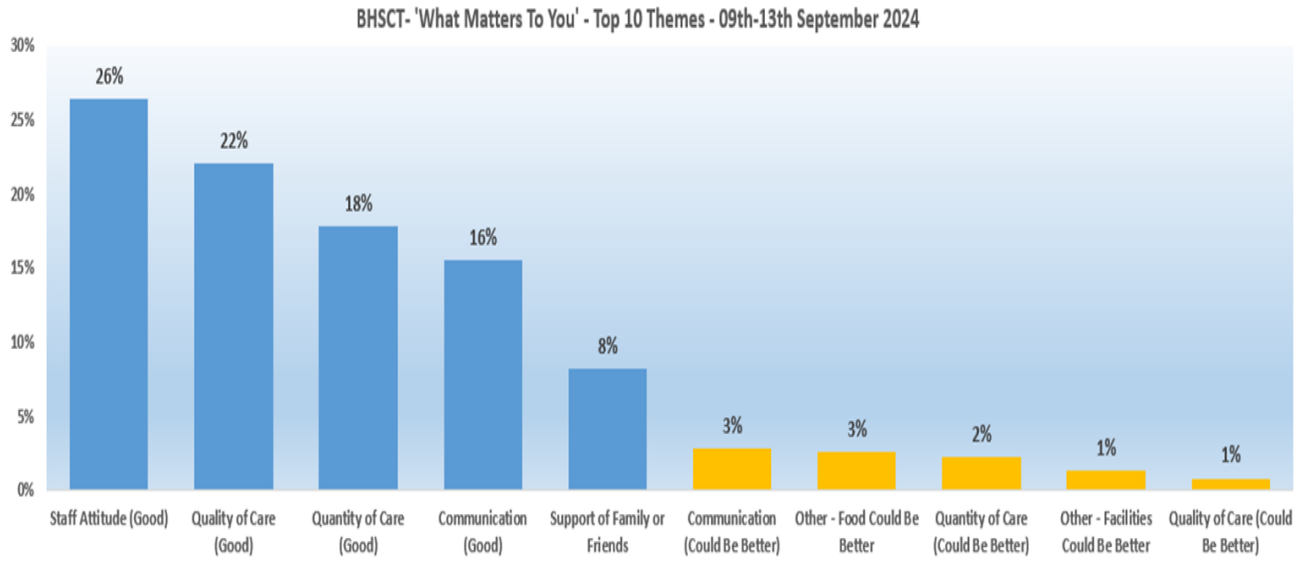
Maggie Ireland, Project Manager, Real Time Patient Experience, with team members at Beechcroft who kindly facilitated engagement with Admissions Ward patients at Beechcroft.

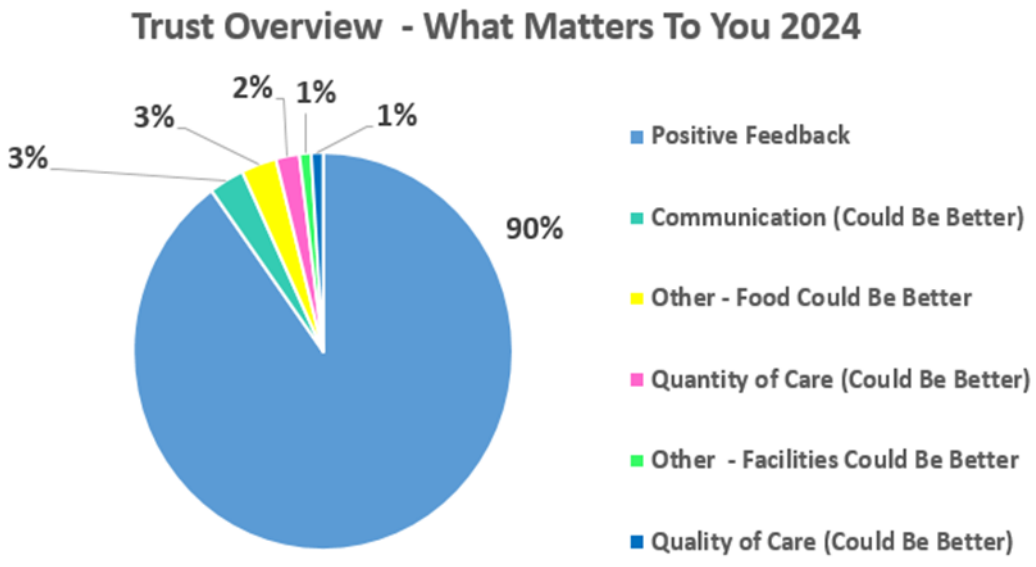
Beechcroft PICU team members with Sister Nicole Watson, who kindly facilitated patient engagement within the unit during the visit.

Artwork kindly shared by a Beechcroft patient who enjoys photographing and painting sunsets along with making clay models, helped by the ward team.

Within the Belfast Trust feedback was overwhelmingly positive with small pockets of feedback identifying things that ‘could be better’ when we asked our patients to consider what matters to them.

Across all Directorates positive feedback accounted for 84%-92% of all themed comments and reports are available for Directorates to consider the evidence of positive cultures as well as potential areas for quality improvement.

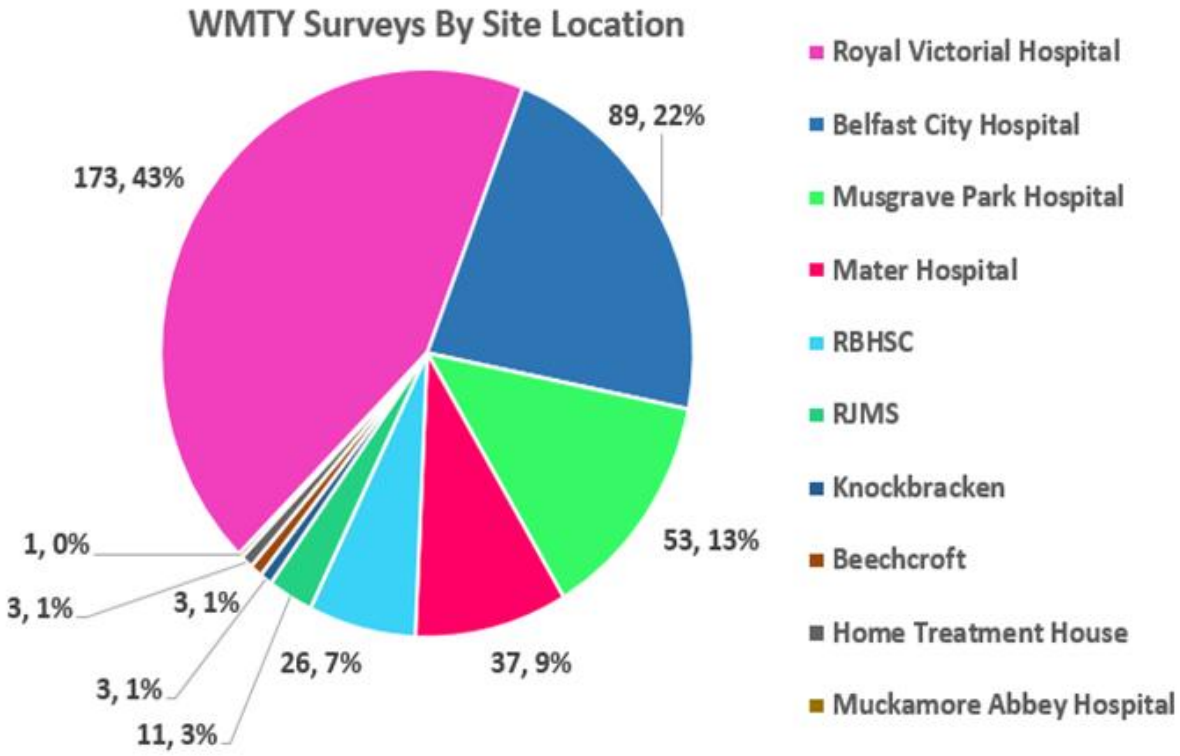




The Royal Hospital site including RBHSC and RJMS accounts for 210 (53%) of all inpatient engagements across the WMTY week. This reflects the distribution of inpatient beds accessible to the Real Time Patient Experience team who undertook surveys on behalf of all available areas.

Engagement across various sites included Beechcroft, Knockbracken, Home Treatment House and Muckamore Abbey Hospital.

In areas where engagement was numerically low, detailed qualitative feedback was gathered. The positive attitude of all teams across the Trust was notable as they warmly welcomed the opportunity for patients to feedback through sharing what matters to them.



Complaints and Compliments

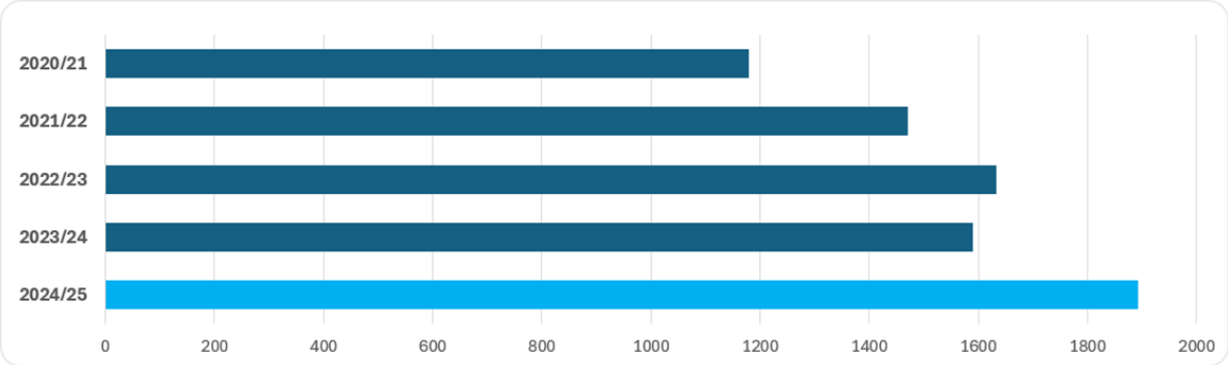
The Trust values service user feedback about the treatment and care we provide for patients. The Trust has put in place resources to manage comments, concerns, complaints and compliments received about our services – whether these are provided directly by us or commissioned on our behalf. These resources cover hospital and community-based

services. We strive to ensure people have a positive experience of our services, but we recognise there will be times when we do not meet service user expectations and when things can go wrong or fall below standard. By listening to people about their experience of healthcare we can identify new ways to improve the quality and safety of services and help to prevent problems arising in future.

Facts and Figures

1,894 Formal Consented Complaints were received in 2024/25, 304 more than those received in 2023/24, representing a 19.12% increase on the previous year's figure of 1,590.

Graph showing Formal Consented Complaints received from 2020/21 to 2024/25

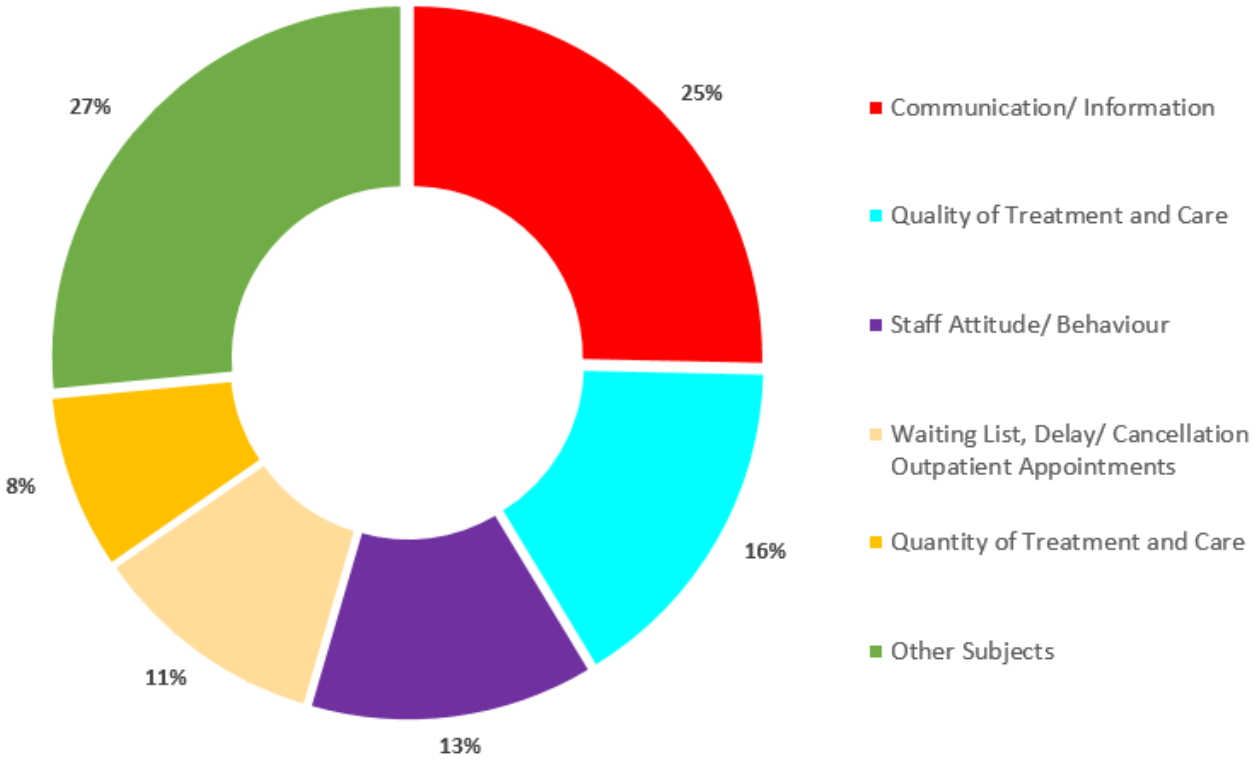


Formal Complaints - Top 5 Subjects 2024/25

The most frequent issues and concerns raised in complaints throughout 2024/25 remained consistent with those identified in previous years:

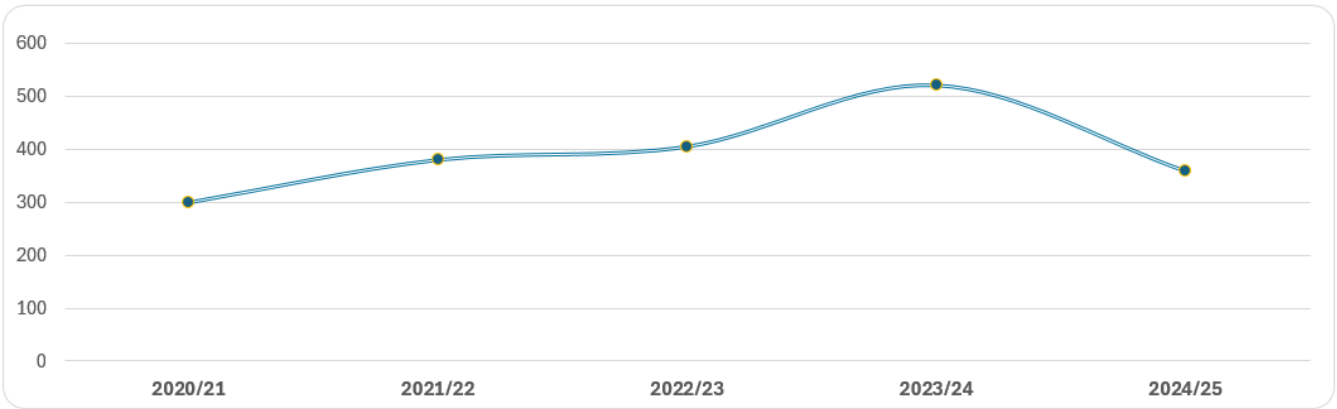
- Communication / Provision of Information
- Quality of Treatment and Care
- Staff Attitude and Behaviour
- Waiting lists / delays / cancellations of Outpatient Appointments
- Quantity of Treatment and Care

Graph showing the 5 most common Complaint Subjects during 2024/25



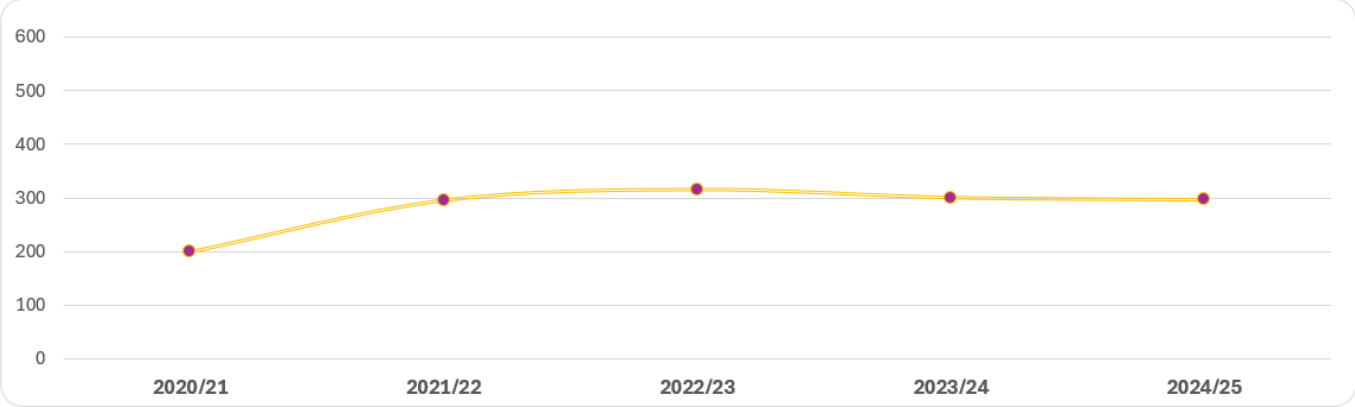
QMS Focus – Safety:

Graph showing numbers of Formal Consented Complaints received about Quality of Treatment and Care during 2024/25

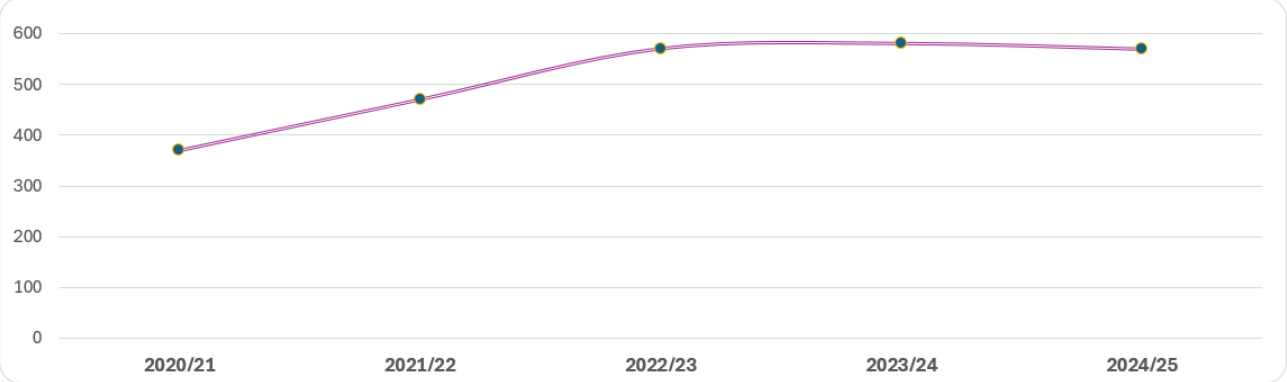


QMS Focus – Experience:

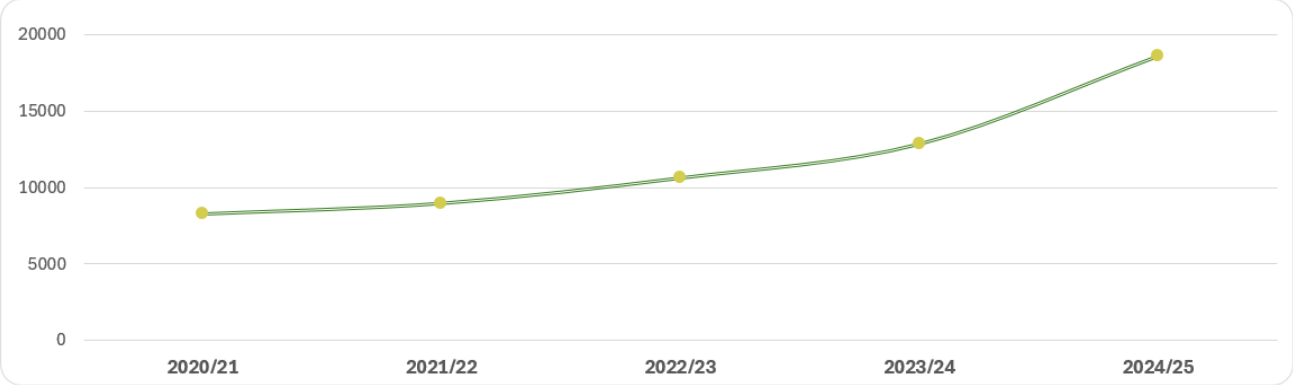
Graph showing numbers of Formal Consented Complaints received about Staff Attitude and Behaviour during 2024/25:



Graph showing numbers of Formal Consented Complaints received about Communication / Provision of Information during 2024/25:



Graph showing numbers of Compliments about our Services formally received during 2024/25:



QMS Focus – Timelines:

Response Timelines for Complaints

> The Complaints Department supports our managers and staff working in wards and departments to help them to ensure that all complaints received about our services are answered comprehensively and in a timely manner.

Although the Trust aims to respond to complaints in 20 working days, complex complaints (such as those involving a range of services and departments) can require additional time to investigate.

Graph showing the response times for Formal Consented Complaints received during 2024/25

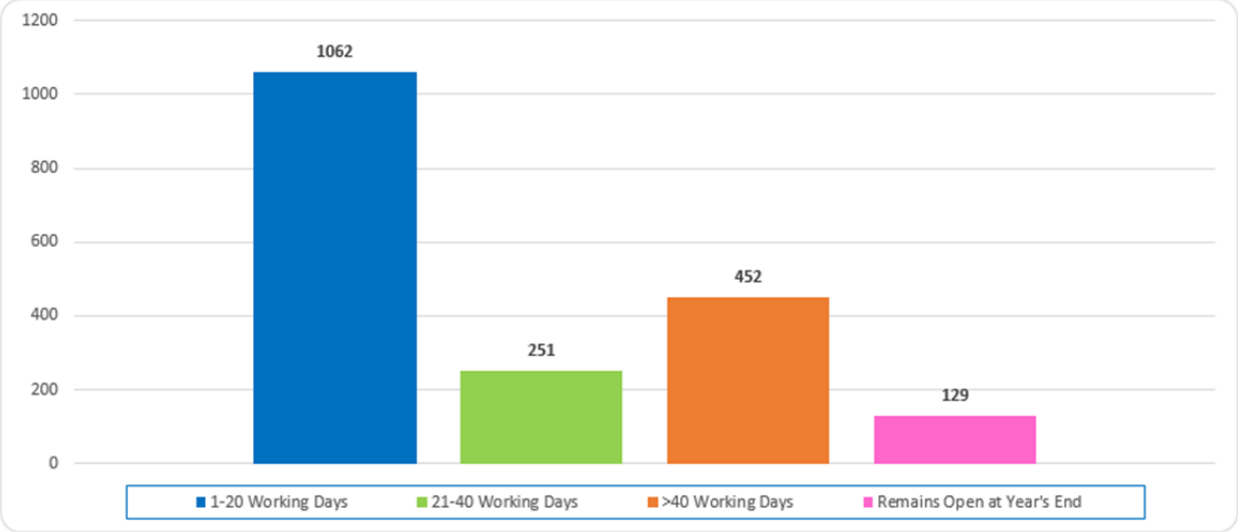


Table showing the response times for Formal Consented Complaints received by the Trust during 2024/25

Acknowledgement of complaint within 2 working days	**98.69%**
Complaint response within 20 working days	**55.82%**
Complaint response within 40 working days	**69.05%**

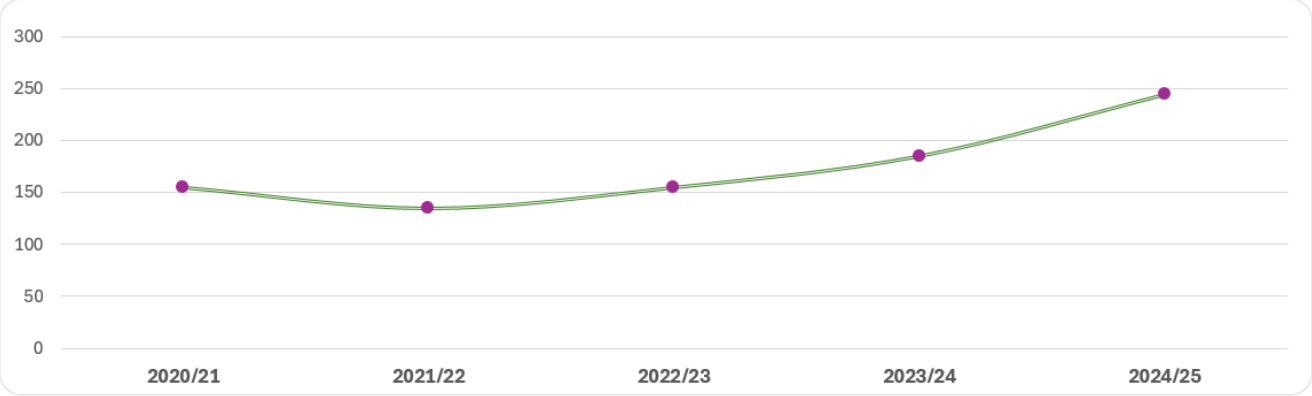
The Complaints Department maintains close communication with services where responses have been outstanding for a long period. This included a Quality Improvement Project aimed at promoting timely responses to complaints and a strong commitment to training by staff of the Complaints Department for those working in our services who are responsible for responding to complainants.

Regular reports continue to be shared with services throughout the year including formal reports identifying all complaint cases in each service area where a response was awaited for >40 working days.

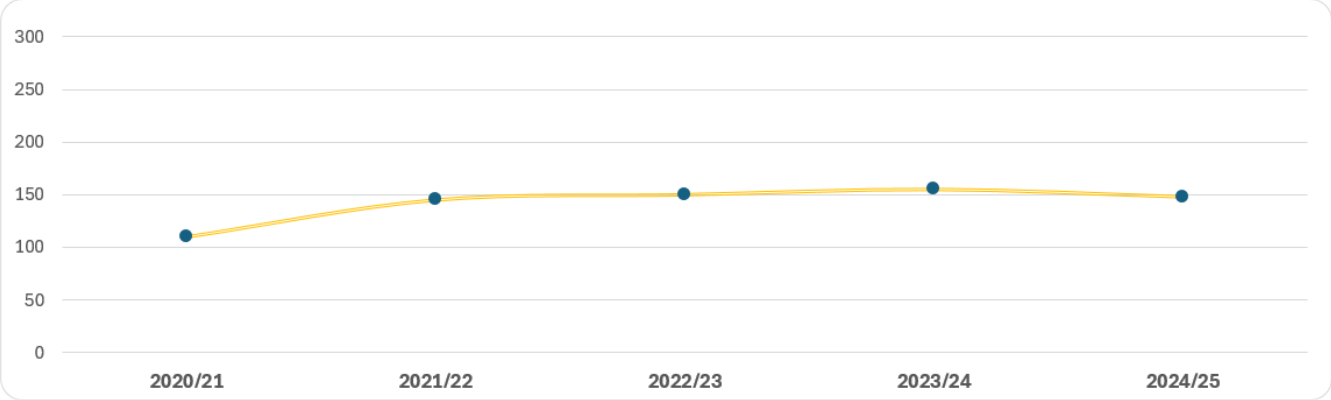
The Trust also continues to encourage and support staff to resolve complaints on the frontline - increasing the numbers of complaints addressed informally within wards and departments and increasing the numbers of formal complaints addressed within 5 working days.

QMS Focus – Timelines:

Graph showing numbers of Formal Consented Complaints received about Waiting Lists / Cancelled Services for Outpatients Appointments during 2024/25:



Graph showing numbers of Formal Consented Complaints received about Waiting Lists / Cancelled Services for Planned Hospital Admissions during 2024/25:



Learning from Complaints

The Trust continuously seeks to ensure that where it is found because of a complaint that there was a shortcoming in the service identified that the Trust learns from the outcome of the complaint and seeks to make changes to avoid any repetition of the problem.

Example:

A complaint was investigated by the Northern Ireland Public Services Ombudsman (NIPSO) which made recommendations for change.

A patient underwent a procedure within the Trust. Following the procedure, the patient developed symptoms and became critically unwell. It was established that the symptoms developed by the patient were a known complication of the procedure. However, on examining the record of the care provided, NIPSO could not find recorded evidence that this specific risk had been discussed with the patient as part of the consent process prior to their procedure.

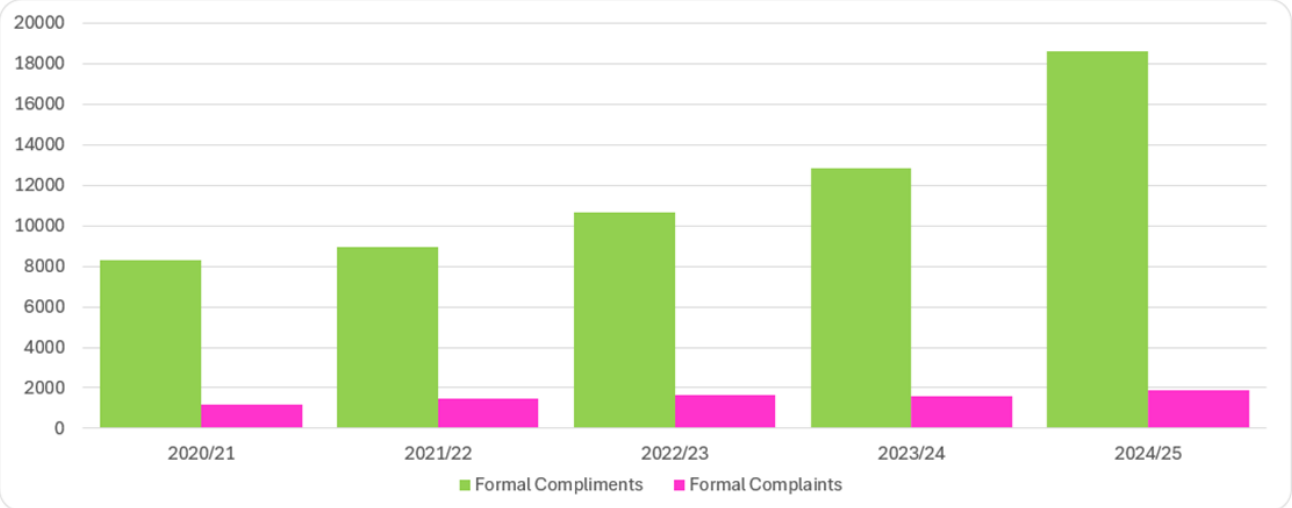
As a result of NIPSO's findings and recommendations, the Trust reviewed its consent process for the procedure to ensure that this risk

was specifically drawn to the attention of patients. In particular, the Trust ensured that the patient's record- which is held on a system accessible to patients – included complete and comprehensive information about the full range of possible complications that could arise from this procedure.

Compliments

In line with Department of Health reporting requirements, services across the Trust are asked to share compliments they have received centrally with the Complaints and Compliments Department. This is done by email including copied documentation as appropriate. The compliments received are grouped by service and by theme. This data is used to produce reports on a quarterly and on an annual basis on the number of compliments received by the Trust.

In addition to expressions of gratitude, and commendation of care received informally by staff in wards and departments throughout the year, the Trust also continued to receive formally reported compliments about many aspects of our services with a total of **18,590** compliments notified to our central complaints and compliments team during 2024/25. Graph showing the comparative number of formal compliments and formal consented complaints received over the past 5 years.



Incidents and Serious adverse incidents (SAIS)

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.”

Adverse Incidents happen in all organisations providing healthcare. Belfast Trust meets this challenge through the promotion of a culture and system of reporting all incidents when they occur to learn from them and to prevent re-occurrence. **“Vision - A world in which no one is harmed in healthcare, and every patient receives safe and respectful care, every time, everywhere. World Health Organisation (WHO), Global Patient Safety Action Plan”**

The Belfast Trust aims to encourage an open reporting and learning culture, acknowledging that lessons need to be shared to improve safety and apply best practice in managing risks. Incidents reports are provided to several specialist groups e.g. Trust Assurance Committee, Invasive intervention group, Health and Safety Group, Management of Aggression Group, Safety Improvement Team, to help identify trends and areas requiring focus and to allow measurement of the impact of incident reduction projects within the remit of these groups.

A **Serious Adverse Incident (SAI)** is a classification of incident that is subject to Department of Health procedures for reporting and investigation. SAIs will include ‘an incident where there was a risk of serious harm or actual serious harm to one or more service users, the public or to staff.’

Facts and Figures

In the year 2024/25 there were a total of

- 55,139 adverse incidents reported.
- 188 were reported as SAIs.
- 77% of adverse incidents affected patients or service users.
- 15% affected staff/contractors/vendors
- The remaining 9% affecting the organization as a whole or public/visitors.

Top 5 Incident Types 2024/25

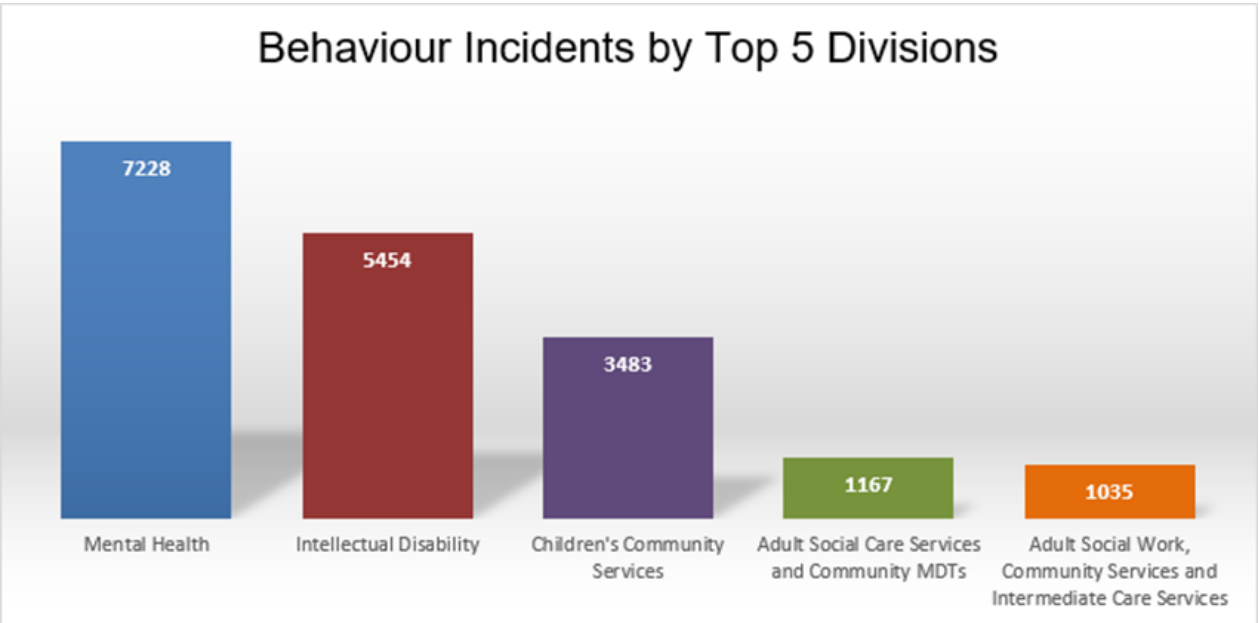
Behaviour – 20,243 (37%)

Accidents/Falls – 8,870 (16%

Medication/Biologics/Fluids – 6,425 (12%)

Service Disruptions – 3,187 (6%)

Pressure Ulcers – 2,015 (4%)



Work is ongoing to tackle the root causes of these incidents to reduce their occurrence and examples of this are as follows:

Behaviour

(Note that many of these incidents occur because of challenging behaviours associated with some intellectual disabilities and mental health conditions)

The Trust has a zero-tolerance approach to violence and aggression towards Trust staff.

Safety Intervention Team

Deliver Safety Intervention training programmes throughout the year to Trust staff at varying levels, following completion of a zero-tolerance risk assessment and training needs analysis.

Support the Trust in the development of policies and procedures pertaining to this area of expertise.

Provide advice to staff and managers on restraint reduction, restrictive practices and minimising the risk of violence and aggression.

Monitor and review all incidents involving the use of physical interventions. This is to recognise trends and hotspots and provide additional support and guidance for service areas on reducing occurrences of incidents and learning from incidents.

Safety Intervention Training Benefits:

Recognise & Respond to Escalating Behaviour

Staff learn to recognize signs of distress and gain a broad range of tools to help them intervene early and a clear understanding of using the right skills at the right time to effectively de-escalate when conflict arises, so that behavioural crisis doesn't occur. The training incorporates trauma-informed and person-centred approaches.

Recognise & Respond to Crisis Behaviour

When faced with a behavioural crisis that places staff or others at risk of injury, staff learn to focus on the least restrictive physical intervention to ensure the Care, Welfare, Safety and Security of those in our care.

Recognise & Respond to Higher Risk Crisis Behaviours

Offering a wider array of verbal, non-restrictive and restrictive interventions to manage risk behaviour

Best Practice Learning

All verbal and safety intervention training is based upon the latest principles of learning with an emphasis on strategies that can be used by staff. Physical interventions within the Crisis Prevention Institute (CPI) have been independently risk assessed, following published research which demonstrates that they maximize safety and minimise harm and follows international standards of best practice.

Evidence Based & Fully Accredited

All courses are based upon the latest research and include approaches that have a proven track record of effectiveness. Safety intervention training is fully compliant with current statutory and legal requirements. Nationally and internationally accredited by Restraint Reduction Network Training Standards.

Mental Health Services

All incidents graded as moderate and above severity, as well as incidents graded minor or insignificant, but with a potential of a medium or above consequence are reviewed by the Collective leadership Team (CLT), at the weekly governance huddle and feedback returned to the appropriate service area with comments or further action if required.

Incidents of violence and aggression are discussed locally at Ward/ Department level during team meetings and at monthly Patient Safety Meetings.

Within Mental Health Services a Physical Intervention (PI) report produced on a weekly basis is distributed to the service areas within Mental Health Services for review and escalation. The Divisional Nurse (CLT) also has oversight of this report. The PI report includes all aggressive and self-harming behaviour incidents. The service monitors the use of Physical Intervention, Prone and Supine restraint, IM rapid tranquilization and seclusion.

All Mental Health Incidents are discussed at monthly Divisional Governance Meetings. Trends and patterns are collated for wider discussion. When themes are identified, these incidents are grouped and reviewed collectively to identify any possible learning.

It should be noted that often when a peak arises within a Mental Health inpatient facility, it can relate to an individual or a small cohort of individual patients who have been admitted and who are very unwell.

Support for staff involved in incidents of violence and aggression is provided as and when necessary.

Intellectual Disability Services

All incidents of aggression are reviewed daily during safety huddles at both hospital and community levels and discussed in live governance meetings. Inpatient aggression incidents are specifically addressed at ward-level clinical improvement meetings.

The Monthly Divisional Governance Meeting reviews these incidents using collated weekly safety reports, these include data trend and pattern analysis. These findings are presented to the management team to embed proactive crisis management and protection plans within the Division.

A review of patient placements and co-location at the MAH site has led to relocating some patients to environments better suited to their needs, such as individual PODS or annexes. These settings promote increased independence and prepare patients for community living.

Delayed discharges of some children at Iveagh have been escalated with respective Trusts.

The focus on accelerated resettlement is being revised, recognizing the potential harm to individuals. Some inpatients, who do not wish to remain in the hospital, are at risk due to factors such as personal frustration, low staffing levels and boredom, which may lead to dysregulated behaviours.

Accidents/Falls

(See page 71 of this report).

Medication/Biologics/Fluids

(See page 84 of this report.)

Service Disruptions

(59% relate to lack of staff / non availability of beds)

These incidents occurred throughout the Trust with particularly high numbers in the Emergency Depts (Royal and Mater sites) and the Mental Inpatient Centre (Belfast City site).

Incidents are reviewed on an ongoing basis via the live Governance arrangements in each of the relevant Directorates. Regular review and update of business continuity plans would be key.

Communication with Site Coordinators and escalation to senior management would occur when required, to ensure appropriate action is taken to minimise impact on ongoing service delivery. This can sometimes require actions being taken throughout the Trust. These issues require entire HSC system review to resolve.

Pressure Ulcers

(See page 77 of this report)

Serious adverse incidents (SAIS)

Serious Adverse Incidents (SAIs) form a very small proportion of all adverse incidents across the Trust each year, with approximately 1 SAI for every 250 Adverse Incidents.

Due to their potential seriousness and often complex nature, the process of a SAI review provides the opportunity for important learning to be identified to prevent reoccurrence and increase safety across the Trust and wider Health & Social Care.

Of the 42,863 incidents reported in 2024/25, 188 met the criteria for reporting as SAIs. This equates to 0.4% of the total incidents reported throughout the Trust. Approved incidents as at date of report completion. This report does not include incidents reported by Independent Sector Providers (ISP). For this reporting period there were also 11,575 ISP Incidents.

Outstanding SAI Reviews and Actions Taken to Address

Reviews outstanding in relation to Serious Adverse incidents continue to be a challenge to the Trust. Additional processes have been brought into the Trust to raise awareness of what was outstanding, identify bottlenecks in the review processes and providing support / guidance to Commissioning Directorates to try and move complex SAI reviews on to completion.

Internal processes include weekly discussions at the Trust Governance call; monthly discussion at SAI Group, SAIG (Trust Assurance Group), generation of monthly Quality Management System (QMS) data shared within the organisation and specifically shared as part of the Executive Team Safety Huddle arrangement; quarterly review of SAI data by Assurance Committee of the Trust Board, divisional meetings co-ordinated between members of Directorate Collective Leadership teams and Medical Director's Office with a focus on outstanding SAI reviews.

External to Trust processes, SPPG has supported a bi-monthly Trust performance meeting that includes a specific focus of the SAI reviews outstanding and the stage these outstanding reviews are at, as well as covering outstanding SAI queries and Terms of reference.

SAIs with Catastrophic Severity

Unfortunately, some of the SAIs conducted concern incidents that resulted in a patient death or an incident leading to death (graded as Catastrophic). Of the 188 SAIs raised during the year 2024/25, there was 40 with Catastrophic severity. Table 1 provides a breakdown by Directorate and Level of Review.

Table1: Breakdown of SAIs with Catastrophic Severity by Directorate and Review Level

Directorate	Level 1	Level 2	Level 3
ACOPS and AHPs	2	1	0
ACCTSS and Surgery	5	0	0
CH/NISTAR and MDS	4	0	0
Children's Community Services	1	0	1
MHID and PS	17	1	2
Strategic Development	1	0	0
TOR and Opts/Imaging/MP	1	0	0
Unscheduled Care	4	0	0

Table2: Top 2 Type Tiers for SAIs during 2024-25

Type Tier	Count	%
Behaviour	41	21
Diagnostic Progresses / Procedures	31	16

Learning from SAIs

Every week new SAI notifications and SAI recommendations from completed reviews are presented at the Trust Weekly Governance call. Any learning (including immediate) identified by the relevant Directorate would be discussed as part of this call.

Learning is also a specific focus on Directorate reports at the monthly SAIG meeting. A summary of Learning Themes from completed SAI reviews continues to be brought every 6 months to this meeting.

Of the 302 reports submitted during the reporting period 01 April 2024 to 31 March 2025, 275 reports had learning themes confirmed. This identified a total of 487 themes. The table 3 provides a breakdown of sub-group learning themes for the top 2 learning theme groups.

Table 3: Breakdown of Top 2 Learning Theme Groups from SAI Reports completed during the period 2024-25

Learning Theme	Count
C: Deficient Checking and Oversight	**176**
C1: Medication Error	21
C2: Misinterpretation or mishandling of test results	25
C3: Unexpected perioperative death (within 24hrs)	1
C4: Wrong - site/ implant/ procedure/ patient	6
C5: Risk Management Failure	30
C6: Staff training not up to date	11
C7: Related to checking aids e.g. tick box	18
C8: Failings/ errors in documentation	64
D: Mismanagement of Deterioration	**101**
D1: Failure to act on or recognise deterioration (incl escalation)	42

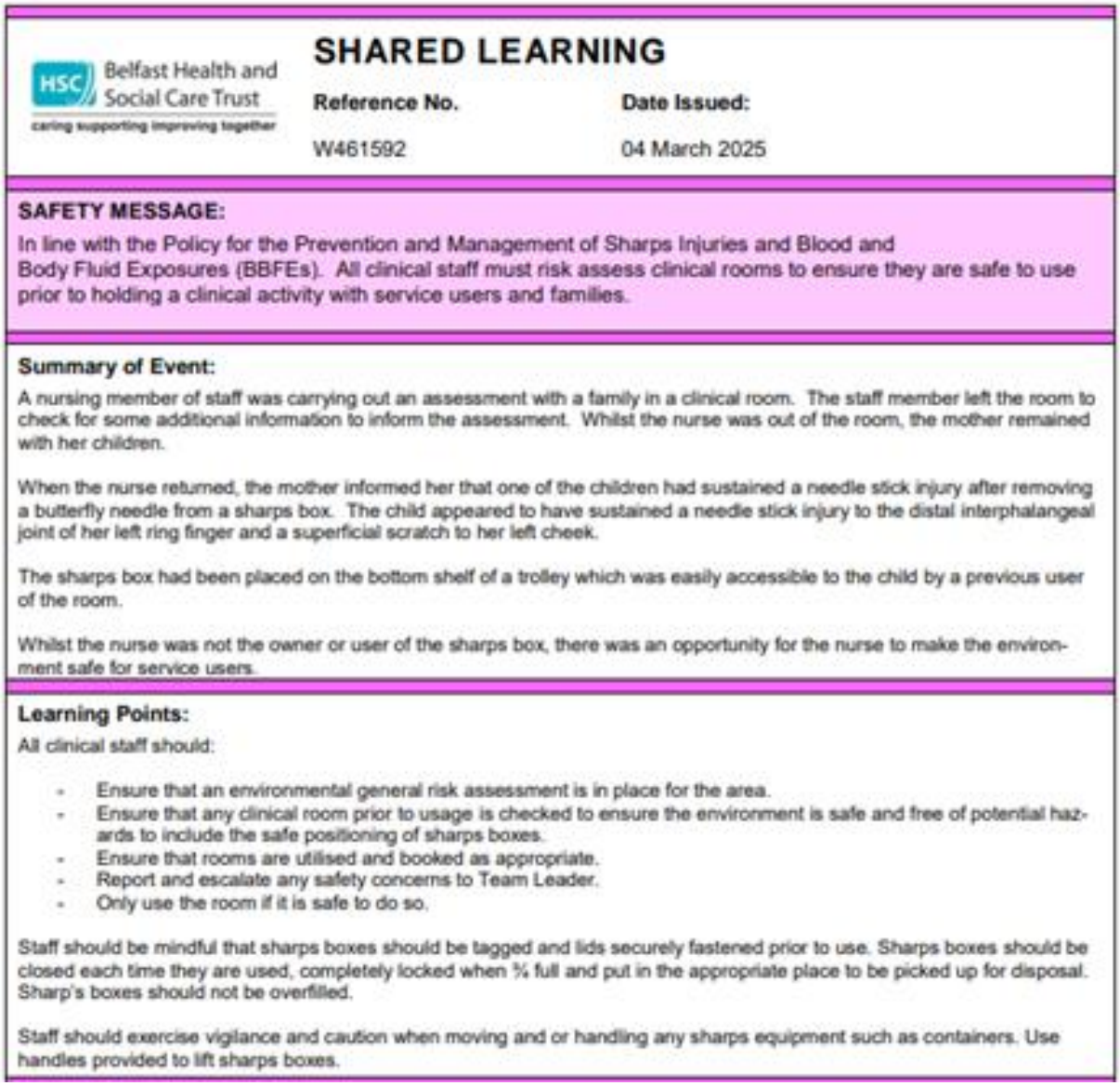
Learning Theme	Count
D2: Failure to give ordered treatment/ support in a timely way	28
D3: Failure to observe	10
D4: Staff training/ skills deficiency	21

Work is underway to potentially add some additional learning themes to the current list to assist some services accurately capturing their key themes, for example Social Work.

Shared Learning from Incidents and SAIs

The importance of identifying learning at an early stage and ensuring all services who may need to know about this is continually highlighted, whether this be via the Weekly Trust Governance call arrangements or by one of the established groups that sit within the Assurance Framework that actively look at incident and SAI data or as part of the regular Divisional huddles completed.

For the reporting period 2024 to 2025 there were 16 Shared Learning Letters and 11 Safety Message of the Week (SMOTW) issued re Incidents; and 25 Shared Learning Letters and 4 Safety Message of the Week (SMOTW) re SAIs formally issued. All of which are available on the LOOP Learning Library within the Trust. Please see below two example Shared Learning Letters issued within this period, one linked to incidents, and one linked to SAIs.



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SHARED LEARNING

Reference No. W461592

Date Issued: 04 March 2025

SAFETY MESSAGE:

In line with the Policy for the Prevention and Management of Sharps Injuries and Blood and Body Fluid Exposures (BBFEs). All clinical staff must risk assess clinical rooms to ensure they are safe to use prior to holding a clinical activity with service users and families.

Summary of Event:

A nursing member of staff was carrying out an assessment with a family in a clinical room. The staff member left the room to check for some additional information to inform the assessment. Whilst the nurse was out of the room, the mother remained with her children.

When the nurse returned, the mother informed her that one of the children had sustained a needle stick injury after removing a butterfly needle from a sharps box. The child appeared to have sustained a needle stick injury to the distal interphalangeal joint of her left ring finger and a superficial scratch to her left cheek.

The sharps box had been placed on the bottom shelf of a trolley which was easily accessible to the child by a previous user of the room.

Whilst the nurse was not the owner or user of the sharps box, there was an opportunity for the nurse to make the environment safe for service users.

Learning Points:

All clinical staff should:

- Ensure that an environmental general risk assessment is in place for the area.
- Ensure that any clinical room prior to usage is checked to ensure the environment is safe and free of potential hazards to include the safe positioning of sharps boxes.
- Ensure that rooms are utilised and booked as appropriate.
- Report and escalate any safety concerns to Team Leader.
- Only use the room if it is safe to do so.

Staff should be mindful that sharps boxes should be tagged and lids securely fastened prior to use. Sharps boxes should be closed each time they are used, completely locked when ¾ full and put in the appropriate place to be picked up for disposal. Sharp's boxes should not be overfilled.

Staff should exercise vigilance and caution when moving and or handling any sharps equipment such as containers. Use handles provided to lift sharps boxes.

In addition to this the Trust would continue to receive external learning from the SPPG that has arisen from SAI reviews completed across HSC Trusts. Any learning relating to SAIs would be formally shared and noted at the next SAI Group.

Shared learning outside the SAI process is also considered for reporting through as per regional procedure to PHA / SPPG for their consideration.

Work is underway in the review of learning and how this is presented on the Loop to identify any improvements.

Work is also currently underway within Northern Ireland in the update of Regional Guidance with this expected to be issued early 2025. The new guidance will look to support the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement Adverse Incidents / Serious Adverse Incidents (SAIs).

