

Recommendation	Trust Response
Leadership and Culture	
<p>The Trust should take action to address the perceived culture and focus of the Trust. This might include making a public commitment to clearly signal to staff and the community they serve, reasserting that patients, their families and their care and treatment are the primary focus of the Trust. (HSCB1)</p>	<p>The Trust acknowledges that for many staff, the perceived priority has been on targets and budgets. The Trust has in place regular ward and department level surveys of patient experience, and uses these to drive improvement. The Trust is considering further means to ensure that it is clear to staff and our community that excellent patient and client experience is the key result for all services.</p> <p>The Trust will bring forward a campaign and supporting projects on promoting the importance of excellent patient and client experience by June 2012.</p>
<p>Leaders in the Trust should consider how to promote respectful collaborative partnerships to support those at the front line to deliver that care, empowering and supporting staff to provide the best care and treatment possible, recognising and valuing every member of staffs' contribution to the safe effective patient journey. (HSCB2)</p>	<p>In the unscheduled care area, the Trust has established joint working arrangements to support teams at the important interfaces between community and hospital in relation to discharge management, and within the hospital setting in relation to admission and patient flow.</p> <p>The Trust has a program of support to facilitate clinical teams to agree 'always and never' behaviours.</p> <p>The key focus is on the development of respectful collaborative relationships that support teams to deliver the best possible patient experience.</p> <p>The Trust uses well-recognised 'Investors in People' (IiP) standards in training, staff development, leadership development and staff engagement processes. The Trust will develop a plan to pursue external IiP accreditation to further develop these processes, and to provide assurance that effective staff support and development are in place. Plan to be in place by</p>

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	<p>September 2012.</p> <p>We continue to have regular joint forums with our TU colleagues on a range of issues which include communication and engagement with staff.</p> <p>A broader Staff Engagement Strategy is being developed, and the Trust has undertaken an organisation-wide survey as first step, to inform that strategy.</p> <p>The draft strategy is currently under review by Trust staff and Staff-side colleagues. The strategy and a supporting plan will be in place by July 2012.</p>
<p>The Chief Executive and Senior Management Team should consider maximising their presence on the Antrim site through either relocation or increased senior team office space to allow the regular scheduling of work on site. (HSCB3)</p>	<p>The Trust accepts the needs for enhanced presence of very senior staff on the Antrim site. The Chief Executive has established an office on site to support an increased presence, and regular senior team meetings are scheduled on site.</p>
<p>The mechanisms used to support and engage medical staff, should be reviewed and strengthened as a matter of urgency. (HSCB4)</p>	<p>Following a previous independent review commissioned by the Trust, an action plan was put in place to improve the engagement of medical staff. A range of measures have been taken, including a review of the medical leadership posts, the development of support programmes for clinical leadership, and the development of additional fora and groups to take advice from medical staff on service management and development.</p> <p>The Trust senior team will take stock of the effectiveness and measures taken, and consider what further action is required by July 2012.</p>
<p>The Trust should ensure that all nursing staff have access to Practice Development support at ward level and have access to appropriate staffing levels. (HSCB5)</p>	<p>The Trust accepts the importance of practice development, and with the support of the HSCB, has already invested in practice development to ensure improved support to staff.</p>
<p>The Trust should review current managerial systems and processes used to ensure the maximum contribution of social work and allied health professionals to the patient journey.</p>	<p>The Trust supported by HSCB is supporting each ward team to focus on measures to improve the patient journey. Work has been completed in Wards A4 and C4 and is ongoing in B3 and C5.</p>

