Western Health and Social Care Trust

ANNUAL QUALITY REPORT 2025/2026















Chief Executive's Foreword



It is my pleasure to present the 14th edition of the Western Health and Social Care Trust's Annual Quality Report 2025-26, which highlights the work undertaken across the Trust to improve the quality, safety and experience of care for the population we serve.

This report demonstrates our continued commitment to delivering services that are safe, effective and person-centred. It reflects the dedication, professionalism and compassion shown every day by our staff, service users, carers, volunteers and partners. Despite ongoing challenges facing health and social care services, our teams have remained focused on improving outcomes, listening to those who use our services and ensuring that quality remains at the heart of everything we do.

Throughout 2025-26, we have continued to strengthen our culture of learning, openness and continuous improvement. The report highlights progress across a wide range of quality improvement initiatives, patient and client experience work, staff engagement programmes and safety improvement activities. We have also continued to develop our approach to co-production, recognising the value of working in partnership with service users, carers and communities to design and deliver services that meet their needs.

We are encouraged by the achievements described within this report, including improvements in patient safety, staff development, innovation and collaborative working. These successes have been made possible through the commitment of colleagues from across the organisation who strive every day to provide high-quality care and support.

At the same time, we recognise that there remain areas where further improvement is required. We are committed to learning from incidents, feedback, complaints and compliments, and to using this information to drive meaningful and sustainable change. Quality improvement is an ongoing journey, and we remain determined to build on our progress while addressing the challenges that lie ahead.

On behalf of the Trust Board, I would like to sincerely thank all staff, service users, carers, community representatives and partner organisations for their contribution during the year. Your dedication, insight and support continue to help us improve the services we provide and make a positive difference to the lives of those who rely on them.

I commend this report to you and invite you to learn more about the work undertaken across the Trust to improve quality and outcomes for the people and communities we serve.

Karen Hargan
Chief Executive
Western Health and Social Care Trust

CONTENT

WHAT IS THE ANNUAL QUALITY REPORT? Page 6
ABOUT THE WESTERN HEALTH & SOCIAL CARE TRUST (WHSCT) Page 6
WHSCT SERVICES AT A GLANCE Page 8
WHSCT STRATEGIC PRIORITIES Page 9

THEME 1: TRANSFORMING THE CULTURE

- Trust Vision and Values Page 11
- Staff Culture Survey Page 11
- Team Development and Team Support Page 12
- Flexible/Agile Working Culture Page 12
- Staff Equality, Diversity & Inclusion Page 13
- Patient and Client Experience Page 13
- Personal and Public Involvement (PPI) Page 15
- Complaints and Compliments Page 19
- Learning From Incidents Page 24
- Leadership Safety Culture Walkrounds Page 28
- Quality Improvement Page 29

THEME 2: STRENGTHENING THE WORKFORCE

- Induction Page 33
- Leadership Programmes Page 33
- Learning & Development Page 33
- Coaching and Mentoring Page 33
- Supervision Page 35
- Staff Achievements Page 46
- Looking After Our People Page 50
- Revalidation Page 52
- Mandatory Training Page 54
- Staff Training Page 54

THEME 3: MEASURING THE IMPROVEMENT

- Reducing Healthcare Associated Infections:
  - Methicillin Resistant Staphylococcus Aureus (MRSA) Page 61
  - Clostridium Difficile Associated Disease Page 62
  - Healthcare-Associated Gram-Negative Bacteraemia Page 63
  - Methicillin Sensitive Staphylococcus Aureus (MSSA) Page 63
  - Hand Hygiene Page 64
  - Orthopaedic Post-Operative SSI Surveillance Page 64
  - Caesarean Section Post-Operative SSI Surveillance Page 65
  - Breast Post-Operative SSI Surveillance Page 67
  - Critical Care Device-Associated Infection Surveillance Page 67
- Safer Surgery – WHO Surgical Safety Checklist Page 67

- Maternity Quality Improvement Page 68
- Paediatric Quality Improvement Page 70
- Falls Page 78
- Pressure Ulcers Page 80
- Preventing Venous Thromboembolism (VTE) Page 85
- Medicines Management:
  - Medicines Reconciliation Page 85
  - Insulin Safety Page 86
  - Omitted and Delayed Doses Page 87
- Reducing Cardiac Arrest Rates in Hospital Page 88