How the Organisation Learns

Quality Improvement

May 2024	STEP-UP Graduation 8 Staff. Total Graduates = 215
May 2024	First STEPS 15 Staff. Total Graduates = 101
Sept 2024	SQB Graduation 23 Teams, 137 Staff. Total Graduates = 840
Sept 2024	ScIL Belfast Graduation, 21 Staff Total Graduates = 156
Sept 2024	Safetember 2024 https://belfasttrust.pagetiger.com/safetember-2024/2
March 2025	March to Safety 2025 https://belfasttrust.pagetiger.com/march-to-safety-2025/1
March 2025	Emergency Department / Zone B QI Projects Celebration
Ongoing	43 Shared Learning Documents on the Loop

	Learning Library
Ongoing	Belfast Support team (BeST) 127 Peer Supporters. 8 requests
Ongoing	EQI Training, 143 Staff Trained. Total Trained = 2021
Ongoing	Schwartz Rounds, 8 Sessions for 300+ Staff
Ongoing	QI Project Surgeries, 25 Completed

Feedback

'I feel these sessions are so beneficial and allow a safe space to discuss issues within work that are not always made vocal'.

'Relly excellent and can't wait for the next one'

Personal and Public Involvement (PPI) - Explaining Key Work

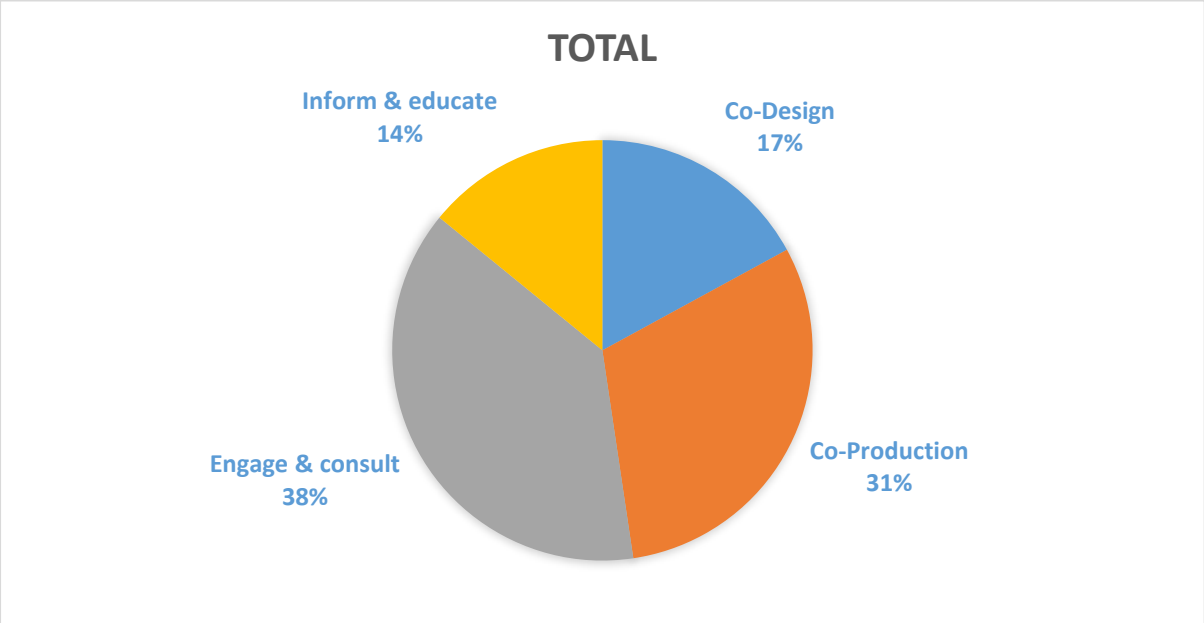
Belfast Health and Social Care Trust continue to advance work to embed Personal and Public Involvement (PPI) as a key element of Quality Improvement. The Involvement and Partnership Team work across the Trust to support the implementation of the statutory duty to involve and continue to implement the Department of Health Co-Production guide and the Belfast Trust Involvement Strategy, 'Involving You – From Them and Us to We' (2019-2025), which sets out the Trusts vision, commitment and integrated approach to Patient and Client Experience, PPI and Co-production.

PPI is included in the Trust Assurance Framework and reports via the Involvement Steering Group. The Trust captures involvement activity taking place across the Trust on a bi-annual basis. During the 2024/25 period, the following involvement work was reported:

Round 3: April – September 2024 – 71 returns submitted

Round 4: October 2024 – March 2025 – 99 returns submitted

Involvement is undertaken at different levels with co-production being seen as the pinnacle of involvement. Across the Trust a range of involvement activity is being undertaken across the different levels.



The Trust is required to submit this information to the Public Health Agency bi-annually to provide assurance that we are meeting our statutory duty to involve service users and carers.

In June 2024, the Trust piloted an Involvement Human Library as part of this assurance process. The Human Library is a safe space for service users, carers and staff to share their lived experience of their involvement journey – how they found it, the challenges, benefits and the impact it made. The Trust showcased five involvement projects with service users, carers and staff involved being invited to meet with the Public Health Agency to talk about their involvement work and understand the difference that involvement made to the programme of work.

Trust involvement projects showcased:

- Deaf Sign Language Forum
- Learning Disability Accommodation Group
- Carers Network
- Learning Disability Communication Passport
- Snowdrop Group

Photo – Involvement Human Library event. Learning Disability Team, PPI Team and Public Health Agency

PPI Training

The Involvement and Partnership Team deliver a modular based training programme, Engage & Involve, to support the development of staff knowledge and skills to undertake PPI.

The training provides a range of different levels to allow staff to identify what will best suit their needs. During the 2024-2025, 698 staff participated in PPI training.

PPI Training is always very positively evaluated and comments received include:

- Training was very good with a good amount of information provided.
- Facilitators were very friendly, approachable and knowledgeable on the subject.
- Resources available and examples of work and sharing practical ways of engaging
- Group activity of how to practically use PPI in real life

PPI is a core module of the Trust Safety Quality Belfast (SQB) training programme which includes SQB PPI Advice clinics to support projects to embed involvement.

Service User Carer Opportunity to Participate and Engage (SCOPE) training is also delivered to service users and carers who would like to get involved with the Trust. SCOPE provides an induction to the Trust and the programme of work which they may get involved in. During this year, 8 training sessions were delivered to support 30 service users and carers to better equip them with knowledge and skills to get involved.

Opportunities and support for involvement

Information regarding PPI is shared across the Trust via the dedicated LOOP section on the Trust intranet platform. This provides access to PPI training and resources including a range of tools. The Trust external website, 'Involving You' section was updated to ensure a range of information is available to service users, carers and the public who wish to get involved. A total of four newsletters were developed during this period to showcase the range of involvement work being undertaken:

The Trust maintains the virtual Involvement Network and regularly promotes involvement opportunities. During this year, we have reviewed service user and carer membership to ensure it is up to date. The Network provides a platform to share involvement opportunities and

keep a range of stakeholders up to date with opportunities to get involved and training available.

Work with service users and carers during this period has included:

- Co-producing a Seniors Booklet
- Reviewing and renewing the Sign Language Group to evolve into a Forum model to engage with wider communities
- Facilitating the Learning Disability Community Forum

There continues to be a wide range of service user and carer engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which facilitates people to become involved in the development, improvement and evaluation of Trust services. Staff strive to ensure that involvement opportunities are accessible to people and that people are supported to be involved in a way that suits their needs, experience and ability. Opportunities to get involved are shared via the Trust Involvement Network and across services.

There are several Trust-wide User Forums and specific Service User groups facilitated by and linked to the Trust, which can provide opportunities for service user and other stakeholders to engage in decision-making, feedback processes and associated risk issues. Groups include the Carer Network, the Snowdrop Group and HIV Service User Forum.

The Trust participates in the Regional PPI Forum which is hosted by the Public Health Agency and its related subgroups to advance involvement.

Reader Panel

The Trust Reader Panel has increased its membership to 27 people who are service users and carers who work with the Trust to improve patient information. The Panel reviews and feedback on a range of Trust information produced by different Services and has included patient information leaflets, posters and booklets.

Celebrating involvement

The Trust continues to recognise the service users and carers who get involved. In April 2024, the Trust launched the ‘Celebrating Involvement’ artwork at Belfast City Hospital. The artwork was a collation of individual mosaic hearts, which had been created by service users, carers and staff at the Trust Involvement Celebration event in 2023. All the individual mosaics were used to develop the artwork which acknowledges and recognises the significant input which service users and carers make to Belfast Trust to help us to continually improve in partnership.

Re-energising Involvement - Involvefest 2024

The Trust hosted ‘Involvefest’ in November 2024 to refresh involvement. Through this work, the Trust provided support for PPI through staff training, hosting PPI clinics, engaged new service users and carers to join the Involvement Network and hosted 3 Workshop events to engage service users and carers to have a conversation to advance involvement.

Improvement Projects

Have A Say About Your Day

Team: Jenny Busby, Niamh O'Donnell, Christine McClean, Fiona Magee, Dean Lewis

With thanks to Helen Ward (Ward Manager) & all staff on Six Mile Ward
Muckamore Abbey Hospital

Project overview

Six Mile is a forensic ward within Muckamore Abbey Hospital (MAH), a Mental Health and Learning Disability Hospital. The ward houses 8 service users.

Concerns were raised about the low levels of engagement in meaningful activities whilst on the ward.

Why this project?

The learning disability population engages significantly less in meaningful activities compared to the general population. This lack of engagement in activity can adversely affect quality of life, mental health and potentially lead to behaviours of concern.

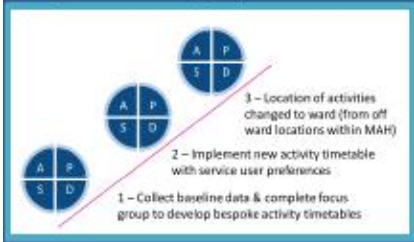
As these service users work towards community resettlement, it is crucial to enhance their activity engagement prior to their discharge.

Aim

Increase total number of activities attended on a weekly basis, by providing bespoke activity timetables, by 30% for service users in Six Mile ward in Muckamore Abbey Hospital by May 2024

How did we do this?

Progress of the project



Safety & quality

HSC Belfast Health and Social Care Trust
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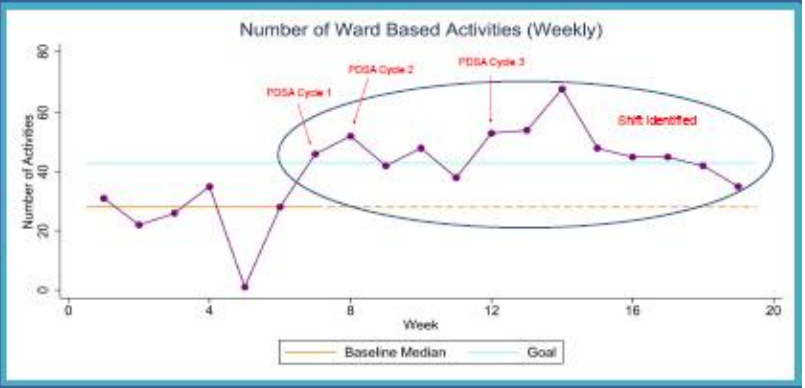
What did we find?



Results

Increased engagement. Service user engagement in ward-based activities increased by an average of 66%

Positive Feedback. Both service users and staff provided positive qualitative feedback.

High Support Success. Activities were most successful when conducted on the ward with high levels of staff support.

Leadership Impact. Success was dependent on the project team leading the activities.

Moving forward

Natural embedding. Consider ways to integrate activities more naturally into the daily routine to reduce dependency on the project team's high input.

Mitigating fatigue. Develop strategies to mitigate against staff and patient fatigue, which was seen towards the end of the project.

Upskilling staff. Ensure that ward-based and community staff, are trained in the importance of person - centred activity.

Benefits to the Service

Empowerment. Service users were included at all stages of the project, empowering them to share their views and make choices.

Integrated targets. Speech and Language Therapy and Occupational Therapy targets were embedded within the activities.

Quality of Life. Positive responses from service users and staff indicated a significant impact on quality of life.

Personalised support. Development of personalised advice sheets for all service users to highlight their specific interests and level of support required to engage in activity.

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We can't get no (20%) satisfaction!

Safety & quality

SQB 2023-2024. Project Team 10:

Rachel Hill, Emma Molloy, Orla Holmes, Ryan Leslie, Amanda Crossan, Damian O'Neill.

Background

- Cystic Fibrosis (CF) outpatient clinics run in a unique manner to avoid direct patient to patient contact in order to minimise the risk of cross infection.
- To effectively do this, patients with CF (pwCF) are allocated individual rooms at clinic and each discipline within the CF team then assesses the pwCF in turn. Thus, patient appointments can be between 1 and 2 hours long.
- We feel the patient experience and the flow of CF staff within these CF clinics could be improved to benefit all parties.
- We decided to engage with patients from the outset to formally examine their satisfaction with the current clinic format. We anticipated that by reviewing and changing in line with feedback, we would improve the patient experience.

Aim Statement

To improve the patient experience of attending CF outpatient clinic, through co-production and streamlining of current practice. This will be demonstrated by a 20% improvement in patient satisfaction.

Outcome measure:

Routine Clinic Patient Experience Survey & Patient stories

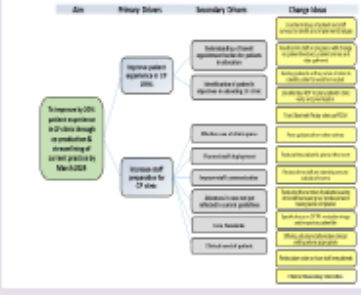
Process measures:

- Checklist for CF staff for CF clinic
- Patient questionnaire at end of CF clinic

Balancing measure:

Time and motion studies from Clinic (pre & post) by end of June 2024

Driver Diagram



Patient feedback

"At the end when I see the doctor on a few occasions I haven't been told I can leave and end up being forget about in the room"

"I may not often need to see every member of the team at every appointment if my condition is stable, so if I could chose who I would like to see this could speed up the process"

"The travel as I am from Newry, so can take a while out of my day."

Pareto Charts

The Patient survey identified many areas of potential improvement. Thematic analysis found that the majority of patient dissatisfaction stemmed from two areas; Convenience and Patient-centred care. The follow-up survey showed improvement in both these areas.

PDSA Cycles

- Questionnaire to all CF patients at clinic
- Introduction of pre-clinic telephone calls to provide choices

PDSA Cycle 1.

A series of five PDSA cycles were performed with minor changes to the format, timing and content of pre-clinic calls as well as the format of the clinic itself. These tests of change, showed an improvement in patient satisfaction, attendance at clinic and provided the opportunity to fill slots that were created by patients who confirmed their inability to attend.

Run Charts

Discussion – hurdles, barriers, enjoyment, what did you learn, benefits for service area, finances, other reflections

We realised that whilst we do have high levels of patient satisfaction in our service there are issues in relation to patient flow in clinics that need to be addressed such as patients not knowing when their appointment is completed so they can go home.

We gained better understanding of the parking issues, travel distance and pressures our patients face when they attend a CF clinic appointment.

We learned a lot about our team and how everyone views change differently and of the need to work together. The PPI input and patient surveys provided invaluable perspective on our service.

As part of our improvement plan, we also surveyed 9 other NHS CF centers across the UK and Scotland, to determine if anyone had solved the problems associated with CF clinics.

We learned QI methodology from our many challenges, mistakes and real life experiences.

Post-project, patient feedback.

"Choice between face to face or virtual is great for those travelling a fair distance or have busy lives. Especially if they attend regularly."

"They (clinics) seem more structured and efficient. The thing I like most is getting the chance to talk to the specialists I need to see most for that visit and getting the chance to see all the team."

Future plans

We have learnt that despite strong satisfaction from patients using the CF service, there were several areas for improvement.

These included:

- a need to provide more choice in the format of appointments, eg: Telemedicine of phone clinics.
- Improving communication within clinic.

The next stage in our QI journey will explore the potential of a hybrid model of virtual and F2F clinics for patients. Despite our high satisfaction rates, patient's clearly wish to have both choice and involvement in how their care is provided.

Heading Home Together

B. Rao, C. Black, C. Glover, B. McCann,
S. Hollywood, G. Hanna.
Regional Neonatal Unit, Royal Maternity Hospital

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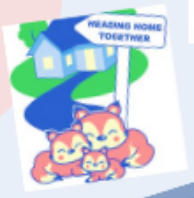
Safety & quality

REGIONAL NEONATAL INTENSIVE CARE UNIT BELFAST



A family integrated Care Project

Background

Family integrated care is an evidence based model of care that improves outcomes for infants and their families

It is recommended by the British Association of Perinatal Medicine

The benefits:
- Reduced mortality
- Reduced infection rates
- Increased breastmilk feeding
- Earlier discharge
- Improved parent wellbeing

The goal of FICare is to facilitate partnership between parents and NICU staff, to promote parent-infant interactions, and to build parent confidence

It involves:
- Empowering parents
- Focusing on parent wellbeing
- Parent involvement in cares
- A welcoming and supportive environment
- Unit culture change

Parent Voices

"We live 90 miles from the hospital, so we have a lot of travelling. We also have other children at home"

"Thanks for the fantastic parents' program that brings us all together"

"The required milestones to my baby being able to come home have not been clear"

"We have been so thankful for the staff and facilities provided"

Aim Statement

To improve parent experience scores of family integrated care (Ficare) in Regional NICU for high risk infants, born *less than 32 weeks* by 10% by the end of June 2024

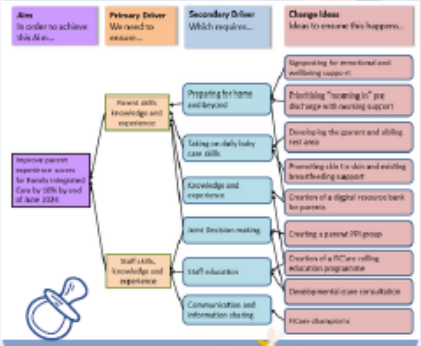
Parent PPI Group

We created a Parent Advisory Group to inform our changes and give a parent perspective on:

- Creating our questionnaire
- Understanding what parents want from the NICU team in supporting FICare
- Developing parent education sessions
- Creating parent friendly resources

What changes?

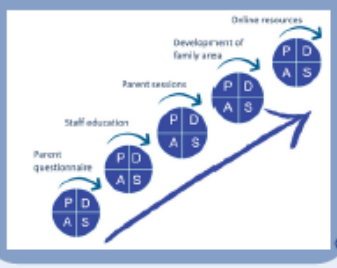
Our driver diagram demonstrates the changes we decided to make to achieve this aim



PDSA Cycles and Changes

We created a parent experience questionnaire to capture data
This is a measure of how well we are implementing Ficare and how this impacts parents' experiences taking care of their baby

We implemented PDSA cycles based on change ideas and continually collected data when babies reached 28 days old and at the point of discharge



Challenges and Learning

Challenges	Getting questionnaires completed Time for staff training
Learning	QI Methodology PPI processes Developing multiple modes of teaching materials
Enjoyment	Working with past parents Teamwork across the unit Seeing the benefit for families
Benefit to families	Confidence in caring for their baby Holding baby Siblings meeting earlier

What's next?

- Starting a Developmental Care Ward round
- Rolling out the FICare model through the Neonatal Network
- Ongoing liaison with the Parent Advisory Group
- Linking into our Buttercup Discharges Project
- Moving into a New Maternity Hospital with single rooms
- Creating a monthly parent feedback dashboard to create legacy and keep up motivation for change

Project Progress in Data

We obtained baseline data demonstrating a median questionnaire score of 104

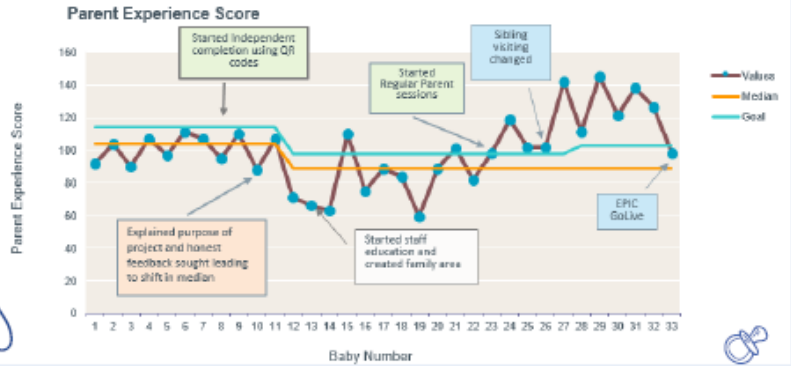
On reviewing the responses, we recognised parents were being overly generous in their feedback and we explained the purpose of the project more clearly

Subsequent questionnaires reflected more realistic feedback, which shifted the median baseline and therefore the 10% "goal" line

Over time, PDSA cycles had an impact on the parent experience scores

Our Run chart demonstrates that an initial trend upwards in parent experience scores eventually turned into a *shift* over the goal line, in keeping with a sustained change

Since the EPIC go-Live we have noted a dip below the goal line again and this has given us a new motivation to keep up our changes and refocus from computers at the bedside, back to parents and babies!



From 'Us & Them' to 'We' in RD*

NHS Education for Scotland

*Radiotherapy Department
Belfast Cancer Centre

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

AIM: To increase feedback from service users to 20% of new treatment referrals = 16 items per week

Introduction: The Burning Platform for Change: The Radiotherapy Department is made up of 120 people across 4 teams. Approx. 4,000 new patients are referred for treatment each year. Over the last 5 years there has been a decline in feedback from service users. Data shows that in 22/23 there was an average of *4 items* of weekly feedback compared to 10/8pw in 19/20 & 18/19 respectively. To meet legal obligations in relation to Personal and Public Involvement (PPI), Trust Corporate Objectives, RD Team Objectives 23/24 & to satisfy CHKS accreditation a target of 20% of total new referrals was set for 23/24 = 16pw. Committed to excellence in service delivery, to continuous improvement the teams wanted to know what it was doing well & what it could do better to improve patient/carer/family experiences and outcomes.

Methods: The Model for Improvement was used with PDSA cycles to drive improvement. A process map (Fig 1) with staff and patient feedback helped understanding of the current system. Drafting a project charter and developing a driver diagram (Fig. 3) generated change ideas for testing. **PDSA cycles** were then used to implement and evaluate tests of change. This meant there was clarity around what we wanted to achieved and what changes could be made to achieve our aim. Weekly run charts were created to help identify when a change led to an improvement and to share the progress of our project. Kotter's 8 steps were used with a particular emphasis on creating a sense of urgency. Following support from the Service Manager, 16 meetings with project change champions from the staff group (Fig. 2), patients and volunteers occurred throughout the project

Fig. 1: Process Map following staff meeting

Fig. 2: Project Change Champions

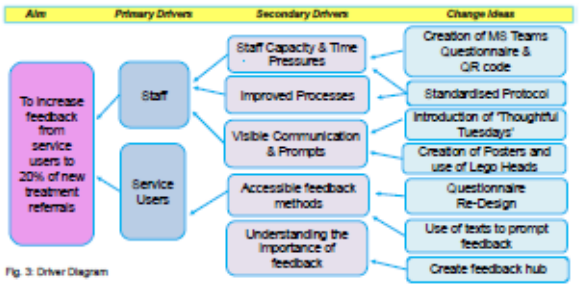
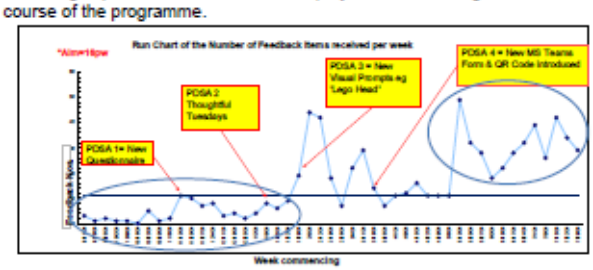


Fig. 3: Driver Diagram

Change Ideas:

1. New more accessible questionnaire
2. Lego Heads to collect forms
3. Thoughtful Tuesdays
4. Posters as prompts
5. Feedback Hub set up
6. MS Teams Form
7. Creation of QR Code

Results: The run chart below shows the outcome data of feedback items per week and is annotated for the 4 PDSA cycles. The first 20 data points show a shift being lower than the median of 11. After PDSA 3 there was a non-sustained increase in feedback, At this time there were staff and capacity issues. A greater understanding of the system created more dialogue and focus within the department around this issue. With PDSA 4 a new MS Teams form and QR code with a dedicated member of staff was assigned, following this the data demonstrates a shift with 12 data points above the median indicating improvement. There were 20 project team meetings over the course of the programme.



Process Changes:

PDSA 1: New Re-designed Feedback Questionnaire (co-produced with staff, patients, carers and volunteers)

PDSA 2: Implementation of one focused day per week to gain feedback by staff branded 'Thoughtful Tuesdays'

PDSA 3: Use of visual aids inc new feedback boxes shaped as Lego Heads / a feedback hub and new posters

PDSA 4: Use of new online Questionnaire & QR code used via text and in patient literature

Measures

Outcome= Number of feedback items per week

Process= Number of project team meetings

Conclusion: There was an improvement in the outcome measure and continued work will confirm if this is sustained.

Personal Learning: Although the Model for Improvement was helpful in achieving improvement it was a challenge to deliver a project when based in a different site within the Trust. Using a Run Chart aided in sharing progress but requires understanding of data. The project was helped by involving an executive sponsor. I will continue to utilise the skills from this QI programme.

Next Steps: Sustainability is key for the future of this project. It will rely on the ongoing participation and enthusiasm of feedback champions. The development and delivery of a standard operating procedure has been identified as a vital next step in enhancing our process.

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ScIL Scottish Improvement Leader

Redesigning the collection of choking incident data for Belfast

Starting the journey of utilising choking data proactively.

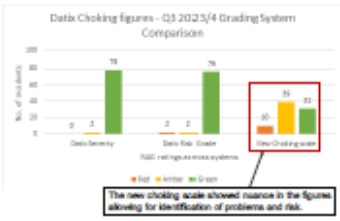
There has been great focus across Northern Ireland over the last five years on improving dysphagia care for our patients. Across the region we collate figures on the number of choking incidents occurring across all care services and report these to the Public Health Agency. However, we are unable to use these figures pro-actively to assess risk in our daily work as the scaling lacks detail. In order to better direct policy, care and resources we need our data to have more nuance. This is a large task and through learning about our system in Belfast, it was initially broken down into two key areas. 1) Increasing accuracy of current risk scaling and 2) Creation of useful communication format and means to channel to teams. As work began, it became evident that we needed to add another strand which was 3) Improving staff accuracy in incident reporting. In order to progress, we needed to address this issue first. **Aim: To decrease the amount of choking incidents incorrectly categorised on datix by 30% by the end of March 2024**

Method

Analysis of our current data set showed our system had little nuance and had no capacity for risk analysis. We developed a new choking severity scale (based on Sheppard et al, 2017*) in conjunction with wider SLT and datix teams.

Level	Classification of severity
0	Risk identified, with preventative action taken (no actual choke)
1	Incorrect item offered/taken without choking incident (e.g. incorrect IDDSI level, thickener, medication form or communication of SLT recommendations)
2	Coughing on any intake. SLI self-cleared
3	Intervention required by other(s) to clear occlusion (e.g. backslaps, abdominal thrusts and or suctioning)
4	Emergency care needed (e.g. ambulance called, medic called to scene)
5	Admission to ward/unit or transfer (if inpt) for pulmonary consequences

By retroactively applying this in an early PDSA, it helped us know our system better and showed up areas that were underreported, namely the more 'minor' incidents.



Further exploration showed that many of these incidents were not unreported but misclassified as 'nutrition' or 'other' and therefore were not showing in the choking data. We then had to change the direction of focus to staff knowledge with regards to what and how to report a choking incident before we could move forwards.

Process changes

Through a driver diagram we identified a need for targeted training of all staff and a need to target Nurse Development Leads in particular to assist in reinforcing the message. We met with leads and were able to add our message to nursing team meetings.

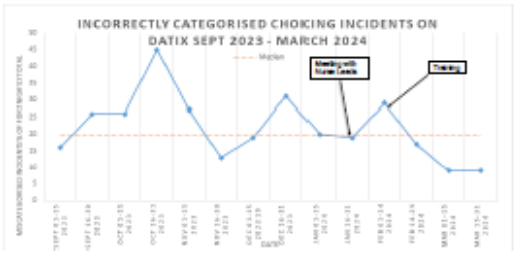
We developed a short training video to go out to all staff which could also be shared with teams by their leads. This was a two minute video demonstrating what constitutes a choking incident (by regionally agreed definition) and how to report them. This was developed in conjunction with the Datix team, and in line with their training aims. This went out across the Trust.

Measures

- Outcome: Percentage of total choking incidents that were misclassified
- Balancing: Therapist time to collate datix information.
- Process: Number of Nurse Development Leads addressed. Number of participants competing the training

Results

Initial data showed that a median of 20% of all reported choking incidents were being misclassified. Although no definitive conclusions as to improvement post training can be drawn as there is not enough data to show a certain shift or trend, the initial figures are promising and appear to be moving in the right direction. Further monitoring through the next couple of months is needed to see if this marks 1) a shift and 2) if that is sustained.



Next steps

Further to the targeted training on choking datix completion, the datix team are adding a wider training component on correct completion of datix more generally. This will help to reinforce current messaging and aid standardisation for this project. Monitoring of the current data will continue. Work is continuing to make the choking incident training accessible on the Trust intranet.

There are many more stages to this project to get to our final aim of meaningful choking data shared with teams for pro-active risk identification. A key final component will be correlating our collection with the regional checklist to enable smooth thematic analysis.

Learning from this project has really shown me the importance of working across teams and taking time to know your system. Within Trust it has helped raise awareness of the importance of accurate data collection by fundamentally working together towards creating a data system that can then work for us. Data collection becomes more meaningful and by engaging others in the design of our system we can ultimately create better care.

*Sheppard, J.et al. "Validation of the Choking Risk Assessment and Pneumonia Risk Assessment for adults with Intellectual and Developmental Disability (IDD)." Research in developmental disabilities 66 (2017): 61-79.

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2. STRENGTHENING THE WORKFORCE

Staff Induction

Statutory Mandatory Training

	Position at March 2024	Position at March 2025	Percentage Improvement
Adverse Incident Reporting	71%	89%	+18%
Quality 2020	61%	77%	+16%
Information Governance	*	66%	*
Equality, Good Relations & Human Rights	*	51%	*
Fire & Environmental Safety	38%	51%	+13%
Health & Safety Awareness	71%	89%	+18%
Infection Prevention Control	*	*	*
Manual Handling	*	56%	*
Safeguarding Adults & Children Level 0	69%	86%	+17%
Overall, Trust position	*	65%	*

Corporate Welcome

In June 2024, Belfast Trust introduced the new EPIC electronic patient record system, marking a major step in how we deliver care and manage

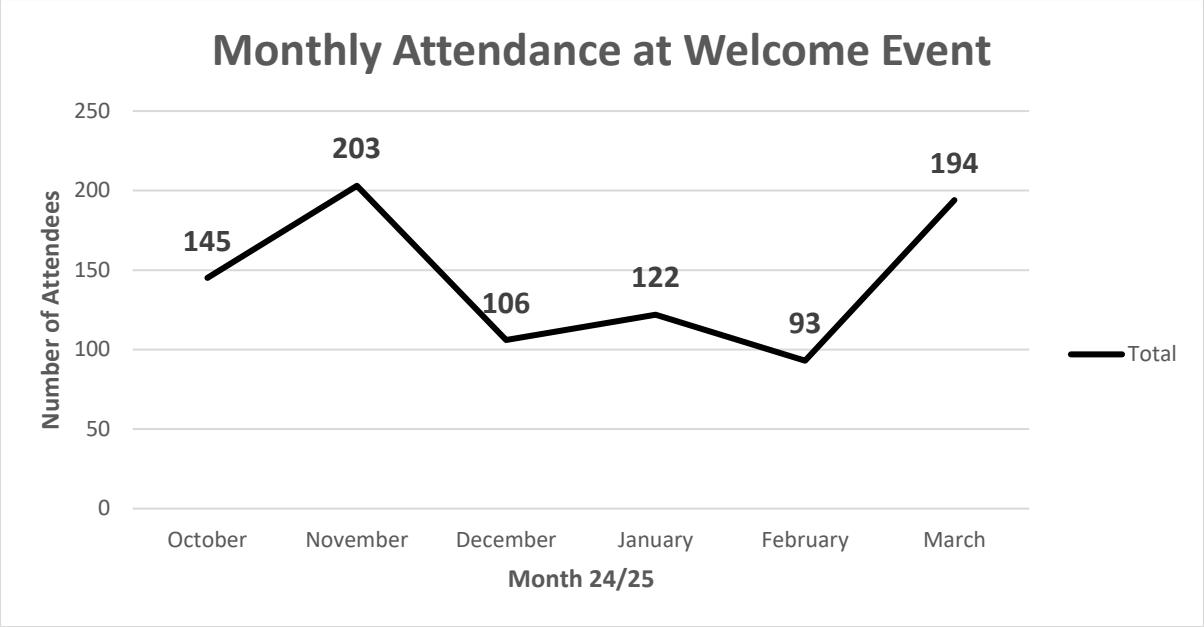
services. This transformation also brought an opportunity to enhance how we welcome and onboard new staff.

Feedback from staff surveys, focus groups, and managers highlighted that our previous onboarding process felt too long, too complex, and disconnected. In response, we redesigned the experience to ensure that every new colleague feels informed, connected, and supported from day one.

We introduced a digitally enabled, people-first onboarding model built around our HSC values. Key features include:
• A single start date with a monthly corporate welcome event for all new starters — regardless of role or grade — to build a sense of community and connection across the organisation.
• Improved communications and pre-arrival information, helping staff feel prepared and informed before their first day.
• Close coordination between IT, HR, and Payroll teams to ensure systems and access are ready from day one.
• A streamlined model, delivered by just five HROD staff, capable of welcoming over 240 new colleagues each month.

Since its launch:
• **864** staff have attended welcome events across **8 events**
• **76%** of participants rated the session 8 or above when asked ***how likely they were to recommend it to a friend or colleague***

This new approach sets the tone for a positive employee experience from the start, helping staff feel part of the Trust community from day one.



Vocational Learning

The Vocational Learning Team within POD has continued to support the development of healthcare support staff through the RQF programme. In September 2024, **three** candidates successfully completed the **RQF Level 2 programme**, while **eight** candidates completed the **RQF Level 3 programme,** with a further two completions expected. Fifteen candidates began the RQF Level 3 programme in January 2025, including two from theatre settings. These programmes continue to play a vital role in strengthening the knowledge, skills, and confidence of staff working in clinical support roles across the organisation.

95% of new Nursing Assistants completed the Nursing Assistant Induction between April 24 and March 25

Supervision, Coaching & Mentoring

Coaching continues to be a valued part of the Trust's approach to leadership development, supporting personal growth, reflective practice, and confident decision-making at all levels.

- 13 staff commenced a coaching qualification in February 2025
- 9 staff successfully completed a recognised coaching qualification.

- 20 staff accessed 1:1 coaching to support their development.
- Coaching supervision was delivered by 2 senior HR coaches, providing dedicated support to 25 social work leaders.

As part of our wider leadership offer:

- The Coaching Skills for Leaders portfolio course was attended by **95** staff, equipping managers with essential coaching approaches for everyday conversations.
- **31** staff participated in the "Manager as Coach and Mentor" module within the Managing with Care programme this year, reinforcing compassionate, values-based leadership.

This continued focus on coaching helps embed a culture of curiosity, reflection, and empowerment across our leadership community.

Leadership programmes

Leadership development continues to be a strategic priority for the HR People and Organisational Development team, helping staff build the confidence and skills needed to lead effectively and grow into future roles.

No. of Participants *(April 24 – Mar 25)*	
HSC Values Workshop	**258**
Leadership & Management Development	**586**
Portfolio Courses	**5,250**
OD Workshops	**405**

This year's offering spanned a wide range of development pathways — from virtual sessions to accredited programmes — designed to empower

leaders at all levels. The Managing with Care programme ***(48),*** along with the Aspiring Managers Programme ***(261),*** ILM Level 3 ***(28)*** and 5 ***(5),*** and the Band 6/7 Leadership Programme ***(244),*** have all played a key role in developing leadership capability and building confidence across the organisation. Programmes were delivered using blended learning approaches, including peer-based sessions, action learning, interactive webinars, and practical toolkits.

Being Belfast Learning Academy: Foundations of Leadership
Development is underway for the Being Belfast Learning Academy, a new learning ecosystem that will house all future organisational development and learning content.

The first curriculum to launch is the Foundations of Leadership, designed to support staff new to leadership roles. This programme will equip new managers with the essential skills, behaviours, and tools to lead effectively and in line with HSC values. It is:
• multi-dimensional
• Self-directed and interactive
• Tailored to real-life management challenges

The Foundations of Leadership programme will be mandatory for all staff stepping into leadership positions, with an expectation that it is completed within the first 6 months of their role. This ensures protected development time from the outset and a consistent approach to early leadership development across the organisation.

Impact of Encompass Implementation
During the Encompass rollout in June, July, and August 2024, Learning & Development activity was stood down, with only urgent Organisational Development interventions being progressed during this period.

During this period, the People and Organisational Development Team played a key role in supporting training efforts, with approximately 19,000 staff trained on the Encompass system.

This represented a significant organisational effort and was a major enabler of the successful Encompass implementation.

Digital Learning via LearnHSCNI

Belfast Trust continues to prioritise accessible, high-quality training for all staff, supporting safe, effective, and compassionate care across the organisation. A major enabler of this has been the rollout and continued development of the LearnHSCNI Learning Management System (LMS).

During 2024/25:

- **9,044** new LearnHSCNI accounts were created for Belfast Trust staff
- The platform supported **34,902** active users
- Staff obtained **54,148** mandatory training certifications

LearnHSCNI now acts as the central platform for all learning activity and recording, including booking training related to the Encompass electronic patient record system. This integration ensures that learning is aligned with wider digital transformation efforts across the Trust.

The platform continues to offer:

- Clear visibility of compliance and renewal dates
- Personalised learning pathways tailored to staff roles
- Flexible access to virtual and in-person learning
- A streamlined “My Learning” dashboard for staff and managers

With ongoing development of the platform, LearnHSCNI is supporting a culture of continuous learning and digital confidence, ensuring staff are

equipped with the knowledge and skills they need at every stage of their career.

Staff Achievements - Recognition Certificates

As part of the 2024 Staff Experience Survey, employees were once again invited to recognise colleagues who had made a positive impact in their workplace. This initiative, which allows for anonymous nominations, continues to shine a light on the everyday excellence that often goes unnoticed. These certificates serve as a simple yet meaningful way to appreciate the efforts of individuals who contribute to a supportive and effective working environment. To mark these achievements, virtual recognition events were held in November 2024.

3,724 Recognition Certificates have been awarded. Totalling to almost 10,000 since 2021.

- *"I received two [certificates] and was so honoured! Thank you very much to you all and for holding this event to recognise it all".*
- *"I was honoured to receive two recognition certificates for holistic care of ICU patients - lovely to receive and know that people took time to make nomination, and thank you to trust for organising this event"*
- *"Thank you! And well done to everyone recognised. Thanks too to those who arranged this event - very much appreciated".*

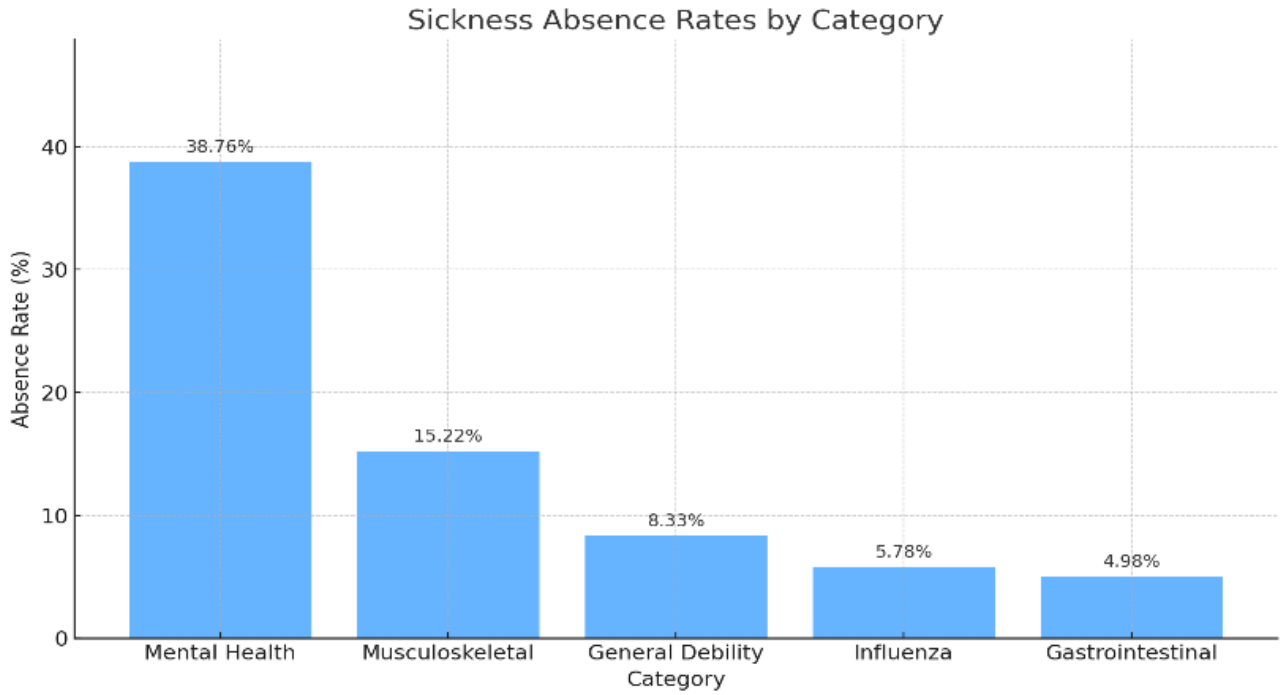
Staff Absenteeism

The Trust remains dedicated to delivering a safe, effective and high-quality service to patients and service users. It recognises its responsibility to support employees who provide our services by ensuring a working environment that upholds and promotes positive health, wellbeing, and professional fulfilment.

The Trust is committed to managing attendance in a consistent, effective, and compassionate manner, adhering to HSC Values, the Trust Attendance Management Protocol, best practices and employment legislation.

From 01 April 2024 to 31 March 2025 the Trust Sickness absence rate was 9.33% (hours lost) Mental health was the most common reason for absence (38.76%).

Graph showing Sickness Absence Rates by Category



There are numerous reasons why an individual might experience a decline in their health and wellbeing health during their career. The Trust

continues its commitment to offering a variety of health and wellbeing initiatives, resources, and services to support all staff in maintaining their health at work and facilitating a timely return to work when absences occur.

The Trust's Attendance Management policy aims to ensure that sickness absences are managed fairly, promptly, and compassionately, considering the unique circumstances of each employee. The Trust provides the necessary and appropriate support to help employees maintain regular and effective attendance at work, thereby ensuring that patients and service users receive the highest quality of care.

The Management of Attendance Team in Human Resources & Organisational Development continues to work in partnership with staff, Managers, Occupational Health and Trade Union colleagues to support those staff who have had time off because of ill health. In relation to encouraging employees to manage their mental health, the Trust also continues its commitment to support a wide range of initiatives, including.

There is also Understanding Neurodiversity in the workplace support clinic for managers.

During the period 01 April 2024 to 31 March 2025 the Attendance Management Team in HR:

- Provided a monthly absence report to Trust Board.
- Provided absence reports monthly to Directors, & Senior Managers to monitor and support the reduction of sickness absence and comply with Directorate Delivering Value requirements.

- Provided our Trust absence reports to the regional group monthly to monitor and benchmark Trust performance in the region.
- Held monthly Attendance Improvement Programme Board meetings which reports to the People and Culture Steering group via the New Ways of Working Group.
- Supported Line Management and staff through approximately **1141** absence review meetings.
- Supported **89** staff through the process of ill health retirement.
- Supported **139** staff through the process of ending their employment on the grounds of ill health.
- Facilitated and supported **59** staff in the medical redeployment process.
- Held **11** monthly Attendance Case Management Meetings providing the opportunity for Managers, Occupational Health Practitioners and relevant Human Resource Management Representatives to discuss complex cases and agree next steps.
- In complex absence cases the Attendance Team initiated and attended **6** case conference meetings with the Occupational Health team, employees and appropriate line management.
- Delivered Attendance Management training to **876** managers
- Supported managers in the management of attendance through toolkits and bespoke advice

Recruitment and Retention in the Social Work & Social Care Workforce

Key to the delivery of safe and effective services is a sufficient and sustainable social work and social care workforce. Like other professional groups within Health and Social Care there continues to be a shortage in supply of qualified social workers in NI. Measures have been taken at both Departmental (DoH) and Trust level to address this. Forty additional Social Workplaces were commissioned by the Department in 2024 with graduations expected in 2026 (relevant-graduate route) and 2027 (under-graduate route). The Trust is also financially supporting additional places via the Open University pathway

alongside DoH-funded places. To date, 34x staff have enrolled on the OU degree pathway – with 4x graduates to date, 4x graduating in 2025, 4x due to graduate in 2026. 8x due to graduate in 2027 and 14x due to graduate in 2028.

Our workforce is our most valuable asset and BHSCT have established a Social Care Workforce Steering Group and a Social Work Recruitment Retention Strategic Group both of which are focused on stabilising the workforce to ensure the safe and effective delivery of high-quality care. Each group has several Workstreams with focus areas:

Social Care Workforce Steering Group

- Leadership and Management
- Learning and Career development
- Healthy Teams

Social Work Recruitment and Retention Strategic Group

- Organisation and Workforce Capacity:
- Enhancing Leadership
- Being Just and Open Culture
- Staff Experience and Wellbeing

A further corporate workforce group has been established for Children's services in recognition of the challenges with recruitment and retention in these services.

Key achievements

- Leadership Development – social work staff completing Leaders in Practice and Stronger Together Leadership Development programmes, planned delivery of Band 7 Social Work Leadership Development Programme in 2025/26 with a focus on staff retention

- Development of ‘School of Social Work’ via the Being Belfast Academy – developing structured learning and development curriculums focused on leadership for social workers at all levels
- Similar approach being considered for a ‘School of Social Care’
- Planned ‘Social Care Learning and Career Development’ event for 2025/26 – profiling study and job progression opportunities within social care
- Greater understanding of social work vacancies for social work across the Trust – use of requisition trackers to monitor
- Development of reporting processes to understand workforce pressures including vacancies for Social Care
- 4x Valuing Social Work and Social Care Staff events – staff care events promoting physical and mental wellbeing
- ‘Move a Mile a Day in May’ – social work and social care staff participating in month-long initiative to promote physical and mental wellbeing
- Recognition event for 57x social workers who were nominated for the Regional Social Awards 2024
- Growth of the social work Bank within year has added a new supply of staff to some services
- Reduction in staff turnover in some service areas
- Voluntary Transfer Policy developed and due to launch in 2025/26 – retention strategy for Band 6 staff
- Successful recruitment drives across, Regional, Graduate and Bespoke cycles for Band 5AYE and Band 6 social workers
- International Recruitment project commenced in 2024/25 – initial pilot to recruit 10x Internationally qualified social workers
- 3x Staff Resilience Workshops run for social work and social care managers – helping staff think about what they need as a leader to support the resilience of their team
- Development of pilot for non-car drivers – financial support scheme developed within Trust to support newly recruited social workers who do not yet have their driving licence to achieve it within 6 months of appointment. This pilot will be restricted to Family Support and Looked After Children’s Teams.

Challenges in filling all vacancies persist and will require regional collaboration with key partners and will be aligned to the recommendations of the DoH Workforce review recommendations. The Trust continue collaboration with the DoH on workforce plans for safe staffing and are represented on the DoH Social Workforce Implementation Board chaired by the Chief Social Work Officer. The Trust have been consulted by the DOH on a 10-year workforce plan and await publication of same.

Policy Developments and Equality Duties

Trust Governance and Assurance Framework: Policy Standards & Guidelines: In terms of policy development, Belfast Trust has developed a range of assurances to ensure that leaders, policy makers and decision makers are aware of our Section 75 and wider equality duties. These assurances include:

- Policies considered and approved by Belfast Trust Policy Committee and Policy and External Guidance Assurance Committee (formally known as the Standards and Guidelines Committee) provided they have been subject to an equality screening.
- All equality screening templates require a tripartite signature by the policy lead, an equality manager and an employment equality manager as appropriate.
- All our completed and approved equality screenings are uploaded quarterly and are available on the Trust website.
- Our Policy template and ‘How to Write’ a policy guidance are all available on the staff intranet ‘The LOOP’ contains explicit reference to the need for an equality screening.
- Staff have access to a training masterclass on how to undertake screenings and have support of guidance/ toolkit. https://view.pagetiger.com/equalityscreening/1

The Trust screened 94 policies and proposals including 1 Equality Impact Assessment (EQIA) outcome report completed during the 2024/2025 year.

All quarterly reports for the reporting period are made available on the Trust's website:

Equality and Human Rights Screening - Apr to Jun 24

Equality and Human Rights Screening - July to Sept 24

Equality and Human Rights Screening- Oct to Dec 24

Equality and Human Rights Screening - Jan to Mar 25

Read&Write Software Support for Staff

The Trust is the only health Trust in NI to have a license for Read&Write Assistive Technology software. The software is available to all staff, Trust wide without the need for disclosure of a disability.

It is particularly supportive of staff who have difficulties with reading and writing online e.g. neurodiverse staff, staff with a visual impairment, staff whose first language is not English and staff with anxiety. In addition, it is available to families of staff. 500+ staff have accessed the software. It is recommended by Occupational Health colleagues, part of the staff B-Well support hub and promoted by the Social Workers learning and development team particularly for new social workers who use the software in university.

Investment in this software underpins our commitment to provide reasonable adjustments and equity of access for our staff. The software is easily and freely available to all our staff and has proved invaluable in the timely reduction of barriers to online communication. An online Read&Write Staff Guidance has been designed to help staff access the software and to optimise use of the software.

Staff have access to toolkits to support their provision of accessible communication including the use of interpreting and translation services.

https://belfasttrust.pagetiger.com/accessibleandinclusivecommunication/1

https://view.pagetiger.com/belfasttrustinterpreting/1

3. MEASURING THE IMPROVEMENT

Reducing Healthcare Associated Infections (HCAIs)

Central Nursing

Reducing the risk of Healthcare Associated Infections (HCAIs) continues to be a key priority for the Belfast Health and Social Care Trust (BHSCT). A range of strategies are employed to minimise HCAIs, including continuous risk assessments for patient placement, strict adherence to hand hygiene practices, appropriate use of personal protective equipment (PPE), implementation of Aseptic Non-Touch Technique (ANTT), antimicrobial stewardship, maintaining a clean environment, and effective decontamination of equipment. Wards and departments, with oversight from Health Care Associated Infection and Antimicrobial Stewardship Improvement Team, remain committed to driving improvements and fostering positive change in these areas.

Measuring the Improvement

The Department of Health (DoH) Northern Ireland set new Maximum Target Incidence Rates for MRSA blood stream infections and Clostridium difficile infections (CDI) in line with the new UK AMR National Action Plan 2024-2029. Given the challenges associated with reducing Gram-Negative Bacteraemia (GNB) infections to date, no maximum target was suggested for 2024/25, but rather each Trust were encouraged to minimise risk factors for GNB infections where possible.

The 2024/25 Maximum Target Incidence Rate for CDIs was 23.7% with an outturn of 21.68%. For MRSA bacteraemia the Maximum Target Incidence Rate was 4.313% and the outturn 2.71%.

HCAI 24/25	Cumulative Incidence Target Rate Outturn	Maximum Incidence Target Rate 24/25	Outturn 24/25	Target per quarter based on 100,000 Beddays	Percentage cases per month as of end of Mar 25	Cases April - March
C.difficile	21.68	23.7	22.0	5.93	22.0	118
MRSA	2.71	4.313	3.0	1.08	3.0	16
All Gram Negative*	223	42.64	41.5	10.66	41.5	223

2024/25	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
*C.difficile**	9	10	12	8	9	13	13	8	13	6	8	9
MRSA	3	0	3	2	3	2		1	1		1	
All Gram Negative #	11	24	21	18	27	20	22	16	16	20	18	10

Below is the BHSCT's five-year datasets for CDI and MRSA bacteraemia.