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(HSCB6)	<p>Every acute hospital ward will participate, and this will be completed by Dec 2012.</p> <p>Interface meetings between community and acute service staff to explore and resolve issues arising as patients move between hospital and community have been established and occur monthly.</p> <p>The Trust's Executive Director of Social Work is conducting a review of the interface between the hospital social work service and other disciplines as part of the patient journey between hospital and community services.</p> <p>Review to be complete by July 2012.</p> <p>The Trust continues to work with the support of expert facilitation from the RCN to support the development of the interface between patient flow and the other clinical teams. The review will be complete by July 2012, and will then form part of the established programme of support for ward sisters.</p> <p>A programme of multidisciplinary round table discussions have been established with ward based teams involving the Acute Director, the Medical Director and the Director of Nursing to identify further potential issues or improvements. These will be complete by June 2012.</p>
<p>The Trust should consider strengthening the working relationship between all hospital and community staff, to achieve a better understanding of challenges and opportunities and help achieve a shared patient/client focus, this could include for example, a review of the roles of the hospital and community social work teams to clarify responsibilities and maximise impact on patient flow into and out of the hospital. (HSCB7)</p>	<p>The Trust accepts the need to ensure strong and productive joint working for hospital and community based social work. The Trust's Executive Director of Social Work is conducting a review of the interface between the hospital social work service and other disciplines as part of the patient journey between hospital and community services.</p> <p>Review to be complete by July 2012.</p>

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Management of the Challenge	
The Trust led by the Human Resources Department, Professional Leaders and Staff Side Representatives should review support mechanisms available to staff and strengthen these where appropriate. (HSCB8)	The trust has a range of mechanisms in place to enable staff to work in an environment where they feel valued and supported. This includes the work referred to at HSCB 2 above. We will establish a review of current arrangements to bring forward plans to further enhance these by July 2012.
The Trust should consider the development of an engagement strategy which focuses on regular communications with all staff and other stakeholders. Where action to improve quality of care of services is taken as a result of this engagement the actions should be communicated with staff. (HSCB9)	The Trust has developed additional mechanisms to communicate with front-line staff and will review these as part of a revised communication plan by June 2012, in addition to communication with other stakeholders.
The management arrangements for Urgent Care should be reviewed and potentially changed. The Trust within the Northern Ireland system is in a unique situation in having responsibility for care in the hospital, social care and community care. These different parts of the care system appear to operate as separate units causing delays and duplication. A Senior Executive responsible for the whole patient journey should be able to improve the flow of patients through the system. (R2)	Following concerns on delays in inpatient admission in several Trusts, a regional programme of improvement has commenced that included nomination of a Senior Executive for the performance of unscheduled care. This is a short term process, and the Trust will review the success of the arrangements in place in July 2012, and consider a review of structures as part of that process.
The system of communication from the UCPB to front line staff should be reviewed. (HSCB10)	The Trust has developed additional mechanisms to communicate with front-line staff and will review these as part of a revised communication strategy by June 2012.
The Chief Executive should consider means to ensure that the Director of Nursing has the authority to manage the safe effective patient journey and address any barriers to quality care and following evaluation of impact give consideration to extending the SEPJ groups timeframe. (HSCB11)	<p>The Director of Acute is responsible for Unscheduled Care and the Director of Nursing has overall lead for Patient Experience. They will work together to progress improvements.</p> <p>The Trust will review the success of the arrangements in place in July 2012</p>

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<p>The Trust should consider means to strengthen the reporting framework in place to ensure the outcomes and challenges of both groups are reported to SMT and Trust Board to help ensure appropriate, sustained organisational focus on this challenge. (HSCB 12)</p> <p>The NHSCT Board should be provided with a specific board paper every month on urgent care and the performance in A&E. (R4)</p>	<p>Unscheduled Care is debated in depth at each Board meeting, and at SMT meetings.</p> <p>During a workshop held with Trust Board executives and non-executives to review the reports, the proposal for a dedicated Board report was noted and welcomed.</p> <p>Revised reporting requirements will be implemented and new reporting in place for August Trust Board.</p>
<p>The Trust should consider mechanisms to report performance and progress to patients, their families and staff. (HSCB13)</p>	<p>A revised Communication strategy will be developed and implemented by end June 2012. A review will take place by end Sept 2012.</p>
<p>The Trust should simplify processes and explore, with staff, the use of ICT solutions to some of the challenges faced to reduce the reliance, where possible, on paper based working practices. (HSCB14)</p>	<p>Systems in place elsewhere in N Ireland are being reviewed to identify best practice for implementation in the NHSCT.</p> <p>Work is progressing with HSCB staff on linking acute and community systems to enable improved information to front line staff in community to support discharge planning.</p> <p>Priority areas for improvement will be agreed and enhanced ICT systems implemented from July 2012 onwards.</p>
<p>The Trust should continue its investment in the development of these staff alongside the ward sisters which is essential to improving working relationships. (HSCB15)</p>	<p>The Trust is working with RCN to support the development of the interface between the patient flow team and other clinical teams.</p> <p>This process will be complete by July 2012 and will then form part of the established programme of support for ward sisters.</p>
<p>The Trust should give consideration to the Patient Flow and associated teams transferring to the Director of Nursing. (HSCB16)</p>	<p>The Trust is reviewing current management arrangements and will conclude this review by June 2012.</p>
<p>The Trust should examine mechanisms which link together</p>	<p>The Trust has embarked on a detailed programme to monitor patient</p>