Clostridium difficile

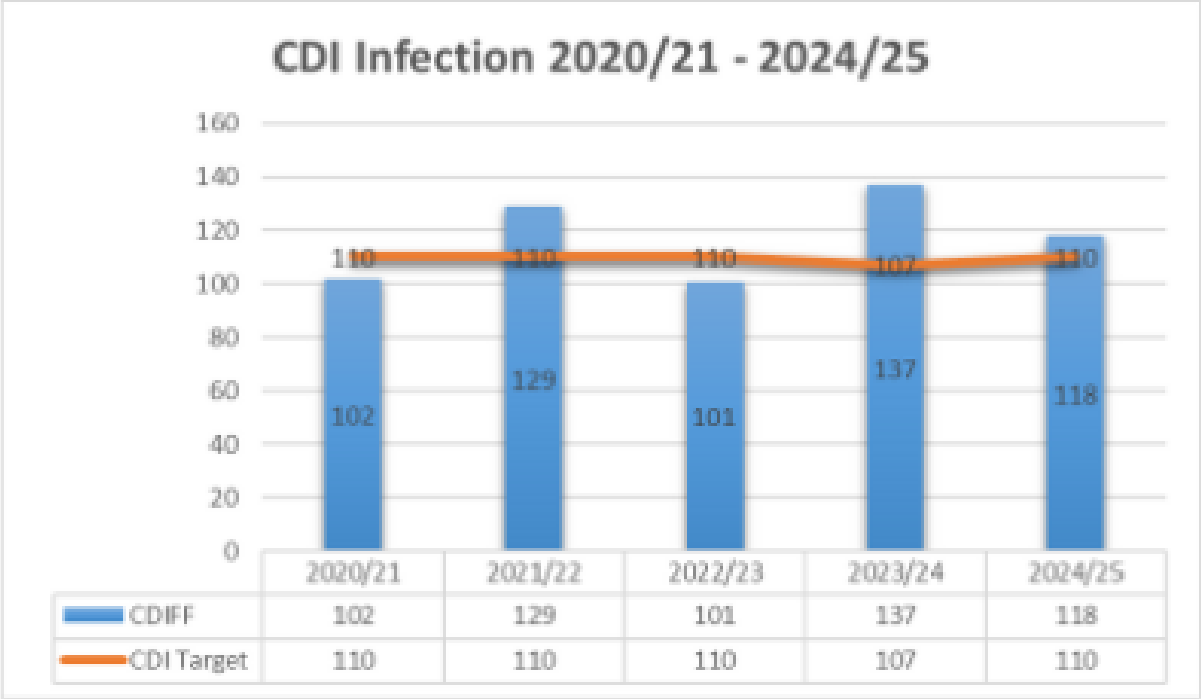


Chart showing Total Number of *Clostridium difficile* Infections. Target = 110, Result = 118 (01.04.2020 – 31.03.2025).

Post-COVID-19 there has been a significant increase in *C. difficile* infection rates both regionally and nationally, potentially the contributory factor is increased use of antimicrobials in both primary and secondary care. The patients presenting to BHSCT ED are often sicker than those that historically presented. In addition, this increased presentation to EDs frequently equates to inpatient wards running at over-capacity with longer patient stays, which in turn has a direct and commensurate increase in antibiotic use.

There is regular microbiology input, in both ICU and haematology/oncology, areas have significant input from the Antimicrobial Stewardship pharmacy team and audit findings indicate antibiotic prescribing is appropriate.

Post Infection Review Learning: *C. difficile* infection recorded on Part I of the death certificate.

MRSA Bacteraemia

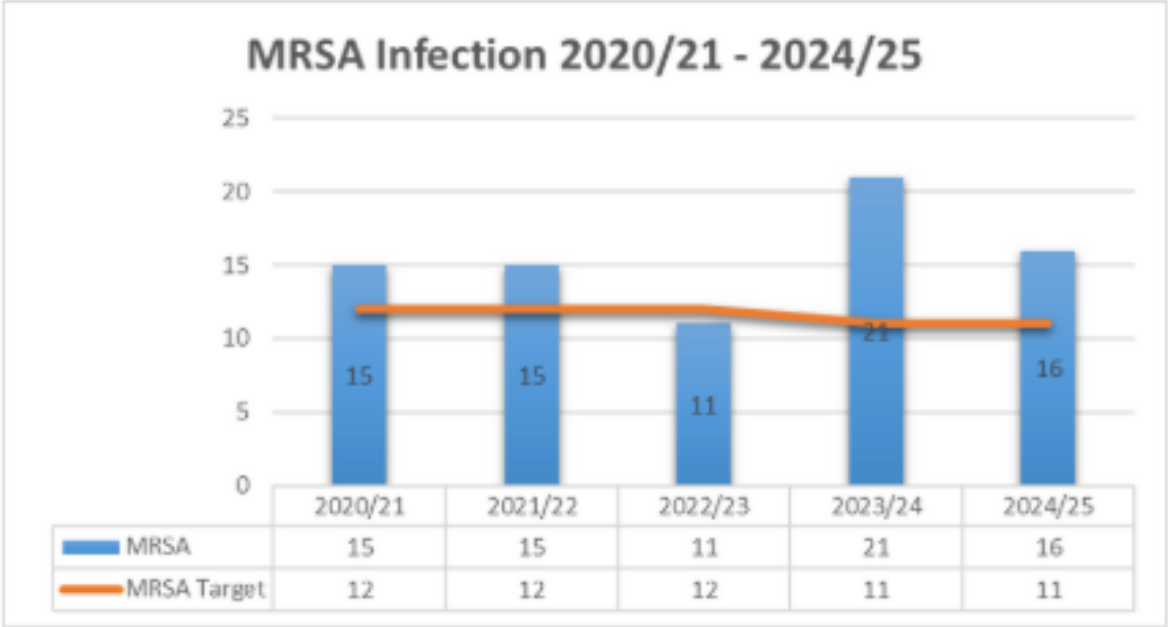


Chart showing Total Number of MRSA bacteraemia episodes. Target = 11, Results = 16 (01.04.2020 – 31.03.2025).

Post Infection Review Learning: MRSA bacteraemia

Importance of timely completion of an IPC risk assessment on every patient when admitted and on transfer to assist in effective communication between wards and departments.	Ensuring compliance with the '*Methicillin Resistant Staphylococcus Aureus screening and management of colonised patients'* policy, ensuring 'at risk' patients are screened timely and correctly. Followed by subsequent suppression or decolonisation therapy as appropriate.	Management and monitoring of peripheral venous catheters (PVCs) and central venous catheters (CVCs) – siting only where clinically required, ensuring detailed record keeping of clinical indication, insertion dates etc., removal of vascular access lines when no longer clinically indicated.
Escalation through the Divisions of the mandatory requirement of medical staff to have two yearly or yearly ANTT assessments (depending on the area of work).	The requirement for service groups to carry out auditing of ANTT, hand hygiene and PPE.	Insertion of urinary catheters only when clinically indicated, applying the principles of ANTT, and removal as soon as they are no longer required.
Importance of daily review of patient placement and importance of retaining accurate records of patient placement.	For deaths attributed to MRSA bacteraemia, ensuring consultants/senior clinicians have oversight of juniors completing death certificates.	Documenting the taking of blood cultures including date, technique, by whom and how many attempts were required.

Gram-Negative Bacteraemia

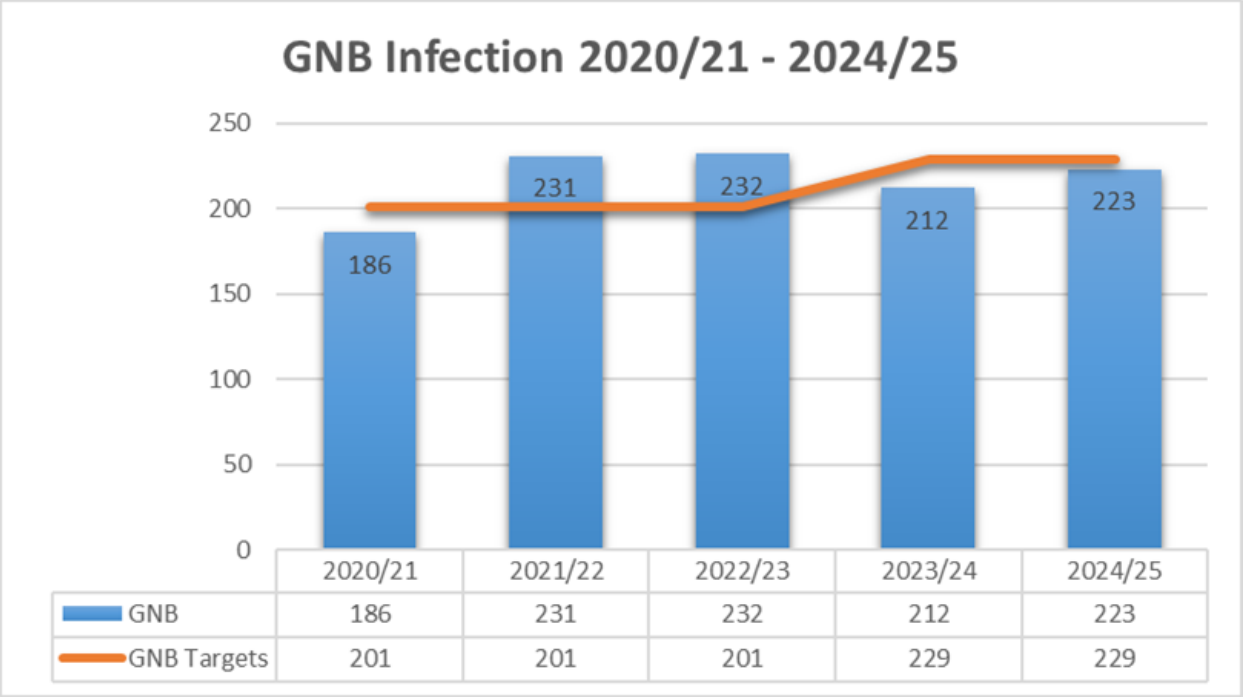
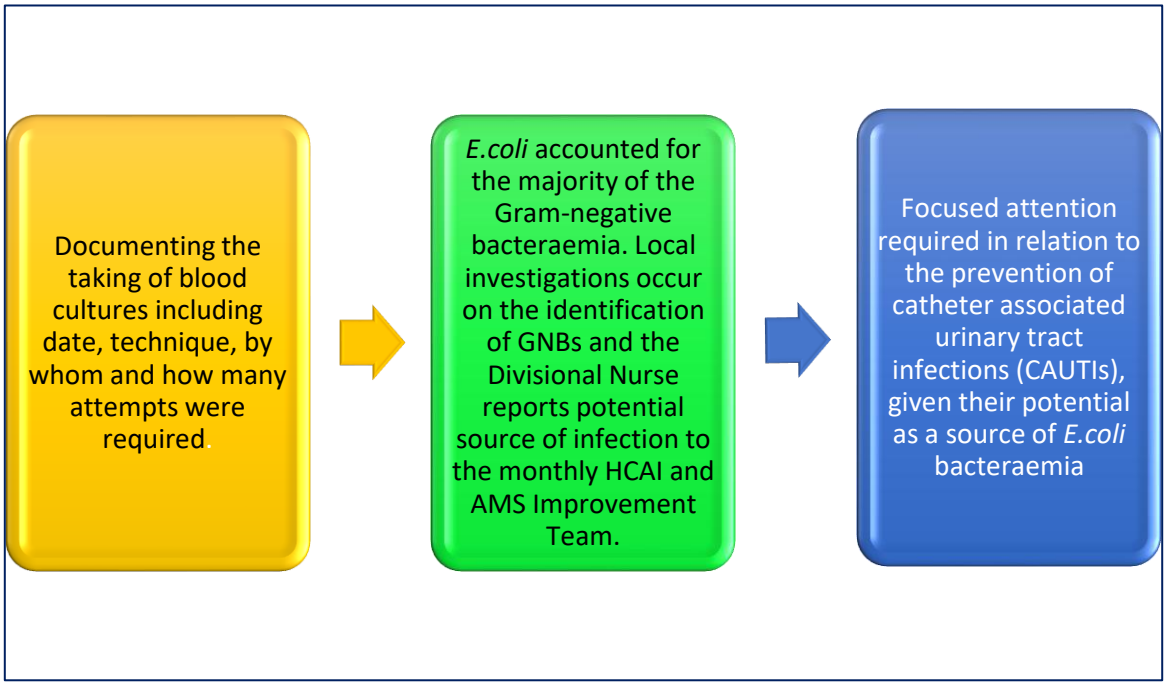


Chart showing Total Number GNB episodes. Target = 229, Results = 223 (01.04.2020 – 31.03.2025)

Learning: Gram-Negative Bacteraemia



Respiratory Virus Infections

In 2024/2025, the IPC Team observed a steep rise in cases of Influenza A cases and a decrease in cases of COVID-19; this was in keeping with regional and national trends, overall, the IPC Team managed:

- 1225 COVID-19 positive results down 4% from 2023/2024
- 1805 Influenza positive results, up 117% increase from 2023/2024.
- 74 COVID-19 outbreaks, which is approximately a 53% decrease from Year 2023/24
- 25 Influenza outbreaks, up 108% from 2023/2024.

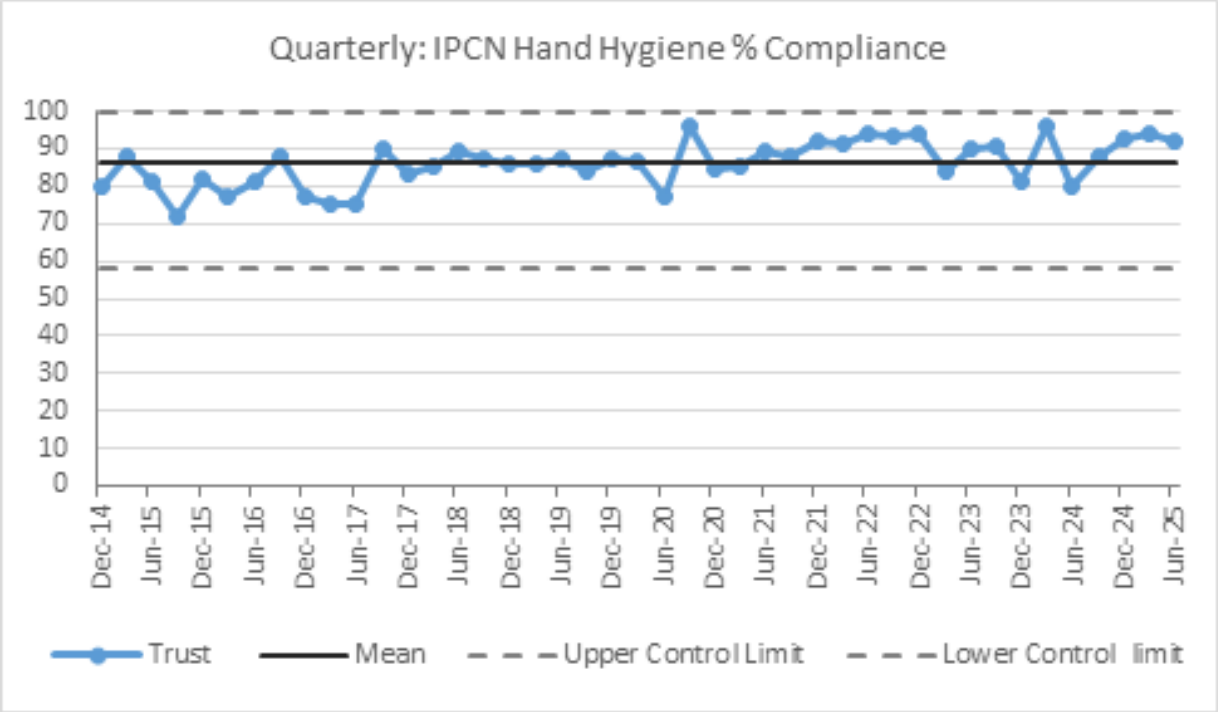
The IPC Team supported 6 Independent Care Homes in COVID-19 outbreak.

Hand Hygiene

Hand Hygiene is a key Infection Prevention and Control (IPC) measure to protect patients, visitors, and staff and to reduce HCAIs. All staff, regardless of banding, profession or working must adhere to the Trust Hand Hygiene Policy. Audits are crucial to monitor compliance. Service Areas undertake regular peer audits of each ward and department with the *minimum* compliance score set at ≥80%. The BHSCT Hand Hygiene Policy outlines the audit and escalation processes.

IPC Team's proactive audit of clinical practice was not possible; IPC Team moved to a reactive model of audit, generally in response to outbreaks and/or increased incidents (exception Augmented Care Areas). There were 54 Hand Hygiene (HH) audits undertaken across the BHSCT during 2024/2025 with an overall average score of 86%.

Independent Hand Hygiene Audit Compliance



The IPC Team continue to support areas obtaining non-compliant audit results through education (on both Hand Hygiene and peer auditor training) for all members of the multi-disciplinary team, consideration of practical solutions (such as location of hand sanitiser dispensers) and monitoring of practice until compliant scores are obtained.

Safer Surgery: WHO Checklist

The WHO Surgical safety checklist has been in place across all theatre departments within the Belfast Trust since 2010. It is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying and checking essential care interventions.

The checklist ensures that each surgical team has taken all the right steps before and after surgery to ensure patient safety for example by making the surgical team aware of any patient allergies, minimising the

risk of surgery on the wrong site or the wrong patient or minimising the risk of the wrong procedure being performed.

Compliance with the checklist is measured through monthly audits which are reported on at Specialty, Divisional and Trust level.

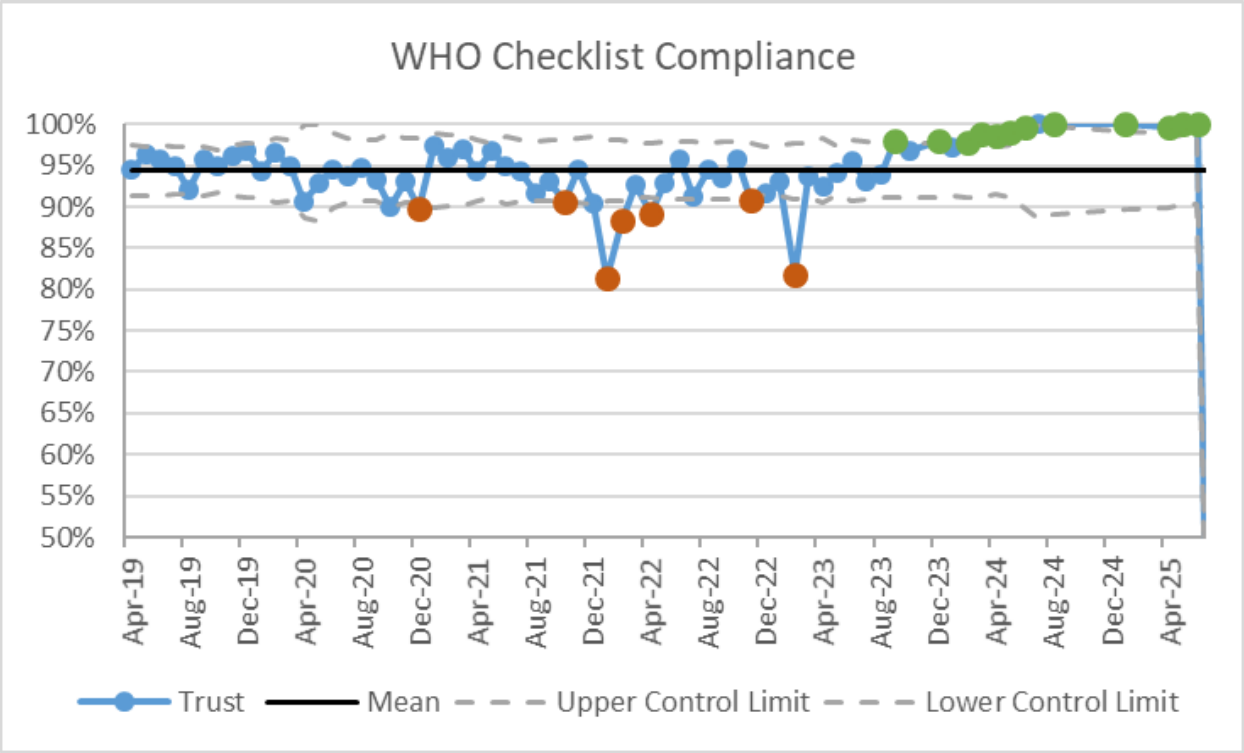


Chart showing WHO Checklist Compliance (Mean = 94%).

Falls

In the 2024/25, period **2,472 falls** were recorded within the acute adult inpatient area. This represents a 7.2% increase compared to the previous year. During the same period, 69 falls classified as moderate or above were recorded. This represents a **13.7% decrease** in serious falls, compared to the previous year.

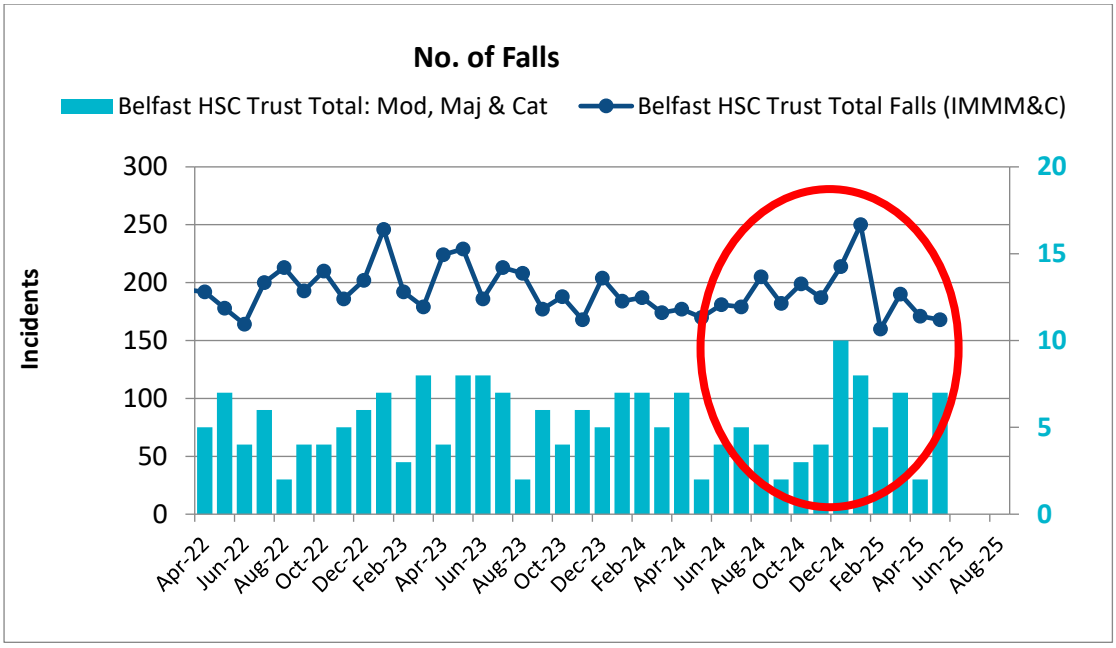


Chart showing Number of Falls Data. Average Number of Falls range from 170 to 250 per month from April 2024 to March 2025, an average of 206 falls per month

Key: Mod, Maj and Cat = Moderate, Major and Catastrophic

Key underlying factors contributing to falls identified from post fall review:

1. Failure to review and update fall risk assessments at key stages outlined in the 'Management and Prevention of Adult Inpatient Falls in a Hospital Setting', policy
2. Failure to adequately communicate the findings of risk assessments
3. Failure to implement risk control measures/ fall prevention strategies
4. Failure to ensure correct levels of supervision.

Actions taken to reduce harm from falls within the BHSCT

Meadowlands 3, MPH commenced a quality improvement project focusing on falls prevention in Feb '24. A review of all falls from Sept 24 – Nov 24 was completed and PDSA cycle1 focused on

patient falls occurring on day duty. Staff felt there was a correlation between tea break times and increased patient fall incidents. An assessment of the current staff tea break schedules was completed to determine overlap. A revised break schedule to ensure optimal staff presence during high-risk periods was introduced. **PDSA Cycle 1**: 'Adjusting staff tea break schedules as a falls prevention strategy to reduce patient falls on Meadowlands 3'.

- Further PDSA cycles included; Intentional Rounding to all patient bays/rooms to identify potential risks eg mobility aid within reach,participation of all staff in completing the FallSafe audit and reflecting on the results, night duty staff; ensuring night lights were utilised within patient bay/rooms.
- Signage developed by Ward E, MIH falls QI project was implemented, highlighting the patient's mobility status, supervision required, and mobility aid used.

Data collected pre falls project, Meadowlands 3, MPH from Sept 24-Nov 24 **total =16 falls**. Falls data collected from Apr 25-Jun 25; **total = 6 falls**.

Withers MPH identified an increasing number of falls occurring from Jan '25- April '25. Ward Mangers were asked to complete a falls action plan, bespoke to their ward. By the 30th of April '25 each ward had successfully:

- Introduced a FallSafe notice board
- Investigated all falls recorded on datix and discussed with MDT
- Nursing Development Leads reviewed falls documentation on Encompass and addressed issues e.g. Bed rail matrix
- The safe and appropriate use of bedrails was discussed at safety briefs and the use of alternative fall prevention interventions highlighted e.g. falls assistive technology/ low entry beds.
- Implementation of bedside signage, highlighting patients fall risk, mobility and supervision requirement.

- FallSafe audits completed showed compliance in 4 areas had improved with 2 areas identified as requiring additional support.

Wards C, D, E MIH Additional fields were integrated into the datix report to support staff to record an accurate account of the fall incident. The aim, to assist in the root cause analysis and help identify timely learning. Ward C, D and E are currently piloting the post fall documentation on datix. Feedback from Ward Managers has been positive; it reduces their time in retrospectively acquiring the information, provides an accurate account of the incident aiding a timely response to sharing the learning from the incident and identifies areas of documentation that have been omitted.

FallSafe Coordinator continues to:

- Lead and support the implementation of the FallSafe Care Bundle and serves as the central point of contact for fall prevention initiatives.
- Provides FallSafe Awareness sessions to the multidisciplinary team and encourages staff to utilise the fall e-learning modules on Learn HSCNI. Four hundred and ten staff participated in FallSafe training from April ‘24 – Mar ‘25.
- Supports FallSafe Champions in fall prevention best practices.

Falls prevention

- The BHSCT continues to implement FallSafe, a UK based quality improvement programme, spearheaded by the Royal College of Physicians and the Health Foundation, to embed evidence-based care bundles and multifactorial assessments into the acute adult inpatient setting. The FallSafe Coordinator works closely with the MDT to optimize patient safety and supports ward areas in reducing patient falls and related injuries by promoting best practices and education. This work advocates ensuring a safer environment for patients, to help reduce the patient’s risk of falling,

protecting vulnerable patients and supports the BHSCT commitment to high-quality safe care.

- Regional Inpatient Falls Group incorporates MDT staff from all Trusts; it sets direction and informs strategy on falls prevention for adult inpatient wards.
- Regional shared learning from serious falls is submitted monthly to the PHA by each Trust and this helps develop regional falls quality improvement work. The group is currently reviewing a regional approach to staff education on 'the safe use of bed rails', developing a regional bed rail policy along with an advice leaflet for patients. The group is currently working on the annual 'Learning from Falls newsletter' The newsletter shares key learning from incidents of inpatient falls across HSC Trusts, which have been identified from post fall review. The fourth edition is due to be published September 2025

ENCOMPASS

- The introduction of ENCOMPASS in June 2024 provides a digital record of the fall risk assessments and prevention strategies. It provides a regional approach to fall prevention and streamlines documentation, supports real-time decision-making and improves patient safety. The fall risk assessments support clinical judgement by providing staff with fall prevention interventions to consider e.g. low entry bed/ falls assistive technology and offers guidance within the system to support staff e.g. NICE guidelines on recording CNS observations. When a patient is identified at risk of falling, a falls icon is displayed on the patients storyboard to alert the multidisciplinary team (MDT) to the heightened fall risk. However, changes are required to the falls build to improve compliance and ensure consistency.

FallSafe KPI /Audit

- A new Falls KPI has been developed, reducing the number of elements audited from 13 to 8 and is completed monthly on five

patients. The target/goal is to achieve 95% (> or greater) compliance.

- The measure will be calculated as individual compliance for each of the 8 elements of the Falls KPI:

8 Elements include:

1. Mobility
2. Vision
3. Elimination
4. Lying & Standing BP
5. Delirium

(Three elements have two parts)

- Regional guidance has been developed to support Nursing Leads and managers, navigate the Encompass Inpatient Nursing KPI Dashboard to cascade training to clinical staff
- Audit compliance will provide assurance that staff within HSC are delivering safe, effective evidence-based falls risk assessments and care, with an overall aim to reduce the patients' risk of falling to the lowest level reasonably practicable. The collection of this data will also allow clinical staff to identify potential areas of concern contributing to inpatient falls and empower them to develop strategies to address this adverse patient outcome.

Falls Forum

The Falls Forum plays a key role in coordinating, reviewing and improving falls prevention efforts within the acute adult inpatient wards. The Forum acts as a collaborative platform to drive inpatient fall prevention efforts. It ensures the injurious inpatient falls are systematically reviewed, lessons are shared, and continuous improvement is embedded in ward practice. The group has recently been successful in the procurement of 'flat lifting equipment' for the Fracture Service on the Royal Victoria site.

Pressure Ulcers

Pressure ulcers range in severity, from patches of discoloured skin to extensive wounds filled with necrotic tissue and involving fascia, muscle, and bone (CKS 2024). They usually occur over a bony prominence but may also be related to a medical device or other objects. Complications of pressure ulcers include pain, infection, and increased mortality.

They are recognised as one of the top three burdensome harms (Slawomirski et al, 2017), and result in the highest number of healthy life years lost (Hauck et al, 2017). In addition, Guest et al (2017) demonstrated that they detract from scarce NHS resources, resulting in the highest number of bed day losses, and high treatment costs (thought to be more than £1.4 million every day).

Number of Pressure Ulcers Reported

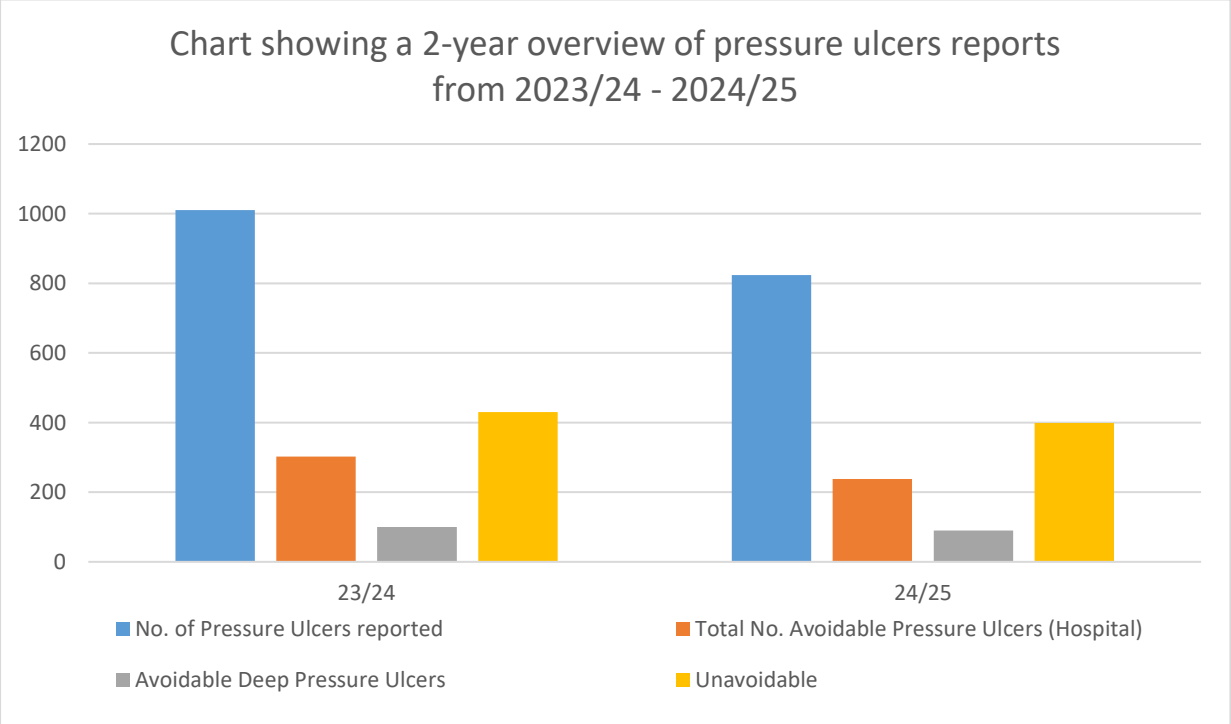
To prepare this, report all pressure damage (n=5176) reported as a Clinical Incident was interrogated from April 2023 to March 2025**. 877** incidents were excluded from this report as they developed outside the Belfast Trust. This does not mean that the incident was ignored, rather the appropriate care authority was asked to review.

Incidents removed from the Belfast Trust Figures.

Reason	Number
Admitted to the Caseload with Pressure Damage	439
Acquired in Nursing Homes	51
Acquired outside of Belfast Trust	268

Duplicates	2094
Total	2852

A further **399 reports** of Cat 1 pressure ulcers were removed from this analysis as non-blanching redness is not considered a clinical incident.



From 01/04/24- 31/03/25, 824 people developed a pressure ulcer whilst cared for by the Belfast Trust (Primary and Secondary Care). This is a decrease of 186 people in comparison to 2023/24. In 69% of cases (570 people), pressure damage was deemed unavoidable. This meant that there was no shortfall in nursing care, rather, the patient was medically unstable and could not be turned, or care was declined/could not be provided as per the patient's expressed wish. In 31% cases (254, pressure damage was deemed avoidable). Our incidence rate of avoidable pressure damage was 0.2%/1000 bed days. In 2023/2024 it was 0.5%.

Key Learning: Themes identified from post pressure ulcer Incident reviews:

Whilst our rate per 1000 bed days is low. We are acutely aware that every avoidable pressure ulcer causes pain and distress for our patients. To understand what we need to do better; a thematic analysis was undertaken. The data tells us that 80% of avoidable pressure damage relates:

1. An inadequate pressure ulcer prevention plan
2. Inadequate repositioning regime, i.e., patient not repositioned in keeping with their assessed need
3. Pressure Ulcer risk not identified on admission, or re-evaluated if the person's condition changed
4. Pressure Ulcer incident was not investigated – Superficial pressure ulcers are investigated by the Ward/Department Sister/Charge Nurse, or their deputy. If they do not complete this analysis the incident is deemed avoidable.
5. Caused by medical equipment which was not repositioned as often as needed
6. Vulnerable heels not elevated off the bed
7. Pressure points not checked at least once per shift
8. Patient up to sit for long periods without a pressure relieving cushion.

All these issues can be addressed and will require a commitment to the provision of education on pressure ulcer prevention, shared learning, and the purchase of pressure relieving cushions for prevention. We also need to use of data proactively, i.e., to recognise and respond to gaps in care before the patient comes to harm.

Collaborations

Regional: The Trust actively participates with the PHA and other HSC Trusts through The Regional Pressure Ulcer Group. In this group pressure ulcer rates and improvement work is shared and discussed to determine share best practice and learn from others. In 2024, this group updated the Regional Pressure Ulcer Prevention Leaflet for Patients and Carers. And, following the Belfast Trust's work with TILII (Tell it like it is) to produce an 'easy read' pressure ulcer prevention booklet, the

Regional Pressure Ulcer Group decided to adopt and adapt the booklet for use across Northern Ireland.

The Trust worked with the PHA, and the CEC to create and deliver a pressure ulcer prevention package for midwives. This includes a SSKIN Bundle Care Plan on Encompass, an eLearning package (available through LearnHSCNI), and online training through the Clinical Education Centre.

Queens University – The Trust worked with School of Nursing and Midwifery, Queens University Belfast, to deliver a 12-week module on pressure ulcer prevention and management. In 2024/25, 53 post registered students from across Northern Ireland undertook the Module.

We also worked with a service user and the School of Nursing & Midwifery to produce a video entitled 'Happy Skin Healthy You'. This demonstrates simple actions that a service user can take to look after their skin. This video was used in the National Stop the Pressure Campaign (see below) and can be viewed here: Happy Skin Healthy You

National: In November 2024, the Belfast Trust partnered with the PHA, NI Healthcare Trusts, educational partners, and the UK 'Stop the Pressure' 4 Nations Campaign (Society of Tissue Viability, UK), to raise awareness of communicating pressure ulcer prevention to people with a range of disabilities. The Belfast Trust Tissue Viability Nurse Team and the Learning Disability Nurse Team led on the creation of 5 short Makaton videos relating to key element of the SSKIN Bundle Care (Surfaces, Skin checks, Keep Moving, Increased Moisture Management and Nutrition).

Next Steps:

Over the next financial year, the Trust will work to address issues detailed in the thematic review. For example, we will develop a sitting

protocol which will be incorporated into our pressure ulcer prevention and management policy.

We will also support the development and testing of an Encompass Report which relates to key performance indicators for pressure ulcer prevention.

The Trust will once again take part in the annual Stop the Pressure campaign – the theme this year is person focused and is entitled ‘What Matters to Me”

Example of Good Practice

The Tissue Viability Nurse (TVN) Team review pressure ulcer incidents reported on Datix daily. If the patient has sustained superficial damage, the TVN will alert the Ward Sister or District Nursing Sister to complete a post pressure ulcer incident review. By completing this review, the team caring for the patient can compare care delivered against national and international standards of care. This enables them to see what was done and what could be done better.

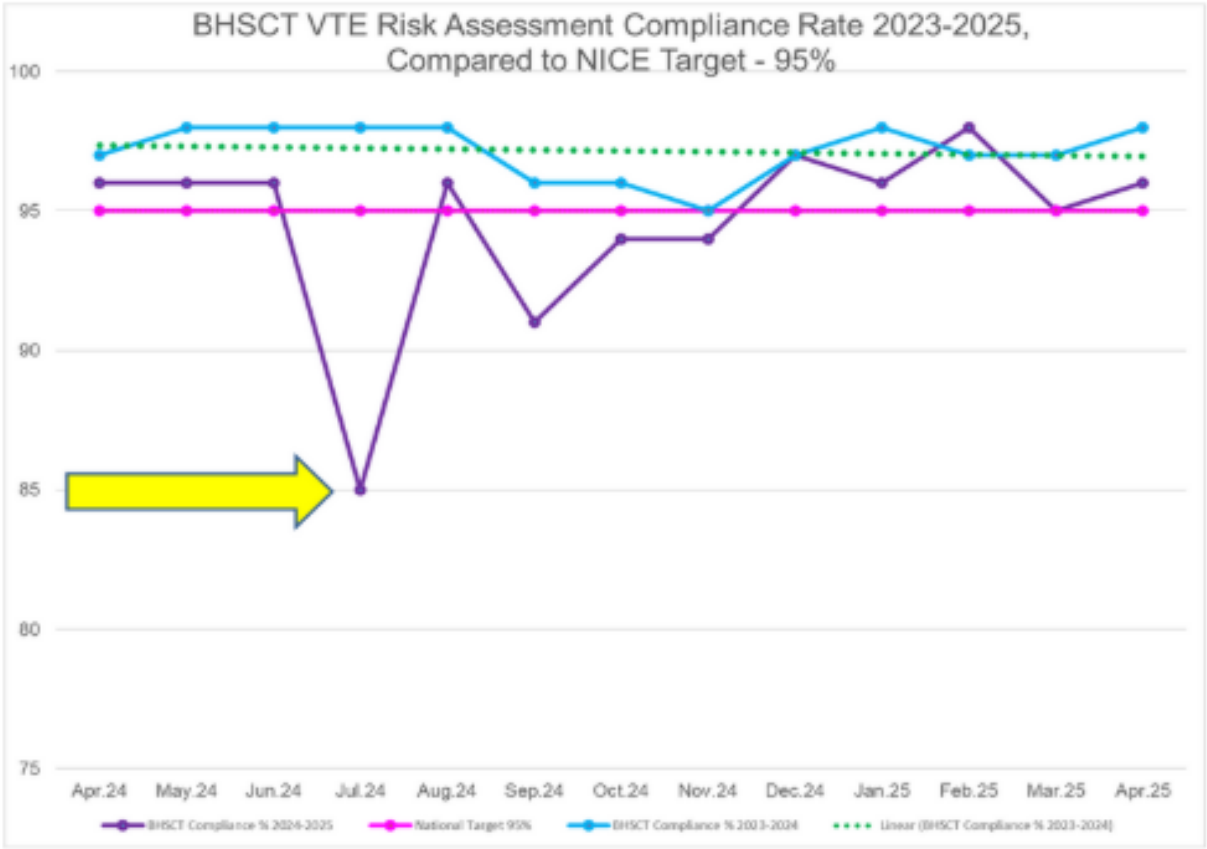
If the TVN notes a significant pressure ulcer they will immediately contact the ward to gather more information, ensure a management plan is in place, and plan to see and assess the person as needed. Following this, they will undertake a review of care alongside the nurse-in-charge of the ward/department. This means that care is peer reviewed. If there appears to be an omission in care, the Tissue Viability Nurse will assist the Ward Sister and an Assistant Service Manager to investigate further.

Venous Thromboembolism (VTE)

In 2020 the All-Party Parliamentary Group for Thrombosis (APPGT) reported estimated annual cost of VTE across NHS Trusts alone, more than £165 million. In addition, the NHS claims related to venous thromboembolism (VTE) have resulted in substantial litigation costs. From April 1, 2012, to March 31, 2022, NHS Resolution documented 687 closed VTE-related claims, with 411 settled and damages paid totalling over £23 million.

The incidence of VTE is 1-2 persons per 1000 of the population, and risk increases with age, 1 in 20 people will have a VTE at some time during their life, with half associated with prior hospitalisation for medical illness or surgery. Crucially two thirds of these events are preventable. To date, it is impossible to identify those individuals who will develop a VTE, therefore a risk assessment is the first step in preventing death and disability from VTE and vital to indicate need for appropriate thromboprophylaxis. It is important to note that patients who are risk assessed are 15 times more likely to receive some form of thromboprophylaxis.

The BHSCT strives to achieve zero patient harm, and trust wide, staff endeavour to maintain high level of compliance regarding VTE risk assessment, achieving, maintaining and often exceeding the Trust target.



The introduction of Encompass in June 2024 has revolutionised how we work providing access to patient information, in real time. Audits are undertaken remotely, saving time travelling between five hospital sites. Digital records provide comprehensive knowledge in one location and expedite analysis of both patient demographics and treatment details, enabling pertinent information gathering, regarding admission date/discharge, details of risk assessment not completed/potential omission/s of medication or missed opportunities for mechanical prophylaxis.

Epic facilitates timely contact with the managing team efficiently and effectively. However, the BHSCT exemplary compliance rate *(graph 1, green linear line)* in VTE risk assessment completion did fall below standard for July 2024, as staff grappled with a new way of working *(graph 1, purple line).* Unfortunately, VTE Risk assessment was not made mandatory on the new digital system, but with medical, nursing and pharmacy and Encompass teams' collaboration, there has been a plethora of solutions and education sessions, in person and on teams, put in place and continues to be a working progress. The need for 'hard stop' VTE Risk assessment identified and escalated, resulting in NI Trusts working in partnership to resolve the issue.

Encompass has also enabled the VTE team to investigate and analyse patient information following identification of a confirmed thrombotic event on digital imaging platform, SECTRA, checked daily, using code selection. The team can survey admission history for each patient during the 90 days prior, to establish if risk assessment completed, and within 24 hours of admission. Other factors under scrutiny include renal function, patient weight, missed doses and use of anti-embolism hosiery. Collection and interpretation of all data allow us to determine if the patient has a Hospital Associated Thrombosis (HAT). Information then shared with Admission Consultant and team, regarding outcome of initial findings, with some requiring further investigation / root cause analysis at ward level.

Research has shown that Hospital Acquired Thrombosis account for up to 60% of all diagnosed VTE, defined as associated with an admission or day procedure in hospital within 90 days prior to a confirmed diagnosis of deep vein thrombosis (DVT) or pulmonary embolism (PE). In comparison, BHSCT data demonstrates that 51% of VTE diagnosed were associated with being in hospital. Graph 2 illustrates BHSCT specialities where most HAT have occurred, reflective/ indicative of the high-risk patient population.

VTE prevention is key and begins with awareness and culminates with decisive action that anticipates risk, mitigates harm and elevates the standard of care. The BHSCT VTE team, supported by colleagues across all disciplines and specialities continue to embed how vital VTE risk assessment is, in improving health outcomes for the patients who come into our care. VTE prevention is now included in mandatory training and the VTE team committed to being proactive in BHSCT safety campaigns, namely 'March to Safety' and '**SAFE**tember', providing education sessions, both face to face and using various media platforms. '**CLOT**ober' founded, and earlier this year we had our first multidisciplinary conference with Deputy Chief Medical Officer delivering the opening lecture. A register of VTE champions established, to stay informed and ensure good and consistent practice at ward level. We continue to collaborate with our colleagues in NHS England and HSC Ireland to exchange ideas and experience to influence and improve practice.

Medicines Optimisation

The Northern Ireland Medicines Optimisation Framework aims to support better healthcare outcomes for our population by focusing attention on gaining the best possible outcome from medicines every time they are prescribed, dispensed or administered. The framework supports quality improvement through the consistent delivery of recognised best practice and supports the development and implementation of new evidence-based practice.

Pharmacy teams across the Trust are involved in several safety and quality initiatives supporting medicines optimisation for both inpatients and outpatients. A few examples are below:

Orthopaedics pharmacist

Optimising Orthopaedic Theatre Efficiency Through Proactive Pharmacy Pre-Admission Interventions

In response to significant elective orthopaedic waiting lists across Northern Ireland, the pharmacy team at Musgrave Park Hospital has extended its role in the pre-admission process beyond medicines reconciliation. Building on the success of a prior SQB initiative, the team has begun proactively contacting patients within a critical window prior to surgery to identify and resolve medicines-related risks that could result in same-day cancellations.

Theatre slots are an invaluable resource in the current climate of long waiting lists and operational pressures. Nationally, cancelled surgeries are a persistent issue—with an estimated 1 in 25 operations in the UK cancelled on the day, often due to preventable reasons such as medication mismanagement or recent health changes. Pharmacy is uniquely positioned to support safer, more efficient pathways to surgery.

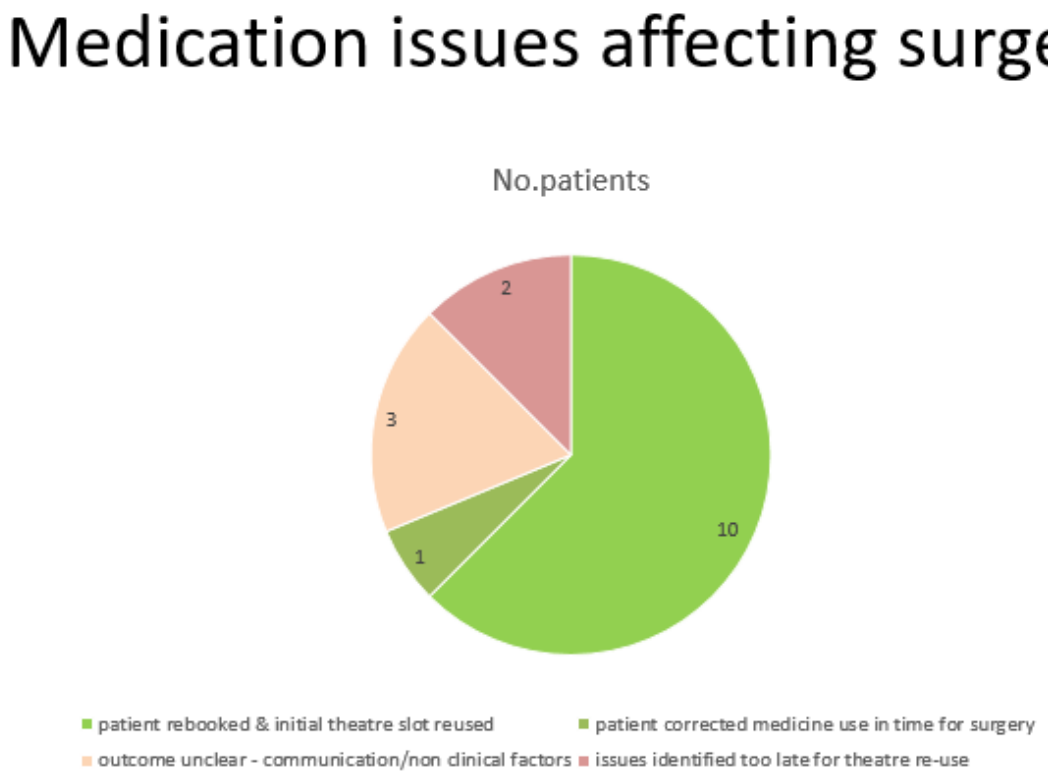
By contacting patients approximately 4-7 days before their scheduled orthopaedic procedure, the pharmacy team aimed to:

- Identify patients who had not followed key pre-surgery medicines advice (e.g. stopping Sodium-Glucose Co-Transporter 2 (SGLT2) inhibitors such as dapagliflozin or anticoagulants) which could lead to cancelled surgery on admission
- Escalate clinical issues (e.g., recent infections or procedures).
- Enable timely replacement of cancelled patients to avoid theatre downtime.

Impact Summary

Of 20+ cases reviewed since late 2024 – the pharmacist was able to positively intervene to re-educate the patient and rectify medicine related

issues. In 11 cases this supported re-allocation of theatre time with surgical colleagues to prevent wasted theatre capacity.



The project demonstrates a clear return on investment for minimal pharmacist time. Future directions include:

- Formalising the call window to maximise the chance of arranging a replacement.
- Embedding pharmacy alerts for high-risk medicines (e.g. SGLT2 inhibitors, anticoagulants).
- Sharing data with perioperative team to drive wider MDT engagement in pre-op optimisation.

This pharmacist-led model has potential scalability across other high-demand surgical specialities to protect valuable theatre time and enhance patient safety.

Dermatology: Ustekinumab Biosimilar Switch program 2024-2025

The BHSCT dermatology pharmacist, working with colleagues in dermatology has succeeded in completing a ustekinumab biosimilar switch. A biosimilar is a biological medicine that has been shown to have no clinically meaningful differences from the original in terms of quality, safety and efficacy. In chronic disease management, patients may have reservations about switching from well- established therapies to new biosimilar medicines which are made from living cells and natural ingredients, hence this is different to a branded to generic switch.

Biosimilar brands of dermatology medicines were launched in September 2024 and switching began in BHSCT in December 2024 - 73 patients were on the originator brand of ustekinumab - Stelara and the biosimilar brand Uzpruvo was selected for use in dermatology.

Switching patients to biosimilars offers opportunity for more cost-effective use of medicines. However, lack of knowledge and misconceptions among patients and HCPs about the effectiveness and safety of biosimilars can contribute to poor switch rates. Patient and GP letters were created and issued out highlighting the reason for the switch with positive framing being utilised. Patients with any concerns were reassured with a telephone call by the pharmacist with clear, confident and accurate information provided.

Results

Of the 73 patients on Stelara in September 2024 67 (92%) patients were switched to biosimilar brand Uzpruvo. The switch was completed in February 2025. Significant cost efficiencies have been made by this switch enabling health services reinvestment in other therapies/treatment pathways.

As of July 2025, no patients have switched back to originator brand Stelara highlighting a positive reaction to the biosimilar brand, Uzpruvo with no issues experienced to date.

The high switch rate achieved by this positive, pharmacist led program supports medicines optimisation in dermatology patients and the use of cost-effective therapies.

BHSCT pharmacy undergraduate experiential placement quality (2024/25)

There have been significant developments in the undergraduate training for Pharmacy students in N.I, with a greater emphasis on experiential learning (EL) in primary and secondary care sectors. This will prepare pharmacists to have a greater role in providing safe and effective clinical care to patients and the public and from 2026, pharmacists will be prescribers at the point of registration.

In 2024-2025, clinical education & clinical pharmacist teams facilitated 151 pharmacy undergraduates (2nd-4th year) from QUB and UU for 18 weeks of EL. A key emphasis is placed on evaluating the experience of students and the quality of EL provision in training pharmacists of tomorrow. We have recognised continued high rates of satisfaction from students in the EL, in line with the regional average – see table below.

How would you rate your hospital experiential learning (EL) overall?		
Student Year Group	**BHSCT student EL rating** (rating 1-5)	
2nd Year	4.5	Response rate **67%** (36/54)
3rd Year	4.6	Response rate **52%** (28/54)
4th Year	4.5	Response Rate **85%** (33/39)

Below are some of the students and pharmacists' comments on their experience with EL.

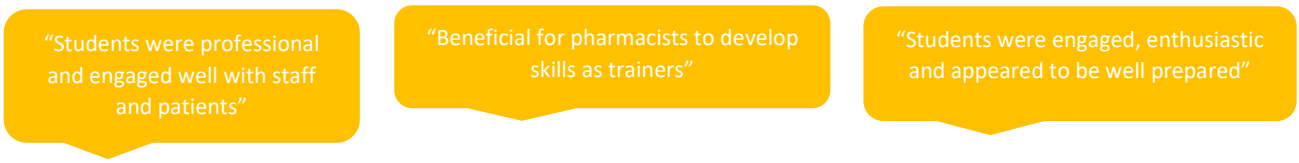
Student feedback

"My confidence in talking to patients has immensely developed"

"My practice supervisor(s) were really knowledgeable and really good at their jobs. It was really inspiring"

"They fostered such a strong learning environment!"

Pharmacist feedback



Some new concepts were introduced in 2024/25 to enhance the quality of EL.

- **Introduction of Inter-professional learning (IPL) with 3rd year nursing students and 2nd year pharmacy students** (completed two activities together on the ward patient observations (NEWS2) and pharmaceutical calculations (IV drug administration).
- *"IPL is an excellent way to incorporate MDT working. Both the nursing and pharmacy students enjoyed the experience and were proud to represent their profession when completing the tasks." Pharmacist.*
- **Introduction of Near-Peer teaching with 4th year pharmacy students and 2nd year pharmacy students**

"I feel that continued incorporation of near peer teaching is invaluable: It gives the 4th year student responsibility, It enhances 4th year student confidence in their own knowledge, 2nd year students may prefer to be taught by someone closer in experience to them (less intimidating), given that this is their first hospital placement and it supports clinical pharmacists with time management." Pharmacist.

Improving Safety through Compliance with Ward-Level Labelling of Insulin Pens

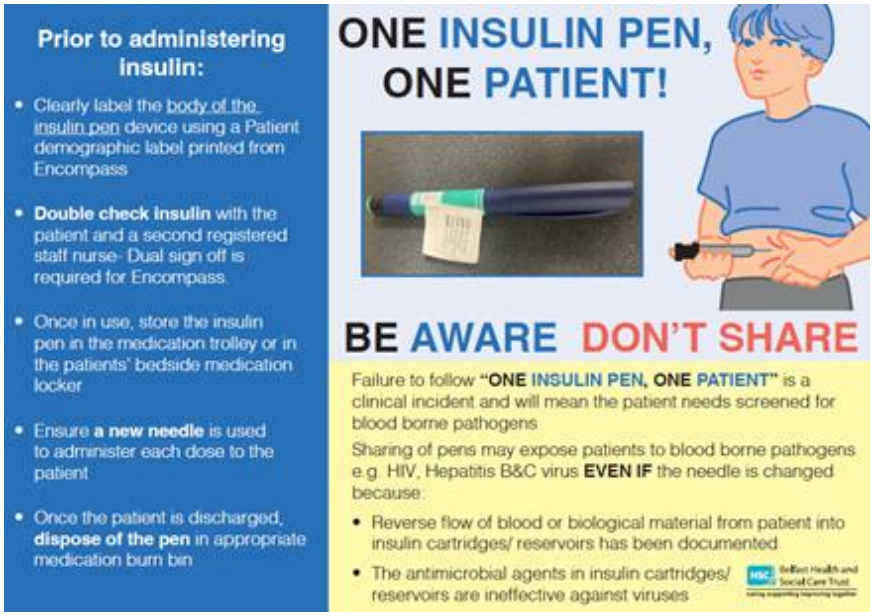
In 2022, following an incident involving the administration of insulin to a patient from an unlabelled, previously used, pre-filled insulin pen, a Trust wide Shared Learning letter was issued. This reminded staff that pre-filled insulin pens are for use by a single patient only and should be labelled with a patient identifier label.

Following this, an audit identified that pre-filled pens held as ward stock were not being consistently labelled at ward level, with only 29% of ward

stock prefilled insulin pens in use having a patient identifier label attached. To address this, a blank pre-printed patient identifier label was developed alongside a short educational presentation for nursing staff. This approach was piloted on several wards by the Medication Safety team with assistance of clinical pharmacy technicians supporting and providing education and label resupply. Re-audit a year later showed 100% compliance with pen labelling at ward level.

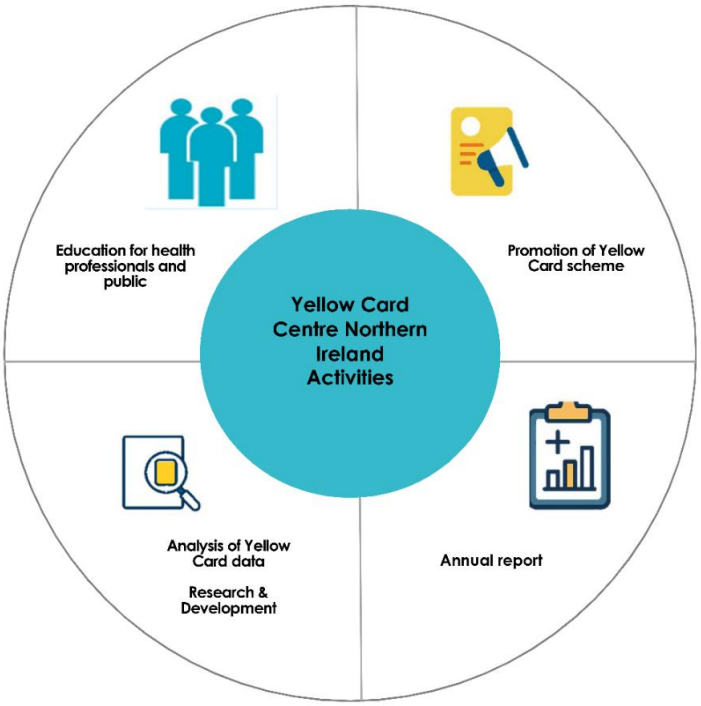
In June 2024, the Trust moved to a single electronic healthcare record (Encompass) and the ability to provide wards with this blank pre-printed patient identifier label was no longer available. Post go live, several incidents were reported related to unlabelled, in-use insulin pens being found at ward level. Whilst Encompass offers alternate options to print a patient identifier label at ward level, some of these options introduce additional safety risks.

The Medication Safety team worked with Encompass and Nursing colleagues to agree on a labelling option at ward level. An updated short educational video was produced, alongside a poster, and distributed to all wards both via email and in hard copy in April 2025. Wards were asked to confirm that they have highlighted the need to label insulin pens at ward level with their staff, and that they have included the educational video in staff inductions and displayed the information poster at ward level. As of July 2025, 65% of wards have confirmed they have carried out these actions. Currently a re-audit is underway to measure compliance with these actions.



Yellow Card Centre Northern Ireland

The Yellow Card Centre Northern Ireland works in partnership with the MHRA to promote and support reporting of suspected adverse reactions to medicines and healthcare products to the Yellow Card scheme.



The first annual report for 2023-2024 was published on 12th June 2025.

The report shows that 797 reports to the Yellow Card scheme were made from Northern Ireland, an increase of 32% compared to 2022. The full report can be found at Yellow Card Centre Northern Ireland | Belfast Health & Social Care Trust website

The second annual report for 2024-2025 is anticipated around November 2025.

NI Clinical Research Network

The Belfast Health & Social Care Trust (BHSCT) is the hosting organisation for both the Northern Ireland Clinical Research Network (NICRN) coordinating centre, and the Northern Ireland Cancer trials network (NICTN). The BHSCT accounts for most clinical trials and other high quality research projects active within the HSC environment. The Networks deploy a range of clinical research staff including, nurses, AHPs, optometrists, imagers, radiographers, a clinical psychologist, health care assistants and administrative teams to help support the service across the BHSCT sites. We maintain our commitment to the teams and provide ongoing professional development and learning across all disease specialities and sites throughout the year.

Over the reporting period NICRN/NICTN have experienced some significant challenges whilst the Trust restructures its research approval service. Within this reporting year we are pleased to confirm that NICRN/NICTN:

- Supported the delivery of 202 studies active within BHSCT.
- Twenty-six of these were new studies opened within year and 25 closed out.
- During running these trials, 3638 participants were screened for their suitability and 837 were recruited.
- These participants ranged across 13 of the 14 regional disease specialities.
- Most studies, 163 (80%), were non-commercially sponsored studies.
- Only 39 (19%) were commercially sponsored.
- Almost two thirds (138 /63%) were interventional in design and 64 (31%) observational.
- Proportionally the Critical care, Oncology and Neurodegenerative specialities accounted for the largest proportion of recruitment in year with 20%. 11% and 12% of total BHSCT recruitment respectively.

Below are examples of the great work the NICRN and NICTN are delivering on behalf of BHSCT.

The FAST Clinic

In October 2024, the Northern Ireland Cancer Trials Network celebrated success at the Advancing Healthcare Awards hosted at Stormont Hotel. The ‘FAST Clinic Team’ was awarded ’Best collaboration between clinic, academia and industry’ and was also named ‘Overall AHA Winner 2024’ for their ADVOCATE project - ADVancing radiOtherapy teChniques as A TEam!

The FAST clinic is an innovative research procedural clinic set up in 2015 at the Northern Ireland Cancer Centre; a partnership between the NI Cancer Trials Network, the NI Cancer Centre Radiotherapy Department and ProEX Prostate Cancer Centre of Excellence (Queen’s University Belfast). FAST has enabled patients with prostate cancer to have access to advanced image guided radiotherapy techniques offered through local, national, and international clinical trials - a notable example of research and service working together for the benefit of our patients.

The most significant outcome from the FAST clinic was the introduction of the safe and accurate delivery of SABR, which now enables radiotherapy treatment to be delivered as five fractions over 1.5 weeks, rather than 20-39 fractions over 4 to 8 weeks. This has huge advantages for both the patient and the radiotherapy department.

To date, 77 patients have received prostate SABR five fraction radiotherapy through a clinical trial. Experience and expertise gained in trials has enabled 107 patients to be treated with SABR as standard of care treatment - the first centre on the island of Ireland to deliver this cutting-edge technology. The radiotherapy department has already saved 134 hours of radiotherapy by utilising SABR, freeing up capacity on linear accelerators for other cancer patients.

The FAST clinic and the implementation of SABR was only achievable with the development of a large multi-disciplinary Belfast Trust group, closely partnered with QUB (ProEX) and commercial companies.

Performance and efficiency of this clinic have demanded an ongoing collective approach working across professional, departmental and institutional boundaries.

The partnership by the Consultant Clinical Oncologists, NI Cancer Trial Network-Clinical Research Radiographers, Radiographers, Physicists, Clinical Research Fellows and Treatment Planning Technicians has enabled 145 patients to enrol in world-class radiotherapy trials receiving leading-edge advanced radiotherapy.

The knowledge and skills gained by team in the FAST clinic will be utilised as a foundation to advance radiotherapy techniques for prostate cancer patients across Northern Ireland.

Critical Care SOS Trial

The NICRN Critical Care Team in Belfast HSCT, have recruited 46 patients to the SOS (Sugar or Salt) trial, becoming the second highest recruiting centre in the UK.

Doctors need to know the best treatments for severe brain swelling after head injuries to improve outcomes for patients. The two main drugs that are currently used to treat brain swelling are hypertonic saline (a strong salt solution) and mannitol (a sugary solution). Currently, it is not known which drug is the most effective treatment for brain swelling. The study aims to look at adult patients who are admitted to the ICU with a traumatic brain injury and raised intracranial pressure. Patients are randomised, half the patients will receive hypertonic saline and half will receive mannitol. The study will compare how effective the different drugs are at reducing the pressure on the brain. It will also assess which is better at helping the patient to recover.

The SOS trial is open in over 22 centres throughout the UK and is a challenging trial to deliver – patients with traumatic brain injury arrive at all times of day or night and need to be treated as an emergency when intracranial (brain) pressure rises, so this is hard work. We would like to thank the team for all their hard work and progress in the trial.

Outstanding Recruitment for Belfast Trust Orthopaedic Trials

Congratulations to Belfast Trust based Orthopaedics Research coordinator Ms Sharon Marks who recruited well to both the **DUALITY** and **LIT** studies. Both studies fall under the WHITE Platform: World Hip Trauma Evaluation (WHiTE) – a framework for clinical trials for fragility hip fracture in those aged 60 and over.

WHITE PLATFORM 12: DUALITY: Dual mobility (DM) versus standard articulation total hip replacement (THR) in the treatment of older adults with a hip fracture. The study aimed to determine the clinical and cost effectiveness of dual mobility versus standard articulation total hip replacement, in the treatment of adults aged 65 years and over with an acute, displaced intracapsular hip fracture.

Dr Owen Diamond is the PI for DUALITY. The study recruited 26 patients. The RVH site received a special mention in the WHiTE PLATFORM Newsletter, for being the second highest recruiter for the study. Second only to the Royal Cornwall Hospital.

WHiTE10 – LIT: Lidocaine Intravenous Trial (LIT). This study aims to investigate the use of a drug called 'lidocaine' to see if it reduces the risk of delirium during surgery for a hip fracture.

Dr Ciara O'Donnell is the PI for LIT. The study recruited 30 patients. The RVH site got another special mention in the WHiTE PLATFORM Newsletter 4 for being the fifth highest recruiter for the study.

Amazing recruitment for a national trial and an outstanding achievement for the entire research team; coordinator Ms Sharon Marks; PI's Dr Owen Diamond; Dr Ciara O'Donnell and sub–PI's Daryl McCauley; Krishanu Dey; Ethan Toner; Chris Madden -McKee.

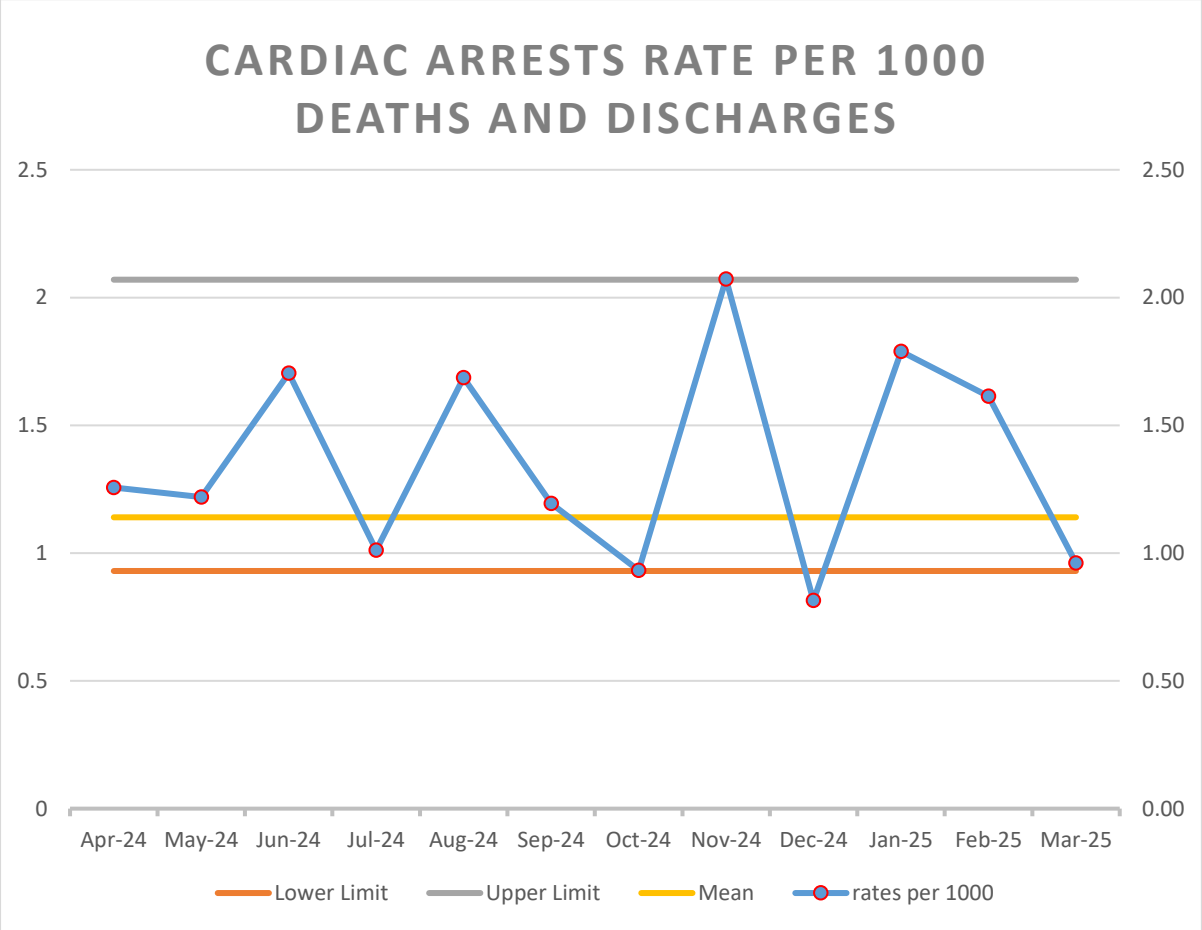
Professor Giuliana Silvestri Receives CBE Medal at Windsor Castle

Last July we celebrated our esteemed colleague, Professor Giuliana Silvestri, Clinical Director for Ophthalmic Services and NI Clinical Research Network Vision lead. Prof Silvestri received the Commander of the Order of the British Empire medal (CBE) for services to

ophthalmology and eye care in Northern Ireland, at a ceremony in Windsor Castle. Huge congratulations again to Prof Silvestri, CBE on this momentous day, from your colleagues at the NI Clinical Research Network and Belfast Trust.

Cardiac Arrest Rates

This data shows an increase in cardiac arrest calls by 20% in 24/25 compared to 23/24. Areas that data has been collected from are areas that use the 6666 call to activate the crash team. Areas excluded are Emergency department, ICU, CCU as these areas do not consistently call the crash team. This was regionally agreed to exclude these areas by all trusts in N.I.



Improvement Projects

"Safety is Critical"

Safety & quality

Working collaboratively to develop a process with secondary care to improve the discharge of patients requiring critical medications

Belfast Health and Social Care Trust
caring supporting improving together

By Gael Gartside, Michelle Mc Mahon, Lauren Donnelly and Kate Neilan

with thanks to Patricia Mc Cann, Rachael Smyth, Tina Irwin and Sarah Moreland

Introduction to Project & Defining the Local Problem

Local Problem
A number of patients discharged from hospital without onward referral to Community Health Nursing or are discharged without Patients Specific Direction (PSD) to enable the administration of time critical medication/ insulin.

Causing-

- **omissions/ time delay in administration of time critical medication**
- **District Nurses spending additional time contacting the ward or traveling to the GP surgery to get medication prescribed**
- **Ongoing stress to patients, staff, and carers**

Our Projects aim is to:

- **Improve patient safety**
- **Administer critical medication on time**
- **Improve the discharge process for patients requiring Diabetes injectable medication by Community Health Nursing**

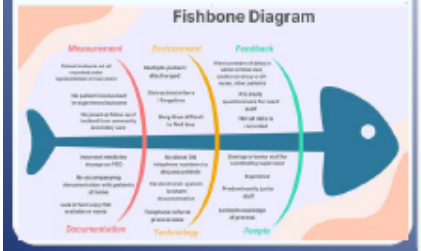
Aim Statement

By May 2024 there will be a collaborate working process with secondary care to improve the discharge of patients requiring Diabetes injectable medication by Community Nursing by 30%.

Change Ideas & Driver Diagram

Highlights:
Our change ideas included:

- Developing links with secondary care key players.
- Meeting with the ward E Sister, Clinical Educator in the MIH to discuss the project and development of discharge flowchart for patients requiring time critical medication
- Receiving feedback on current ward issues included in fishbone diagram
- Engagement with ward staff and junior doctors to discuss the discharge process
- QR code on poster for feedback



Progress of the Project

Plan- Develop a medication discharge flowchart and educate registrants and medical staff on the process of discharging patients that require critical medication

DO- engagement session and training of ward staff on Discharge process flowchart Laminated posters displayed at nurses station

PDSA

ACT-Use data collected to adjust the flowchart process and redistribute to Ward E for ongoing use

STUDY- review data from ward E on discharges, time district nurse spent on contacting the ward re referrals and arranging PSDs to be written

Measure and Charts

Discharge Flowchart created to support ward staff

Run Chart

We selected a ward at random which had a combination of variables which impacted on the discharge of community patients who required critical medication.
These variables included:
Referral not completed to community district nursing, no PSD completed or incorrect documentation noted.
The data showed between 4th October to 13th November there were 5 incidences occurred.
Following engagement with the ward manager and ASM, the incidences reduced to 0.
The introduction of our discharge flowchart poster has proven the value of this project.

Discussion – hurdles, barriers, enjoyment?

What we enjoyed:
Learning form each others clinical expertise
Introducing change that made a difference for patients
Reducing patients, staff and carers anxiety/stresses
Improve patients satisfaction

Our Learning and Reflections:
Our initial thoughts were to run the project across all hospital sites.
Following guidance and on reflection we started small concentrating on a smaller area that incidents were highlighted due to a combination of variables for patients discharged from hospital requiring time critical medication

Benefits for the service area:
Collaborate working within Community Health Nursing and secondary care. Developing a process that enhanced safe, efficient and effective care

What is next for the project?

This project was conducted in 1 ward within secondary Care. We will continue to evaluate this project, particularly with the introduction of encompass and the progression of digital documentation referrals.
We will plan to escalate to roll out the discharge process workflow poster to further wards within the Belfast Trust.

Working together · Excellence · Openness & Honesty · Compassion

If I Could Turn Back Frailty

MIH: Sonya Blythe, Nicola McMullan, Eoin Mahon, Dr Hannah Moore, Kerry Coogan & Louise Donaghy

RVH: Cathy Bannister, Andrea Graham, Rebecca Smyth, Dr Moses Mushipe, Neelima Drawid & Ruth Watkins

Gimme! Gimme! Gimme! (Background)

•The prevalence of frailty among people aged 60+ in Northern Ireland is estimated at 21% with rates rising with age. (Frailty and Disability, Research Brief, CARDI, 2014).

Frailty is a way in which you can compare risk between people of the same age. It cannot be cured but can be managed.

•One way in which acute providers can improve outcomes for older people is to effectively identify frail patients when they arrive in hospital by recording their clinical frailty score (CFS), preferably as early as possible, so that appropriate interventions can be implemented.

•Currently the clinical frailty score is not routinely recorded in the BHSCT older people areas and our goal was to focus on AMAU in RVH as it had cohort of frailty patients being assessed directly from ED and Ward D on MIH.

I Found Someone (Aim)

By May 2024 we want to improve the recognition of frailty in 50% of the patients admitted to Ward D (MIH) and AMAU (RVH) over the age of 65.

Love and Understanding (Driver Diagram)

You haven't seen the last of Me (What is next?)

•Undertaking this project highlighted the importance of an MDT approach which is paramount to ensure compliance in undertaking Clinical Frailty Screening and the recording of scores for all patients. The plan moving forward is to ensure this is highlighted at daily staff huddles to encourage active participation across the MDT.

• "Champions of the CFS" will continue to be encouraged to ensure frailty is everyone's business with education continuing for all new members of the MDT.

•Learning from this project has already spread to Ward 5E, RVH with 54% and also Ward C, MIH with 62% of CFS being completed for all inpatients on admissions

•We are the first inpatient wards within the Trust to commence and achieve CFS completion. We want to build on efforts made and hopefully set the example to scale the project to all wards within the Trust, this is in line with the NHS Frailty Benchmarking audit. Also within Encompass, the aim is to achieve compulsory completion of clinical frailty screening into assessment templates.

Believe (PDSA Cycles)

Training
Baseline: To understand staff awareness on frailty via a survey.
Training was undertaken with the staff in Ward D and AMAU using a MDT approach via e-learning.

Screening & Recording
CFS screening commenced, using a MDT approach.
CFS posters displayed in clinical areas.
CFS recorded in an agreed place.

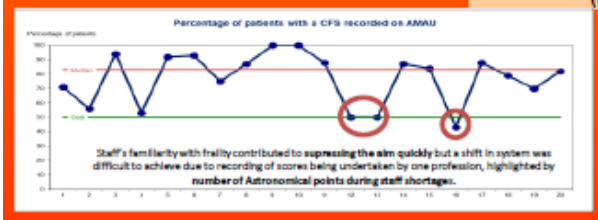
Study Changes
Has the score been recorded during the admission?
Is there a MDT approach?
40% of patients had their CFS recorded.

Champions
Champions identified in each area, a MDT approach.
To encourage uptake across the MDT to record CFS.
Reminders at daily MDT meetings.

Proud Mary (Results)

- 85% of staff can score frailty using the clinical frailty scale
- 97% of staff completed the frailty e-learning training
- 76% of patients admitted to AMAU had their CFS recorded (Aim Achieved)
- 69% of patients admitted to Ward D had their CFS recorded (Aim Achieved)

Runaway (Run Chart)



Belfast Health and Social Care Trust — caring supporting improving together

Safety & quality

Belfast Health and Social Care Trust

caring supporting improving together

Improving asthma care by implementing the BTS asthma discharge bundle in the Royal Victoria Hospital

Claire Butler (Consultant RVH), Sara Gordon (RNS RVH), Dawn Stirling (RNS RVH), Lorraine McKenna (RNS RVH), Roseanna Christie (Sister, ward 7CCB), Laura McKendry (Sister, ward 5F)

Background:

- Admission to hospital with an acute asthma attack is serious and potentially life threatening, our team was keen to develop a quality improvement project that would impact on patient safety and reduce morbidity and mortality in these patients
- Four people die from asthma every day and tens of thousands of people are admitted to hospital each year with a life threatening asthma attack (Asthma UK, 2024)
- Care bundles have been very effective in standardising care in other areas
- The asthma discharge bundle is currently not utilised within the Belfast trust.
- Implementation of the asthma discharge bundle would ensure the six dimensions of quality care are fulfilled - safe, timely, effective, efficient, patient centred and equitable care.

Aim Statement:

To improve inpatient care for patients admitted to the respiratory units by completion of the BTS asthma care discharge bundle in 70% of patients by June 2024

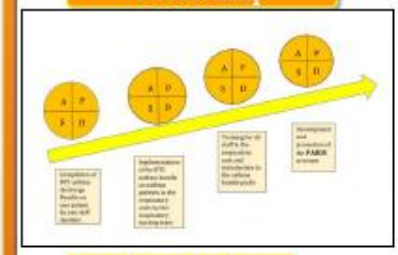
Driver Diagram:

Fish Bone: Cause and effect diagram

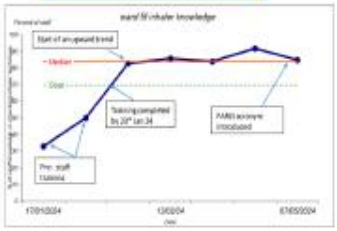
Project Measures

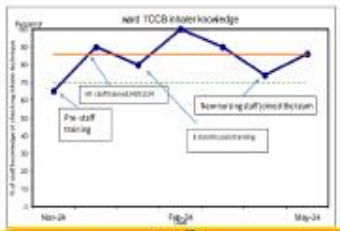
Outcome measure:	Percentage of patients with acute asthma admitted to the respiratory unit who have had a discharge bundle completed (aim for 70%)
Secondary Measures * Main focus for this project*	• **Measure impact of training on nurses on respiratory unit - 70% of respiratory unit nurses will rate themselves as knowledgeable in assessing inhaler technique by June 2024** • Patient feedback - patient experience questionnaire
Process measure	Percentage of patients with acute asthma admitted to the respiratory unit Percentage of patients with acute asthma admitted to the respiratory unit with peak flows and inhaler technique checked by nursing staff
Balancing measure	• Allocation of respiratory patients to the respiratory unit • Availability of bundle packs for easy access • Number of respiratory patients in the hospital on a given day

PDSA Ramp



Run charts





Results:

- Ward 5F has seen an increase in percentage of knowledge in staff which appears to be maintained at present
- Ward 7CCB training was initiated in November. Due to the lapsed time between training and new staff moving to the unit the percentage of knowledge has fluctuated, but remained above the goal line

PARIS acronym:

Five key components of asthma care

P- Peak flow measurement an
A- Asthma discharge bundle pack
R- Respiratory nurse referral
I- Inhaler techniques checked
S- Supervise inhalers being taken and sign the kardex

Discussion:

Enjoyment & learning:	• Working as a team and networking • Learning new skills in quality improvement and utilising these skills to examine the system in which we work and how best to initiate changes • Improving communication and leadership skills • Collecting data - only a small portion of data that was collected was analysed for this project, we will continue to analyse our data collected and learn from it
Benefits to the service:	• Improved knowledge in regards to asthma care within the respiratory unit teams and wider teams such as the patient flow team • Asthma patients are being placed on the respiratory wards, '*right patient, right place, right time*' • Nursing staff when surveyed 100% felt they could teach a patient how to correctly use their inhalers with our most common devices • Patients felt more confident in managing their asthma post asthma education
Challenges:	• Encompass - training and the implementation of the new system • Bed pressures - high demand for respiratory beds throughout the year • Staffing - staff sickness and staff retention • Additional time for education from the RNS team and the ward nursing teams • Time to meet up as a team - often short and ad hoc
Reflections:	This was our first quality improvement project, our initial aim had to be reduced a number of times as the project was too big, however we were able to complete the study over the two respiratory units so all respiratory ward staff felt involved

The future:

- We will continue to implement the asthma bundle, in September 2024 we will transition to the new BTS Asthma Care Bundle
- We will continue to educate staff and ensure that the PARIS acronym is fully embedded in ward culture
- We will continue to analyse the outstanding data to identify if we have reduced inpatient stay days or re-admissions to A&E
- We hope to publish our findings in ARNS if our findings are positive
- Respiratory care is an area of high interest, it is continuously changing and the staff are extremely diligent and motivated, this makes it an exciting learning environment for future quality improvement projects

With special thanks to our mentor Claire Shannon and all the staff in ward 7CCB and ward 5F for all your help and support

SAFE PATIENT DISCHARGE
Communication with Primary Care

Project team: Leonie Dolan, Rebecca Hull, Robyn James
Contributors: Aishling Smith, Dr Lyndsey Spratt, Dr Sandra Phillips, Alexis Anderson

The Human Factor

Eric is an 80 year old man admitted to the Hospital at Home Team following a fall. Being treated at home reduced Eric's risk of delirium, deconditioning and respected his wish to remain at home, close to family.
Eric was assessed by the MDT and one of the contributing factors to his fall was his blood pressure (BP) medication. Changes were made to his medication to prevent further falls.

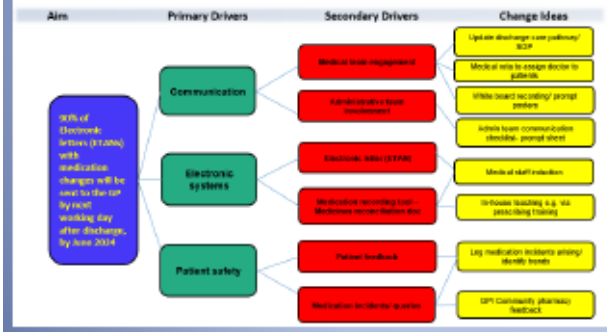
Option 1:
ETAN not completed and GP not aware of changes made to BP medications. On repeat prescription Eric had a further fall and was transferred to hospital.

Option 2:
ETAN was completed and the GP notified of changes to medications, with prescriptions updated. Eric's main contributing factor to falls risk was reduced.

Aim Statement

90% of Electronic letters (ETANs) with medication changes will be sent to the GP by next working day after discharge by June 24

Driver Diagram

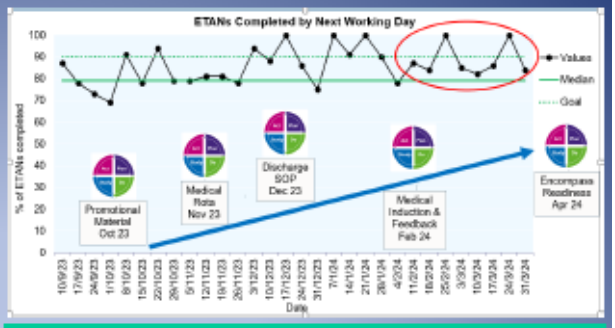


Measures

Outcome measure:
1. Changes communicated via ETAN by next working day
Process measure:
1. Number of incidents / queries per month
2. Number of patients discharged
Balancing measure:
Initially increased workload on admin and medical staff offset by reduced workload for GPs and H@H staff to clarify issues.

Results

- Baseline median before project showed that 79% of ETANs were completed by next working day.
- Run chart shows a shift in the data in February and March and ETANs completed has increased to 86% during these months.
- Improvement in completion rate is seen after implementation of a rota and staff induction.
- Medical staff survey results indicated 100% satisfaction with the induction provided.



Discussion

Staff engaged positively with this project and acknowledged the benefit of exploring change ideas. We did not achieve our aim of 90% of ETANs being completed by the next working day however as the run chart shows there are a number of occasions were the team achieved 100%, exceeding our aim.
Challenges the project faced:

- Winter pressures / time constraints
- Service review process by senior leadership team
- Resources/ changing staff
- Tracking incidents/ queries

Anecdotally the team did report a reduction in the number of medication queries coming from GP practices and community pharmacies. Like with Eric's story by achieving option 2 we are helping to safeguard our patients, ensuring the correct medication is delivered to the right place at the right time.

From our data collection we can identify 2 instances where alternative means of communication were used, namely these are admission to hospital and palliative discharges. A future aim of the team would be to develop contingency plans around annual leave and bank holidays as there was an isolated reduction in number of ETANs completed by the next working day over the Christmas period.

Along this journey we developed a Standard Operating Procedure (SOP) to support the discharge process. This is an ongoing piece of work and needs to incorporate the organisational changes associated with Encompass.

Evolution of the Project

The results show improvement has been made but this is an ongoing process. It is important to acknowledge the significant change Encompass has made to our discharge process, and new workflows will take time to embed. We need to maintain momentum in training and awareness to support staff during this time in order to ensure a sustained change.

"Change is not an event, it is a process"

Belfast Health and Social Care Trust
Safety & quality

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caring supporting improving together
Safety & quality

KEEP CALM and PREP

(Prostate Radiotherapy Prehab)

Denise Crone, Sarah Jane Flynn, Katie Henry,
Sharon Kelly, Lindsey McMullan, Ryan Newburn
(and Eric the Enema!!)

The Cancer Strategy for Northern Ireland 2022-2023 action point 17 states:
'Develop and implement prehab and rehab services on a regional basis for those who will benefit.'

prehabilitation
(noun) \pre-a-'bi-la-tā-shən\
: to prepare someone for the challenges of cancer treatment.

Why Prostate Prehab?

- Improve radiotherapy treatment accuracy
- Reduce bowel and bladder toxicity
- Reduce radiation dose to patients due to additional rescans
- Recommendations for Prehab from the Department of Health (DOH) Cancer Strategy NI

In the first quarter of 2024 baseline data indicated almost 40% of Dr X's prostate patients required an additional radiotherapy planning scan due to poor bowel and bladder preparation

Project Measures

Outcome Measure	• Percentage of rescans since the establishment of the Prehab clinic
Process Measures	• Number of rescans since clinic established • Number of rescans from January 2023 to date • Time spent seeing patients in Prehab clinic against time spent processing on pre-scan phone calls
Balancing Measures	• Patient Satisfaction (increase or decrease as a result of the Prehab clinic • Patient preparation compliance (increased or decreased) • Scanner appointment capacity (increased or decreased) • Peer support for patients (group setting)

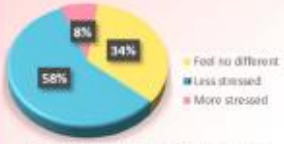
Service User Feedback

Aim

Reduce the number of rescans by 10% for Dr X's prostate patients by June 2024

PDSA Cycles

Stress and Anxiety post Prehab Clinic



(NB. Those who said they felt "more stressed" reported stress in day-to-day life)

Strategy

To develop a **Prehab**ilitation Clinic for prostate cancer patients prior to radiotherapy planning scan. To improve patient information on the importance of bowel and bladder preparation and reduce the number of rescans

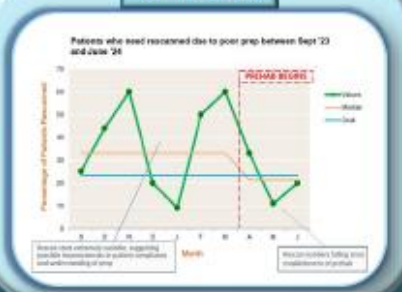
Results and Benefits

- Rescan rate reduced to ***22%***
- ***100%*** of patients attending prehab felt better prepared
- ***160 scanning minutes (i.e 5+ patient appointments)*** saved after implementation of prehab clinic over a 3 month period
- Reduction in radiation dose due to decrease in patient rescans
- Better utilisation of staff time with group prehab clinic rather than individual patient phone calls

Challenges

- Room availability
- Appointing patient to the clinic
- Staff availability
- Impact of Encompass

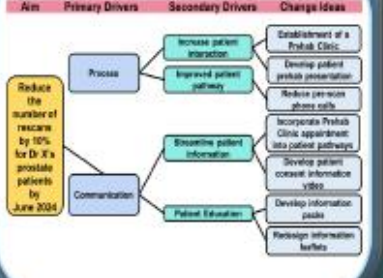
Run Chart



Aim Achieved

44.4% reduction in rescans by June 2024 (*from 39.6% to 22%)

Driver Diagram



Service User Feedback

Next Steps

- Evaluate impact of Prehab clinic on the re prep of patients during treatment
- Roll out of Prehab clinic to all prostate patients to all prostate patients *(potential to save up to 4 hrs staff time per month)*
- Develop holistic side of Prehab Clinic (e.g. fatigue management, nutrition and psychosocial support), in line with NI Cancer Strategy recommendations

Improving Patient Hydration On A Care Of The Elderly Ward

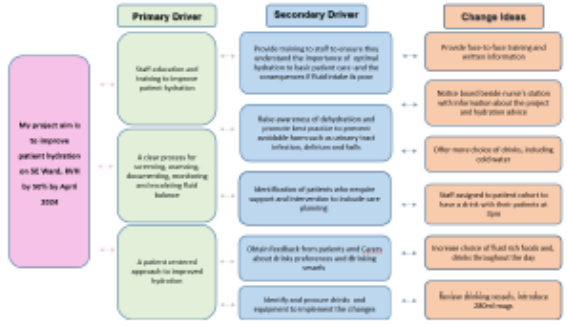
Belfast Health and Social Care Trust

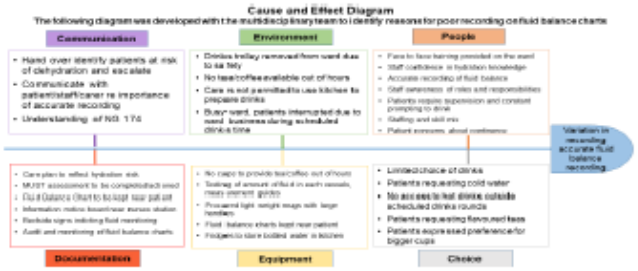
This Quality Improvement Project was undertaken to increase awareness of the importance of good hydration and monitoring with both staff and patients on a Care of the Elderly Ward at RVH, BHSCT, with the intention of achieving the optimal hydration of 1500mls, which is the agreed good standard for fluid intake for adults in 24hrs. The Francis report of the Mid Staffordshire Public Inquiry detailed examples of poor nutritional care and recommended that the "arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation". Although previous work to improve hydration has been undertaken, improvements have not been sustained, therefore a multidisciplinary approach was adopted that included patient, staff and carer involvement.

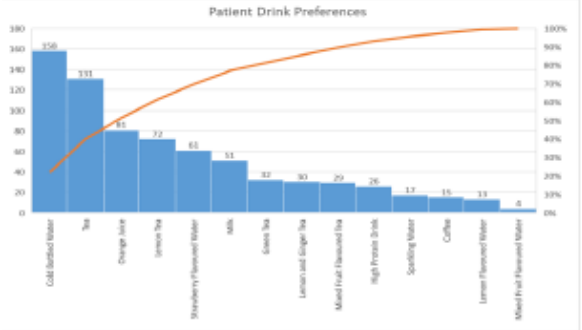
Project Aim: To achieve a 50% increase in the average oral fluid intake of patients on 5E Ward RVH, to ensure optimal hydration by April 2024.

Method:

A quality improvement methodology was used including stakeholder engagement and Plan-Do-Study-Act learning cycles to influence, engage and educate staff, patients and carers to increase awareness about the importance of good hydration and monitoring, with the intention of achieving optimal hydration. Quantitative data was collected by auditing eight patient fluid balance charts, selected at random, weekly. The baseline average daily fluid intake ranged between 800mls to 1,000mls. To achieve optimal hydration of 1500mls, a 50% increase in daily fluid intake was required. Qualitative data was collected from staff about their understanding of the importance of optimal hydration and accuracy of fluid monitoring. Feedback was obtained from patients and carers about drinks preferences and drinking vessels.

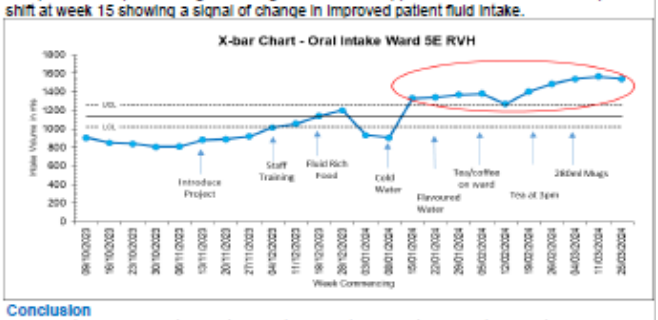






Results:

The X bar chart shows that, over 24 weeks, 192 fluid balance charts were audited, 8 patients fluid balance charts were chosen at random weekly, and the oral fluid intake for a 24 hr period was recorded. The average fluid intake improved by 76%. Baseline completion of fluid balance charts on the ward appeared to be poor at the beginning of this project. With the development of staff training and fluid rich food, at week 7, there appeared to be the start of a trend in the improvement in patient fluid intake and fluid intake recording. At week 8 patient average fluid intake dropped to an average of 934mls, staff reported at this time there were staffing pressures on the ward, temporary staff were used and fluid intake recording may have declined as a result. With the introduction of further drinks options, staff taking a drink with patients at 3pm and larger drinking vessels, there appears to be the start of a 10 point shift at week 15 showing a signal of change in improved patient fluid intake.



Project Measures:

Outcome - Optimal patient hydration, 1500mls in 24hrs.
Process Measure -Staff training to understand the importance of good hydration. Audit and monitoring of compliance with FBC completion, appropriate escalation and care planning.
Patient and carer involvement to ensure understanding of good hydration
Balancing measures -Improved recording of fluid intake
Improved hydration assessment

PDSA Cycle 1	**Test training material developed for staff**
PDSA Cycle 2	Test re introduction of menu cards post COVID, fluid rich food included as a choice
PDSA Cycle 3	Develop patient questionnaire to identify patient preference of drinks, Pareto chart shows patient preference, cold water was the top choice
PDSA Cycle 4	Test introduction of flavoured water introduced at patient request
PDSA Cycle 5	Test will tea/coffee made available for patients at evenings and night-time improve fluid intake
PDSA Cycle 6	Test if staff joining the cohort of patients that they are looking after and having a drink with them at 3pm will improve socialisation and encourage patients to drink
PDSA Cycle 7	Test 280mls mugs, introduced onto the ward, so that patients are given larger volumes of fluid when served drinks

Conclusion

This quality improvement project shows the importance of staff education and training regarding the importance of patient hydration. Training to explain the process for screening, assessing, documenting, monitoring and escalating fluid balance has improved the recording of fluid intake. A patient centered approach to improved hydration and asking patients and their carers what they want, helped to shape the provision of choice of drinks and vessels. This project required additional resource to provide a wider variety of drinks options and drinking vessels. There is a financial cost and it will be dependent on the service whether they continue to fund these changes.

Key Learning

Other care tasks can be prioritised over hydration. Assumptions are made about patient's drinks preferences, patients were not given the opportunity to choose the type of drink they preferred. The choice of drinks was limited to tea, water and milk, a drinks menu has been developed and patient choice increased. Poor assessment, documentation, monitoring and escalation of patients identified at potential risk of dehydration, when addressed through awareness, information and training, improved.

Achievements:

The value of a multidisciplinary approach was the key of success to achieve the aim of improving patient hydration and improving quality of care. The Patient Experience Team will continue to monitor the fluid intake and output of 10 patients bimonthly. Patients identified at risk will be discussed at the ward 'safety brief'.

Next Steps

The project will be shared with other stakeholders, PHA, wards/care home settings. The project lead is supporting the Infection Prevention and Control team with a Quality Improvement Project to reduce catheter acquired infections which builds on this project. Establish a multi-disciplinary working group, using data collected from Encompass, to look specifically at the management of hydration in patients, to report to the Trust Food and Nutrition Committee. This work will be scaled and spread across the Trust.

Contact: Karen Devenney - Senior Manager Nursing, Patient Safety, Quality, Infection Prevention and Control: *Karen.Devenney@belfasttrust.hscni.net*

Key reference material
Francis. R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013
Nutrition and Hydration Guidance, www.england.nhs.uk, 2015 - 2018
Improving Hydration of Care Home residents by increasing choice and opportunity to drink: A quality Improvement Study, Professor Jennie Wilson, 2019.

The Race for PACE

To improve the completion of Person, Assessment, Care of Plan and Evaluation (PACE) in Ward 7B by 50% by April 2024

Introduction

The PACE Framework (NIPEC 2016) allows nursing documentation to record individualised person-centred care across nine domains. It also encourages registered nurses to evidence their decision-making and clinical judgements. To meet the standard of compliance, the nine indicators are required to have a compliance completion rate of above 85%. Outcomes from Post Fall reviews and SAI's have highlighted poor documentation during this process and recommended further training to be completed. The introduction of Encompass has provided an ideal opportunity to review, refresh and refocus attentiveness to PACE.

Aim

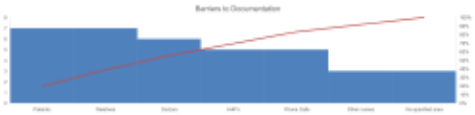
The Aim of this project is to improve the percentage compliance completed of Person, Assessment, Care of Plan and Evaluation (PACE) in Ward 7B by 50% by April 2024.

Methods:

Quantitative & Qualitative data analysis: questionnaires were collected and discussions with nursing staff were completed to establish existing knowledge and barriers in PACE

Data analysis: assessments calculated from nursing documentation was analysed. The percentage of these assessments should be above 85%

Pareto chart: helped to understand barriers in completing nursing documentation in a contemporaneous way



Project Measures

Outcomes:

•Percentage compliance of completed of an appropriate PACE assessment

Process:

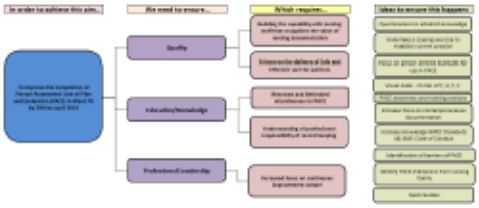
•Staff Education/Training sessions

Balancing:

•Reduction in complaints, these will be measured within Datix System

Process Changes

This Driver Diagram demonstrates what is required to deliver on our Project Aim

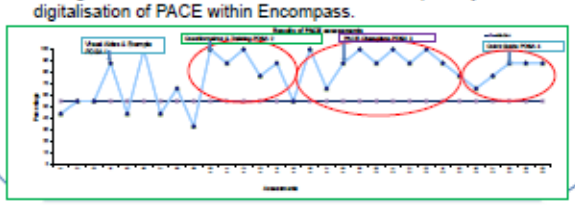


PDSA Cycles

PDSA Cycle 1 Visual Aides and Examples
PDSA Cycle 2 Questionnaires and Training
PDSA Cycle 3 PACE Champions
PDSA Cycle 4 Quick Guides

Results

This project demonstrated in a run chart of % compliance in completed PACE assessments improvement . This is was shown by the shifts after PDSA cycles were implemented. By the 18th Assessment (PDSA 3) our aim of 50% improvement was achieved and this remained constant for the majority of the time thereafter. It highlighted the ward needed to identify all staff need to be trained in PACE. As a result the focus on PDSA 4 was having a Quick Guide, this would be essential, especially with the digitalisation of PACE within Encompass.



Barriers identified by Staff

Key Learning Points

- This was a difficult project to get started – original ideas overlapped with other projects
- Sickness and outbreaks as well as ward pressures have slowed progress
- Identifying PACE champions to bring this forward and sustain this for the future
- There needs to be a review, refocus and refresh on PACE framework throughout across all ward settings in preparation for Encompass

Conclusion

- QI methodology helped to understand why PACE was not being fully utilised on ward
- Data challenges vital to interpret and learn from data to continue improvement
- Encompass will change how nurses document in the future

Next Steps

- Continue to review, refresh and refocus on PACE within ward to complete Driver diagram

References
NIPEC (2016) PACE Pilot Project Planning Person Centred Nursing Care Evaluation Report July 2016

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Belfast Health and Social Care Trust
caring supporting improving together

Safety & quality

Reducing Omitted Doses

Pharmacy & Nursing Team: Judith Martin, Victoria Banks, Anna Holmes, Eric Byrne, Brandon Cooke, Paula Ramsay, Clare Crawley, Cathy McQuillan, Sophie Fox

Introduction

Omitted doses of medicines are one of the most commonly reported category of medication incidents on the BHSCT incident reporting system. Omitted doses have a negative impact on patient experience due to the harm that can be caused from an omitted dose. Measuring omitted doses is also a good indicator of the quality and reliability of broader medicines management processes in a given area.

Patient safety is a primary concern, and can be compromised when medicine doses are omitted. We need to find out the underlying causes of an omitted dose and address these with actions.

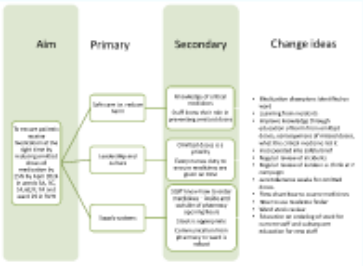
Economic data on the financial cost of omitted medicines is limited. However, an article published by East London NHS Foundation Trust reported the implementation of their project eliminated an estimated 2,690 omitted doses over the course of a year, which would have been expected to give rise to 25 'adverse drug events' (ADEs) and they estimated this to have the potential to save more than £34,000 per year across six wards.