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<p>patient satisfaction with staff satisfaction. This information should be shared with the Trust Board, SMT, staff and their representatives, patients and their families. (HSCB17)</p>	<p>experience and these reports are presented to SMT and to Trust Board.</p> <p>Patient experience is also reported to Unscheduled Care Action Plan Steering Group. The Trust will consider means for communication with other stakeholders as part of the revised Communications Strategy by June 2012.</p>
<p>The Trust should consider creating further opportunities for GPs and Hospital staff to come together to learn, debate and discuss issues of common concerns or interest. (HSCB18)</p>	<p>***</p> <p>This will be progressed via improved communication with hospital medical staff and improving the mechanisms for communication between primary and secondary care clinicians, to include a shared education programme.</p> <p>The revised communication plan to be complete by June 2012 will include GP engagement.</p>
<p>Building on the work progressed to date, the Trust should undertake a series of round table discussions, on a ward by ward basis and involving all professions, to identify and address local communication issues. The Trust should give consideration to using external facilitation to support this work. (HSCB19)</p>	<p>The Trust supported by HSCB is supporting each ward team to focus on measures to improve the patient journey. Work has been completed in Wards A4 and C4 and is ongoing in B3 and C5.</p> <p>Every acute hospital ward will participate and this will be completed by December 2012.</p> <p>The Medical Director and the Director of Nursing to identify further potential issues or improvements. These will be complete by June 2012.</p>
<p>The development and implementation of pathways should be managed in a phased way to maximise multidisciplinary engagement and enable pathways to be tested and adapted as required. (HSCB20)</p> <p>Careful introduction of a small number of Ambulatory Care Pathways. Too many were developed to be practical to implement. The setting of these pathways should be carefully examined as often the care can be safely delivered</p>	<p>Work has progressed on the development of pathways within secondary care. A proposal has been made to the HSC safety forum for a collaborative approach to further develop pathways with primary care. This work will be taken forward through the joint Trust/Local Commissioning Groups Professional Advisory Groups which established in February 2012.</p> <p>The establishment of these joint Professional Advisory Groups has supported improved joint working between primary and secondary care.</p>

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<p>away from the A&E in the community or a different part of the hospital. Lessons learned from the introduction of the Early Pregnancy Unit and elsewhere in the UK should be used in this work. (R10)</p>	<p>The current GP/ Trust ambulatory care pathways are being reviewed and will be further developed by Sept 2012.</p>
<p>The work progressed to date should be shared with staff and key stakeholders and any positive or negative impacts discussed and resolved in a collegiate way with a focus on what is best for patients. (HSCB21)</p>	<p>A 'referral hub' working group, jointly chaired by a Trust clinician and a GP will review mechanisms to improve GP access to consultants for advice and guidance, and streamlined patient referral.</p> <p>The Trust has developed additional mechanisms to communicate with front-line staff and will review these as part of a revised communication plan by June 2012, in addition to communication with other stakeholders.</p>
<p>The Trust should agree a medical recruitment plan, exploring all options both medium and long term. This recruitment strategy should be informed by information gleaned from exit interviews, and feedback from medical staff in training. (HSCB22)</p>	<p>The Trust explores all possible mechanisms to fill medical vacancies. This has included consultant interviews following national advertisement in recent weeks.</p> <p>Further discussions will take place with NI Medical and Dental Training Agency regarding recruitment options, and a recruitment plan prepared and implemented. Feedback will be sought through exit interviews and from staff in training. Recent feedback from staff in training has been positive.</p>
<p>The Performance Management and Service Improvement Team of the HSCB should work with the Trust to complete an audit of patient moves in the hospital to quantify the scale of the issue and report to the Safe Effective Patient Journey Group. If necessary a review of the current admissions process involving all sub specialities should be conducted. (HSCB28)</p>	<p>Regular audits are undertaken. The Trust will Review the evidence from these audits and consider the potential to alter the management of admissions – June 2012.</p>