Nurses have the opportunity to influence and improve the incidence of blank spaces and the recording of medicines not being available on the kardex and so this will form the basis of the improvement work.

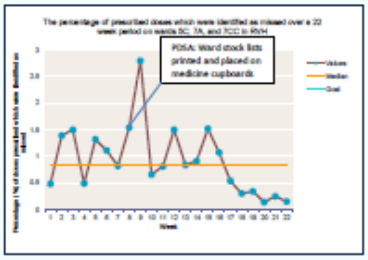
Aim Statement:

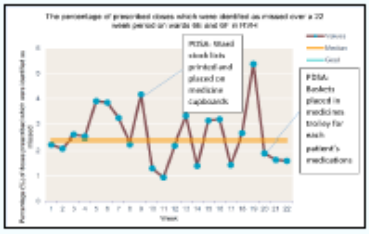
Reducing omitted doses of medication by 25% by April 2024 in wards 5C, 6E/F, 7A and L7CC in RVH.

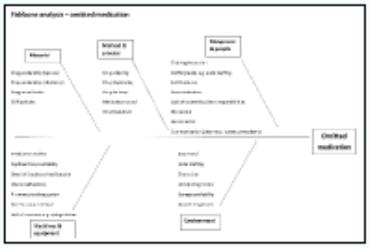
Change Ideas & Driver Diagram



Our journey through PDSA







Measures:

1. Medicines omission audit tool – using an audit form, collate data on omitted doses with no interventions for baseline data. Once data gathered, identify trend for omitted doses and target reason for omission with an intervention.
2. Medication safety thermometer – use the run charts provided on omitted doses to mirror impact of change/sense check
3. Feedback from staff
4. EHS activity can be reviewed for the wards audited to see if orders during EHS are for new patients only

Discussion

It was an ambitious project to involve so many wards, but it was a highly motivated and enthusiastic team who are passionate about reducing omitted doses and the negative impact this can have on patient experience and safety.

The team included like-minded colleagues within pharmacy and nursing staff, allowing for a wider approach to ascertain why omitted doses occur and developing solutions in an attempt to reduce these. For example, Ward Sister on 6E/F advised given the nature of a very busy acute and unpredictable ward, that a "Think at 2" kardex sweep intervention would simply not work and had previously been trialled with no success, however other Ward Sisters thought this was a possible solution and keen to trial. This meant it was less of a pharmacy-only driven project, and with Ward Sisters' "buy-in" would more likely be adopted by nursing staff administering medications to patients.

As with all change ideas, we did experience some obstacles – the most obvious being Encompass Go-Live which particularly impacted on pharmacy services, with the sheer amount of training involved and complete overhaul of processes. The team was also delayed in implementing any change ideas, as we were delayed with baseline data collection (SQB Workshops helped with this), but actual data collection was fairly quick and easy with the tool designed and used.

From the graphs some impact was made in a short space of time. In particular, on 6E/F the medication baskets reduced the number of omitted doses and this reduction was maintained, for at least a few weeks (as far as the data points show us). The ward is keen to continue with this and re-audit in the coming months, to determine if we can meet our goal of 25% reduction.

From Week 16 onwards, for all project wards excluding 6E/F, there is a very clear downward shift in the percentage of omitted doses and we achieved our aim.

Medication Safety Thermometer results for 6E/F also showed a general downward trend for omitted doses, reducing from high-teens/twenties to most less than ten percent between Oct 2023 and May 2024.

What's next for the project

The change post Go-Live to pharmacy processes alone has been immense, and so a complete review of all aspects and possible causes of omitted doses is required, multiple projects could then be undertaken and the team are highly motivated to continue. E.g. looking at courier delivery of medications to wards, dispensary processes when an item is out of stock, the impact of Encompass on omitted doses.

We will continue to involve the nursing staff in all change ideas involving ward processes as this is a vital element to success.

Working together · Excellence · Openness & Honesty · Compassion

NHS Education for Scotland

Open or Closed?

The importance of improving outpatient administrative processes so as patients do not get lost to follow-up.

Introduction: An open registration (OP Reg) is created when a patient attends an appointment but there is no record of the patient being discharged, placed on a waiting list or being offered a further appointment. This is a patient safety risk and could contribute to patients being lost in the system. In September 2023 the School of Dentistry (SoD) had 1895 non-consultant led OP Regs. These were patients who had attended a Dentistry student for treatment. Whilst these patients were deemed to be low risk they were either lost to follow up or should have been discharged from the service. The Project team intend to use the same principles applied to the SoD improvement work as a scale and spread opportunity for the other services within the Trust who have large volumes of OP Regs.

Aim: To reduce the number of non-consultant led (Dental Student) OP Regs in the School of Dentistry by 50% by the 31 March 2024.

Method: It was important for the success of this project to establish a dedicated team who would have the necessary skills and understanding of the IT systems within the Trust so as to be able to interrogate the data available. The Project team consisted of a Project Manager, Admin Manager, Graduate Interns, SoD students and the SoD Admin.

A process mapping exercise was completed and from this the team developed a driver diagram.

Outcome measures

Outcome measures: a weekly open registration report will be reviewed and analysed to ascertain if any improvement or deterioration in open registrations for the SoD, has occurred. Outcome measures measure results which ultimately reflects on the quality of the project.

Process measures

Process measures used, such as those defined in the PDSA cycles will ascertain if the system or process change delivers the desired impact. The process measure indicate effectiveness / efficiencies.

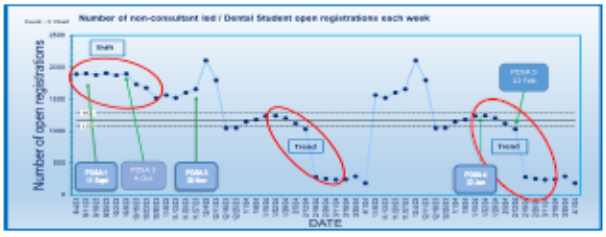
Balancing measures

Balancing measures are used to identify whether or not changes designed to improve one part of the system have a detrimental impact on other parts of the system. By recording the number of new Op Regs created each day this identified if other parts of the service were impacted by this particular project.

Change ideas formed the basis of the PDSA cycles and through weekly monitoring the data was extracted and collated.

Run charts were used to record the data. This is an opportunity to review trends or patterns over the timeframe of the Project. Following personal learning and development in relation to the development of SPC charts, these were used to provide a closer analysis and review of the data.

Outcome Measure:



By 25 March 2024 the number of open registrations had decreased from 1895 to 180. This represents a reduction of 1715 Op Regs ie. a 90.5% decrease in the number of student led open registrations.

The chart above demonstrates the impact of PDSA cycles whilst also identifying shifts and trends following the introduction of the change ideas.

Process Measure:

The chart below demonstrates special cause variation. A change over in staffing and unawareness of the processes caused this impact. Education of staff regarding the importance of completion of clinical outcomes was rolled out. The reduction in the number of clinical outcome forms, not completed, demonstrates that the number of open registrations also reduced as these are inextricably linked.

Conclusions & Achievements

There has been a significant reduction in the number of open registrations within the SoD. This is demonstrated within the Outcome chart.

Shifts / Trends demonstrate that it can often take an integration of many change ideas to have an overall impact on the outcome for a project.

The ability to demonstrate scale and spread has been demonstrated through applying the same change ideas to the wider Trust (Specialty) open registrations.

Balancing Measure:

A review of other open registrations within the Trust identified that there was no impact on specialties where we were not applying the same project PDSAs. There was also no impact on other work streams as part of the outpatients modernisation such as missing outcomes and the monitoring of DNAs or an increased in waiting lists – due to the work that the team are focusing on.

Key learning achieved

Having a clear vision and regular contact meetings with Services helps to provide a combined vision and clear understanding of the project. Regular communication and contact points during the project and specifically when reviewing the impacts of each PDSA cycle helps to maintain momentum and enthusiasm for the project.

A combination of change ideas, within my project demonstrated that a one size fits all approach was not going to have the desired outcome.

Next steps

Further scale and spread opportunity exists within the Trust . I would like to apply the same change ideas to other areas of outpatients modernisation.

I will be applying for elective access monies to develop a team to take forward change ideas identified in this project as I would like to continue my journey of quality improvement and to inspire other staff to do the same.

Contact:
clare.lundy@belfasttrust.hscni.net

Key reference materials:
https://learn.nes.nhs.scot
https://hub.scot
https://qiolothian.scot.nhs.uk

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Improving adherence to the Chronic Obstructive Pulmonary Disease Discharge Bundle

NHS Education for Scotland

Introduction:

Shockingly 22% of patients will have died within a year of their **first** admission to hospital with an exacerbation of COPD and 50% will have died within 4 years[1]. However if the evidenced based interventions included in the BTS COPD Discharge Bundle[2] are implemented, the patient outcomes are known to significantly improve. These are complex interventions which require ongoing input from the specialist respiratory MDT. They include nicotine addiction support, attendance at pulmonary rehabilitation, correct choice of inhaled therapy and enhanced self-management skills.

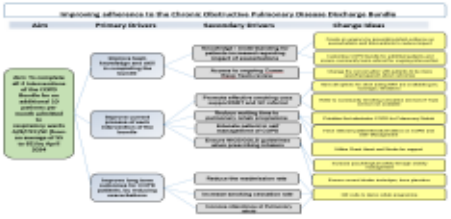
Aim: To complete all 4 interventions of the COPD Bundle for an additional 10 patients per month admitted to respiratory wards A/B/7CC/5F, by March 2024.

Method:

- The project team included the Respiratory MDT team from the Mater/Royal and the Community Respiratory Team.
- Model for Improvement[3] was the methodology used for this QI.
- The evidence was shared to create a sense of urgency for this quality improvement project at an integrated team study day.
- Process mapping was undertaken to ensure we knew our system.
- A project charter was agreed and a Driver Diagram was developed to guide the project.
- Monthly data collection and analysis was undertaken and shared.
- Human factors were considered and examined to understand the effects of teamwork, interventions, processes, culture and the workspace and organisation.
- The additional 10 patients/month will increase adherence to reach the 770 COPD patients admitted per year.

Process Change:

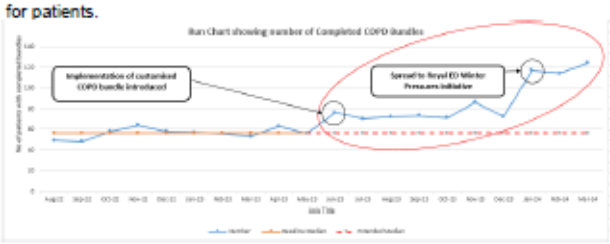
- The change ideas are focused on 3 key areas: the team, the processes and the patient outcomes.
- The bundle itself was adapted and customised for Belfast Trust.
- The discussion with patients was more open and transparent so they could understand the importance of the interventions on their future outcomes.
- Our smoking cessation support changed and NRT resources improved.
- First COPD patients were prioritised for pulmonary rehab access.
- Importance of inhaler technique/self-management were emphasised.



Refs:
[1]Sulaiaa S. et al Thorax (2012); 67:957-963
[2]BTS COPD Discharge Bundle https://www.brit-thoracic.org
[3]The Improvement Guide, 2nd Edition. Provost & Murray (2011)
[4]Langley et al (2009) The Health Care Data Guide

Results:

The run chart shows the baseline data from August 2022 and when the QI project started in June 2023. We were able to demonstrate we met our aim quickly because we have a cohesive, committed and highly specialist team who all prioritised this quality improvement. There has been a shift in clinical practice above what was anticipated. We introduced a further change idea in January 2024 when a respiratory nurse specialist was seconded to RVH ED to ensure that the COPD bundle was commenced at the earliest opportunity for patients.



Conclusion:

We have achieved and sustained our initial aim through collaborative teamwork and have incorporated this COPD Bundle into Encompass so the improvement can be maintained.

Key Learning:

The importance of knowing your system and then ensuring an agreed vision. Display the plan through a driver diagram which everyone understands and owns. Collecting the right data from the beginning is essential.

Measuring interventions and their outcomes is a big driver for sustained change. The QI process and model for improvement helps build team morale and pride in the service.

Achievements:

- Increased my knowledge of QI.
- Understand data and QI Charts[4].
- Improve the knowledge, skill and appreciation of QI across the wider Respiratory MDT.

Next Steps:

Develop a live registry of COPD patients to ensure access to the right interventions to reduce/prevent exacerbations. Continue to liaise with other HSC Trusts across NI to scale up and spread the COPD Bundle. Develop admission profile data to determine the long term impact of the COPD bundle on readmissions and mortality to address population health issues for these patients. It would be beneficial to discuss funding for a Respiratory Nurse Specialist to implement the COPD Bundle in ED as this could result in an ongoing reduction in the number of admissions for COPD patients over time.

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ScIL Scottish Improvement Leader

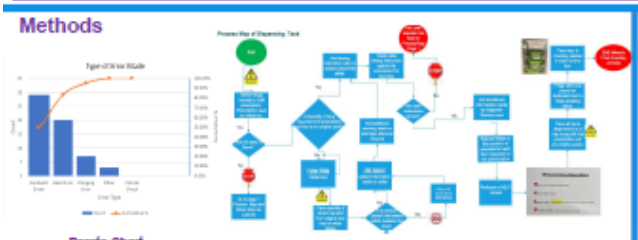
Reducing dispensing errors in Satellite Pharmacy Belfast City Hospital

Employing Quality Improvement (QI) methodology to change the dispensing process to consistently improve dispensing accuracy

Introduction: The World Health Organisation challenge is to reduce severe, avoidable harm related to medicines by 50% in the next 5 years. The Satellite Pharmacy dispenses Systemic Anti-Cancer Treatments (SACT) to patients in the Belfast Trust and records a number of near miss dispensing errors weekly. A near miss dispensing error is an error picked up by the pharmacist's final check, before it is released to a patient. Reducing the number of near miss incidents will reduce the risk of a patient suffering severe avoidable harm from an incorrect medication. This project employed QI methodology to review the dispensing systems in Satellite pharmacy and to plan, implement and study if making small changes to current systems can result in a consistent improvement in accurately dispensed medicines.

Aim: To reduce the number of near miss dispensing errors made in the Satellite Pharmacy non-aseptic dispensing unit each week by 40% (n=6) by the 31st of March 2024.

Methods

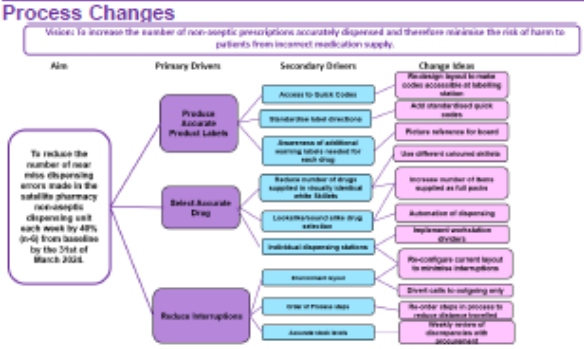


Pareto Chart — Process Maps

A multidisciplinary team processed mapped the current dispensing system and the baseline near miss data was themed and plotted as a Pareto chart. This allowed the team to understand the current system and answer the three questions in the Model for Improvement helping to define the project aim, the outcome, process and balancing measures and the change ideas that may lead to improvements in the measured outcomes. These change ideas where then tested, studied and refined using Plan-Do-Study-Act (PDSA) methodology.

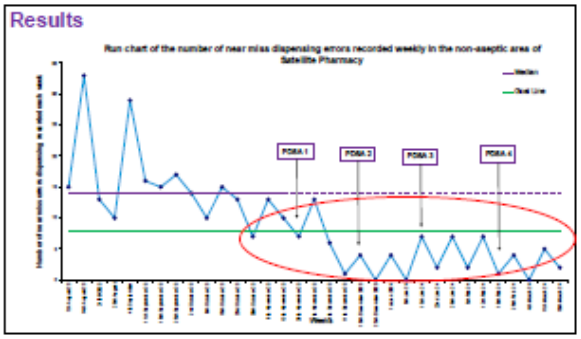
Measure Type	Measure
Outcome	Number of near miss errors recorded each week
Process	Number of days pick list completed
Balancing	Number of near miss errors recorded from aseptic dispensary
	Number of datix incidents recorded that reached patient from non-aseptic dispensary
	Staff satisfaction feedback

Process Changes



PDSA	Change tested
1	Divert telephone to outgoing only
2	Implement workspace barriers
3	Dispensing check aide memoire
4	Alter process steps to gather then label

Results



- The run chart above shows a shift below the median from the 23rd of October onward, there is only one "run" from this date onward showing special cause variation. This suggests the change ideas tested can consistently reduce number of dispensing errors made.
- From early December, the aim of a 40% reduction in near miss errors was reached. This has been maintained, with a zero error rate recorded on some weeks.
- There were no significant changes in the balancing measures monitored during this project and the process measure indicated a 92% compliance with daily completion during the project.

Conclusions

Using QI methodology to make small changes to the dispensing process has resulted in improved dispensing accuracy, reducing the number of weekly near miss errors to below the 40% target. Staff working in the area on the project team found this a positive experience."

"Being involved in [the project] and learning about QI and the tools had you thinking differently about the tasks you had been just doing daily, and how they could be safer"

Key Learning

Spending time to understand your system is the most beneficial investment that can be made in any improvement project.
Staff who work in the system every day are the subject experts and can drive and sustain the improvements if listened to and supported.

Next Steps

- Continue to develop and implement change ideas on the driver diagram that have not yet been explored.
- Learning from this project to be shared with other dispensaries in BHSCT to begin to spread improvement.

Contact: Linzi Magee, Medication Safety Pharmacist, Belfast HSCT Linzip.magee@belfasttrust.hscni.net.

Key References: Kotter JP, (2012) *Leading change*
Lloyd Provost P, Murray, Sandra K. (2011) *The Health Care Data Guide: Learning from Data Improvement*

ScIL Scottish Improvement Leader

Many thanks to the Pharmacy Satellite team for their engagement and enthusiasm for this project and to my mentor James Taggart for his support and advice.

4. RAISING THE STANDARDS

Emergency Department (ED) Information

Belfast Trust - Emergency Departments (RVH, MIH and RBHSC)
*includes UCC and Minor Injury Units.

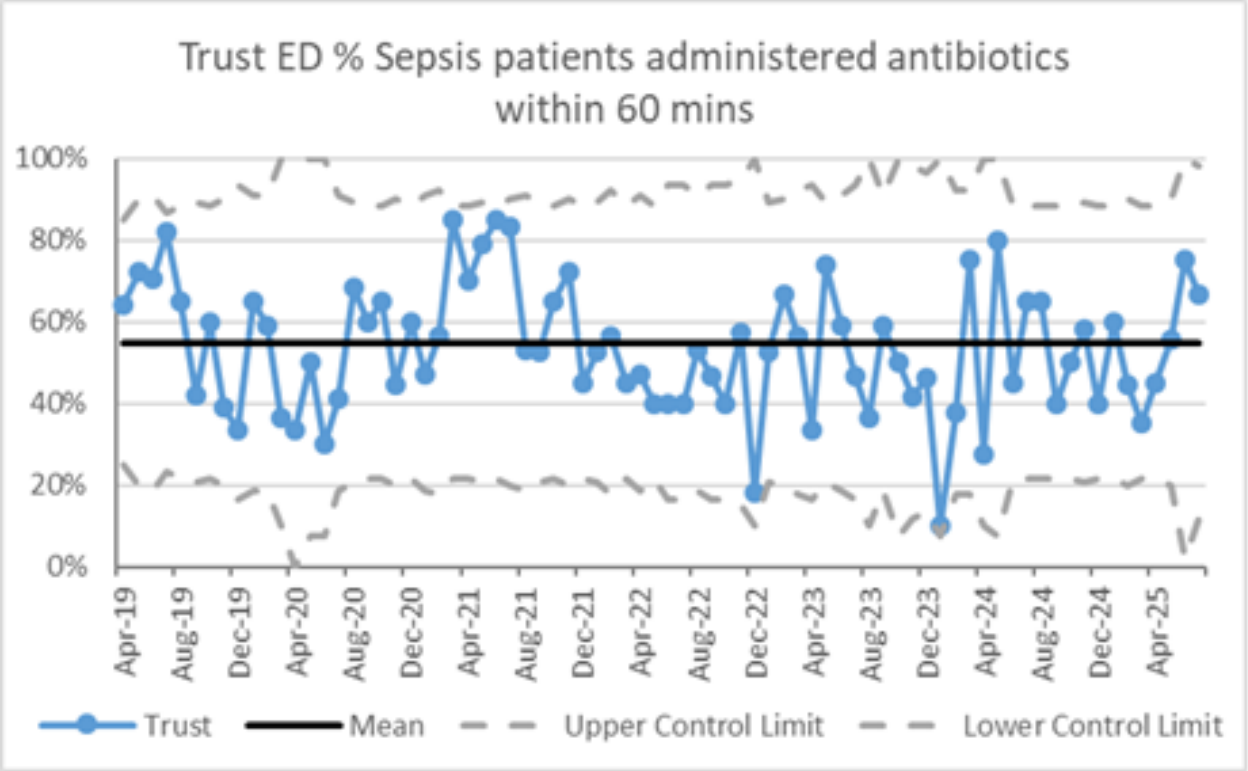
	2021/22	2022/23	2023/24	2024/25
% in 4 hours	53%	48%	44%	37%
12 hour waits	19,536	27,837	31,796	34,284
% of patients who Did Not Wait	8%	9%	11%	12%
Average time from arrival to first seen by Clinician/ENP (in mins)	137	164	178	221
Percentage of attendances who reattended within 7 days	2.4%	2.8%	2.8%	5.9%

*Emergency re-admission rate (CHKS monthly data points – Last 2 years is not available due to the launch of Encompass.

Sepsis in Emergency Departments

Sepsis is a condition where the body has a severe response to infection injuring its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognized early and treated promptly. Sepsis 6 is the name given to a bundle of interventions designed to reduce the mortality of patients with sepsis through timely intervention.

The graph below shows the percentage of patients who were administered antibiotics within 60 minutes of arrival to the emergency department.



Mortality Information

The Trust robustly reviews the deaths of patients in our hospitals and compares this information with other peer hospitals for the same period. One way in which this information (known as the crude mortality rate) is shared is via a graph called a Funnel Plot Chart. Funnel Plots add an element of statistical reliability to basic figures; they do this by applying statistical control limits above and below the average performance of a group. These limits are represented by the top and bottom lines on the graph with an average line in the middle.

*Standardised mortality ratio (Funnel Chart) is not included in this year's report as this information is not yet available via Encompass.

Emergency Department ED) Improvement Work

On 3rd March 2025 the ED team at the RVH held a celebration event highlighting their ongoing improvement projects and achievements.

See below for a range of ED Quality Improvement Project posters.

Enhancing patient safety through in situ simulation:

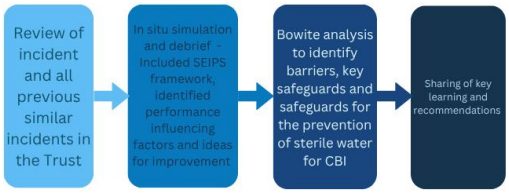
Utilising in situ simulation to understand work as done in the Emergency Department

Emma Greenwood, Louise McKee, Nicola Weatherup, Nadine Brown
Belfast Health and Social Care Trust

Introduction

Several incidents involving the administration of incorrect fluids during continuous bladder irrigation (CBI) for clot retention, specifically the use of sterile water instead of sodium chloride 0.9%, had been identified within the Emergency Department (ED) and other areas across the Trust. These incidents mainly occurred outside the urology ward. Utilising sterile water for CBI can lead to dilutional hyponatraemia and significant harm. 3L bags of sodium chloride 0.9% are used in CBI (not 1L bags, sterile water for irrigation is generally 1L bags).

Figure 1: Summary of method



Methodology

A medical student (patient), an ED clinician and three staff nurses of varying skill mix participated in an in situ simulation involving a 74-year-old male presenting with frank haematuria and clot retention. Following the assessment by an ED clinician, nursing staff were tasked with obtaining the appropriate equipment and fluids for CBI.

Using the SEIPS framework (1) during the debrief, multiple systems interactions and performance-influencing factors were identified and discussed. Contributing issues included a crowded environment, frequent interruptions, disorganized paperwork, and the inability to locate an up-to-date Standard Operating Procedure (SOP). A 1-liter bag of sodium chloride 0.9% was found adjacent to a similar-looking bag of sterile water, both marked with red writing (Fig 2). Participants in the simulation also generated and discussed improvement ideas.

We compared the anticipated workflow (work as imagined) with both the recent incident and the simulation outcomes to further understand work as done. A Bowtie analysis (2) was conducted to identify potential controls and safeguards to mitigate future risks (figure 3).

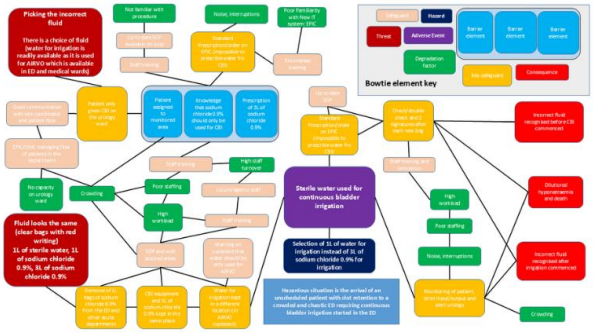
Results

The findings were presented to the review team investigating the patient safety incidents. The participants of the simulated enhanced learning, including a fifth year medical student, cited it as their most informative experience on three-way catheters and CBI. Key recommendations included ensuring such patients are managed in the urology ward as soon as possible, removing 1L bags of sodium chloride 0.9% for irrigation from wards, co-designing the SOP for non-urology staff relevance, redesigning electronic prescriptions to prevent water prescription, implementing double-checking protocols, alerting the MHRA regarding the fluid similarity issue, collaborating with universities on CBI education, providing e-learning for all staff, and establishing a designated CBI cupboard in the ED.

To disseminate the findings and foster a culture of safety, a learning lunch was organised for all staff, encouraging collaborative discussion and feedback. Attendees noted that they gained insight into the local context of such incidents, the importance of design of equipment and medication packaging and the necessity for system change or redesign, rather than relying solely on reminders or education.

Figure 2: 1 litre of sodium chloride 0.9% and 1 litre of sterile water

Figure 3: Bowtie analysis



Conclusion

This holistic approach not only enhanced understanding of the incidents, but also generated realistic improvement initiatives and also promoted engagement amongst healthcare staff in implementing safety practices.

References

1. NHS England (2022). SEIPS quick reference guide and work system explorer. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf.
2. McLeod, R. and Bowie, P. (2021). Guide to conducting BowTie analysis | Turas | Learn. [online] Nhs.scot. Available at: https://learn.nes.nhs.scot/78838 [Accessed 19 Dec. 2024].

RVH POCUS GOVERNANCE QIP

Dr Adam Gowdy ST6 EM, Dr Catherine Gallagher F2 IEM, Miss Katie Whitburn MS4,
Dr Chris Lowry Cons EM, Dr Emma Greenwood Cons EM and Dr Louise McKee Cons EM

Project Background

Point-of-care ultrasound (PoCUS) is increasing in use within clinical environments in many areas of healthcare. There are clear guidelines in relation to governance standards in relation to PoCUS including documentation of patient details, recording of scans, review of imaging, safe image storage and infection prevention and control. These have real world patient safety effects and are often poorly adhered to.

SMART Aim

To improve RVH ED saved PoCUS scans compliance with BMUS/RCR (British Medical Ultrasound Society / Royal College of Radiology) guidelines to 70% by May 2025.

Change Ideas

Use of the SEIPS (Safety Engineering Initiative for Patient Safety) framework and a driver diagram to formulate our change ideas (use QR code for larger versions).

Measures

Data on all PoCUS scans in RVH ED from May to March (6 weeks of missing data due to machine availability) was collected on a weekly basis and assessed compliance with adequate patient details on each scan; name, hospital number, DoB and username. Usernames were collected by a Microsoft Forms to improve ease of use. Baseline data was collected over a period of 13 weeks which crossed over the August changeover of resident doctors to ensure a fair sample.

A process map was made showcasing it took 341 seconds to input the required details, balancing measures were considered but not felt to be significant, as 341s as a percentage of total patient length of stay is negligible.

Compliance rate is presented as a percentage of scans performed that week.

We also collected the number of scans being performed and the number of users each week. By doing this we wanted to try and show the number of "ghost" scanners was falling. Ghost scanning is when a clinician performs a scan without saving any images.

PDSA Cycles/Interventions

1. 23rd August - staff survey on PoCUS Governance and feedback - week 13
2. 9th October - Trust email about BMUS guidelines - week 19
3. 22nd October - QIP Poster in handover room - week 16
4. 17th December - What's app message to regs - week 24
5. 5-7th February - PGCert Emergency Nursing Teaching Day, Trust email on QIP update and barriers/feedback - week 30
6. 26th February - Staff training day - week 33

Results

Our results are displayed on the run chart below. Our project has been successful in meeting its aim, a shit can be seen.

Our baseline median rate of compliance was 13.5%, after our interventions, our new baseline median is 72.5%, above our target of 70%.

Data on the number of weekly scans being performed and the number of weekly users, both showed an increase (data showcasing this is available via the QR code). This is important as we feel this may reflect a reduction in "ghost scanners", this is very hard to prove.

Our baseline survey results (full results available via QR code) showed that 97.5% of ED staff wanted to use PoCUS more in their clinical practice.

Discussion

Our interventions have showcased an improvement in our compliance rate with national guidelines. We believe that these changes are likely possible within other departments. We identified our key stakeholder group to be the higher specialty trainees and focussed one of our interventions towards them.

We were able to secure loan devices from companies as part of our business case to assess which machines would be most beneficial. These machines helped to increase the exposure of the project within the department and weren't necessarily a "PDSA cycle" but likely contributed to our results.

Learning

This project offered us the chance not only improve the quality of care in relation to PoCUS governance, but the chance to formalise our learning through the STEP Program.

The program facilitated our learning which was enhanced through the IHI QI learning modules and has helped deepen our understanding of QI methodology alongside empowering us with transferable skills to help future projects more successful and increase sustainability.

A key tool was the use of the SEIPS framework which was new to most of the team. This allowed us to come up with change ideas and issues in relation to our new machines that we may not have thought of otherwise. We would encourage others to consider using it in the future.

Next Steps

This presented project is a small sample of how we tried to improve PoCUS perception within our department.

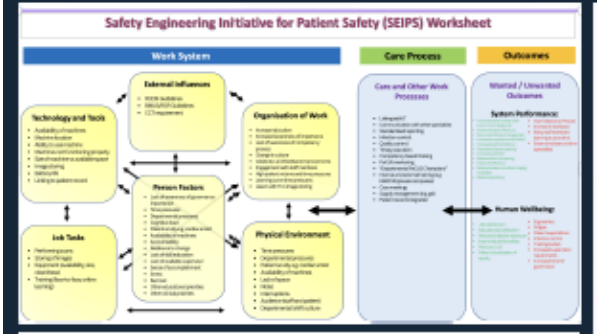
We conducted a baseline survey on staff perceptions and how that could be improved, we have submitted a business case for two new ultrasound machines.

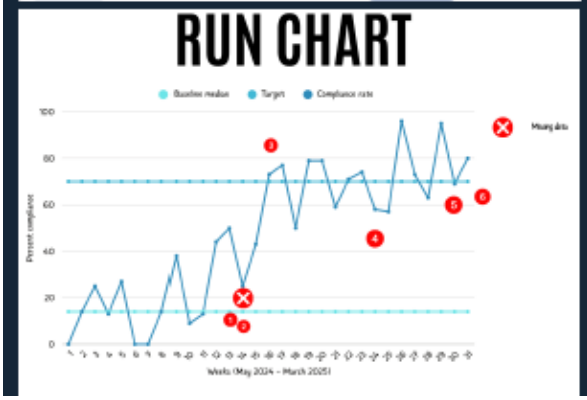
We plan to have a senior doctor "refresher" course. We are expanding the project within the department to include infection prevention by enrolling "PoCUS Champions" and integrating PoCUS as part of the daily resus team huddle.

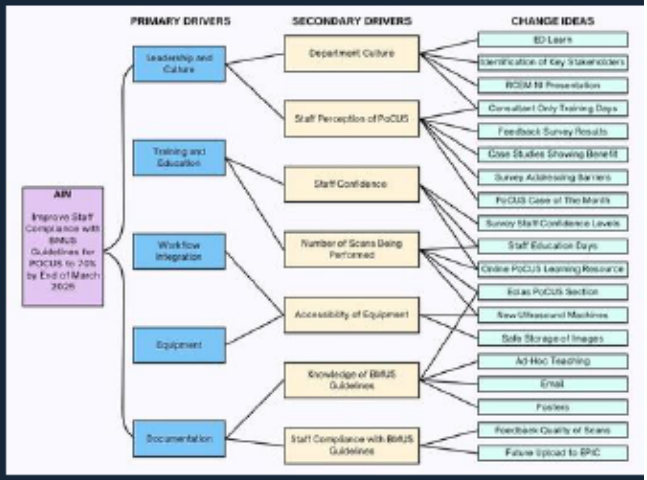
We will also look to expand into other departments using PoCUS regularly.

We are linking in with the IT department on the best method of long-term safe storage of saved images.

When we get our new machines, we will record "how to" videos for uploading to the departmental "Eolas" app.







References

Please use the QR code to access references and further resources

BRISTOL PATIENT SAFETY CONFERENCE 2025

HSC Belfast Health and Social Care Trust

Enhancing Morbidity and Mortality Meetings in the Emergency Department. A focused approach to case discussion and learning

Dr. Emma Greenwood, Dr. Peter Cuthbert, Dr. Louise McKee

Background

A review of monthly M&M meetings in the ED revealed low attendance and a lack of meaningful dialogue regarding cases discussed. The meeting was also almost exclusively attended by consultant staff. The focus of the project was to improve learning from mortality reviews, introduce learning from excellence and improve psychological safety.

Aim: To improve the attendance at the ED M&M meeting by 50%, by December 2023

Method

QI methodology was used to improve this. Baseline measures revealed that the median attendance to the meeting was 17 members of staff. All of which were almost exclusively consultant staff. Stakeholders included senior staff including trainees, SAS grade doctors, senior nursing staff, ACPs and other healthcare professionals. Change ideas included triage tool to review deaths, M&M hot topics and more (fig 1 and fig 3)

Fig 1: DRIVER DIAGRAM: To increase M&M attendance by 50% by Dec'23

Fig 2: Force field analysis

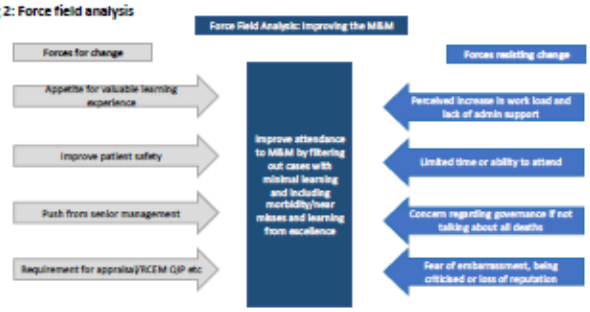
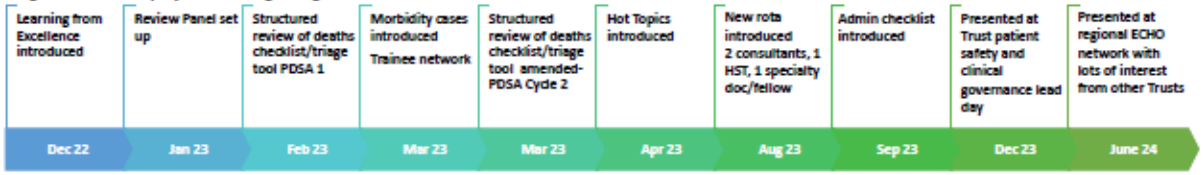


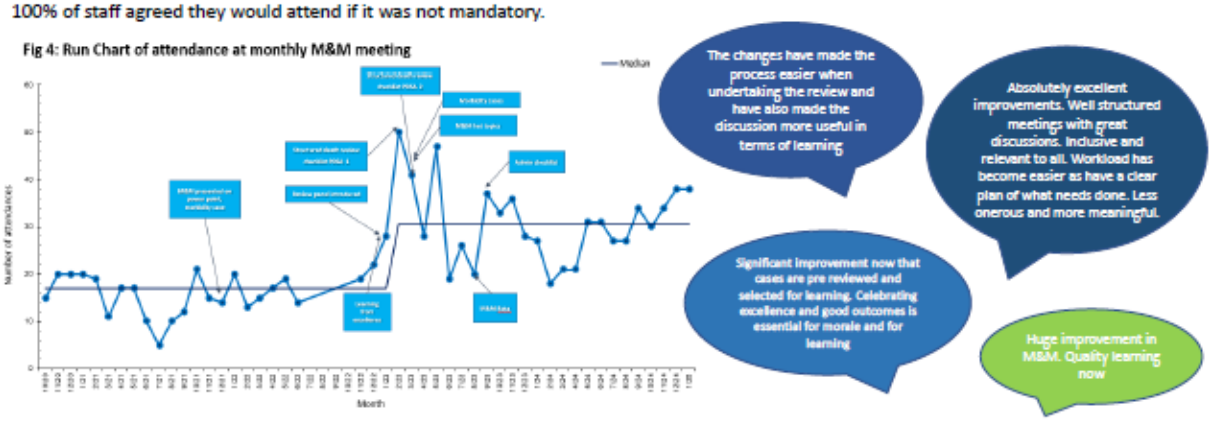
Fig 3: Time line of project including change ideas



Results

The median attendance increased from 17 to 30 that has been sustained, surpassing the initial aim (see Fig 4). Triaging the cases allowed focus on cases with meaningful learning. Involving non-consultant grade staff has improved engagement with the meeting and psychological safety. There was overwhelming positive feedback from staff, 100% of staff agreed or strongly agreed there was an overall improvement, 100% of staff agreed they would attend if it was not mandatory.

Fig 4: Run Chart of attendance at monthly M&M meeting



Conclusion and next steps

Introducing a 'learning from excellence' case brought about enthusiasm to attend meetings. Discussion of morbidity cases/SAI cases is now routine and staff involved have led the discussions, suggesting a safe space for these discussions to occur. A systems approach is used to look at these cases, removing blame and identify learning with the commissioning of improvement work. The project has been presented at several forums within the Trust as well as at regional events, generating interest amongst many colleagues and the sharing of ideas.

ED EDUCATION STATION

Belfast Health and Social Care Trust
Dr Noleen Osborne, ACP Rachael Lusty
Dr Emma Greenwood Dr Louise McKee

PROBLEM?

80% of staff do not attend M&M
70% not aware of recent SAIs
50% do not keep up with emails
"Information overload"
"Not able to access emails from home"
"I don't even have a trust email"

AIM

EDUCATION HUB

WHY?

Clear, timely communication of safety alerts helps prevent harm, supports informed decision-making, and strengthens our safety-first culture

PROCESS

TOPICS

PDSA TIMELINE

RESULTS

90% of staff found useful/very useful

LESSONS LEARNT

Large-scale initiative with Substantial commitment
Visibility matters – Posters and visual displays significantly improved awareness compared to email alone.
Multiple channels are essential – app posters, handover
Timing and repetition help

FUTURE...

Expanding to other ED within trust
Expand to other wards within hospital
Mobile Education station to wards/departments
And ...ED EDUCATION STATION Conference??

BRISTOL PATIENT SAFETY CONFERENCE 2025

Introduction of Discharge Observations for Category 2&3 Patients Discharged with No Follow-up from RVH ED

G. GUINNESS, L MCGEOGHAN, FY2 TRAINEES

INTRODUCTION

Discharge observations—defined as vital signs recorded within one hour prior to discharge—are crucial in Emergency Departments (EDs) with high acuity and rapid patient turnover. They support the monitoring of clinical progression and early detection of potential deterioration, thereby ensuring safe discharge. In Belfast Trust EDs, timely discharge observations have directly led to emergency interventions, such as identifying new hypotension in a patient with back pain, prompting imaging that revealed an imminent abdominal aortic aneurysm rupture. Despite their importance, due to rising pressures, times between last observations and discharge can be significant, with baseline data showing some intervals exceeding nine hours. Recognising the risks associated with such delays prompted a Quality Improvement project in RVH ED to introduce and promote discharge observations, aiming to reduce this interval and enhance patient safety.

AIM

To reduce the average time between **last observations to discharge by 25%** in category 2&3 patients in RVH Emergency Department discharged home with no follow up by **May 2025.**

DRIVER DIAGRAM

Aim- To increase uptake in completion of discharge OBS by 25%

- Staff Education
  - Raise awareness of new protocol through discussion at handover and placing physical posters in ED
- Availability of observations machines
  - Ensure current machines working/charged
  - Assess capacity for funding for new machines/ updated machines
- Space for completing discharge obs
  - Implementation of 'discharge observation station'
- Change in culture
  - Qualitative survey for staff feedback and ideas for progressing
  - Assess staff adherence and satisfaction with new protocol

Why?

- Patient safety
- Detect deterioration
- Fewer failed discharges

METHODS

- **IHI Quality Improvement Methodology used to implement discharge observations.**
- **Initial data collection over two weeks established a baseline average discharge delay.**
- **A staff survey was then conducted to assess awareness and gather qualitative feedback**
- **Using this insight, five PDSA (Plan-Do-Study-Act) cycles were implemented.**
- **We worked with encompass staff to create a programme which allowed us to collect the key information of all category 2 and 3 patients discharged daily in RVH ED. This enabled daily data collection and weekly data analysis.**

PDSA 1: Importance of timely discharge observations discussed at safety huddle - aim of obs within 1 hour prior to discharge

PSDA 2: Poster with QIP information emailed to all staff, discharge obs importance mentioned at medical handover.

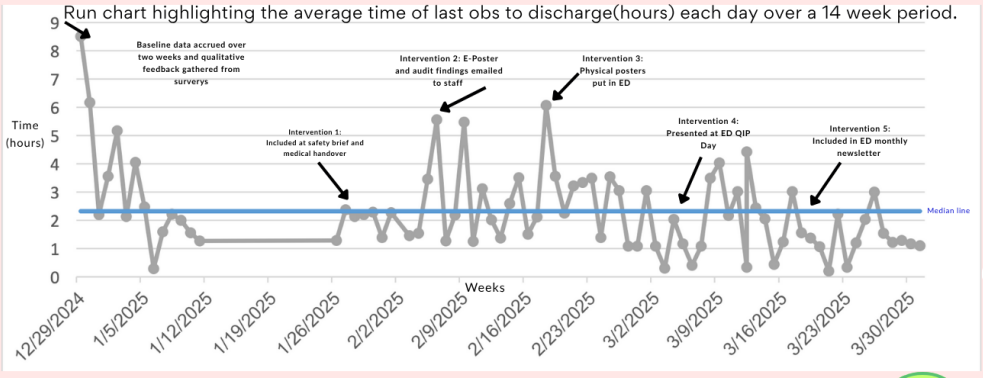
PDSA 3: Physical posters put up around ED - key areas of visibility for patients and staff.

PDSA 4: Presentation to consultants, resident doctors, admin and nursing staff at ED QIP Presentation Morning, Feedback received and steps to ensure continuity of project established,

PDSA 5: Published poster promoting QIP in ED Safety Newsletter

RESULTS

Run chart highlighting the average time of last obs to discharge(hours) each day over a 14 week period.



ANALYSIS

Average time from last obs to discharge:

3 hours 46 minutes → **2 hours 3 minutes**

- This is an overall **reduction of 45.5%** in the time from last observations to discharge

CONCLUSION

45.5%

- Reduction of 45.5% in the average time from last observations to discharge of category 2&3 patients discharged home with no follow up.
- Continued awareness to all staff of the importance of discharge observations is required to maintain a decline in average time.
- Further interventions to ensure continuity include the department introducing new observation machines which automatically link to encompass.

NEXT STEPS

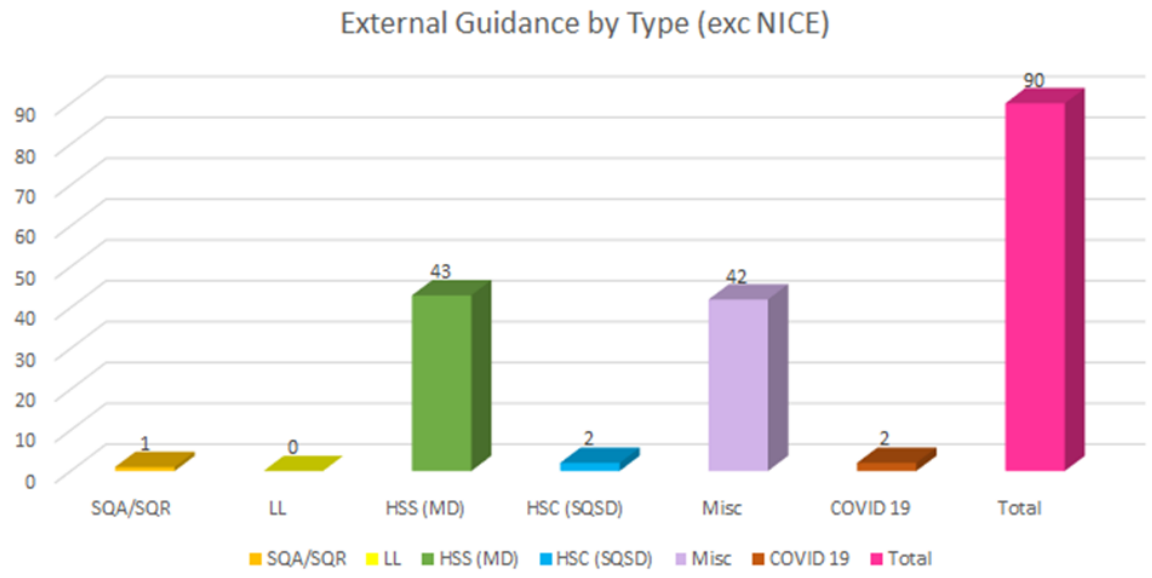
- Discharge observation station
- Installation of new observation machines which automatically link to encompass servers - in progress.

External Guidelines

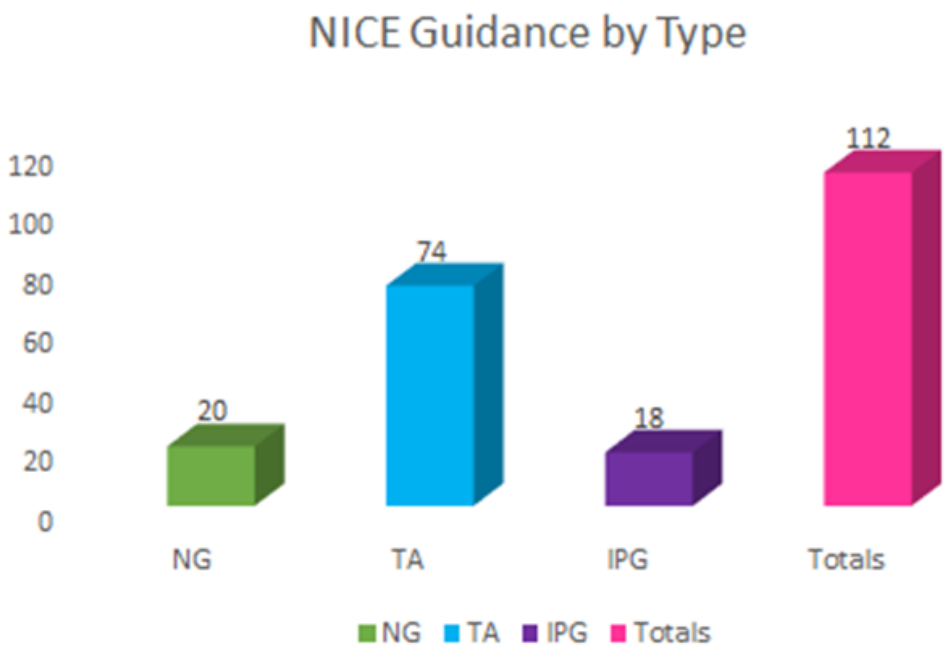
The Trust receives external guidance from many sources, i.e., the Department of Health (DoH), Strategic Planning & Performance Group (SPPG) and the Public Health Agency (PHA).

The chart below provides a breakdown of External Guidance (excluding NICE) received during April 2024 – March 2025. There was a decrease overall in the number received (90) compared to April 2023 – March 2024 (139).

Safety Quality Alerts/Reminders (SQA/SQR), HSS (MD), Misc & Covid-19 related correspondence decreased, with HSC (SQSD) correspondence remaining the same. From 2024-2025 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports have been disseminated by the Standards & Guidelines team via the Outcome Review Assurance Group (ORAG). 5 NCEPOD study reports were received during the reporting year.



There has been an increase in NICE Guidelines (NGs) received during this timeframe, however Technology Appraisals (TAs) and Interventional Procedure Guidance (IPG) received have decreased.



External Guidance – Actions taken to improve processes and minimise number of outstanding external Guidance:

The Standards & Guidelines Department have developed a policy regarding The Management of External Guidance (including NICE Guidelines) to inform and guide BHSCT staff on the processes of dissemination, implementation, submitting responses and monitoring compliance.

Recruitment of a Band 5 Administration Manager has also taken place, with the expectation that outstanding responses and backlog issues can be eradicated.

The team continue to provide administrative support to help areas complete their baseline assessment tools (BATs) and have been working collaboratively with other Trusts in NI to contribute to the completion of BATs for regional services commissioned through BHSCT.

Clinical Audit

- National and regional audits supported by the clinical audit team
- Local clinical audits are also supported (resource dependent) as a means of measuring practice against defined standards to:
    - Provide reassurance that compliance with standards is good
    - Highlight poor compliance to reduce risk and inefficiencies
    - Lead to improved patient care and outcomes

Clinical Audits Registered 2024/2025	
Local Clinical Audits	126
National Clinical Audits	37
Regional Clinical Audits	27
Total	190

Clinical Audit (NICE)

National Comparative Audit of Bedside Transfusion Practice 2024 Re-audit (NHS Blood and Transplant, 2024 – report published 22/07/2024)

Background

Ensuring the right blood is given to the right patient is a crucial aspect of transfusion practice and undertaking the correct pre-administration bedside checks in the correct way is a critical point in reducing potential errors. NHS Trusts are required to ensure that all staff involved in the transfusion process are adequately trained and that robust policies are in place to cover all aspects of transfusion care. These policies must specifically include the pre-transfusion bedside administration checks, the care of the patient during a transfusion episode and the management and reporting of any adverse events.1 A patient safety alert issued by the Department of Health in 2017 highlighted that

patients were being harmed, and some had died, as a result of being given incorrect blood, including ABO incompatible transfusions. Most could have been prevented if the final bedside check had been carried out correctly. This alert encouraged use of a structured bedside checklist, both to prompt all necessary checks, and to allow documentation that all steps were performed. A series of national audits of bedside transfusion practice have been carried out since the mid-1990s with the last performed in 2011. Those audits highlighted that a small proportion of patients receiving blood were vulnerable to errors due to lack of adequate pre-transfusion identification checks and appropriate observations. Previous cycles of this audit focussed on retrospective notes-based audit to confirm whether the bedside transfusion process was being followed. On this occasion we used a prospective observational methodology to better understand the reasons for errors and identify opportunities for improvement. Electronic blood management systems have been recommended, with an aim to improve transfusion bedside safety via barcode scanning technology. This enables an automated electronic check of the component to be transfused against the patient's requirements in the Laboratory Information Management System (LIMS). This audit will record the use of these systems and their impact on compliance with bedside checks. This audit will provide data and insight into current practice and highlight areas where further work is required to meet national standards.