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A review of the practical out workings of the Trusts' model of 7 days working which has commenced should be completed to ensure value for money, impact and harmonisation of the multidisciplinary teams efforts. (HSCB29)	<p>7 day working is in place in a number of disciplines throughout the Trust however this is not universal and the Trust is currently scoping the further extension of 7 day working across multi disciplinary teams to ensure the reduction in delays in services to patients over the weekend period are realised.</p> <p>An interim report by October 2012.</p>
The Trust needs to further develop new joint solutions to facilitate safe discharge bringing hospital and community staff together. This work needs to be incorporated into the overall performance framework of the UCPB and Safe Effective Patient Journey Group to ensure all staff are held to account for actions taken. (HSCB30)	Recommendation accepted and improvement processes are underway. The actions being undertaken are set out in response to recommendations HSCB 2, 6 and 7 above.
The Trust should concentrate on improving the planning for discharge an element of which is the further promotion of nurse led discharge. (HSCB31)	The Trust has had a long-standing focus on nurse-led discharge. We will work towards increasing nurse led discharge on both sites to achieve a 20% target across the Trust. Plans are prepared and implementation underway. Proportionate improvement targets have been set for every ward following discussion between the Ward sister and the Director of Nursing. All wards are now receiving regular feedback, and good progress is being made.
<p>The SEPJ Group should review the current internal performance indicators and consider including elements such as:</p> <ul style="list-style-type: none"> ▪ Targets for each ward to maximise the discharges before 1pm. ▪ Evaluation of the hospital based patient transport service. ▪ Evaluation of the impact of pharmacy on delayed discharges. (HSCB 32) <p>The discharge team in the hospital should be given more</p>	<p>Good progress has been made between January and April in increasing discharges prior to 1pm. This will be reviewed by the Rapid Discharge team on a weekly basis. Changes to pharmacy processed have started to support timely discharge. Monitoring is in place to measure improvement of pharmacy changes on discharge process.</p> <p>Local Transport service has been enhanced (from February 2012) and monitoring to take place to monitor impact on discharges every month. Further liaison with NIAS required and will be take place by end June 2012.</p>

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power to demand more rapid response times from pharmacy, transport and social care, all of which are cited as reasons for delayed discharge. (R9)	
The Multidisciplinary team should review the referral systems and consider that rather than medical/surgical consultants determining the wider needs of patients, the ward sister should determine which assessments (AHP/Social Care) will be/are required once the patient has been deemed medically fit. (HSCB33)	An audit of the wards will be taken forward to establish a baseline position and to identify opportunities for improvement in the assessment process. Actions will be progressed from the audit and monitored to track improvements.
Long waits for elective care are compounded by the lack of direct access diagnostics. Urgent direct access should be established. These patients are having an unnecessary outpatient attendance. (R7)	<p>We will discuss with Northern LCG colleagues to agree priority areas for improvement. The Trust will then implement agreed areas for direct access by Sept 2012.</p> <p>A range of direct access services are in place or in discussion with GPs. A pilot to give access to MRI for knees has been in operation since April. Echo & 24hr tape access will commence in August.</p> <p>A pilot direct reporting of X-rays is in place and will be discussed with the Local Commissioning Group for rollout by end June 2012.</p>
Accident & Emergency	
The Trust should ensure mechanisms are in place to support those staff currently working in the Accident & Emergency environment. (HSCB23)	<p>The Trust is taking forward and ED quality improvement plan in liaison with the College of Emergency Medicine. A peer group is to be agreed. This plan will address the need to support staff working in the department.</p> <p>The project will be implemented using short timeline 'plan, do, study, act' (PDSA) cycles (pilot in Antrim).</p> <p>A range of mechanisms to support nursing staff has commenced, including an RCN supported Practice Development programme for Accident &</p>