Aims

The key aim of this re-audit is to determine whether the current BSH guideline 'Administration of Blood Components' (2017) is being followed and to determine if there has been any improvement in compliance compared to previous audit cycles. It also looked to assess whether any specially developed documentation or technologies used to support bedside transfusion practice have a beneficial effect. The audit seeks to understand the reasons for any areas for non-compliance, to help identify the barriers and facilitators of good practice. Results will be summarised nationally and regionally, and individual site data will be fed back to reporters. The findings will feed into recommendations for improvements, and organisations can tailor their response based on

local needs identified by their own site results. The aim is to improve blood transfusion safety by working to reduce the risk of harm due to a wrong component being transfused, and ensure patients are appropriately monitored to detect any adverse reaction.

Methodology

All NHS Trusts and independent hospitals in England were invited to participate in the audit. Trusts/ Health boards and hospitals in Wales, Northern Ireland and Scotland were also invited to participate. Sites were asked to provide data on a sample of up to 40 patients being transfused in the months of March and April 2024. We additionally asked for details of what electronic systems sites had in place to support the bedside transfusion process. The auditor was asked to attend the clinical area shortly after a unit of blood had been collected for transfusion. They observed the bedside checking process, recording any omissions and the reasons for these. The staff member performing the checks was asked to verbalise the process, so the auditor was aware what information they were checking. To ensure patient safety, auditors were advised to offer a prompt if any check had been missed, before transfusion was commenced. Auditors recorded whether clinical observations had been documented pre-, during and after transfusion, either by re-attending the clinical area or looking at electronic records if available. Audit data were entered onto pre-printed proformas which were returned to NHSBT for processing or entered directly into the NHSBT online audit system. In addition, an organisational survey asked Trusts about their policies for performing bedside checks (one-person or two-person and the details of these), the availability of a bedside checklist and the adoption of electronic bedside systems.

Summary

- 2918 transfusions were audited by 166 sites over a 2-month period.
- The audit demonstrates overall reasonably safe practice but has identified areas for improvement.

- Knowledge gaps, staffing pressures, lack of equipment (such as workstations on wheels, ID band printers), environmental factors (space, layout), set-up of systems (e.g. accessibility of a checklist) and varying practice in outpatient settings were all identified as contributing to poor compliance.
- The prospective observational design of this audit enabled auditors to pick up errors or omissions as they happened and to take immediate corrective steps and provide education in real-time.
- Checking process:
    - A pre-transfusion checklist was not used in 14.1% (411/2918) of transfusions. 7.1% (12/168) of sites reported not having a checklist in place.
    - 67.3% (113/168) of sites have a policy requiring a two-person check before blood administration, and of those 70.6% (72/102) specify a two-person independent check. Of 1764 two-person checks observed, 833 (47.2%) were not carried out independently. Misunderstanding about the meaning of a two-person independent check was common.
    - 3.5% (137/3895) of checks were not carried out at the bedside.
    - The checking process was interrupted in 7.8% (210/2690) of cases but was only recommenced from the start in 49.0% (96/196). Most interruptions could be avoided by ensuring equipment, patient and prescription are all ready before collecting units.
- Positive patient ID:
    - 3.4% (99/2907) of patients were not wearing a form of ID, and in two thirds there was no appropriate reason for this.
    - In 7.0% (241/3434) of transfusion checks, the patient was not positively identified by asking them to state their name and date of birth, and these details were not checked against the ID band in 4.1% (140/3420).
- Individual bedside checks:

    - Compliance with most individual steps in the checking process was between 88% and 99%. A visual inspection of the unit (88.5% compliance, 3461/3910) and a check against special requirement stated on the prescription (92.6% compliance, 1444/1559) were most frequently missed.
    - A two-person independent check increased the likelihood that between them, one checker would cover every step.
- Electronic systems:
    - 36.3% (61/168) of sites have an electronic bedside system for pre-transfusion checks.
    - An electronic device was used in 25.0% (728/2913) of transfusion checks observed. Where an electronic device was used, there was lower percentage compliance with all steps of the staff checks, including those (positively identifying the patient, check of details against ID band, ensuring component matches prescription, visual inspection of unit) that the device cannot check.
- Patient observations:
    - A complete set of observations was not recorded pre-transfusion in 6.2% (178/2885) of cases, during transfusion (within 30 minutes of starting) in 11.7% (337/2878) and post-transfusion in 12.4% (354/2850).
- Training:
    - 94.8% (4426/4670) of staff performing bedside checks had completed transfusion training within the last 3 years, but 39 reported having no training and 205 (4.4%) were unsure.

Note that denominators vary as not all questions were answered for all cases audited.

Recommendations

- Hospital transfusion teams should review their training on bedside transfusion practice to ensure:

    - This is in line with Trust policy (e.g. about two-person independent checking, or number of staff required when using an electronic device)
    - This emphasises the reasons *why* checks are required, not just how to perform them
    - Refresher sessions/ bite-sized reminders of key points are available in between the main 2- or 3-year mandatory training cycle
- Ensure a pre-transfusion checklist is available in a format facilitating easy use at the bedside
- When electronic bedside systems to support pre-transfusion checks are introduced, transfusion teams should ensure:
    - The systems are configured and equipment available so they can be used *at the bedside*
    - Training emphasises the continued importance of human checks, particularly those that the machine cannot perform (positive patient ID and check against wristband/ check against prescription/ visual inspection of unit)
    - They continue to review how the devices are used in practice and identify any workarounds which can erode the safety benefits
- If site audit has identified a cultural or systemic issue with ID bands (e.g. not being used in a particular setting, with no risk-assessed alternative) this should be escalated through hospital safety governance, as this represents a risk extending beyond transfusion.
- Empower patients to view the ID check as a positive step to ensure their safety, and to ask for this if it has not been performed – this may be particularly applicable in regularly-transfused patients in an outpatient setting, where there is a risk of complacency.
- Consider whether prompts can be built into the transfusion pathway, for example to ensure that equipment and patient are ready prior to collecting blood, and observations are taken.

Electronic systems and integrated care plans may have a role in this.

- Disseminate local audit findings via a top-down (nursing governance) and bottom-up (ward nurses in charge, staff huddles) approach, to ensure key messages reach the individuals performing these tasks day-to-day. This should include settings not involved in the original data collection.

Read the full Report here:

2024 National
Comparative Audit of

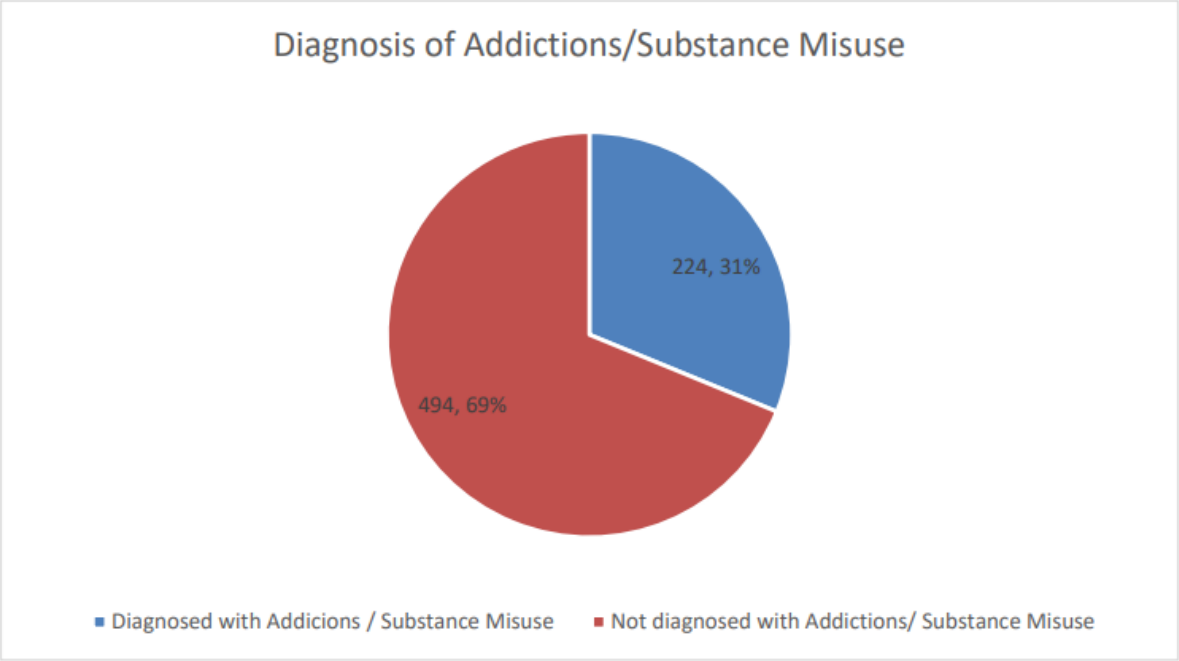
Clinical Audit (RQIA)

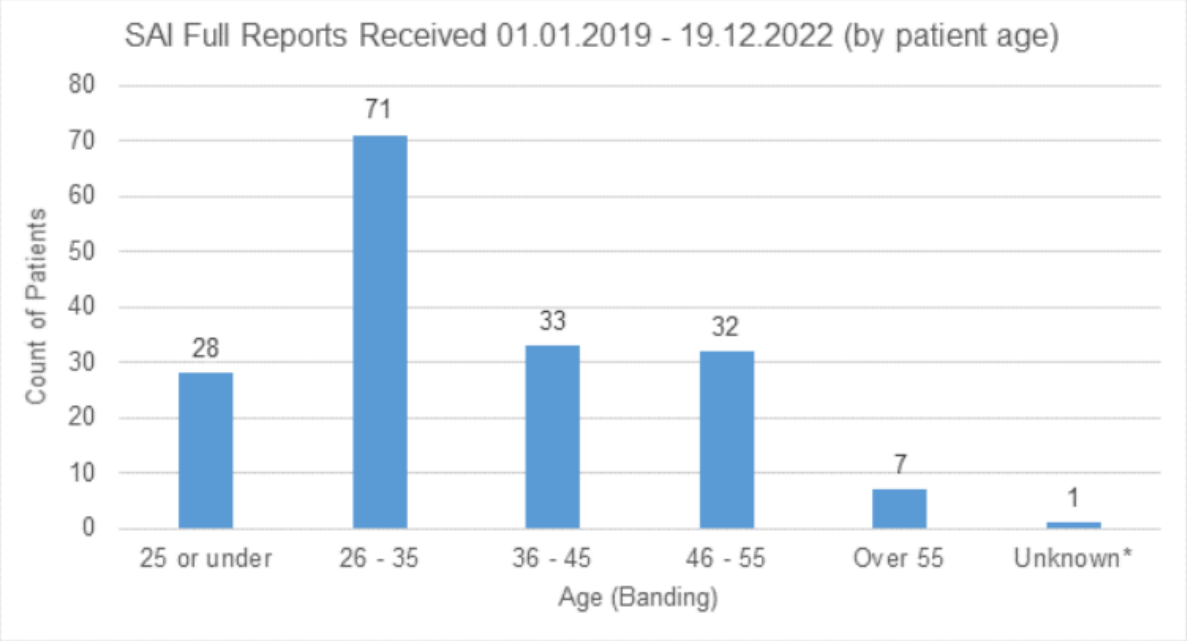
Analysis of Serious Adverse Incidents Reported to RQIA Where the diagnosis is Addictions / Substance Misuse

Overview:

The system for reporting adverse incidents was first introduced in Northern Ireland in 2004 by the former Department of Health, Social Services and Public Safety (DHSSPS), now known as the Department of Health (DoH). Reporting arrangements were transferred to the Health and Social Care Board (HSCB), now the Strategic Planning and Performance Group (SPPG) within the DoH, in partnership with the Public Health Agency (PHA), in 2010. Updates to this regional SAI procedure were implemented in 2010, 2013 and 2016. The current version of the regional SAI procedure1 which was last updated in 2016, advises that SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

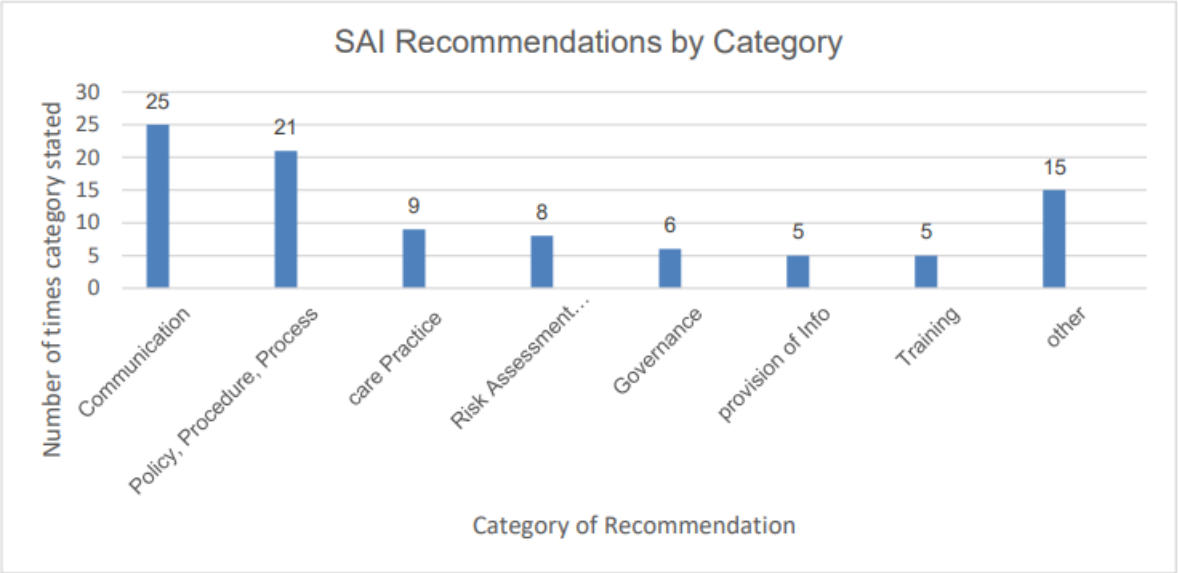
Findings:





Recommendations:

There were 388 recommendations linked to all SAIs received during this three-year period and 109 recommendations linked to SAIs with the diagnosis of Addiction/Substance Misuse.



This report has identified that improvements are required in the SAI process which aligns with the recommendations made in the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022. The DoH has commenced its SAI redesign programme of work in July 2023, and therefore no further recommendations in this regard are stated in this report.

Read the full report:

https://www.rqia.org.uk/RQIA/files/24/24765aab-014c-42bb-ba0b-9aa85e739704.pdf

Cancer Services – Annual Quality Report FY24/25

Throughout FY24/25, the Cancer Services team have worked with the various tumour sites to improve performance against the 14, 31, and 62-day targets for cancer.

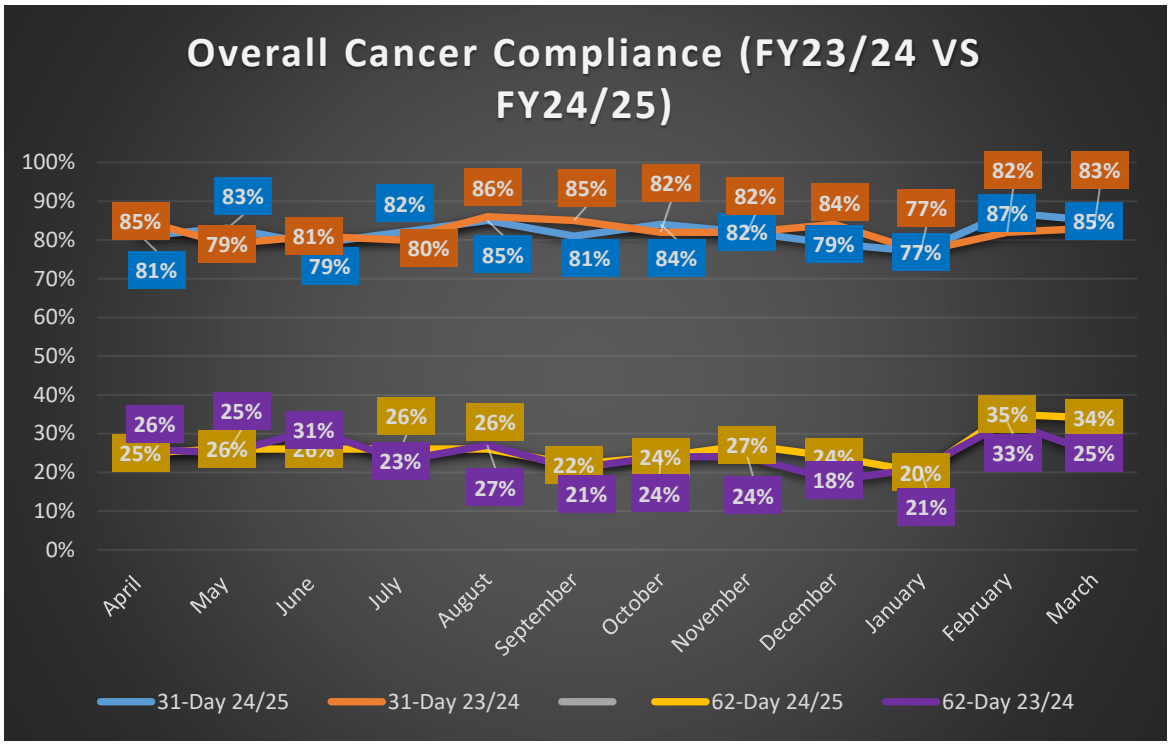
However, meeting these targets continues to be an ongoing challenge, for several reasons:

- Increasing referrals, with limited capacity in meeting demand

- Late transfers from other Trusts to the Regional services at Belfast Trust for discussion at MDM and onward treatment
- Delays in the diagnostic processes
- Cancer Waiting Time Guidance is outdated (from 2008), and is not equitable with the rest of the UK

This impacts on the timely access to the patient's first definitive treatment.

The graph below shows performance against these targets, comparing April 2024 – March 2025 with compliance from April 2023 – March 2024



The Cancer Services team are working closely with the various tumour sites to identify key areas for improvement, including:

- Introduction of a dedicated CUP (Cancers of Unknown Primary) Service and Regional MDM, which offers review, advice, and support of CUP cases – this ensures timely diagnosis, improved survival, efficient pathway to treatment, and better outcomes for patients – this service went live in October 2024.
- Implementation of Nurse-Led Triage with Medical oversight within Urology, to improve patient flow from point of referral.

- Engagement with SPPG for additional funding for the provision of additional Consultant Pathologists to support improvement in diagnostic turnaround (ongoing).
- Ensuring utilisation of Self-Directed Aftercare pathways, where appropriate.

Safety & Quality Visits

Safety & Quality Visits (SQV) help develop a culture of excellence in safety and quality by engaging, inspiring and supporting the workforce to deliver improved outcomes and experience for those in our care. Safety & Quality Visits involve senior leaders visiting both clinical and non-clinical areas to provide an informal method for leaders to talk to front line staff about patient safety, what matters to staff and service users, to share service achievements, good practice and discuss what could be even better.

During the period **April 2024 – March 2025 138 SQVs were scheduled.** However, due to the planned roll-out of **Encompass** and the requirement for pre-go live readiness activities, only **47 SQV took place.**

SQV total	Directorate	SQV took place
26	ACCTSS	x9
14	ACOPS	x6
14	C&SM	x7
2	CCS	x0
13	CH&NISTAR	x3
2	FE&CD	x0
2	HR&OD	x1
18	MDS&NISTAR	x6
9	MHID	x2
2	N&UE	x0
2	PPI	x0
7	SS&SS	x3
26	U&AC	x10

Quality Improvement Projects

NHS Education for Scotland

Back Soon: While you wait..

Deirdre Winters, Interim AHP Co-Director and AHP Professional Lead

Aim Statement:
To reduce the number of patients on the Physiotherapy MSK Outpatient waiting list in West Belfast by 10% by March 2024 to ensure timely access to evidence based patient centred physiotherapy for patients presenting with non specific low back pain.

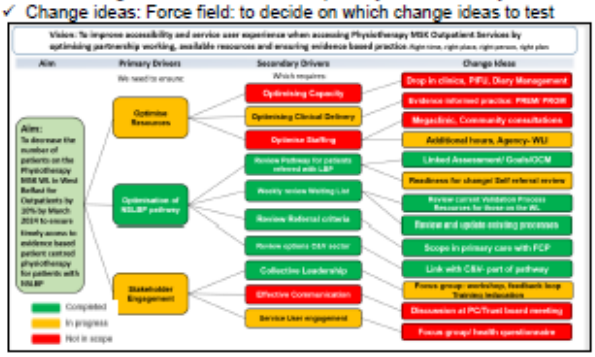
Introduction:

Our aim was to improve the patient journey for people presenting in primary care with non specific low back pain who required onward referral to our Physiotherapy (PT) Musculoskeletal (MSK) outpatient (OP) service in West Belfast. Poor MSK health has a huge impact on people, their families, the NHS and wider economy. (Approximately 30 million lost working days in the UK every year). MSK conditions make up 30% of Primary Care consultations in West Belfast with up to 50% attributed to Back Pain (LBP). Our focus has been to both reduce the waiting time and provide key information for people with low back pain while they wait.

WAITING LIST

Methods: The Model for Improvement

- ✓ A process map to understand the current patient pathway Process Map.pptx
- ✓ Identification of patient cohort on pathway from Primary Care
- ✓ A driver diagram to describe our aim, primary and secondary drivers
- ✓ Change ideas: Force field: to decide on which change ideas to test



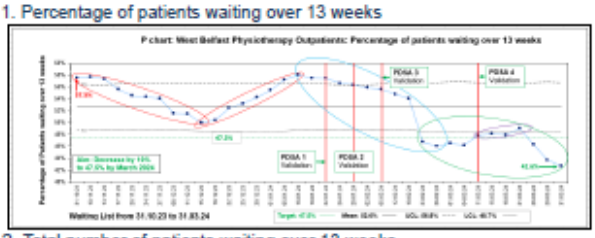
Process Changes: PDSA Cycles.pptx, PDSA Cycles.docx

PDSAs were completed along the pathway. These were underpinned by a measurement plan. There was key learning at every stage and each PDSA cycle was interlinked and mapped to the aim of the project.

Results:

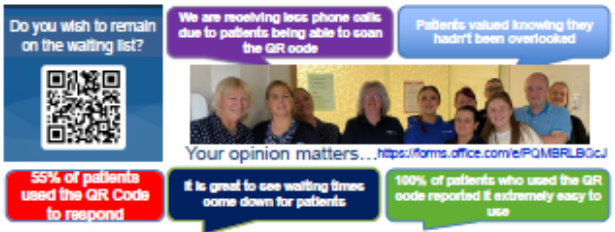
Outcome Measures: There is a shift suggesting an improvement

1. Percentage of patients waiting over 13 weeks



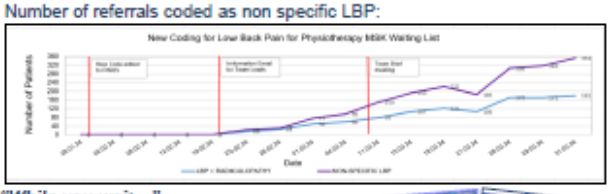
2. Total number of patients waiting over 13 weeks

Process Measure 1: Validation: 1868 Referrals- 55% patients used QR code



Process Measure 2: New electronic system code: triaging clinicians identify patients with Low Back Pain ensuring alignment to optimised pathway

Number of referrals coded as non specific LBP:



"While you wait..."

Back Pain: Patient Information was developed in collaboration with patients/clinicians to send to people referred to the service. The NSLBP stratification tool (STartBack) was also sent for the patient to return.

Sheet 1 Lower Back Pain.pdf, Sheet 2 Contact us if things change.pdf
Sheet 3 Cauda Equina Syndrome.pdf, STarT Back Screening Tool.pdf

Balancing Measure: 50% increase in calls to administration team

Conclusions:

The project outcome suggests an improvement in the percentage number of people waiting over thirteen weeks (57.5%: November 2023/ 42%: March 2024). The current waiting list represents the actual demand for the service. Further time is required to take forward other clinically focused change ideas.

Key Learning Points:

1. Process mapping a known system identifies key areas for improvement
2. Our data did not have the expected level of clinical detail which meant an additional process change was required impacting the time scale for the clinical component of the project. A review of available data at the start of the project would have identified this issue earlier.

Key Reference Materials:

The Improvement Guide and The Health Care Data Guide

Recommendations:

1. Further requirement to process map and streamline the MSK pathway
2. Requirement to review clinical delivery model and test further change ideas to provide timely access to high quality physiotherapy OP services
3. Requirement to seek feedback on resources- do they make a difference?
4. To scale and spread learning to other elective AHP services

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ScIL Scottish Improvement Leader

Breathe Easy: Discharge Planning for Respiratory Patients

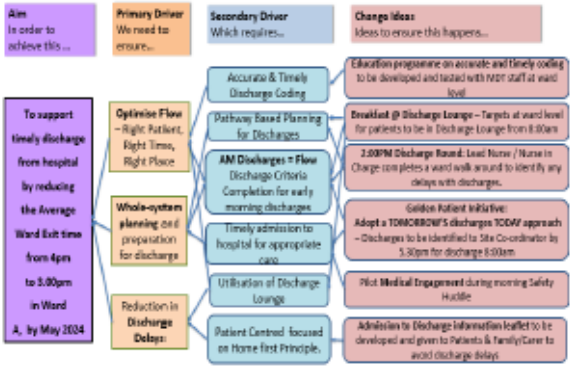
AIM: To support timely discharge in Ward A, Mater Hospital by reducing the average ward exit time from 4:00pm to 3.00pm by May 2024

Introduction:

Ward A in Mater Infirmorum Hospital (MIH) cares for Respiratory Patients within the Belfast Health and Social Care Trust. Safe and timely discharge of one patient can help improve health outcomes of four others.

Demand for unscheduled inpatient medical beds in Belfast Trust has been increasing leading to delays in ambulance handovers and in admitting patients from ED. There has been a Trust wide focus to support safe and timely discharges for all our patients to ensure a home –first principle, Patients who stay in hospital when they are ready to be discharged are at higher risk of hospital acquired infection, lose of mobility and independence. Over the last two years only 5% of patients deemed medicinally fit are getting discharged before 1:00pm from ward A, MIH with further 48% getting discharged before 6:00pm. Timely discharge is fundamental to optimize patient flow and ensure patient satisfaction and through this project the focus was on effective discharge planning from admission while engaging the patients and carers in the discharge process.

Aim & Driver Diagram:



Change Ideas Tested:

- **Education Programme on Discharge Coding:** Initially tested using posters and information leaflets, then held face2face sessions with updates on data recording performance shared on monthly basis,
- **Admission – Discharge Information Leaflet:** Leaflet developed with MDT input, various versions adapted and displayed on ward as communication for patients and families along with admission letter given on arrival.
- **Breakfast @ Discharge Lounge:** Awareness on usage of discharge lounge raised in staff huddles indicates an average increase of 22% of patients are transferred to lounge from Ward A on weekly basis.

Method:

Model for Improvement was applied using small tests of change through PDSA cycles. Establishing a project team, with first meeting taking place on 23/10/2023, this was a fundamental step within this project as having representatives from different professions enabled a holistic approach on the entire patients journey.

To understand the system a number of tools were used, such as process mapping within the MDT, this helped all staff to understand the journey for the patient and also highlighted the role each staff member has within that journey. Fishbone diagram was also used, to help pilot change ideas. Patient feedback via a PPI focus group was established to gain an insight into how patients and families feel regarding discharge process on Ward A. Finally to ensure we captured all thoughts we also implemented questionnaires for staff.

Measures:

Outcome Measure:
- Average Ward Exit Time from Ward A, MIH

Process Measures:
- Number of Patient Home for Lunch by 1:00pm
- Discharge Lounge utilisation from Ward A, MIH
- % of patient discharge from Ward A, MIH Weekdays & Weekends

Balancing Measures:
- Patient Experience
- Staff Experience

Results:

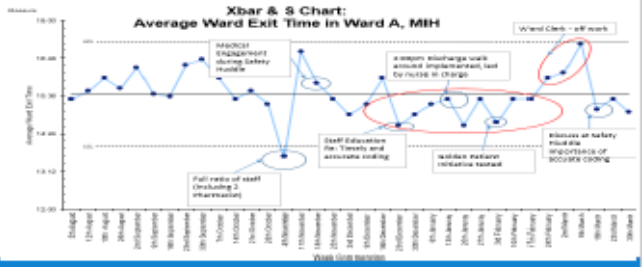
In reviewing project data, baseline indicated an average discharge time on Ward A, MIH of 4:30pm -5:00pm.

As seen on the X bar &S graph there is a shift and a downwards trend from December 2023 to 3:30pm aligned to the introduction of education on discharge coding, and a senior discharge walk around.

This graph does show some variation when Ward Clerk was off, this was counter intuitive, but highlights more training is required on discharge coding across MDT as it should not be reliant on one team.

Key Learning & Next Steps:

- Taking time to educate staff on accurate discharge coding has been fundamental to ensure data recording is complete in real time and this will have a positive benefit ahead of encompass implementation within the Trust.
- Next steps will be to build on improvement made with the multi-disciplinary project group, patients, and careers to reinforce the home first principle in planning for discharge from admission.
- I am excited to use the knowledge and skills gained throughout this course to help improve our organisation.



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ScIL
Scottish Improvement Leader

FACE : Frequency and Caller / Counsellor Experience

NHS Education for Scotland

Lifeline 0808 808 8000 www.lifelinehelpline.info

Increasing the opportunity to better meet the needs of frequently calling callers to Lifeline and improving the client and counsellor experience.

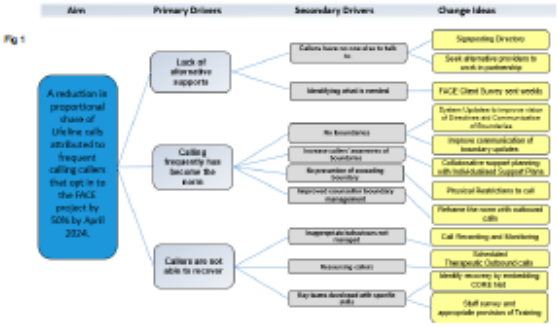
Lifeline is Northern Ireland's crisis response helpline for people experiencing distress or despair. Lifeline is available 24 hours a day, 7 days a week, every day of the year. Calls to Lifeline is a freephone service that aims to provide support for people when they are at their most vulnerable. The calls are answered by trained and highly experienced counsellors. In 2023 data began to evidence that call volume was increasing however call talk time and the number of new callers to Lifeline was not increasing at the same proportion. This led to a suspension of a promotional campaign. Further analysis showed that there was a small proportion of callers accounting for a disproportionate volume of calls. During 2023, 3% of all Lifeline callers accounted for 36% of all Lifeline calls. Access to Lifeline for new callers became limited and it became clear Lifeline was not meeting the needs of frequently calling callers. The FACE project team was established consisting of Lifeline's Service Improvement Coordinator, Assistant Service Manager, Service & Quality Improvement Manager and a dedicated Shift Supervisor. Research around helplines and frequent callers was shared amongst the team. Research papers of similar helplines set a threshold of 20 calls per month. At the start of the project, callers calling Lifeline 20 times a month equated to 3% of all callers. Looking at weekly data during the same period callers calling 9 times or more a week equated to 3% of callers therefore 9 calls a week was set as the threshold.

Aim: A reduction in number of Lifeline calls attributed to frequently calling callers that opt in to the FACE project by 50% / 70 calls a week by April 2024.

Method

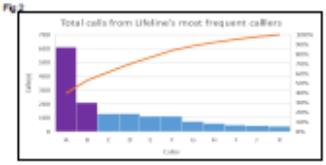
Historical reporting was standardised in line with the threshold of 9 calls a week, a baseline was determined and weekly reporting was established as a method for early detection of new frequent callers and changing calling patterns of existing callers. The model for Improvement was used and the aim identified with how much and by when was set. An understanding of the system was gathered by completing a process map as a team and identify areas in the process for improvement. A driver diagram (Fig.1) was completed to identify change ideas and potential PDSA cycles. 5 of the 12 change ideas were tested.

Fig 1



A client survey was established and shared weekly with frequent callers. Those callers appearing on weekly frequent calling reports for 4 consecutive weeks were discussed monthly with Lifeline's Client Review Group (CRG). During these reviews callers were identified for a FACE Assessment, an individualised support plan and/or scheduled therapeutic outbound calls to aid a reduction in inbound calls.

Fig 2



A pareto chart (Fig.2) was shared to highlight the impact of the most frequently calling callers. The two most frequently calling callers identified as accounting for 49% of frequently calling behaviour. These two callers were the first callers to refer into the project, be assessed, collaborated in the creation of individualised support plans and receive scheduled therapeutic outbound calls.

Call recording and monitoring was piloted for 12 weeks within Lifeline. A staff survey was shared to review the wider teams' perception of the project and identify future changes. All measures were charted weekly and shared with the team to monitor each PDSA cycle. The outcome measure was number of calls into Lifeline from callers who opted into the project to identify if these was a decrease in frequent calling behaviour. The main balance measures was the duration in minutes of Lifeline calls in and out for callers in receipt of scheduled outbound calls. This was to be attentive to the potential of increasing outbound workload at Lifeline. The main process measure was the percentage of calls from frequently calling callers i.e. callers calling 9 times or more a week. This was to identify if overall there was a decrease in frequent calling behaviour.

Change Ideas

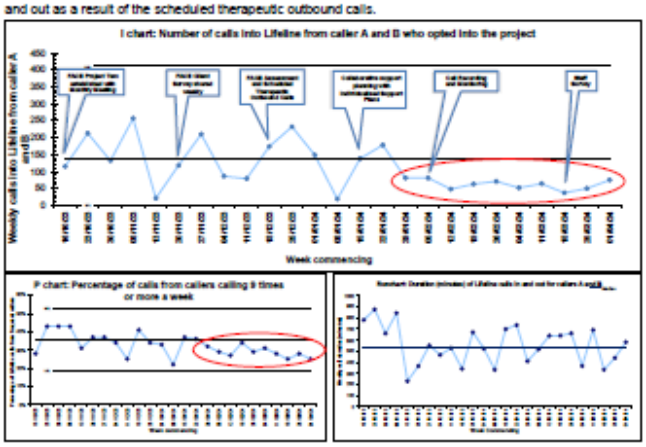
- FACE Client Survey shared weekly with suitable frequently calling callers – there has been a 19% response rate to client survey specifically for frequent callers. Those in receipt of the survey had a minor reduction in calls.
- FACE assessment designed and used prior to Scheduled Therapeutic Outbound calls for caller A and B.
- Individualised Support Plans have been completed for caller A and B.
- Call Recording and Monitoring implemented on 1st February 2024 with call recording on all calls in and out.
- Staff Survey shared to review progress to date and future improvements.

Results

Caller A and B preferred into the project, have reduced unscheduled calls into Lifeline and have been in receipt of more appropriate calls and better meeting their needs. This is identified in the shift of the outcome measure charted below. This is on target and recorded as a reduction of 59% of calls from caller A and B.

There was also a shift in the balance measure demonstrated on the P chart measuring the percentage of calls from callers calling 9 times or more a week. There is an overall proportional reduction of 7% shown in the P-chart. Indicating a direct causal relationship to implementation of outbound calls to Lifeline's two most frequently calling callers. With this shift the team are engaged in moving forward with the more frequent callers to be referred in.

The process measure charted as a run chart shows that there was no increase in the duration of calls in and out as a result of the scheduled therapeutic outbound calls.



Learning

The project was an excellent learning experience using tools from the model for Improvement helped keep the project moving forward. With the nature of the project there was a worry from the wider team that changing how we work at Lifeline may in fact make the problem worse. This fear manifested in a desire to process design the project from start to finish before the first PDSA cycle. Process mapping the service helped the team understand the system and identify areas in which small changes could have a big impact. Teaching the model for improvement to the project team helped reassure the team that each phase of the cycle: Plan, Do, Study, Act in particular plan and study while measuring weekly would allow the service to stop any change that is adversely affecting the service.

Next Steps

The issue of frequent calling has been present at Lifeline to varying degrees since 2014. It is an issue that challenges all helplines worldwide. As such this project will continue to search for new change ideas within Lifeline going forward for continuous improvement. The changes to date have been embedded but there are more change ideas to be tested. There has been 2 more callers assessed and each have had an individualised support plan collaboratively created. There are 4 more callers scheduled to be assessed. The latest staff survey identified new training needs for staff working with the specific presentations of frequent calling callers. The weekly reporting has been maintained and for callers new to Lifeline that are demonstrating frequently calling behaviours over a 3 week period, a letter template regarding use of Lifeline has been designed. Call recording and monitoring has been piloted. Call recording will be used to train staff new and existing with an aspect of the training to focus on frequent calling callers, consistency and boundary management. Each new change will use learning from the model for improvement.

Key Reference Materials

Frequent callers to telephone helplines: new evidence and a new service model: *Jane Pirkis, Ayes Middleton, Bridget Bassilios, Meredith Harris, Matthew J. Spittal, Izabela Fedszyn, Patty Chondros and Jane Gunn*

Systematic Review of Research and Interventions With Frequent Callers to Suicide Prevention Helplines and Crisis Centers: *Brian L. Mishara, Louis-Philippe Cote, and Luc Dargis*

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ScIL Scottish Improvement Leader

It's not easy being green- reducing the environmental impact of metered dose inhalers

QI project on pMDIs and the environment in Allen Ward Royal Belfast Hospital for Sick Children, Belfast Dr Laura Jenkins CF Associate Specialist ,Terri McCann Pharmacist, Christina O'Neill Ward Sister, Emma Quigley Deputy Ward Sister, Tracey McKernan Ward Clerk

Background

The Royal College of Paediatrics & Child Health has stated that climate change is an existential crisis for the health of children & young people (Oct'23). Inhalers account for 3% of the NHS' carbon footprint. Pressurised metered dose inhalers (pMDIs) are the most commonly prescribed inhalers for children & have the worst carbon footprint, with HFA gases that are thousands of times more greenhouse gas warming that CO_2. Allen Ward is a 21-bedded paediatric unit in RBHSC & respiratory conditions are one of the most common reasons for admission. Baseline data over 10 weeks showed a median of 8 pMDIs were being thrown out per week, most inhalers were still full of active drug & should have been returned to patient at discharge. All Clenil® inhalers had over 180 doses. Median weight of Ventolin® canisters was 25.2g (full canister 29g & empty <15g). There are no recycling facilities for inhalers in the Trust.
Aim:To reduce the number of pMDIs inappropriately disposed of for incineration in Allen Ward, RBHSC by 20% by April'24 (8 to 6.4 inhalers per week).

Method

Using the model for improvement baseline data had established there was a need to reduce the wastage of inhalers.
A process map was made to track what happened when inhalers were prescribed on admission through to the time of discharge.
Following the initial mapping, brainstorming sessions were run with nursing and pharmacy staff to generate ideas for change.

Process Change

A driver diagram was constructed to establish change ideas & those that were predicted to have the most impact were selected to be tested. Improvement would be gauged by the following measures.
Outcome Measure: A reduction in number of inhalers collected each week from the recycle box.
Process Measure: Improvements in the knowledge of ward staff on the environmental impact of inhalers.
Balance Measure: Reduction of the carbon footprint by recycling plastic components & by encouraging the prescribing of inhalers with a lower carbon footprint. Reduced costs by fewer inhalers being binned with active medication.

PDSA Cycles

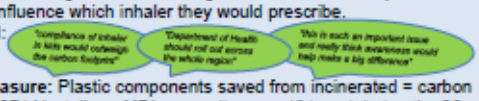
1: Recycling box in drug room (task) but as led to a change in practice due to raising awareness of the number of inhalers being disposed/week.
2: Nursing checklist to highlight patients on inhalers to alert pharmacist for labelling of inhalers for discharge (not completed so discarded).
3: Posters on cupboards in drug & pharmacy dispensing room highlighting the carbon footprint of inhalers and reminder to get inhalers labelled.
4: Pharmacy checklist highlighting patients on inhalers and if they were relabelled rather than new inhalers dispensed. Noted that if inhalers not kept in original packaging then they could not be labelled for home.
5: Feedback from staff survey with dissemination of educational information from NICE on climate change and inhalers.
6: Update at monthly staff meeting with short presentation and added to safety briefing.
7: New posters in drug room highlighting cost and carbon footprint for most commonly prescribed inhalers.

Links: NG80 Patient decision aid on asthma inhalers and climate change (nice.org.uk)
Bulletin 286: Inhaler carbon footprint | PrescQIPP C.I.C
2023 Report - Lancet Countdown

Results

Outcome Measure: There was an 81% reduction in the number of inhalers binned each week. Median dropped from 8 to 1.5 inhalers disposed weekly. There was evidence of special cause with a shift in the number of inhalers being disposed of. To ensure the reduction in inhalers disposed of reflected a true reduction the mean % of inhalers inappropriately disposed of weekly out of all inhalers used per week was checked & has decreased from 36% to 17.3%.

Process measure: More staff are aware of the environmental impact of inhalers with 94% (52 respondents) supporting a recycling scheme for inhalers. 49% of staff agreed that knowing the environmental impact of an inhaler would influence which inhaler they would prescribe.
What staff said:



Balancing Measure: Plastic components saved from incinerated = carbon saving of 9kg. 271 Ventolin® pMDIs were dispensed/binned during the 28 weeks. Currently the Trust has a procurement deal for Ventolin® which has a high carbon footprint- if changed to Salamol there could be a carbon saving of 4423kg, equivalent of a flight from London to Singapore.
£471.88 of inhalers have been unnecessarily thrown away, these inhalers have been replaced by new inhalers at discharge. That is a cost of over £900 to the Trust in 28 weeks, not include the cost of incineration.

Conclusions & Key learning: It was difficult for staff to prioritise a QI project in a busy, acute ward. Barriers included lack of buy in from medical prescribers and the cost implications to over-labelling or changing the type of inhaler. Although the staff survey revealed that staff care about the environmental impact of healthcare and waste, lack of time to focus on this area, means it is low priority.

Future Steps

Roll out recycling boxes to other departments in RBHSC and beyond.
Continue to explore the option of over-labelling of inhalers- cost implications.
Prescribe inhalers with lower carbon footprint if clinically appropriate.
Continue to raise awareness of environmental impact of healthcare and encourage sustainability projects throughout the Trust.

Thanks to all the nursing and pharmacy staff on Allen Ward for their help with this project.

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Dr Laura Jenkins, Associate Specialist Paediatric CF
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Belfast Health and Social Care Trust
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Safety & quality

Reducing the Routine Review Wait List for AMD, Ophthalmology

Project Team: Aaron Quinn, Gary McIlhatton, Natalie Cameron, Noreen Kearney, Paula McIlhatton, Sara McMullan

Aim Statement

Our aim is to decrease the backlog of patients waiting on routine review AMD (Ophthalmology) appointments by 5% By 30th April 2024.

Background

The Age-related Macular Degeneration (AMD) waiting lists had a large backlog of patients waiting 3 months plus for their review appointments which lead to a significant delay in their treatment. These patients were divided over two waiting lists known as Live Imaging and Reviews. As a team we decided to look at what actions we could take to help decrease the waiting time and improve patient care.

Baseline Data

Baseline data was collected between the months of July and September 2023 as seen on Graph 1. This established that the average number of patients on the waiting list was 235, the longest waiter was 12 months.

Methodology:

Understanding our System-

The team developed a fish bone diagram of the service highlighting all contributory factors, including external and internal. This is shown below in Figure 1.

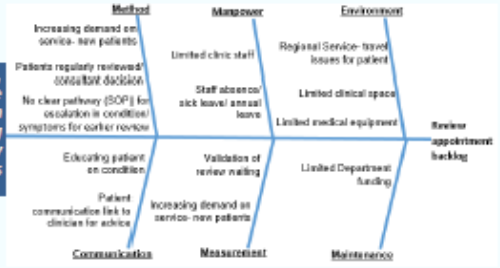

Figure 1, Fishbone diagram highlighting contributory factors

Process Mapping-

The team took part in process mapping, which helped identify bottlenecks and key issues. These have been summarized below:

1. Waiting time for review appointments
2. Capacity for review appointments
3. Duplication of work, patient on multiple waiting lists, due to current processes

these prompted the change ideas as listed in Figure 2.

Project Measures

Outcomes: Number of patients on the AMD Ophthalmology routine review waiting list.

Process: Number of Patients added to the waiting list, removal of duplicates registrations, removal of patients due to validation, patients added to Patient Initiated Follow Up (PIFU) waiting list, Increase in clinic capacity.

Balancing: Patient satisfaction, admin satisfaction and workload, clinical workload.

Process Changes

PDSA 1: Validate Waiting list and identify duplicate registrations

PDSA 2: Merge Image and review waiting lists for better coordination of care

PDSA 3: Start PIFU pathway for patients

PDSA 4: Move eligible patients from existing waiting lists onto PIFU waiting list

PDSA 5: Review reasons for rise in backlog

PDSA 6: Look at reducing clinic capacity to facilitate encompass training

PDSA 7: Review patients returning to WL increasing the waiting times

Results:

Graph 1, Run Chart of AMD routine review wait list

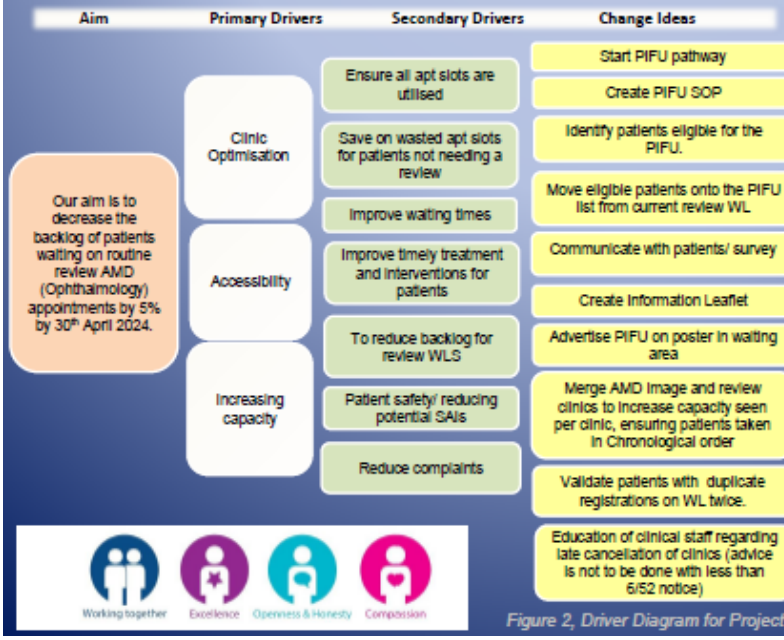

Figure 2, Driver Diagram for Project

Conclusion of Results:

As displayed on Graph 1, initial progress was shown through PDSA Cycles 1-4. Originally the aim was achieved with a 153% reduction by 01/11/23. Unfortunately from months Dec-May clinic activity became an issue, with a substantial amount of sickness/leave causing clinics to be cancelled and patients to remain on the waiting list. This meant the overall aim was not achieved by the end of the set timeframe and in fact the number waiting increased.

Key Enablers:

- Evident need for change
- Patient buy in to new PIFU pathway

Challenges:

- Staff absence and clinic cancellation has greatly affected the success of this project.
- Diverse project group from various specialties. Time to meet and coordinate this project has been challenging.
- To maintain momentum and prioritisation of the project whilst preparing for Encompass.

Next Steps:

- We plan to review other wait lists within the service to see if positive changes can be implemented within other patient cohorts.
- Further work will be done surrounding the AMD routine waiting list, in particular work around clinical activity and productivity, with key focus on management of absence and recruitment of specialist staff to undertake the clinical work.

Belfast Health and Social Care Trust

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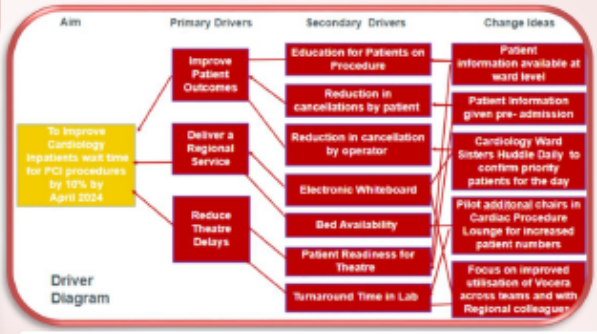
Project Team:
Judith Bell – Scheduler,
Aisling Magowan – Sr Cath Labs,
Gareth Clifford – Cardiac Physiologist,
Carol Skillen - Data Analyst
QI Mentor: Deirdre Donaghy

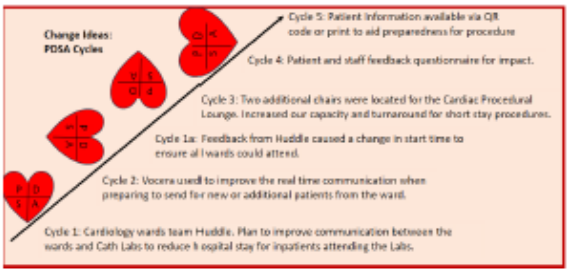
Safety & quality

Let's TALK Hearts
Together we Achieve Lots in Kardiology

Background: There are currently 7 Cath Labs located across the Belfast Trust with a team dedicated to enhancing the quality of cardiac procedures for the population of Northern Ireland. As such there is a high demand for these services and this project focused on reducing waiting times for patients in need of Percutaneous Coronary Interventions (PCI) procedures, a crucial treatment for those suffering from coronary artery disease.

AIM: To Improve Cardiology In-Patients wait time for PCI procedures by 10% by April 2024





Results

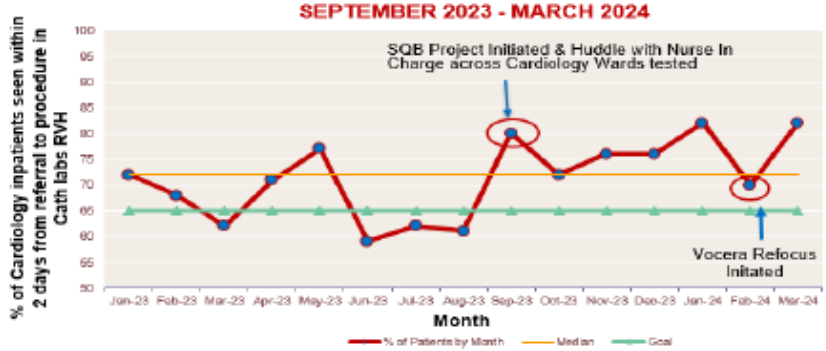
Before project got underway 60 – 65% of inpatients referred for PCI were seen within 2 days from referral in one of our RVH Cath Labs. However as run chart illustrates from September 2023 – March 2024 over 70% of inpatients referred for PCIs are now being seen within 2 days. This has been a steady trend, and the impact of focusing on this cohort of patients has led to a number of small wins:

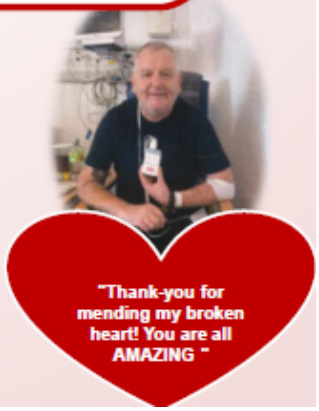
- More pts awaiting PPM identified via daily huddle
- Improved communication with ED cardiology = timely treatment for patients
- Increased capacity for regional Cardiology patients by 30% due to introduction of 2 extra procedural chairs.
- Multi-Disciplinary Team working, barriers broken down.
- 60% of Staff found Vocera beneficial as a form of communication
- 58% staff found morning huddle beneficial

Key learning & Next Steps:

Having engagement across the Multi-disciplinary team and focusing on what was within our gift to change and improve upon was what had the biggest impact on the wider system and improving patient care. We want to continue to improve upon results to date and begin to transfer some learning towards other procedures undertaken across our Cardiac Labs.