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	<p>Emergency staff, and the recruitment of band a senior professional nursing lead.</p> <p>NIMDTA has just reviewed the quality of placements for junior doctors in ED in Antrim – verbal feedback was positive and Trust will implement recommendations once formal report received.</p>
Commissioners in partnership with the Trust should complete the nursing workforce exercise currently ongoing and thereafter, the Trust should bring forward an implementation strategy. (HSCB24)	Workforce exercise is complete and implementation is underway. 40 permanent staff have been recruited.
The Trust should develop an escalation procedure to enable additional nursing staff to be accessed when the department is required to care for patients delayed in Accident & Emergency. (HSCB25)	Escalation procedure has been developed and will be evaluated by Sept 2012.
The Trust should facilitate a multi-disciplinary group to review and if necessary adjust the current working practices in A&E. This group should ensure all staff feel they have a voice in the design and delivery of services and should facilitate the views of patients and users of the service. (HSCB26)	<p>The Trust is taking forward an ED quality improvement plan in liaison with the College of Emergency Medicine. A peer group is to be agreed. This plan will address the working practices in the department.</p> <p>The project will be implemented using PDSA Cycles (pilot in Antrim).</p> <p>A range of mechanisms to support nursing staff has commenced – RCN supported Practice Development programme, recruitment of band 8a professional nursing lead for Directorate.</p> <p>NIMDTA has just reviewed the quality of placements for junior doctors in ED in Antrim – verbal feedback was positive and Trust will implement recommendations once formal report received.</p>
The implementation of the Manchester Triage system in A&E is a matter for immediate attention to ensure patient safety. Following triage, patients should be reviewed and monitored	A protocol has been developed to guide and support reassessment of patients to include physiological assessment and pain scoring. Staff will be trained and protocol implemented. We will audit the service to seek

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to ensure that no patients fall through this safety net. Care following triage should also include a more holistic approach to ensure that fundamental human needs are delivered while patients are waiting. (R1)	assurances on quality of care by Sept 2012.
The completion of the Peer Review Report on the Emergency Department by the Royal College of Emergency Medicine should be progressed and the identified recommendations implemented in a timely fashion, in order to deliver necessary service improvements. (R3)	<p>The Trust is taking forward an ED quality improvement plan in liaison with the College of Emergency Medicine. A peer group is to be agreed. This plan will address the working practices in the department.</p> <p>The project will be implemented using PDSA Cycles (pilot in Antrim).</p> <p>Detailed Gantt chart has been prepared.</p>
Closer working of the A&E team with other specialist teams in the hospital needs to be fostered to reduce unnecessary repeat admission for common problems such as abdominal pain, retention of urine and the placing of patients directly onto elective waiting lists. (R11)	This work will be taken forward by the recently established Trust and Primary Care jointly chaired referral hub group.
Community	
There should be a review of the large number of intermediate and step-down beds with a clear vision of the best solutions for care for these types of patients. Buildings should not be the holy grail; it should be the quality of outcomes and care. Much of the evidence worldwide would support home community packages of health and social care as more appropriate and better value for money. This is not to say that many of these beds do not have a useful function. Improved Monitoring and assessment of the performance of this large resource as a baseline would be the first step. (R15)	The performance and contribution of these beds is closely monitored by the Unscheduled Care Program Board, including admissions rates, length of stay, and discharge settings. The Trust, with the HSCB, is implementing a revised medical model to provide additional cover to these Intermediate Care beds. The Trust is preparing plans for these beds into the future and a paper will be ready for review by July 2012.