INPATIENTS REFERRED FOR CORONARY CATHERISATION PROCEDURES SEPTEMBER 2023 - MARCH 2024





"Thank-you for mending my broken heart! You are all AMAZING "

Making the wait active – Developing a patient-centred model of Orthopaedic Prehabilitation

NHS Education for Scotland

Introduction

The number of patients waiting for a hip or knee replacement living in a state 'worse than death' has doubled during the pandemic.[1] Patients on hip and knee joint replacement waiting lists in Northern Ireland are severely disabled with the worst Health-Related Quality of Life and functional scores studied when compared to published literature and a matched population.[2] Prolonged waits in Northern Ireland are associated with increased dependence on strong opiates, depression, and attendances at unscheduled care.[2] Prior to the COVID-19 pandemic, patients attended a physiotherapy pre-operative education session, however this had many barriers and it did not address the individual needs of each patient or their functional fitness.

Prehabilitation has been shown to reduce length of stay, improve cardiovascular fitness, enhance recovery after treatment, reduce post treatment complications, and enhance quality of life. It offers patients personal empowerment and can promote positive health behaviour change which can impact long-term health. It is also a recommendation in the *Getting it Right First Time in Orthopaedics* Report[3] and *NICE Guidelines for Joint Replacement.*[4] The most current research recommends that patients should have access to pre-operative education and prehabilitation that is specific to the individual needs of the patient, and, offered in a wide range of digital and non-digital formats.[5] For these reasons, modernisation and development of our pre-operative care was deemed necessaryfor our patient population.

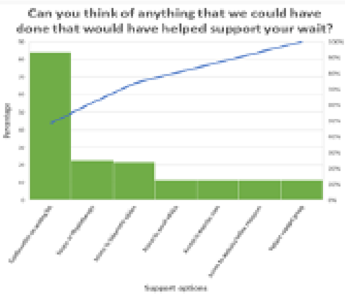
Aim

To increase the pre-operative physiotherapy treatment contact time by 50% (to 30 minutes) to patients on one named surgeon's waiting list for joint replacement surgery by offering personalised prehabilitation care that is specific to individual patient needs and best supports their wait for surgery by April 2024.

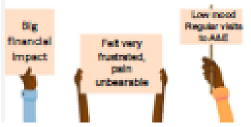
get FIT get READY for SURGERY

Methods

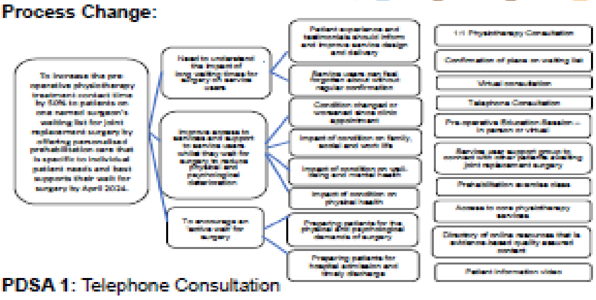
To better understand the experience and needs of our patient group whilst waiting for surgery, a patient survey was sent to all 203 patients who had hip and knee joint arthroplasty surgery in Musgrave Park Hospital in August 2023. 106 patients responded. None of these patients had attended the Pre-operative education session that ran prior to the covid-19 pandemic. Using this data and Model for Improvement tools, it allowed us to better understand service user needs and priorities, the impact of long waiting times on them and then support, develop and test process changes.



- 50% did not want to attend pre-operative education or exercise sessions to prepare them for surgery.
- 33% had no interest in online content.
- 24% had no access to any IT or smart device.



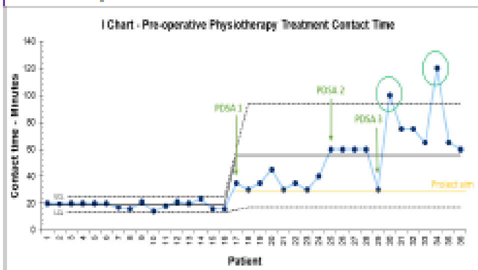
Process Change:

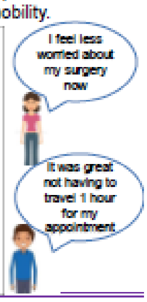


PDSA 1: Telephone Consultation
PDSA 2: Virtual Consultation
PDSA 3: Patient Choice: 1:1 Physiotherapy Consultation, Virtual or In-person Pre-operative Education, No appointment required.

Results

- Average contact time increased from *19 minutes* to *55 minutes* so project aim of 50% (30 minutes) was achieved.
- Patient feedback and satisfaction was very positive.
- 50% did not respond to appointment letter in PDSA 3.
- 1:1 in-person appointments are the least cost effective method of delivery but the most beneficial to patients whose mobility had deteriorated significantly – the 2 points above the UCL line detecting special cause are from two patients who had severe deterioration to their mobility.





Conclusions

A cohort of our patients are significantly struggling whilst waiting for surgery – physically and mentally. Patients have notably different needs whilst waiting and they value choice in the delivery of their care. The data demonstrates personalised prehabilitation care is very beneficial to our patient group.

Key Learning

Understanding your system and baseline data to best design and deliver changes to service is crucial – failing to do so would have resulted in a project that did not meet the needs of all patients.

Next Steps

- Identify the best way to initially target all those who have significantly deteriorated physically whilst waiting for surgery and gather data on outcomes for this patient group eg: length of stay, use of social services etc.
- Finalise production of a patient information video and online content
- Continue to work through change ideas to integrate a patient-centred Prehabilitation model into the orthopaedic patient pathway.

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

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Kelly Carolan Clinical Lead Physiotherapist Orthopaedics
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Patient Initiated Follow-Up (PIFU)

PIFU in Immunology Allergy

Introduction

There is an **increasing demand** on the Immunology service for new and review patients, which exceeds the capacity of the service. Due to the **backlog** with review waiting lists, Immunology Allergy patients were not being seen for review as per the existing pathway. Using existing resources, the team introduced PIFU to the Grass Pollen Allergy clinics, to deliver a better model of care where patients can access clinical teams only if / when they feel they need to.

Baseline Data

- Over a 4-year period, 153 patients commenced Grazax medication
- This should have generated 459 review appointments
- However, 0 patients received a review appointment; but 39 ad hoc phone calls were received

Aim: To transfer a minimum of 2 Immunology Allergy Grazax patients on treatment per week to the PIFU Pathway by April 2024

Methods

Project Team carried out **process mapping**, and identified three key elements:

- Limited clinic capacity – patients were not receiving review appointments
- Patient expectation to be seen three times, but service failing to see them
- Recognition from clinicians that these are generally clinically stable, low-risk patients, and therefore not all patients require a review appointment

Pareto Chart of the telephone audit showed most patients wanted advice on medication side effects, usually within the first three months of treatment

Project Measures

Outcomes:

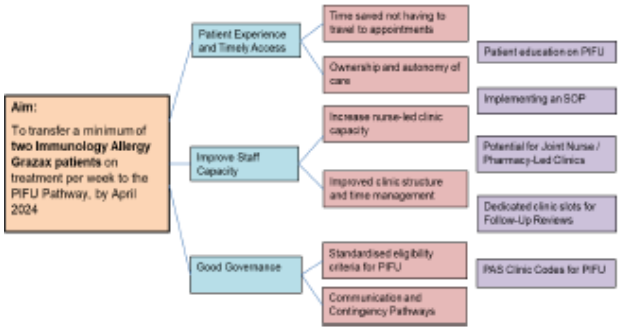
- No. of patients transferred to PIFU Pathway per week

Process:

- No. of requests to activate PIFU
- Time from being put on PIFU and activating PIFU
- Time from requesting appointment to time of appointment

Balancing:

- Patient Satisfaction
- Staff Satisfaction



Process Changes / Model for Improvement

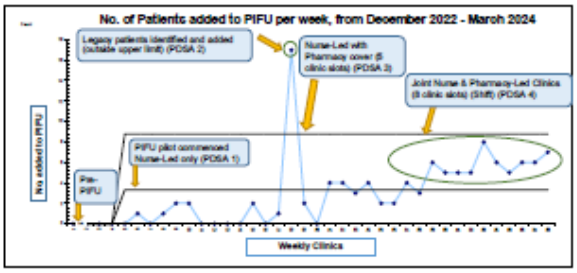
PDSA cycles used to implement and evaluate tests of change

PDSA 1: Test PIFU with one Nurse at Nurse-Led Clinic
PDSA 2: Test legacy patients being added to PIFU
PDSA 3: Test Nurse-Led Clinic with Pharmacy cover (5 slots)
PDSA 4: Test Joint Nurse & Pharmacy-Led Clinic (8 slots)

Key learning from 'Study' of cycles of change: *at PDSA 4, more patients were being seen at clinic, so more patients were being added to PIFU.*

Results

The results are presented in a C-Chart, which indicates special cause.
Shift – 8 or more consecutive points above the mean, showing that significant change is evident with PDSA 4; by delivering joint Nurse / Pharmacy clinics, and increasing the number of patients seen at each clinic, this enabled more patients to be added to PIFU.
There is also a point outside the upper control limit, which was due to a high volume of legacy patients being added to PIFU in the one week.



As at April 2024, 2 patients activated PIFU within one month of being put on PIFU due to side-effects, and received a follow-up call / appointment within one week.

Following surveys, both patient and staff feedback has been very positive:

'It is great to be able to phone the service....PIFU is certainly a good idea' PIFU Service User

'Once PIFU is set up, it is a really easy to use service, focusing on patients' needs and reducing burden on Immunology medical staff' Immunology Pharmacist

Conclusions and Achievements

- The aim has been achieved, with significant reduction in the need for a review appointment.
- This has enabled review appointments to be reconfigured into new appointments to start addressing the existing waiting list backlog.
- Patients are taking ownership of their care.

Key Learning

- Multi-disciplinary buy-in and support is key to success, including buy-in from the patients
- Accountability and ensuring everyone takes ownership of the project, and shares in the small wins

Next Steps

- Initiated scale-up-and-spread, with further work underway to implement PIFU in other Immunology clinics.
- Work underway in the Outpatient Modernisation programme to identify other specialties for scale-up-and-spread at Trust-level, with Immunology being used as the blueprint.

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Scottish Improvement Leader

Reducing the DNA rate in Adult Psychological Therapies Service

NHS Education for Scotland

Introduction:

The Adult Psychological Therapies Service (APTS) provides psychological assessment and treatment for people with a range of mental health difficulties. Due to a variety of reasons, there is a high rate of 'did not attends' (DNAs) which significantly hampers the efficiency and effectiveness of the service. Reducing the DNA rate will optimise resource utilisation and improve timely access to psychological support for patients.

Aim:

To reduce the weekly percentage of DNAs in the APTS by 20%, by March 2024

Method:

Model for Improvement methodology was used to develop, test and implement change ideas. We established a project team to process map for booking and cancellation of appointments and to develop a driver diagram. Changes were implemented in small, manageable cycles using the Plan- Do- Study- Act framework. Monthly baseline data was retrospectively collated and weekly data was collected from the start of the project.

Driver Diagram

Outcome measure:

Percentage of weekly DNAs

Process measures:

Appointment reminder implementation: % of pts who receive reminders for their appointments Number of appointments saved by ringing late clients

Balancing measure:

Percentage of Cancelled appointments(CNAs). Staff feedback

PDSAs: Several PDSAs were implemented in order to test the following change ideas;

Change Idea 1: Awareness campaign to highlight impact of DNAs

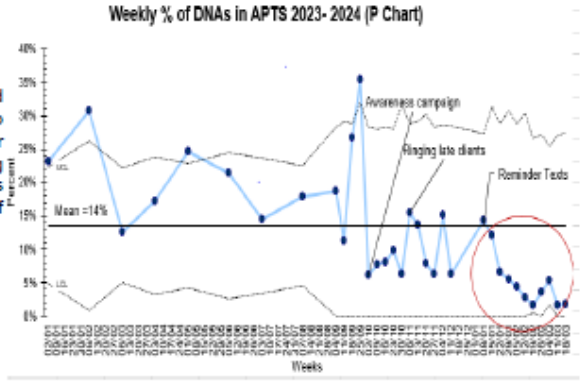
Change Idea 2: Ringing late clients and proceeding with virtual appointment

Change idea 3: Implementation of Text Message reminder system

Results:

A Statistical Control Chart was used to present the data. The P chart demonstrates that that the implementation of text reminders resulted in a trend and a shift signal below the mean of 14%, with the final two weeks of data showing a DNA rate of just 2%. This represents an 85% reduction in DNAs.

Cancellations were recorded as a balancing measure as there was the potential for DNAs to be simply turned into CNAs. Happily the results indicated that the mean CNA rate did not change post PDSA cycles.



Conclusion:

A 85% reduction in DNAs is a huge achievement which far exceeds the original aim of 20%. Undoubtedly, this will significantly improve patient experience and access to psychological services. Importantly, sustaining this improvement in the APTS service will yield an estimated full year saving of approximately £38,400.

A weekly database indicated that ringing late clients to proceed with a virtual appointment resulted in only 2 saved appointments. The staff reported that they felt that this conversion rate was not worth the potential intrusion on the client's life and did not promote a positive therapist/client relationship. Therefore it was agreed that this particular intervention would be discontinued.

The data analysis clearly demonstrated that it was the text reminders that brought about the significant positive change in DNA rate. Whilst the data showed that the awareness campaign did not yield immediate results, it is worth noting that feedback indicates that providing information to clients on the importance of attendance or cancelling in advance had a valuable role in enhancing client understanding and commitment.

Key learning and next steps:

One of the key learnings from this project was the effectiveness of using text messages to remind patients of appointments and thanking them for attendance or cancelling in advance if necessary. This simple yet tremendously effective intervention will be spread throughout psychological services.

The next step for the APTS team is use Quality Improvement methodology to reduce CNAs.

My participation on the ScIL Course has enabled me to feel more confident in using excel and data visualisation tools to analyse and present information effectively in order to continually improve services.

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Deputy Head of Adult Psychological Services

ScIL Scottish Improvement Leader

Repatriation of Post-operative Fracture Patients

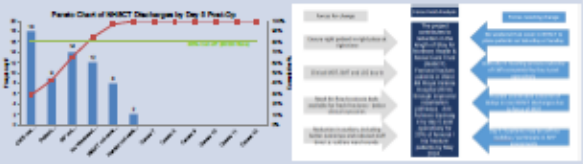
Roisin Kelly, Service Manager
Trauma & Orthopaedics
Belfast Health & Social Care Trust

The project contributes to reduction in the length of Stay for Northern Health & Social Care Trust (NHSCT) Femoral fracture patients in Ward 4B Royal Victoria Hospital (RVH) through improved repatriation pathways. Aim: Achieve discharge by day 5 post operatively for 20% of femoral / hip fracture patients by May 2024.

Method

A Process mapping exercise was undertaken to understand the referral system for post op femoral fracture patients requiring repatriation to NHSCT community beds and packages of care. A force field analysis was utilised to identify potential forces for change and forces resistant to change.

A Pareto Chart was used to prioritise ideas for effective PDSA cycles. The top 3 causes of delayed discharges were noted to be (i). Transitional Forms (CWS) not being completed by Day 3 post operatively (ii). Requests for repeat bloods or updated forms, and (iii). NHSCT Hub services unavailability at weekends.



Process Change

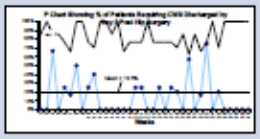
The change ideas generated from the Driver Diagram informed tests of change:

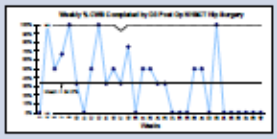
- Introduction of daily (Mon – Fri) Multidisciplinary Team (MDT) Bed Meeting to review patient discharge pathways and allocate assessments to each of the disciplines (Nursing, Medical & Occupational Health & Physiotherapy).
- Introduction of a dashboard CWS tracker and daily Repatriation Sitreps at 1pm with NHSCT Hub and Acute Teams.

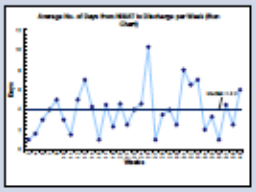
The theory underpinning these tests of change was that completing CWS forms by day 3 post op would facilitate social work colleagues to progress NISAT referral by Day 4 post op and NHSCT to repatriate to community bed or Package of Care within a further 24 hours i.e. by Day 5.

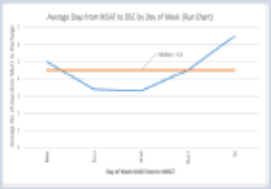
Results

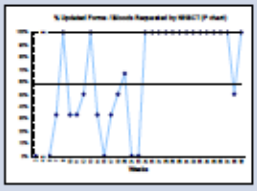
Results are over a 40 week period for a total of 119 patients discharging from 1 of a total of 4 Fracture Wards within RVH. The results show that aim of 20% discharging by day 5 post op was almost achieved at 18.5%. Compliance with CWS forms achieved a mean of 35%. A key factor in achieving timely repatriation relates referral day, with Friday referrals waiting longest.











Conclusions

One of the main successes of the project has been the implementation of the daily MDT Bed Meeting followed by the NHSCT daily Sitrep. Length of Stay has decreased and repatriation flow has improved.

Key Learning Points

Requests for updated forms is not measurable within the current CWS referral system. The Project tracker sheet identified this duplication of workload and initiated joint discussions with NHSCT colleagues to extend CWS validity timeframes to 72 hours.

- Timescales for CWS to be completed within 3 days post operatively are challenging due to the impact of the injury, anaesthetic, surgery and post op delirium associated with this type of fracture in an elderly population.
- Making improvements across 2 different HSC Trusts and between Acute and community services can be challenging.
- Understanding differing professional clinical thresholds for GP acceptance of referrals for ongoing patient management i.e minimally deranged and chronic blood results.

Achievements

- Improvement in patient flow, facilitating ongoing rehabilitation in a less acute and more appropriate environment.
- Reduction in number of outlying patients, thus improving access to specialist fracture wards for fresh fractures.
- Improved team building and understanding of pressures across Trusts through daily Sitreps.
- Reduction in LOS equates to cost savings per surgical bed night.

Next Steps

- Commissioners are currently designing and procuring a dashboard tracker which will more accurately capture performance.
- CWS Transitional Referral Form system may require review, particularly with the planned Encompass Go Live .
- NHSCT Hub weekend opening should be considered.

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Reducing Attendance in Eye Casualty

Improving the likelihood of patients with appropriate acute eye conditions accessing care in Primary Care Optometry

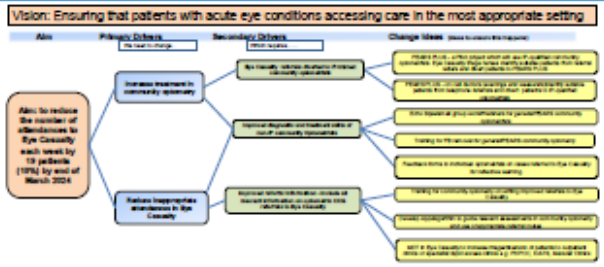
NHS Education for Scotland

Background

Eye Casualty in RVH has an appointments-based system which is overbooked on a daily basis. A Primary Eye Assessment and Referral Scheme (PEARS), available through community optometrists in Northern Ireland, can manage approximately 80% of presenting acute eye conditions. A small proportion of PEARS optometrists are qualified independent prescribers and can manage a wider range of eye conditions. Despite this, up to 20% of patients who are treated in Eye Casualty, RVH would be suitable for either treatment by community optometrists or referral to outpatient clinics (SPPG data & Belfast Trust Ophthalmology Audit and Service Evaluation).

Aim & Driver Diagram

The aim of this project was to reduce the number of patients attending Eye Casualty by 19 patients each week (10%) by March 2024



Measures

Outcome measure

(i) Weekly number of patients attending Eye Casualty, RVH.

Process measures

(i) No. of patients/week send to IP-qualified optometrists via PEARS PLUS.

(ii) Relative no. of patients averted to PEARS PLUS for 4 agreed conditions (foreign bodies (FB), unilateral acute anterior uveitis (AAU), herpes simplex keratitis (HSK) and marginal keratitis.

Balancing measures

(i) Percentage of patients having delayed treatment due to requirement for referral to Eye Casualty after their PEARS PLUS appointment.

Change Ideas and PDSA cycles

PDSA 1 - Triage nurses (Mon-Friday) identified suitable patients and diverted them to participating IP-qualified optometrists (PEARS PLUS) in the community instead of booking them for an Eye Casualty appointment.

PDSA 2 - extended the PEARS PLUS pilot to include Saturday appointments with participating IP optometrists.

PDSA 3 – restricted the list of PEARS PLUS optometrist removing FB to those with a burr (to enable removal of rust rings).

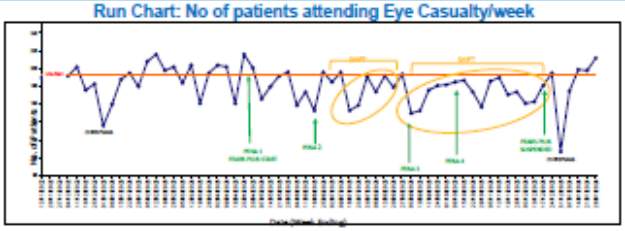
PDSA 4 - extended the PEARS PLUS pilot to include triage by on-call ophthalmology doctors at night/weekends.

Results

Outcome Measure

Eye Casualty has capacity for 180 patients/week but a baseline median of 192 patients/week were attending Eye Casualty at the start of this project. During the PEARS PLUS pilot, the median number of patients fell to 179/week which represents a reduction of 6.25%. This effect caused 2 shifts in a run chart of weekly attendance numbers. Christmas caused astronomical points due to a delay in patients seeking care. PSDA cycles 2 and 4 had minimal additional effect on the success of PEARS PLUS. This scheme was suspended on 8th December 2023 due to funding issues and the median number of patients attending Eye Casualty rose to 195 patients/week.

Run Chart: No of patients attending Eye Casualty/week



Process measures

A total of 628 patients with a median of 19/patients week were diverted to IP-optometrists for community treatment via the PEARS PLUS pilot.

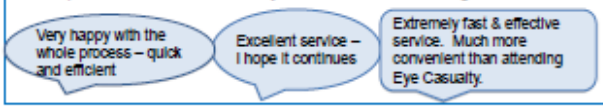
The relative proportions of the 4 agreed conditions attending PEARS PLUS were 42.8% FB, 29.3% AAU, 16.2% marginal keratitis and 11.5% HSK.

Balancing Measure

A total of 10% of patients averted to a PEARS PLUS appointment with community IP optometrists were referred back to Eye Casualty for hospital-based treatment which resulted in a delay in care. Further interrogation of this data will identify areas for improved triage and training.

Patient Experience

An anonymous patient experience questionnaire was issued to a sample of patients (8% of total) who attended for a PEARS PLUS appointment. A total of 88% of patients reported that they were very or extremely satisfied and that the PEARS PLUS appointment was more convenient for them. All of the patients who responded also stated that they would use the service again.



Achievements

In keeping with DOH 'No More Silos' plan, this project promoted collaboration between primary and secondary care. Eye Casualty was able to work within capacity, thus reserving resources for complex patients who needed hospital care. PEARS PLUS also increased the number of patients who accessed treatment closer to their home.

Key Learning

The main limitations were (i) lack of equipment for foreign body removal in some practices (ii) holiday/weekend periods when most optometrists were closed (iii) greater difficulty identifying suitable patients for PEARS PLUS via out of hours telephone calls.

Next Steps

Ongoing training of both general and IP optometrists to maximise the numbers of patients accessing community care.

Secure recurrent funding for PEARS PLUS scheme.

Work towards direct referrals from non-IP to IP practices removing need for Eye Casualty input.

Contact: Deirdre Burns deirdre.burns@belfasttrust.hscni.net

Huge thanks are due to MDT for their contribution to the project:-
Ophthalmic Services Team, SPPG and Dept of Health. N.I.
Eye Casualty Triage Nurses: Sharon Alexander, Geraldine Robinson, Gabrielle McKeating.
Prof. Jonathan Jackson, ScIL Mentor.
PEARS PLUS QI Team, Belfast Trust.

ScIL Scottish Improvement Leader

5. INTEGRATING THE CARE

Improvement Work Undertaken in Community Care

NHS Education for Scotland

Improving Timely Access to the Dietetics Community Nutrition Support Service

Aidan McAlinden, Business & Information Manager, Allied Health Professions

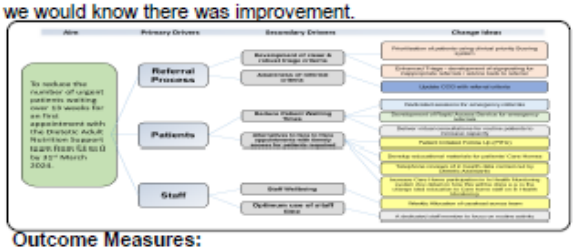
Introduction Allied Health Profession services fall under Ministerial Targets relating to Access Time to services, no service user should be waiting more than 13 weeks for an initial assessment. Timely access to the Community Nutrition Support Service is pivotal in promoting patient health and preventing complications. Increasing demands and challenging caseloads have resulted in extended waiting times for urgent appointments, posing significant challenges to patient outcomes and satisfaction. In recognition of this, my improvement project aims to reduce urgent waiting times. The project aims to streamline processes, optimise resources and enhance service delivery ensuring patients receive prompt, high quality care.

Project Aim To reduce the number of urgent patients waiting over 13 weeks for a first appointment with the Dietetic Adult Nutrition Support team from 54 patients to 0 patients by 31st March 2024.

Urgent referrals are those following triage that meet the referral criteria and have a score of 4 or more.

Method To identify the issue waiting time data was analysed. A cause and effect tool was used to identify the cause of delays in categories such as people, processes, policies, technology . This helped identify barriers to effective change.

The model for improvement was used to identify the goal, help the team identify changes we would test and understand how we would know there was improvement.



Outcome Measures:

- The number of urgent patients waiting over 13 weeks will be tracked weekly.

Process Measures:

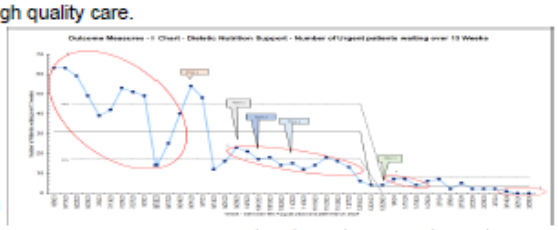
- The length of longest waiting time urgent patients are waiting will be tracked weekly.

Balancing Measures:

- Patient satisfaction
- Staff satisfaction

Change Ideas Tested:

- Prioritisation of patients using clinical priority scoring system (Criteria has been reviewed twice)
- Enhanced triage
- Update CCG with referral criteria
- Remote Consultations conducted by locum dietitian (routine appointments)
- Established dedicated session for urgent patients
- Prompt response for emergency referrals



The following special causes are highlighted in the chart above: 1–unstable system – WL validation results in large reduction in numbers for a short period 2–Special Cause – 8 or more points below the centre line 3–Two instances of special cause where 2 out of 3 points were near a control limit

Results The results from the I Chart indicate that by having clear triage criteria (PDSA 1) coupled with a dedicated resource who delivers virtual consultations (PDSA 2) the team have been able to focus on delivering timely access to the service for urgent referrals (PDSA 4). This has resulted in a reduction of urgent referrals waiting over 13 weeks.

The process measures chart shows the decrease in the length of time urgent referrals have waited for an initial appointment

Qualitative feedback also demonstrates the impact of the project

"My mum didn't have very long to wait to see the Dietitian. She is now getting the nutrients she needs to help her get stronger day by day"
Patient relative

"I now feel like I'm making a difference for my patients. Being able to see them in a timely way means they are getting the care they need when they need it most"
Dietitian

Conclusions The implementation of the improvement project has resulted in a reduction in the number of urgent patients waiting and the length of the time these patients wait. Using targeted interventions, data analysis and stakeholder engagement we have overcome the cause of delays and optimised service delivery.

Key Learning The early identification of the issues laid the project Foundations, this enabled us to address underlying problems. Establishing an understanding of baseline data is vital. This helped understand the system and set benchmarks. Involving all key stakeholders was crucial to identify issues and generate solutions.

Next Steps Following the reduction in numbers of patients waiting I will establish ongoing monitoring to maintain and further improve performance. I will continue to engage stakeholders to address any remaining issues and adapt change as needed. I plan to expand successful strategies to other areas of the AHP service, sharing project results and insights.

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Project Team:
Monique Kritzinger – Assistant Service Manager, Nutrition & Dietetics
Aoife McLaughlin – Nutrition & Dietetics, Community Nutrition Support Team
Sarah Donaldson – Nutrition & Dietetics, Community Nutrition Support Team

ScIL Scottish Improvement Leader

PROVIDING GRRREAT CARE

Restoring Independence, Reducing Care Costs, Revitalising Lives

Community Discharge Service (CDS)
Team: Emily Costello (OT), Matthew Coey (PT), Sarah McConville (OT), Sarah Gibson (PT) and Andrew Todd (OT).
With special thanks to Maryland Interim Unit, Patrick Connolly (OT) and Erin Ewings (CAP).

BACKGROUND

BHSCT contract beds in interim units to facilitate hospital discharges for clients who require ongoing assessment or are unable to access immediate care packages. The trust currently pays £20 per care hour via Rapid Response Domiciliary Care (RRDC) in order to facilitate discharges home from hospital or interim sites, while awaiting permanent contracted care.

Often hospital recommendations do not reflect the clients' changing needs while in an interim unit, which can result in over prescription of care. Similarly, if client's move from hospital to additional beds, where CDS do not provide any input, the recommended care hours may not be reviewed. CDS offer OT/PT/SW assessments for clients in interim units to progress their discharges home and ensure appropriate utilisation of RRDC. The purpose of this project was to optimise resources and the type of input CDS offer to clients in Maryland interim unit and how this influences recommended care hours.

AIM STATEMENT

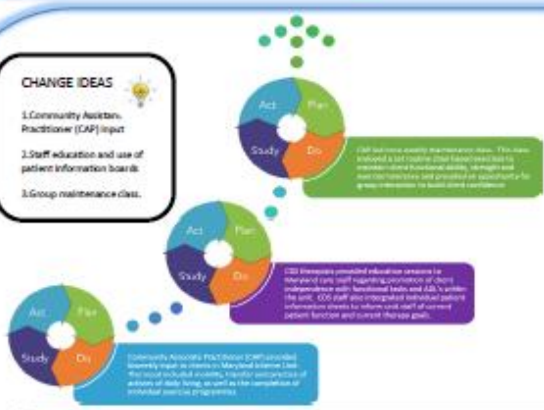
Reduce recommended care hours from point of admission to Maryland interim unit to discharge home in an additional 10% of clients by June 2024.

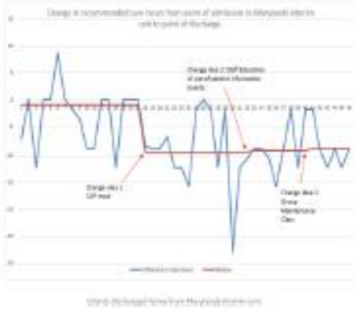
UNDERSTANDING OUR SERVICE

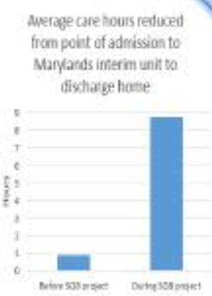
Outcome measures	Care hours on admission and discharge. Barthel and Rivermead outcome measures.
Process measures	Percentage of appropriate client's identified. Tasks delegated to community associate practitioner
Balancing measures	Ensure CPI is not affected and that home based client's are continued to be prioritised. Maintaining distinction between rehab service and interim facilities with CDS input

CHANGE IDEAS

1. Community Assistant Practitioner (CAP) input
2. Staff education and use of patient information boards
3. Group maintenance class.







RESULTS

Baseline data highlighted that 47.1% of clients had reduced recommended care hours from point of admission to Maryland interim unit to discharge home. Of those clients who were part of the project, 97.1% had their recommended care hours reduced on discharge home. Our original aim was to reduce recommended care hours in an additional 10% of client's, however our data shows we have exceeded this gRRReatly.

The total average recommended care hours also reduced significantly, from an average of 0.88 hours per client, as highlighted by baseline data, to an average of 8.72 hours per client by the end of the project. This additional reduction of 7.84 hours, on average per client, equates to a total saving of £8,154 per year, per client.

In addition, the total number of Reduced care hours throughout the project was 248 hours which would equate to a trust saving of £257,920 per year.

During the project we collated data on two functional outcome measures; Modified Rivermead Mobility Index (MRMI) and Barthel Index.
Our data has demonstrated a positive change in both outcome measures. There was an average improvement of 6.8/40 in the MRMI and an average increase in 3.8/20 in the Barthel Index. This reflects improvements in mobility and function and therefore Restoring Independence and Revitalising lives.

CHALLENGES

Time restraints to meet as a team

Some staff absence within interim facility and CAP allocated to Maryland's left role at the end of year and new CAP needed training and orientation to unit and project.

WHAT DID WE LEARN?

Additional input provided by the CDS in Maryland interim unit has had a positive impact on reducing care hours at point of discharge. This in turn has a financial benefit in reducing care costs and ensures appropriate use of domiciliary care at point of discharge.

Increased CAP input has also provided additional benefits to patients through restoring functional ability evidenced in outcome measures as well as patient experience.

Financial benefit as highlighted within the results section.

WHATS NEXT?

Following the success in Maryland interim unit we plan to share our learning with the rest of the team and highlight the positive changes we have made in reduction of care hours and patient experience.

We hope to trial these changes within the other interim units and use our new knowledge of QI principles to monitor the effectiveness on these other sites.

Safety & quality

Refocus Every Hour to Achieve Better

Community Rehabilitation Service (CRS)

Belfast Health and Social Care Trust
caring supporting improving together
Safety & quality

Project Leads: Elaine Monan, Emma Corrigan

Project Team: Craig Ballentine-Kearns, Catherine Campbell, Amanda Dunseath, Roisin McGarry, Danielle McGandy, Judith McSherry, Emma Morris

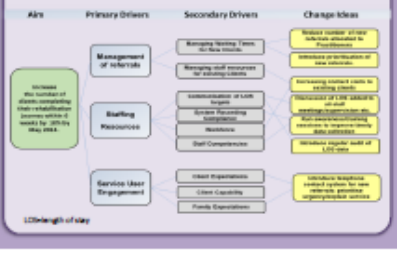
Background & Issue:

CRS provides short-term, multidisciplinary input to clients in their own home, who have recently been discharged from hospital for a variety of conditions. Based on data from April-August 2023, 43% of clients remained on CRS for longer than the target of 6 weeks for rehabilitation. There are ongoing demands to see new clients, address waiting lists & meet additional targets thus stretching resources across competing demands.

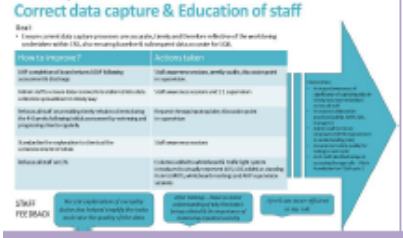
Aim Statement

Increase the number of clients completing their rehabilitation journey within 6 weeks by 10% by May 2024.

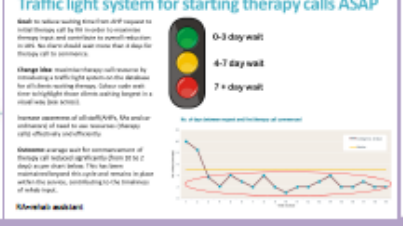
Change Ideas & Driver Diagram



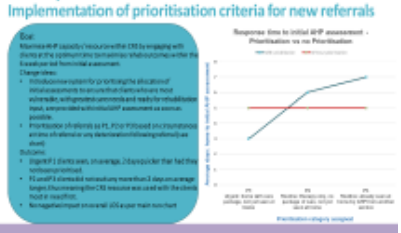
PDSA Cycle 1:
Correct data capture & Education of staff



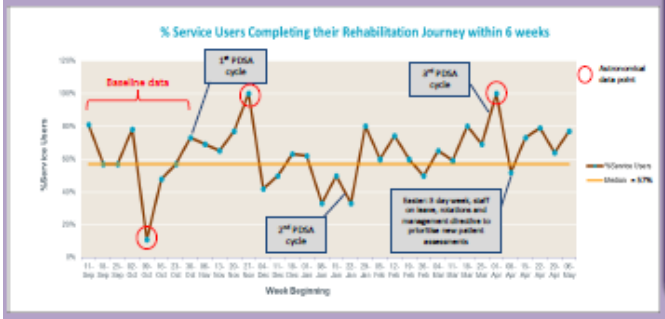
PDSA Cycle 2:
Traffic light system for starting therapy calls ASAP



PDSA Cycle 3:
Implementation of prioritisation criteria for new referrals



Overall length of stay (LOS) run chart



Balancing measures:

No. of referrals accepted & no. of clients commenced were recorded to monitor any impact on the service as a whole.

There was minimum impact on the overall referral (reduced by 9%) and acceptance rates (reduced by 7%) however CRS does not have control over the number of referrals it receives.

Outcomes:

In 12 week period of baseline data, an average of 57% of CRS clients were completing their rehab journey within 6 weeks. Over the course of the project, this figure continued to increase steadily and by the end of May 2024, this had increased to 74%, an improvement of 17%.

On average throughout the project, significantly more clients completed their rehab within 6 weeks (as per run chart).

1 main exception is annotated on chart (Easter). Except for this, there would have been a shift signalling an effective change.

There are 33 useful data points with 11 runs (less than lower range of 12) indicating a significant difference due to the project.

Reflections & Learning

Key Challenges:

- Staffing levels
- Staff valuing the importance of data collection
- Ongoing pressures to see new referrals within 48 hour KPI (key performance indicator) service target which takes staff away from reviews

Key Learning:

- Qualitative feedback from clients and staff confirming the change ideas improved their experiences of receiving care and working within the team
- Communicating improvement data and celebrating small team achievements
- Improved morale and collaborative working between different groups of staff within the team
- Visual methods of communicating information (e.g. length of stay, wait time for therapy) very effective

Client feedback

The staff were so caring and patient

[It was] organised for me to get the rehab carers and it was the best thing that happened to me.....they had me up and getting dressed and showered myself. I am now doing all myself and all I can say they are my heroes

The care started immediately that day and was kind and sympathetic

We were delighted with the treatment we received and would highly commend the team for all the hard work, excellent support and dedication

I continued to receive excellent care at home from the rehab team of OT and physio staff

WHAT'S NEXT?

- Continue to monitor and promote data quality systems put in place through SQB
- Significance of accurate data collection to be key focus of induction for all AHP and admin staff
- LOS remains as standing item on whiteboards, MDTs and at AHP supervision
- Prioritisation to be part of future structure within service where priority based on need rather than date of referral
- Significantly reduced wait time on therapy calls being maintained resulting in clients commencing rehab quicker

Reducing Barriers to Returning home From Hospital

Reducing Length of Stay in Temporary Care Home Placements

Introduction

Belfast HSC Trust commissions 52 temporary care home beds to provide care for patients who cannot go directly home from hospital. This allows a flow out of the acute hospital to be maintained however is a challenge for community social work (CSW) and AHP services. This project was to improve the experience for patients by reducing the time spent in a temporary care home bed by improving the responsiveness of professional staff involved.

Aim: Reduce the length of stay of new patients discharged to a temporary care home bed in Railway Lodge Care Home by 10 days (30%) by 31st March 2024.

Methods

- We brought together a small project team formed consisting Community Social Work, Hospital Social Work, Intermediate Care, Care Home Tracker Team and Trusted Assessors.
- We developed a Project Charter to clarify our work together and identify key measures in the data plan below to ensure we knew if changes were an improvement

Measurement Plan

- **Outcome measure:** Length of Stay as a temporary admission to Railway Lodge for Patients awaiting a care package
- **Process Measure:** Length of time to first contact by CSW in days,
- **Balancing Measures:** Service user survey, Staff survey
- Utilising Quality Improvement Tools of process mapping and force field analysis we developed further understanding of our system and the key challenges. This allowed us to develop change ideas show in the driver diagram shown here.

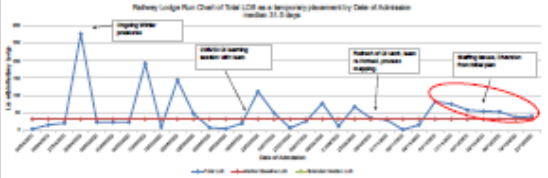
- PDSAs cycles were then use to test the changes ideas in relation to: Communication between Hospital Social Work and Community Social Work, Utilisation of Early Review Team and development of a Monitoring schedule to ensure contact is established once a patient leaves hospital.
- An example PDSA related to communication:

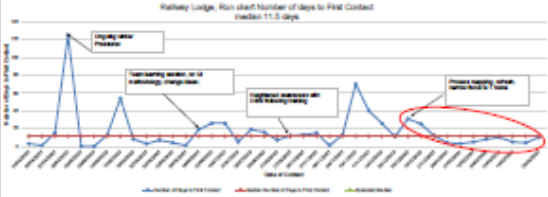
Plan: *We planned to implement first contact within 5 working days.*
Do: *In December 23 we increased the notification of discharge from hospital of the patient through a second pathway i.e. follow up email and phone call.*
Study: *From this we learnt that while targets were not met, there was an overall improvement in response time.*
Act: *This led to further refining of our communication structure with back up from key workers in the Community Social Work Team.*

Results

The run charts below demonstrate results for the outcome and process measures. The median length of stay is 31.5 days. While the chart does not yet show a change in the system there is progress with a downward trend in LOS from 10.11.2023 to 9.12.2023. There is a gradual reduction in variation across the chart of LOS stay demonstrating that during the time of the project that the levels of standardisation in the system are improving. The run chart of days to first contact now shows a shift with more than 6 points now below the median which is significant.

The increase focus on this area while not yet demonstrating sustained improvement has impacted in reducing variability in the patients journey and an indication that further improvements can be achieved.





Conclusions & Key Learning

Applying QI methodology can be challenging in a busy work environment but I have begun to see its benefits as the data at the end of 2023 begins to show improvements.

At this point adding measurement of the financial impact of beginning to reduce the length of stay in terms of bed days saved will begin to become possible.

We can see how when the CSW can see patients soon then this slowly improves the LOS in one nursing home.

Achievements

The data developed in the preparatory work and during the SclL program is now seeing a business case progressed to fund Community Social Work team to allow patients to be seen soon on discharge.

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SclL
Scottish Improvement Leader

Developing and Understanding Key Roles and Responsibilities of Staff within a Children's Home for Children with Disability

NHS Education for Scotland

Introduction

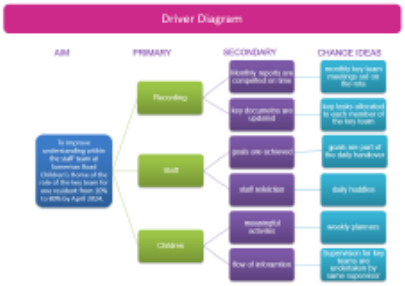
Children's Homes are underpinned by Legislation and Regulations. One key component is that each child is to have a delegated person within the team that has responsibility for ensuring their care planning needs are being met. This is a Social Worker in the team and is known as the keyworker. Their role is to work in partnership with the child, their family, team members and other professionals to ensure that the needs of the child are fully met and that care planning is promoting safe, effective, compassionate and quality care.

The team within Somerton Road Children's Home wanted to develop smaller key teams responsible for a child. The hope was that this would increase the number of staff undertaking daily tasks with the child, support better understanding of the child's needs aligned to that team and enable a more holistic oversight and care planning for them. This would then result in better of care for the child and promote better choice, growth and quality of life for them.

Aim

To improve staff engagement at weekly key team meetings from 10 % - 80 % for one child, to help improve staff understanding of the role of the key team and improve the quality of care for the child from September 2023 to April 2024

Process Change



Improvement Method

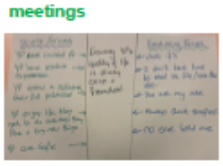
Using the driver diagram, force field analysis and the process mapping we were able to identify out measures and undertake PDSA cycles to test out change ideas.

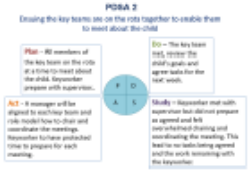
Our measures were –

Outcomes: Increase in the % of staff attending weekly key team meetings

Process: Number of staff who attend the weekly meeting & Increase in the % of staff understanding

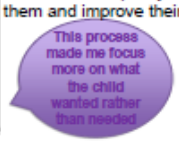
Balancing: Increase in staff sickness on the attendance at weekly key team meetings

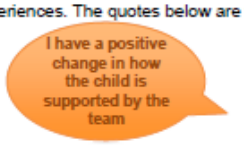




Results

The run chart highlights that while there were some hurdles in staff attending the weekly meetings this did improve and staff's understanding of the role increase which also improved moral with in the team, staff awareness of the statutory functions undertaken each month and enhanced the quality of life for the child as there was not a team working collectively to support them and improve their experiences. The quotes below are from the team.





Conclusion - Engaging with the staff team using the improvement tools helped the project to be achieved. Using the driver diagram with the team to break down the steps made them more achievable and supported the team remain engaged. The PSDA cycles not only helped break done the change ideas it gave a framework to try an idea, look at how it worked and explore key learning. The feedback from the team was that method for improvement is not something that is unusable in our service but can be used in lots of areas of the daily work the team do. The project has improved processes and the team now see the value of this and we are planning to spread this across the other 5 children. I believe the team will be enthusiastic about Quality Improvement and no see it as something down to them but something they can be part of to share and deliver change.

Key Learning Points

- Understanding the psychology of change (staff anxiety) is essential in building team confidence to maintain attendance and awareness of the role of the key team
- Use your data

Achievements

- Increase confidence in staff
- Team cohesiveness
- Improved planning for the child
- Skill development in the team

Next Steps

Scale and spread to the other 5 children

References

The Children's Homes Regulations (Northern Ireland) 2005
Department for Health Minimum Standards for Children's Homes 2019

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ScIL Scottish Improvement Leader

NHS Education for Scotland

To reduce the number of unallocated cases for the community children's with disability (CWD) social work service in BHSCT.

Developing a new and innovative whole systems approach to ensure that children and families get the right access to the right care at the right time.

Introduction

Across much of social services both waiting lists and unallocated cases are seen as a "Wicked Problem", with increased case complexities and workforce issues such as recruitment, staff vacancies and staff sickness and tackling these issues can present as quite a challenge within services. Within CWD the number of unallocated cases continued to grow, particularly over COVID, and with an increase in children not having timely access to care, increasing complaints and legal challenges, it was felt that innovation needed to take place to try and improve how we supported children and families most in need.

Aim

To increase the number of cases allocated within the Children with Disability Service by one case per week by April 2024.

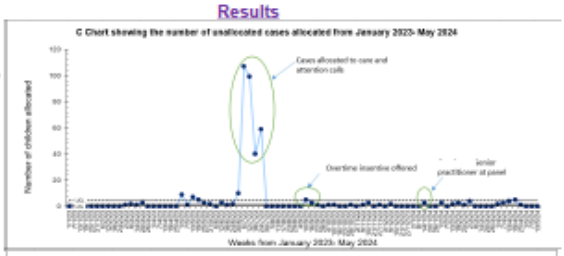
Methods

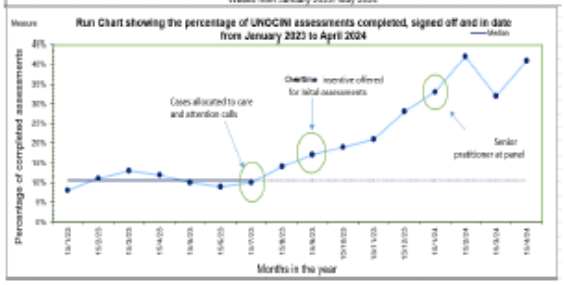
The model for improvement and PDSA cycles were used to test change ideas

- Process map of current referral process.
- Liaison with other services about referral criteria.
- Script and training provided for new staff.
- Introduction of signposting to more appropriate services.
- Introduction of overtime to allow waiting list assessment to be completed.

65% increase in Carers assessments from Mar 23 – Dec 23

Results





PDSA Cycles

The service created a new approach to managing unallocated cases. Cases that were previously unallocated are now managed as care and attention cases, closely monitored by support staff alongside senior social workers.

Conclusion - This initial PDSA Cycle reduced the number of unallocated cases by 81% and was therefore adopted and embedded within the system.

"Actually being asked what can be done to help is so helpful"

"Having a phone call was really helpful"

Referral Panel

The information gathering process at point of referral was often a challenge to complete in a timely manor. To alleviate staff pressures a social worker was aligned to referral panel to provide signposting and advice at point of referral.

Conclusion – The PDSA allows families to have more timely access to the right care at the right time and ensures waiting lists are accurate.

Balancing Measure

It is essential that improvements in one area do not create bottle necks in another. Compliance with 6 monthly review assessments was measured to ensure that children who are open to the service are receiving up to date assessments in accordance with our statuary responsibility.

Next Steps

Continue to monitor project outcomes and continue with a proactive approach for families

Achievements

- Achievement of initial aim of reducing unallocated cases by 30% by June 2024
- Reduction in the number of unallocated cases by 81% by April 24
- Reduction in longest wait for initial assessment from 901 days in April 23 to 330 in April 24 64% improvement
- 75% improvement in completion of SW assessments and reviews
- 93% of families receive direct communication from the service, improvement of 68%

Key Learning Points

Importance of using a whole systems approach to reduce the likelihood of bottle necks within services

The importance of understanding your system before making any changes

Additional resources have been used creatively to support change, for this to continue sustainable funding is essential

Contact:
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ScIL Scottish Improvement Leader

Improvement Work Undertaken in Community Mental Health

Adult acute mental health

PATH - The psychiatric Assessment and Treatment Hub (PATH) are a new initiative within the Belfast Trust designed to enhance patient experience, reduce pressure on emergency departments and support staff. PATH offers timely, person centred care and short-term interventions for individuals who cannot be safely managed in the community. Since launching in November 2024, PATH has led to a 75% reduction in patients waiting in ED for admission to mental health wards.

The MDT collaborates with ED, social work, home treatment teams and inpatient units to ensure compassionate and patient centred care. Patients benefit from a safe, therapeutic environment and improved service user experience- relieving pressure from families and ED staff.

PATH is grounded in empathy, dignity and respect as reflected in service user feedback.

This initiative represents a transformative step in delivering holistic mental health support, reducing unneeded further hospital admission by 42% and enabling continuity of care in the community

Integrating the care – creating new pathways. EASI - Inreach home treatment team

A collaborative initiative between ward 5 and the home treatment team aimed at strengthening the referral pathway between ward 5 and the HTT. The primary objective was to enhance the efficiency of the referral pathway, enhance patient flow and to optimise the discharge process. This ensured that service users were supported to return home at the right stage in the recovery journey.

The EASI Project – Enhancing Acute Service Integration. Home treatment Team Belfast.

Ward 5 in AMHIC was noted to make up the largest proportion of referrals to HTT and have the Greatest number of referrals not accepted.