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Hospital – Primary Care interface	
<p>Hospital clinical staff and general practitioners should be enabled to focus on developing an alternative service for the frail elderly at night and end of life care as a first step towards achieving a shared vision for services for this key group of patients. This work could link with the pathway development due to be facilitated by the HSC Safety Forum and the work already progressed by the Dalriada Urgent Care Service. (HSCB27)</p>	<p>Trust will work with HSCB and LCG to develop and implement a Virtual community Ward model. Timescales are under discussion with HSCB colleagues.</p>
<p>NHSCT and primary care colleagues should agree key performance indicators with the HSCB. These indicators should show measurable improvements within a 3 month period. With the work which the hospital has already undertaken and has agreed to undertake with the help of a committed group of clinical staff from both primary and secondary care, I believe that NHSCT has the capability to show significant improvement. (R5)</p> <p>The development of clinical dashboards in primary care within a learning environment can improve care, improve health and reduce clinical variation and should be explored. (R16)</p>	<p>The Trust will liaise with HSCB staff agree Key Performance Indicators to monitor the agreed action plan. The trust will review the data collection required to capture base data for KPIs. KPI report will be prepared and issued on a regular basis to support monitoring of action plan.</p> <p>The Trust will support the HSCB on the development of a clinical dashboard in primary care.</p>
<p>Evidence from GP's and Consultants of waits of over 6 months for routine letters and only 50% of casualty letters being checked for accuracy are poor and is unacceptable. Immediate action should be taken to resolve this problem. The opportunities for errors due to this situation can only lead to putting patients at risk. The Trust has informed me that action is being put in place to resolve this situation.</p>	<p>The Trust has put steps in hand to secure early improvement in the quality of discharge letters, and to improve the quality of interim discharge information from the Emergency Department.</p> <p>An improvement plan to track delays and further improve performance will be agreed by June 2012. Audit of the quality of discharge letters is undertaken and regularly reported to identify further improvements.</p>

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<p>Sharing of knowledge and development of working relationships between GPs and secondary care clinicians should be facilitated further and the work of the GP Forum to be fully supported.</p> <p>A mechanism for streamlining communication across the primary secondary care interface should be developed, with a safe email system for correspondence considered as one potential mechanism. (R8)</p>	<p>Joint primary/secondary care educational events to be organised (Sept 2012).</p> <p>Professional Advisory Groups (specialty based primary/secondary care groups) have been set up and will be developed over the next 6 months.</p> <p>A pilot email communication system has been carried out in one department and this will be rolled out to the other departments by Sept 2012.</p>
<p>Work needs to be done across primary and secondary care to identify those patients with multiple complex needs, with several long-term conditions, who are often vulnerable due to cognitive impairment. These are the patients with repeated admissions and where personal care plans and specialist team working from a multidisciplinary team in the community can dramatically improve care and reduce admission. One area to start with would be nursing home patients but this should then be extended. (R13)</p>	<p>Trust will work with HSCB and LCG to develop and implement a Virtual community Ward model. Timescales still to be confirmed.</p> <p>The development of ICPs to take forward management of long term conditions will support the care of patients in the community.</p>
<p>Direct access for GP admissions through the junior members of the specialist teams. When beds are not available the decision should be given to the GP as to whether A&E admission is now more appropriate or if the patient can wait at home for a bed to become available. (R6)</p>	<p>Implement rapid access to OPD to prevent attendance in ED or MAU - a small targeted number of OPD slots to prevent admissions in medical specialties. Direct access for medical admissions and GP telephone support will be implemented. Implementation will be phased in. Meeting with HSCB, LCG and Trust staff took place 16 May 2012. Formal 'referral hub' project structure to be established and co-chaired by PCP lead and Trust senior manager. Timescales to be confirmed by this group.</p>
Quality	
<p>The Trust should consider mechanisms to improve the patient experience such as the IHI innovation Series.</p>	<p>This is accepted, please see response to HSCB1.</p>

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Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care. (HSCB33)	
The Complaints and Critical Incident Systems need to be reviewed so that the whole system across primary and secondary care learns from the problems encountered by individual patients. This needs to take place within a learning culture where those working in the system can see clearly how the system is learning and improving. Examples of excellent practice exist elsewhere. (R14)	Review Complaints and Critical Incident Systems to increase learning leading to service improvement. A joint review by the Trust and HSCB review of the current system commenced in March.
Care for all cases when AAH is unable to provide the definitive hospital care should be reviewed by the HSCB and urgent commissioning action taken to improve the situation. This is a particular problem with Orthopaedics when a patient presenting with a fractured neck of Femur is first sent to Antrim which has no Orthopaedics service. The patient waits for an ambulance, waits in Antrim to be seen, waits to be transferred, waits to be seen in Belfast, and waits for surgery in Belfast. All this leads to unacceptable delays, resulting in the real risk of poor outcomes for patients.	The Trust will work with HSCB and BHSCT staff to develop improved patient flow processes so that delays are minimised.