EASI was set up to improve this. baseline data showed **41.6%** of referrals made where Accepted By HTT. Post implementation of a in reach HTT practitioner seen referrals accepted to the caseload increase to **77%**, an increase of 37%

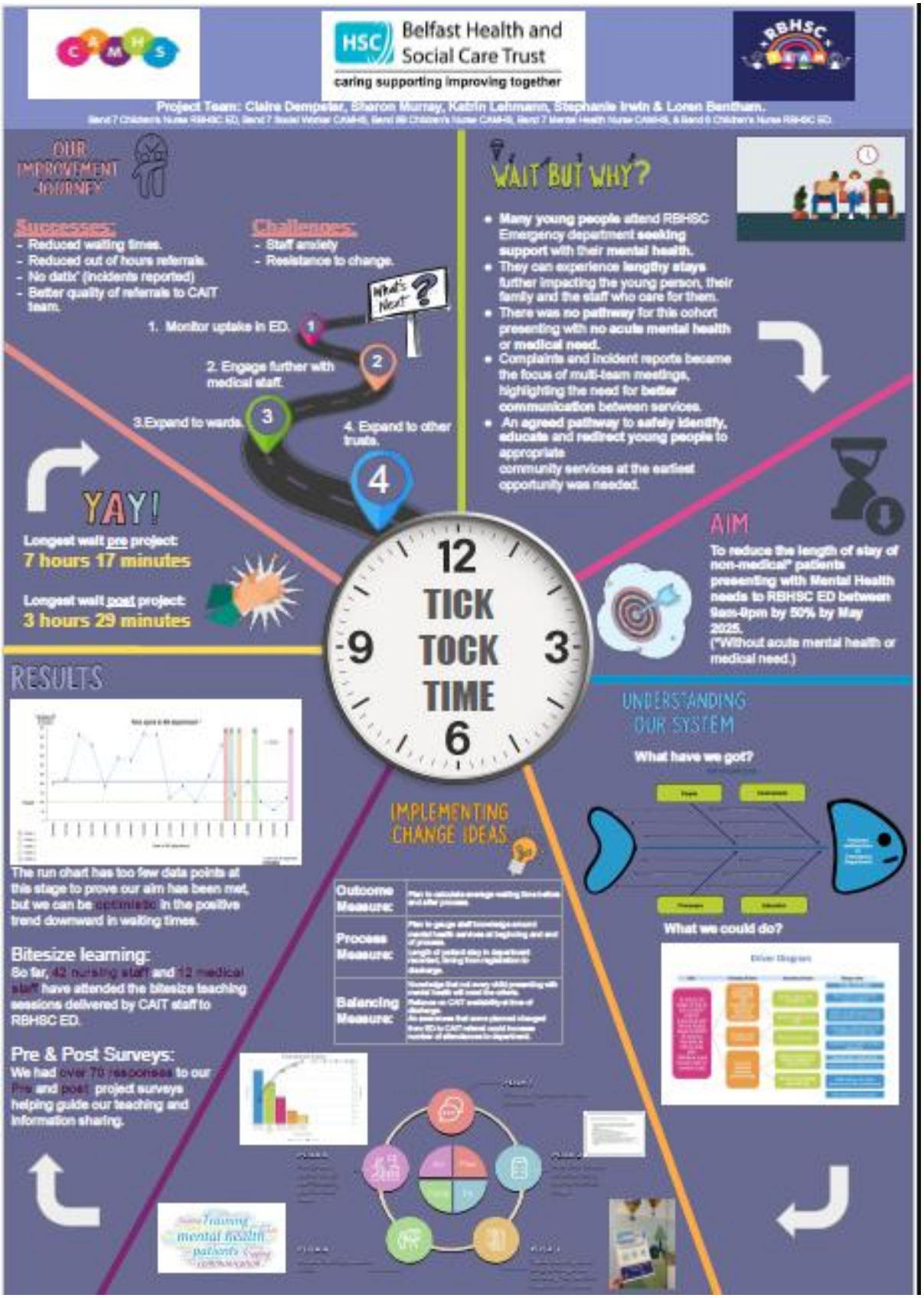
Student Mental Health.

Timely access – Student Mental health has been able to achieve telephone contact within 1 day of a referral being received with 94.2% of the students referred to the service. With an average pf 10.7 working days between referral and first appointment.

- 100% of urgent referrals assessed within 10 working days
- 100% of routine referrals assessed within 9 weeks.
- (Mar 24 – Feb 25), 75.8% of students show Clinical and/or Reliable Improvement.
- (Dec 24 – Feb 25) **100**% of the students who completed an evaluation would recommend the service to friends and family.

Feedback:

*"*Thank you, I didn't think I would make it through. I am not fully recovered but i have hope. I feel very emotional; this service saved my life. The staff are so kind, I don't know how they do it. I called sometimes in crisis, and I got a call back on the same day. She is so lovely, and her words made me feel hopeful, like I wasn't a lost cause. I don't know how to say how helpful this was to me. This service needs to stay and help others like me.*"*


Belfast Health and Social Care Trust
caring supporting improving together
Project Team: Claire Dempster, Sharon Murray, Katrin Lehmann, Stephanie Irwin & Loren Bentham.
OUR IMPROVEMENT JOURNEY
Successes:
- Reduced waiting times.
- Reduced out of hours referrals.
- No datix' (incidents reported)
- Better quality of referrals to CAIT team.
Challenges:
- Staff anxiety
- Resistance to change.
What's Next?
1. Monitor uptake in ED.
2. Engage further with medical staff.
3.Expand to wards.
4. Expand to other trusts.
YAY!
Longest wait pre project:
7 hours 17 minutes
Longest wait post project:
3 hours 29 minutes
WAIT BUT WHY?
Many young people attend RBHSC Emergency department seeking support with their mental health.
They can experience lengthy stays further impacting the young person, their family and the staff who care for them.
There was no pathway for this cohort presenting with no acute mental health or medical need.
Complaints and incident reports became the focus of multi-team meetings, highlighting the need for better communication between services.
An agreed pathway to safely identify, educate and redirect young people to appropriate community services at the earliest opportunity was needed.
12 TICK TOCK TIME 6
9
3
AIM
To reduce the length of stay of non-medical* patients presenting with Mental Health needs to RBHSC ED between 9am-9pm by 50% by May 2025.
(*Without acute mental health or medical need.)
RESULTS
The run chart has too few data points at this stage to prove our aim has been met, but we can be optimistic in the positive trend downward in waiting times.
Bitesize learning:
So far, 42 nursing staff and 12 medical staff have attended the bitesize teaching sessions delivered by CAIT staff to RBHSC ED.
Pre & Post Surveys:
We had over 70 responses to our Pre and post project surveys helping guide our teaching and information sharing.
IMPLEMENTING CHANGE IDEAS
Outcome Measure:
Process Measure:
Balancing Measure:
UNDERSTANDING OUR SYSTEM
What have we got?
What we could do?
Driver Diagram
Training mental health patient's Care

Improve Treatment Completion Time by 30% for GAD patients by May 2024 to Increase Timely Access to Care

Project Team: Joanna Killough (CBT lead), Brenda Raflewski, Laura McKenna and Kathleen McGrory. Email: joanna.killough@belfasttrust.hscni.net

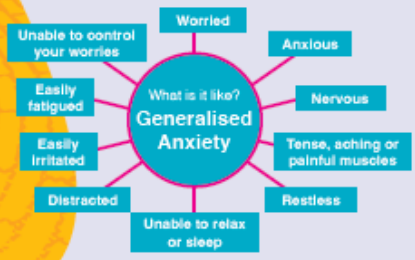
Introduction

Pressures in mental health services due to waiting times have encouraged CBT team to improve timely access to care. We have identified prolonged periods of treatment associated with Generalised Anxiety Disorder. We have implemented a structured treatment plan to improve efficiency whilst maintaining quality of the service.

What is CBT?

Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.

It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.



Aim

Improve Treatment Completion Time by 30% for Generalised Anxiety Disorder patients by May 2024 to Increase Timely Access to

Progress of the Project

3 change ideas have been implemented and embedded in practice.

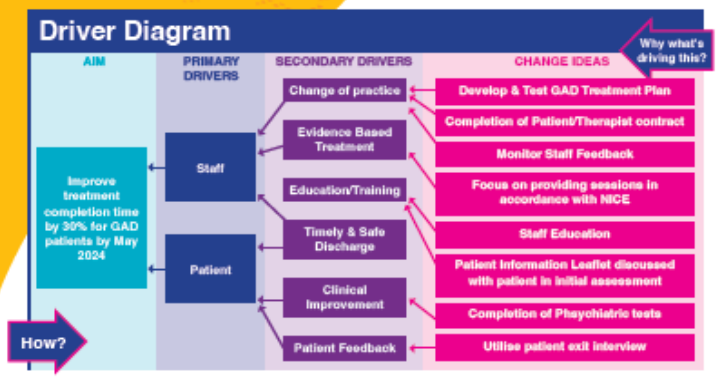
PDSA cycle 1- Develop and implement standardised treatment plan for GAD. **Implemented.**

PDSA cycle 2- New referral process. Test if implementing new referral form and referral meeting reduces inappropriate referrals. **Implemented.**

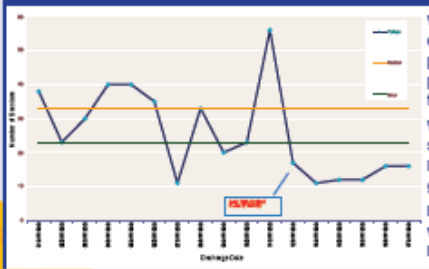
PDSA cycle 3- Patient contract. Test if patient contract reduces DNA's. **Implemented.**

PDSA cycle 4- Screening checklist. To test if this has any impact on DNA rates. **Ongoing.**

Driver Diagram



Run Chart: Number of Sessions for GAD Patients



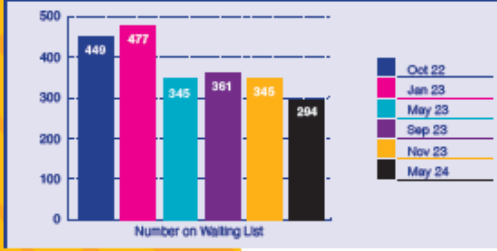
We can see that length of treatment for GAD patients was varied prior to implementing treatment plan.

We wanted to standardise treatment in line with NICE guidelines.

From the treatment plan was implemented this has been successful.

Patient Feedback

Number on Waiting List from Oct 2022 - May 2024



Challenges

Complexity of cases and co-morbidity

Changes to treatment goals and/ or problems during treatment

Availability of retrospective data

Learning

- More efficient use of therapy time
- Importance of data gathering and record keeping
- Implementing QI methodology
- Sharing and learning from other trusts
- The importance of service user involvement

What next for the project

- Continue to embed a data focused approach.
- Create a structured treatment for other disorders.
- Continue to collect data for GAD.

Reducing Active Caseload in a Community Mental Health Team

Aim: To Reduce Active caseload in the East Recovery Community Mental Health Team by 10% by April 2024

Introduction:

The East Recovery Community Mental Health team currently provide assessment and treatment for individuals with serious mental illness. Often the nature of such illness can cause chronic or relapsing symptoms. Historically patients remain on caseloads for many years even when symptoms are well managed. The result is that caseload size is increasing and outstripping capacity. The unfortunate consequence means that there is difficulty in offering timely appointments when patients require additional input to prevent deterioration.

Method:

Establishing a project team was essential to the success of the project. This included administrative staff, personnel in key leadership roles and frontline staff.

To understand our system the project team;

- Undertook a cause and effect exercise shown below
- Carried out a process map of a patient journey
- Held focused discussions with interfacing teams

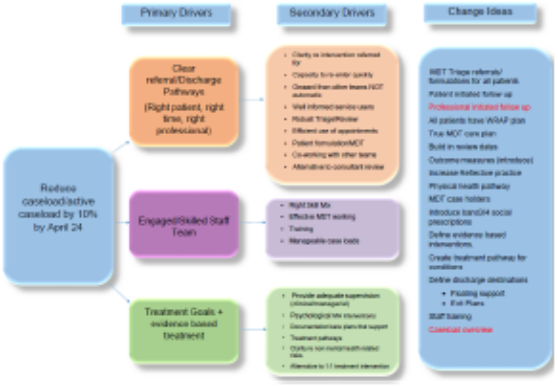
Utilising the model for improvement we developed a measurement plan detailed here and a driver diagram shown below to develop change ideas that were then tested using PDSA cycles.

Measurement Plan:

Outcome measure: Number of patients on team caseload including unallocated and active cases

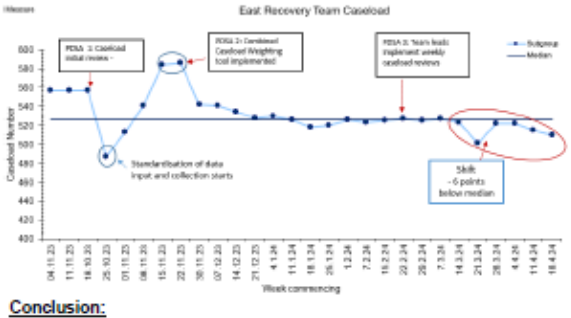
Process measure: Number of patients transferred to PIFU pathway.

Balance Measure: Number of new referrals



Results:

Our baseline measures showed random variation in caseload size. From our first PDSA cycle we learnt that there was a need to have an overview of the caseload with a standard approach to data input and quality assurance of the data. PDSA cycle two tested a caseload weighting tool with the Team Leader having oversight of all practitioner caseloads in one spreadsheet reviewed weekly. This highlighted double counting of patients and records remaining open after discharge showing a greater capacity in the team than previously evident. The run chart below shows a shift following PDSA 3 which utilised a caseload validation tool by team leaders during supervision sessions. The team have achieved an 8% reduction in the caseload



Conclusion:

While initial plans were to test a "Patient initiated follow up pathway", the project highlighted that the service was previously operating in a data blind environment. Bringing the ability to oversee total team caseload in a meaningful way assisted team leaders to explore obstacles to discharge within the team.

Key Project Learning:

Performance data gathered from outside the service was not presented in a way that allowed interrogation of trends.

Improvement means doing differently not doing more of.

Personal Learning:

Ensure I understand the system before jumping to a solution or change idea

Understanding balancing measures

Power of celebrating small wins, 1% on top of 1% soon builds momentum

Achievements:

Involving CMHT in the QI project has brought an enthusiasm to understand the system in which we work and that introducing small changes can have an accumulative effect.

The service has identified resource to provide informatics support.

Next Steps:

Test protected time in MDT meeting for discharge planning.

Identify patients suitable for Patient initiated follow up pathway.

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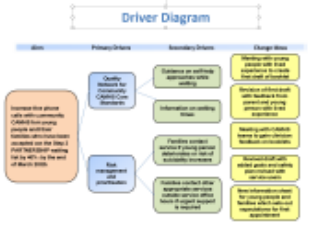
ScIL
Scottish Improvement Leader

Waiting for the first Partnership Appointment at Step 3 Community Child & Adolescent Mental Health Service (CAMHS)

NHS Education for Scotland

Introduction:
Children and young people with complex mental health needs currently wait a number of months for their partnership appointment (beginning of therapeutic intervention) and rarely contact the service. Some young people deteriorate significantly without the service having any knowledge. Encouraging young people and their families to reach out to CAMHS while waiting is the first step of the wider patient initiated follow-op (PIFU) shift towards increased autonomy in CAMHS. If families contact the service with new information or concerns, young people can be prioritised on the waiting list.
Aim: Increase the phone calls with community CAMHS for young people and their families who have been accepted on the Step 3 PARTNERSHIP waiting list by 40% by the end of March 2025.

Methods: Model for Improvement with iterative PDSA cycles to effect and evidence change responding to the data provided. Driver diagram and Pareto chart to understand the system.



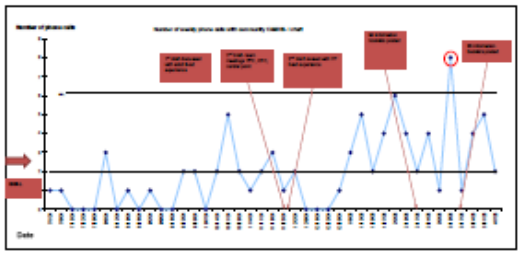
<u>Outcomes measures:</u>
- Number of weekly phone calls with community CAMHS

<u>Process:</u>
- Number of packs given to families at CHOICE appointments weekly

<u>Balancing:</u>
- Feedback from young people, parents and clinicians

Results: A booklet was co-produced with young people and parents with lived experience.

Weekly telephone calls to community CAMHS have increased. There is a point above the upper control limit, which may indicate improvement.



Process measures: A total of 129 booklets were given to young people and parents. Booklets were not provided at the end of the first appointment due to delays in decision-making. Booklets were posted out by administrative staff on 17.02.25 and 17.03.25

Balancing measures: feedback from young people, parents and CAMHS staff

Conclusions:
This project successfully co-produced a booklet for young people and parents waiting for CAMHS interventions and increased phone calls to community CAMHS. 129 booklets were not distributed in a timely fashion.

Next steps:
This project was focused on empowering young people and families to actively contact community CAMHS when required to manage their care. Engagement with colleagues and service users highlighted a gap in terms of preparing young people and families for their first CAMHS assessment. A new information leaflet is current in process. Further meetings with CAMHS staff will explore how practice can be adapted to ensure booklets are provided in a timely manner.

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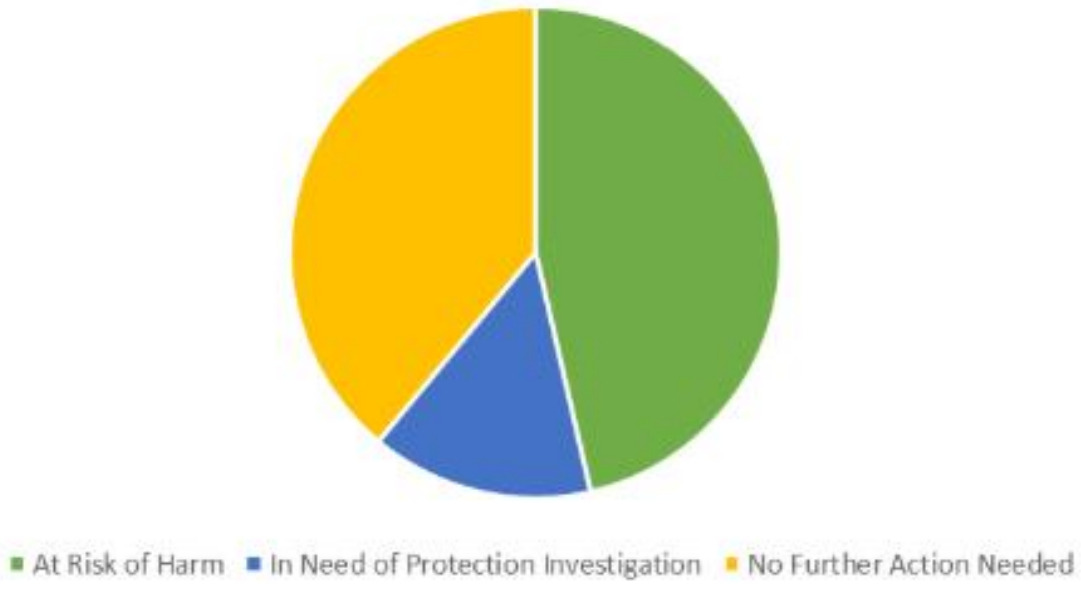
ScIL Scottish Improvement Leader

Adult Social Care Services

Adults referred for investigation and identified as at risk of abuse, neglect or exploitation

In the financial year April 24 to March 25 – there were **4927 Adult Safeguarding (ASG) referrals** received, of which:

- **2286** were screened as “at risk of harm” and had an alternative safeguarding response in place.
- **722** were screened as a “in need of protection investigation” which would have a protection plan in place
- The rest were either screened as **“no further action”** or passed to another trust.



Adults with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

During the reporting year 2024/25 this figure was **zero.**

Adults with a Learning Disability who had an Annual Health Check

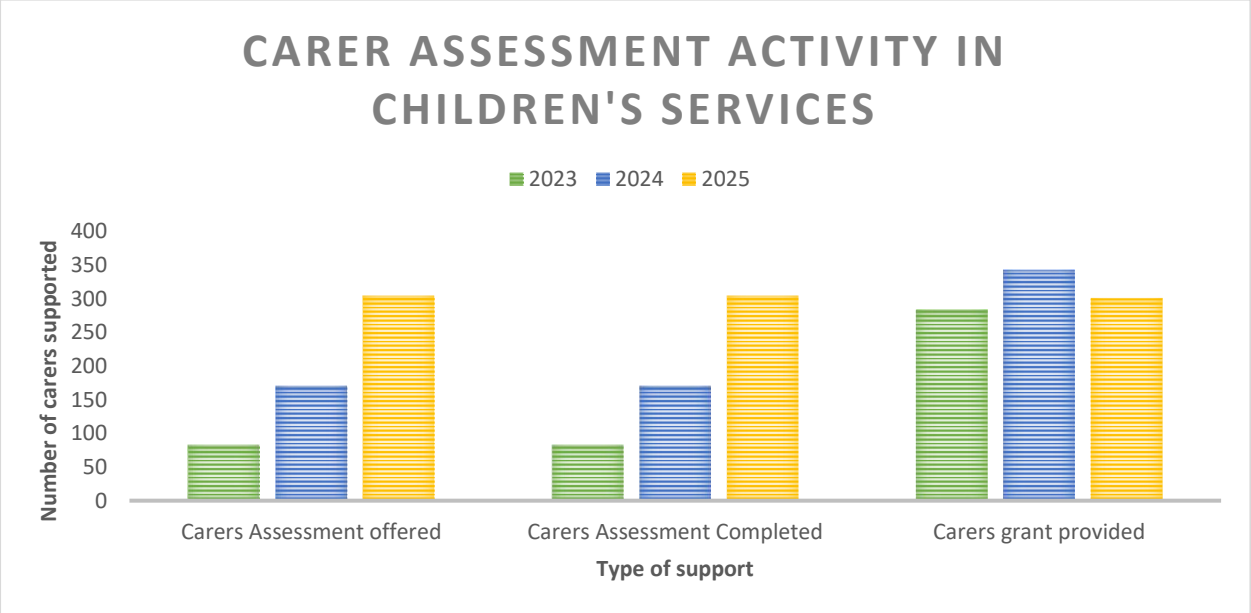
It is estimated that **370** out of **1756** adults with a learning disability had an annual health check. This accounts for **21.3%**

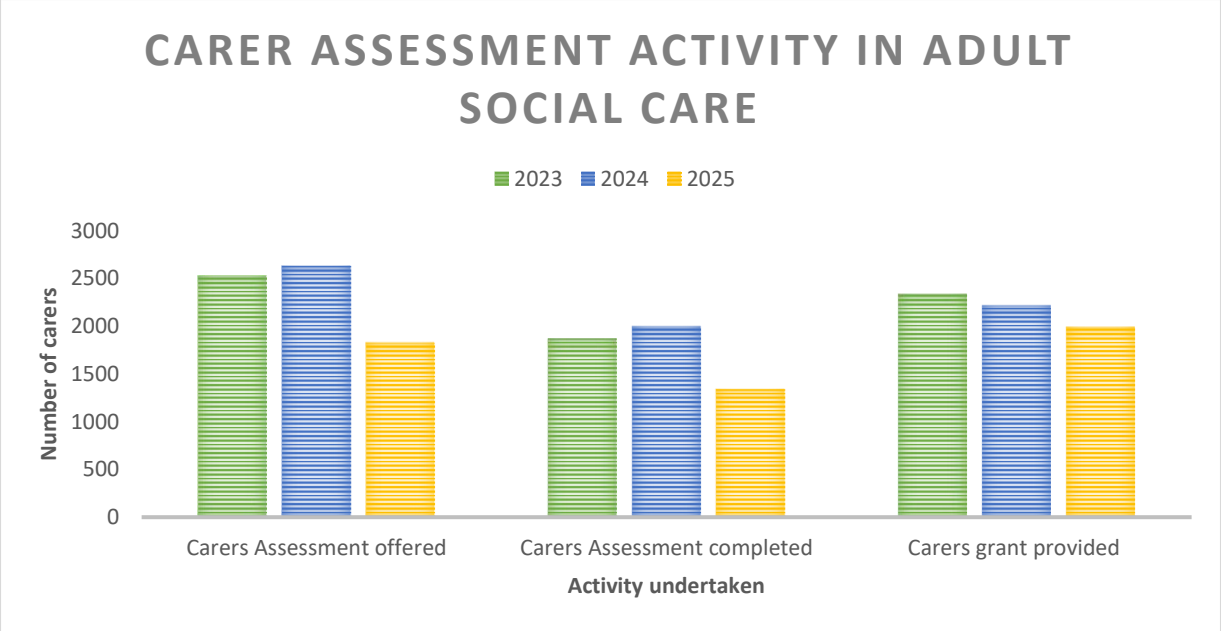
Carer Support and Carer Grant

Children's Community Services offer support to parents/ guardians with caring responsibilities for children with additional needs. This is primarily provided within Children with a Disability Services. There has been a **significant increase in the number of carers assessments offered and completed** within the reporting year from **170** in 2023/24 to **304** at 2024/25. **This is an increase of 44%.**

The number of carers offered a **carers assessment in adult social care has decreased** across this reporting period by 31% from **2632** to **1826** and there has also been a **decrease in the number of carers assessment completed** (by 31 %from **1997** to **1338**) However the the **% ratio of carers accepting the offer of a carers assessment has remained consistent,** with **75%** of carers offered availing of this support.

The number of carers receiving a **carers grant has reduced by 11%** in this reporting period. The Trust reports that **1988** carers availed of carers grant from 1st April 23- 31st March 25.





The Trust is aware that the implementation of Encompass has impacted on quantitative data collection and carer assessment activity is higher than recorded in current systems. A focus on improving both data collection and activity will be prioritised in 25/26. The Trust notes that preparation for Go Live with Encompass and the initial embedding of this new system impacted on staff capacity to complete carers assessments in a timely manner in the first quarter of this reporting period.

Applications for Assessment made by Approved Social Workers

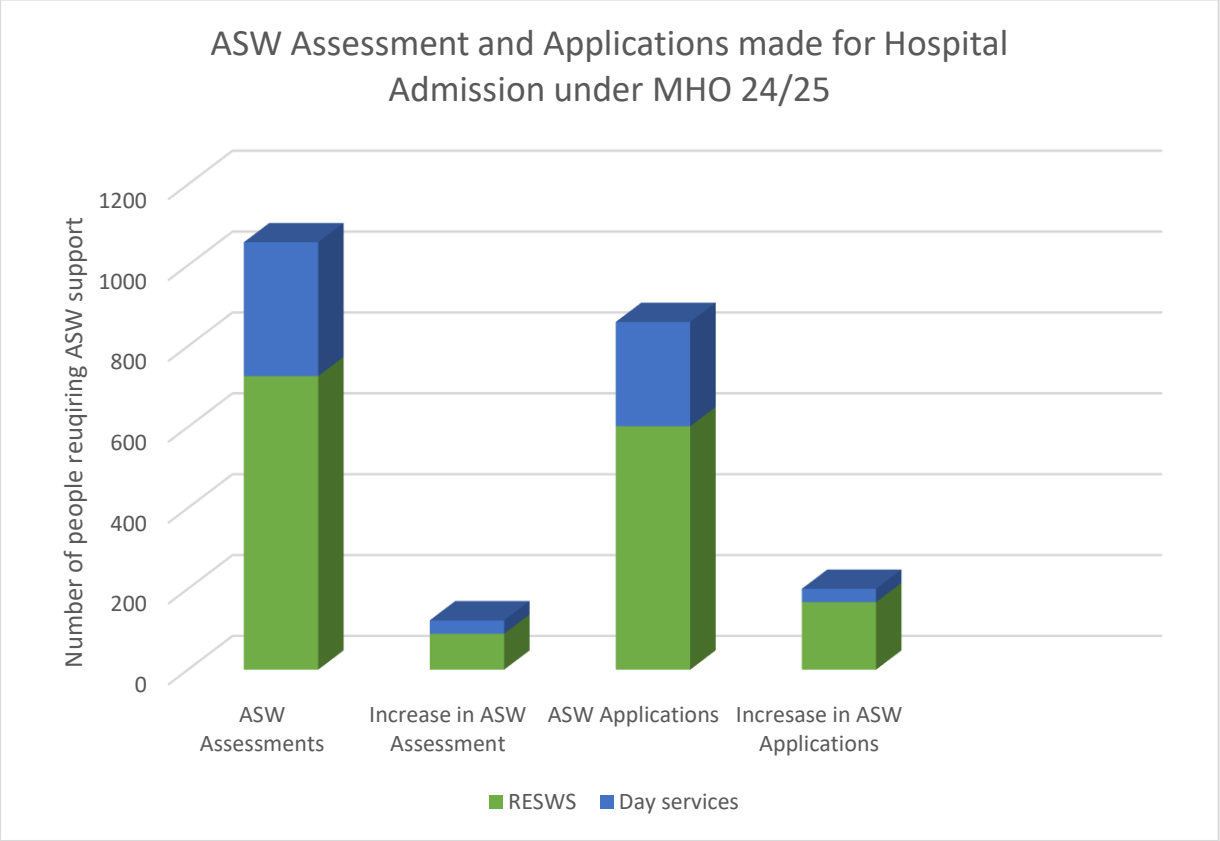
The Trust continues to provide Approved Social Work services both with a daytime rota and in the coordination and management of the Regional Emergency Social Work Service (RESWS), which provides out of hours social work support across Northern Ireland.

The number of **assessments made by Approved Social Workers under The Mental Health (NI) Order 1986 (MHO) has increased in both services in this reporting period.** Day services have seen an **increase of 9.97% to 331 in ASW assessments being completed** from **298** in 2024/25. RESWS have seen an **increase of 12% in ASW assessments being completed** across the region**. (from 637** in 23/24 to **726** in 24/25)

% of applications for a period of assessment in hospital, made by Approved Social Workers. [This is the figure where people have been detained under the MHO]

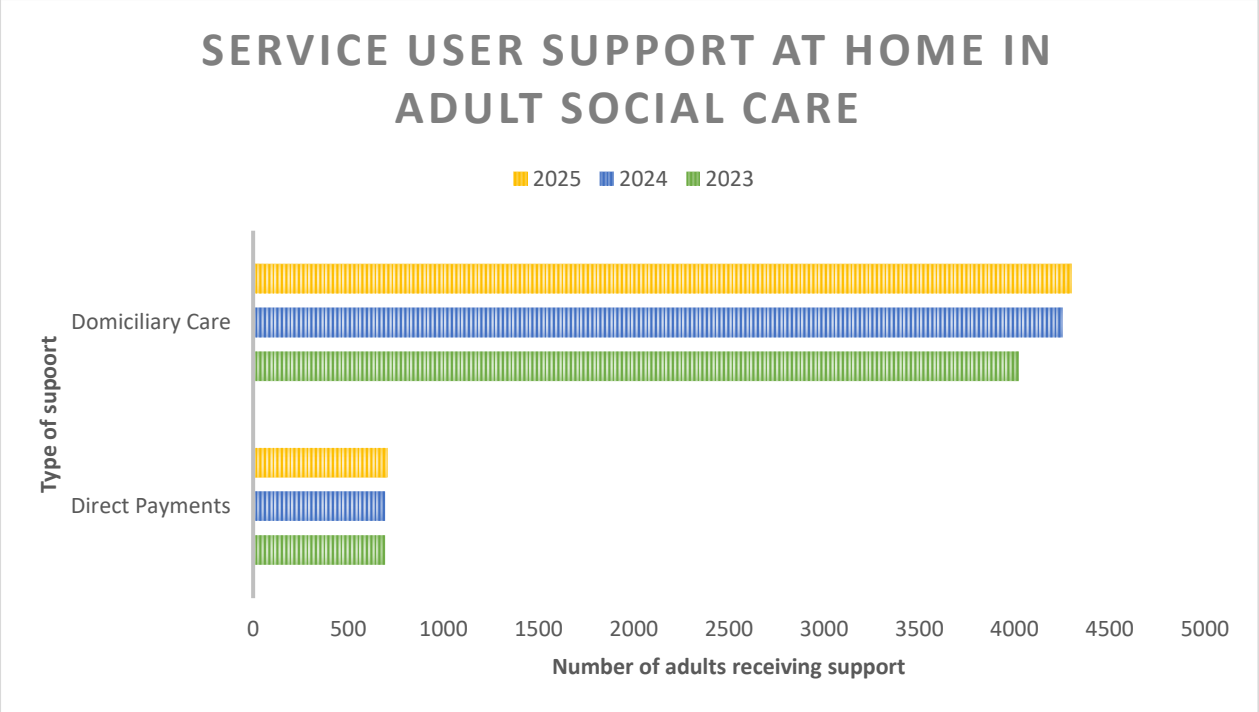
Day services have experienced a **13% increase** in applications for admission to hospital for assessment (from **225** in 23/24 to **258** in 24/25)

RESWS has experienced a **27.5% increase** in applications for admission to hospital for assessment (from **435** in 23/24 to **602** in 24/25)



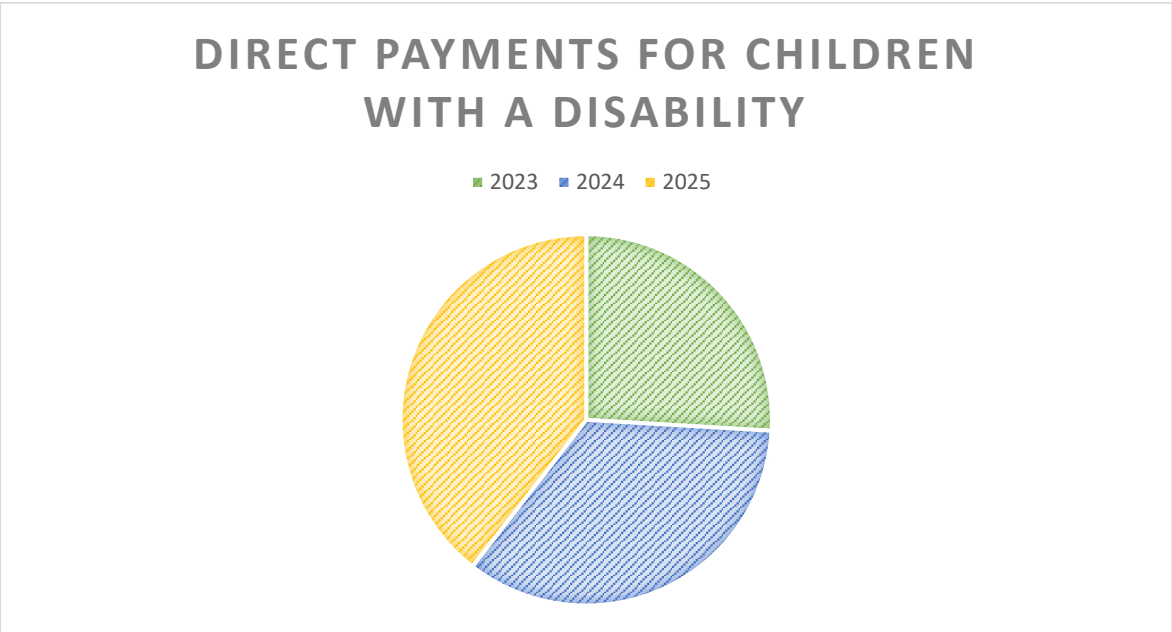
Direct Payments Adult Social Care

The number of adults in receipt of a direct payment has **remained stable** in the reporting period. There are currently **707 adults** in receipt of a service who have chosen direct payments as the way to receive this service. This is an **increase of 2.6%**. **Domiciliary care remains the preferred option** of support for people who require a service at home or in the community.



Direct Payments in Children's Community Services

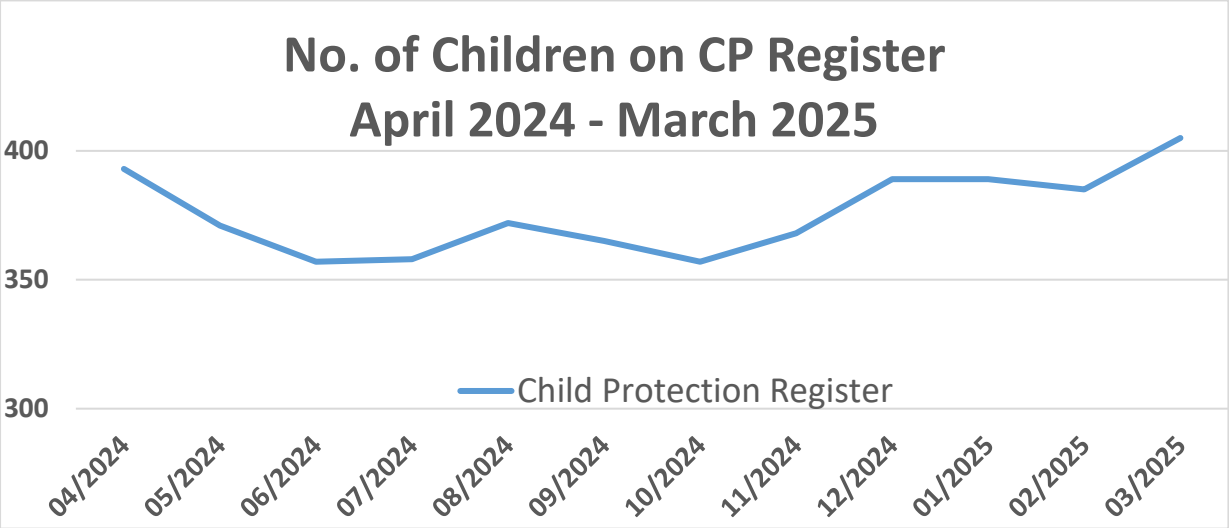
The use of direct payments for children with a disability is a preferred option for support for many parents/ carers. Within this reporting period there is an **increase of 31%** in Direct Payment service provision, with **338 parents/ carers** availing of this method of support for their children **compared to 230 in the last reporting period.**



Children's Social Care Services

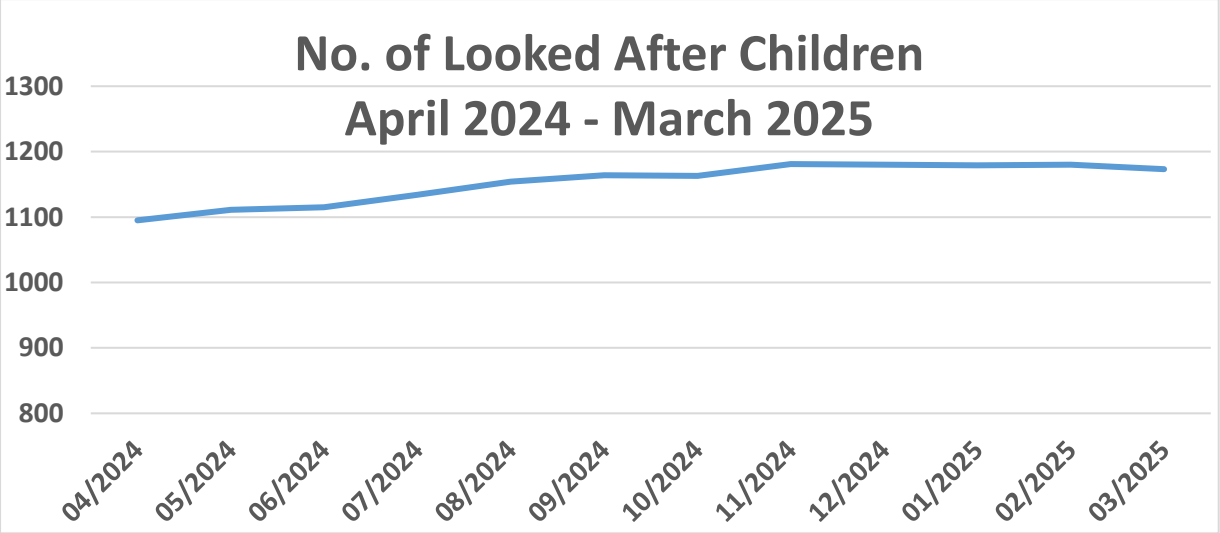
Child Protection (CP)

As of 31/03/2025 there were **405 children on the Child Protection register.** In this reporting period there were **405** children on the Child Protection Register compared to **410** in 2023/24. **Decrease of 1.2%**



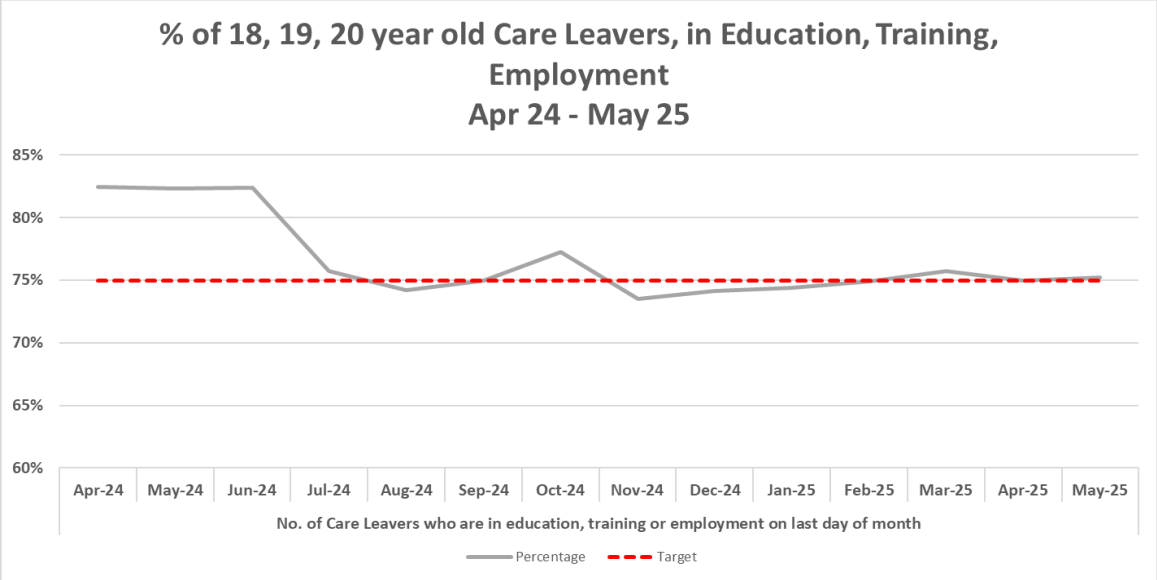
Looked After Children (LAC)

As of 31/03/2025 there were **1172 Looked After Children.** In this reporting period there were **1172** Looked After Children compared to **1095** in 2023/24. **Increase of 7%**



Young People known to Leaving an Aftercare Service, are Engaged in Education, Training, and Employment

76% of young people known to leaving an aftercare service in the Belfast Health and Social Care Trust are engaged in education, training, and employment*. This remains consistent with last year's figures, resulting in no change with the previous reporting period.
*DSF/Corporate Parenting Returns (10.4.10)



Direct Payments

296 of children are currently in receipt of Direct Payments as set against the HSCB commissioning direction target DSF/Corporate Parenting Returns*. This is a 7.8% increase on the previous year.

Due to industrial action the following data is unavailable:

- % of children or young person were seen within 24 hours of a Child protection referral being made.
- % of looked after children within the Belfast Health and Social Care Trust were reviewed within regionally agreed timescales.
- % of all looked after children in care for more than 3 months have a Permanency Panel Recommendation

- % of disabled children has a transition plan in place when they leave school within the trust.

Integrated Care Services

BFI Gold Award: BHSCT Health Visiting Service achieved the highly commended UNICEF Baby Friendly GOLD award in February 2025. This award is granted to services able to demonstrate and achieve sustainability in delivering and implementing the UNICEF Baby Friendly Initiative (BFI) standards. The BFI standards are crucial in ensuring that families receive the best support in building close, loving relationships and in feeding their babies to promote optimal health and development.

Connected Community Care

The Connected Community Care service is an initiative developed by the Belfast Integrated Care Partnerships to connect people to local health and wellbeing support services to help them keep well.

For further information on this service please click HERE

Regional Quality Improvement (QI) Programme for Social Work, Nursing and Midwifery

The Trust was delighted to support 7 social work and social care leaders and 1 nursing leader to complete their Level 2 QI qualification through the Regional Quality Improvement Programme for Social Work, Nursing and Midwifery. The improvement projects undertaken have supported co-production, enhanced service delivery and multi-professional working.

Domestic abuse; improved staff response

This year there has been a continued focus on improving pathways, clarifying service area roles and responsibilities and awareness raising. A 'Z' Card (Credit card sized resource that folds out) was produced to standardise how staff recognise, respond, report and record incidents of domestic abuse. It is a practical guide for staff providing helpful tips on how to respond to abuse and how to safety plan. It also provides a list of useful contacts. This Z card has been disseminated to staff across the Trust and has been positively received by staff.

Domestic abuse; information for the public

A co-production project is on-going, including BHSCT representatives from Adult Safeguarding, Personal & Public Involvement Team, the Equality & Planning Team and Children's Services alongside partner agencies; Women's Aid, Men's Advisory Project, Rainbow Project, NEXUS, ASSIST NI, and PSNI. The aim of the project is to create information that people with lived experience of domestic abuse and sexual violence:

- would find useful,
- is in a format that is useful to them, and
- that will not increase their level of risk.

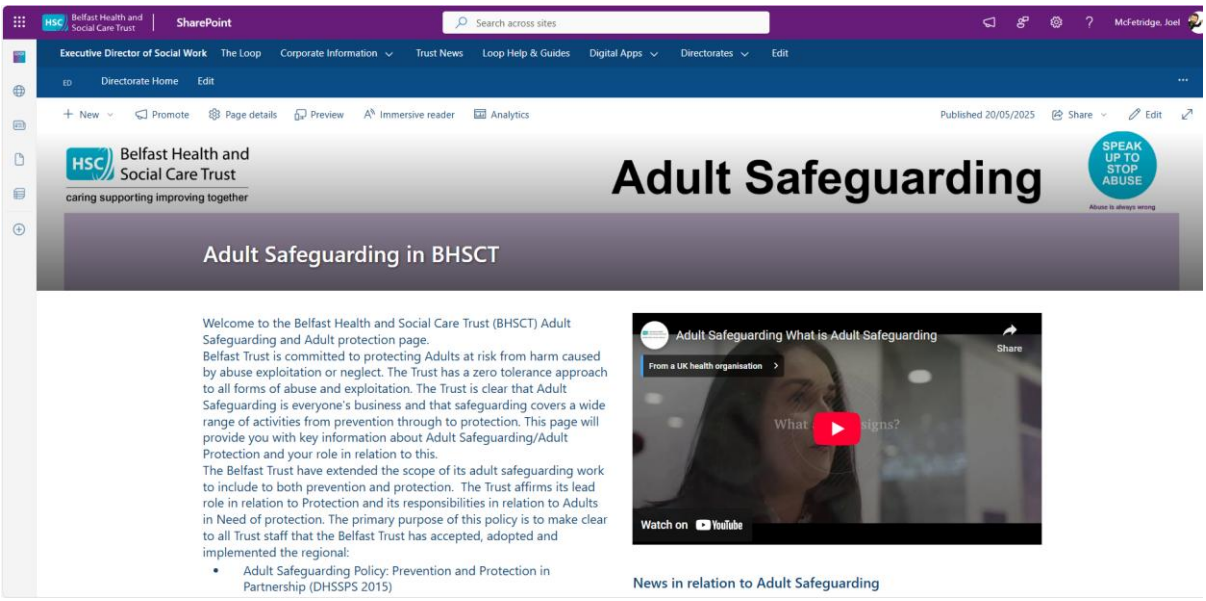
Service user scoping has been undertaken by partner agencies and arising from the outcome of this, posters have been produced and enhanced information added to the BHSCT website.

Work is on-going to produce a page tiger resource which will be accessible via a QR code on posters and on the BHSCT website.

Adult Safeguarding information on the Loop

Adult Safeguarding information was moved from the ACOPS to EDSW section of the Loop this year. In preparation for this a staff survey was widely circulated to ascertain if the current information was useful or if there were any suggestions on how the information could be improved. Twenty-three staff responded. The responses were overwhelmingly positive about the current information; with many comments stating the current format of the information was “easy to navigate”. Any suggestions, which were made for improvement, were actively considered during the move, and any information requiring update was amended during the move.

This process has ensured that the information available to our staff is up to date, relevant, and easily accessible.



BHSCT Hospitals; Adult Safeguarding referral App and monthly activity reporting”- update

The work undertaken to create a standardised Adult Safeguarding app within the acute general hospitals and the development of a monthly Adult Safeguarding Hospital report, allowing service areas to review their adult safeguarding activity to identify trends and patterns, was reported last year. Within this reporting year we are pleased to report that this project was nominated for a BHSCT chairman’s award and was successful in winning first place in the category “excellent use of data”.

Further, the project was accepted for poster submission at the annual Regional Social Work Research Conference, held in Riddell Hall. The poster was voted by attendees as 3rd place poster; again, enhancing the profile of adult safeguarding.

Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and were introduced into Northern Ireland in December 2020. The purpose of a Domestic Homicide Review is to prevent future homicides and improve organisational response to victims of domestic abuse. They are also undertaken to help increase our knowledge and understanding of how domestic abuse occurs and what we can do to help. This is done by reviewing the circumstances leading up to a death and identifying opportunities for change.

Work in relation to DHRs is complex and intensive and has not come with additional funding.

This year BHSCT have:

- Implemented further mechanisms to ensure shared learning has occurred such as presentation at the Outcome Review Assurance Group, the Adult and Children's Safeguarding Committees, and at various support forums.
- Continued to monitor progress against actions agreed by the trust through regular meetings with applicable collective leadership teams.
- Aided staff understanding of the DHR process, using presentations and the creation of flowcharts to explain the DHR process and various BHSCT roles.

Integrated Care System NI

The Trust has recently begun implementation of the shadow Belfast Area Integrated Partnership Board (AIPB), with a move towards an Integrated Care System for Northern Ireland (ICSNI) commissioning framework. ICSNI is a strategic model introduced to transform how health and social care services are planned, managed, and delivered across Northern Ireland. It focuses on locality-based collaboration between health and social care providers, local communities, and service users to improve health outcomes, reduce inequalities, and deliver more person-centred care. The Belfast AIPB will advise on local commissioning of services, to better reflect needs and priorities of the Belfast population through use of population health data and evidence-based priorities.

Under ICSNI, commissioning will be increasingly focused on **outcomes** rather than activity, aiming to improve overall population health and wellbeing.

As part of the implementation process to the shadow Belfast AIPB, the Trust welcomed the provision of a Health Profile of the Belfast population, developed by the Public Health Agency (PHA). This measured deprivation using 2017 Northern Ireland Multiple Deprivation Measure (NIMDM). This is the official tool used to assess and rank the relative deprivation of areas across Northern Ireland, published by Northern Ireland Statistics and Research Agency (NISRA), it considers income and employment, health and disability, access to services, education and skills, living environment and crime and disorder.

Belfast population health profile

The PHA's health profile confirmed that health inequalities in Belfast are prevalent and reflect significant disparities in health outcomes, with Belfast being over-represented in both the most and least deprived Super output areas in Northern Ireland. With a more informed understanding of the current health needs of the people in Belfast, as well as the predictions of future demands, the Trust can plan more

effectively to face the challenges of keeping people healthy, providing high quality care when needed, and promoting equity of opportunity for the people we serve.

Thank You Video from Ms Sara Templar, BHSCT Risk & Governance Co-Director

In closing this year's Annual Quality Report, we want to reflect on the remarkable dedication, resilience, and compassion shown by our people in the Belfast Trust. Our successful roll-out of encompass in June 2024 was testament to the collective commitment of all our staff to work together to introduce a systemwide change. This was no easy task, but the benefits of that effort are clear. The advent of a single digital record for all patients and service users will impact on our ability to plan, evaluate, and improve our services – using real time data – for many years to come.

Our Health and Social Care system continues to face significant and evolving pressures across all our services. And yet, in this context of unrelenting challenge and change, it is your unwavering commitment to delivering safe, high-quality care that has never been more evident. Your consistency and your care have driven meaningful improvements, enhanced patient experience, and ensured that quality and safety remain at the heart of all we do.

The stories, data, and outcomes highlighted in this report are a testament to your professionalism and deep sense of responsibility. Each improvement made, each innovation developed, and each lesson learned is the result of your hard work, collaboration, and drive to do better—for patients, for families, and for one another.

On behalf of the Trust's leadership, thank you for your continued dedication. Let us take pride in what we have achieved together and let it motivate us to keep striving for excellence in the year ahead.

There is an interactive version of the Report HERE