THEME 4: RAISING THE STANDARDS

- Emergency Department:
  - 4 Hour & 12 Hour Standards Page 91
  - Unplanned Re-attendance Page 92
  - People who leave without being seen Page 92
  - Actions taken to improve the provision of emergency care Page 92
- Mortality Ratio and Emergency Readmission Rates Page 93
- NICE Guidelines and Ensuring Compliance Page 93
- National Audits Page 94
- Access and Performance Targets
  - Performance Overview Page 98
  - Cancer Services Page 102

THEME 5: INTEGRATING THE CARE

- Community Care – Supporting People in the Community:
  - Community Discharge Co-ordination Team Page 106
  - Reduced Dementia Assessment Waiting Times Page 106
  - Homecare Optimisation Project Page 106
  - Community Respiratory Team Page 106
  - Review of Older People's Social Work Service Page 107
  - Primary Care Page 107
  - Early Frailty Intervention Team (EFIT) – Co-operation and Working Together (CAWT) Peaceplus Frailty Intervention Project Page 107
  - Advanced Nurse Practitioner in Specialist Palliative Care Page 108
  - Stoma Health & Preventative Exercises (SHAPE) Page 108
  - Community Equipment & Continence Home Delivery Service Page 108
- Mental Health:
  - Regional TOWARDS ZERO SUICIDE PROGRAMME 2026-29 Page 108
  - Suicide Prevention Care Pathway (SPCP) Page 109
  - Safety Planning Page 109
  - Early Post Discharge Page 109
  - Minimising Restrictive Practice Page 109
  - SafeWards Model Page 109

- Implementation of Regional Post-incident Debrief/Defusion Principles Page 110
- Workforce Page 110
- AMHDS Psychiatry Workforce Page 110
- Mental Health Improvement Board July 2026 Page 111
- Recovery Services Page 111
- Crisis Planning Page 113

- Social Care Indicators:
  - Children & Young People Potentially at Risk Page 117
  - Looked After Children Page 118
  - Young People Leaving Care Page 118
  - Adult Social Care Indicators Page 119
  - Direct Payments Page 119
  - Mental Health Page 119
  - Learning Disability Page 120

NEXT STEPS Page 121

WHAT IS THE ANNUAL QUALITY REPORT?

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

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

The report is divided into the following sections in line with the Quality 2020 strategy:

- **Transforming the Culture;**
- **Strengthening the Workforce;**
- **Measuring the Improvement;**
- **Raising the Standards;**
- **Integrating the Care.**

ABOUT THE WESTERN HEALTH & SOCIAL CARE TRUST (WHSCT)

The Trust is a statutory body which is responsible for the delivery of safe and effective health and social care services to a population of approximately 300,000 people across the western part of Northern Ireland, covering an extensive rural and urban geography. The Trust also provides a range of specialist acute services to the population of the northern part of the Northern Trust area, and to people in north Donegal through specific commissioning arrangements. The Trust employs approximately 12,480 staff (2024/25: 12,065 staff approx.). The Trust provides services across 4,842 sq. km of geography and delivers services from a number of hospitals, community-based settings and directly into individuals' homes.

- Acute hospital services are delivered in Altnagelvin Hospital and the South West Acute Hospital (SWAH).
- Omagh Hospital and Primary Care Complex (OHPCC) provides a range of rehabilitation and palliative care hospital services as well as locally based diagnostic, urgent care and community support services.
- Lakeview (a learning disability hospital), Grangewood (a mental health inpatient unit), and Waterside Hospital (a rehabilitation and mental health facility for older people) are all located in Gransha Park.
- The Tyrone and Fermanagh Hospital provides a range of acute mental health inpatient services for adults and older people.

- Social services and many other Trust services are delivered in community-based settings, often in partnership with organisations in the private, community and voluntary sectors.

This comprehensive range of services is provided through the following Operational Service Directorates:

- Adult Mental Health and Disability Services
- Children and Families
- Community and Older People's Services
- Unscheduled Care, Medicine, Cancer and Clinical Services
- Surgery, Paediatrics and Women's Health

The Operational Service Directorates are supported by the following Corporate Directorates:

- Chief Executive's Office
- Performance, Planning and Corporate Services
- Finance, Contracts and Capital Development
- Human Resources and Organisational Development
- Medical Directorate
- Nursing, Midwifery and Allied Health Professionals

Further information on the services provided by the Trust can be obtained from the website: https://westerntrust.hscni.net

Our Services at a Glance

We Deliver Services From:

- 7 Hospitals
- 8 Children's Homes
- 1 Hostel
- 12 Administration Hubs
- 11 Health Centres and Clinics
- 30 Day Care Centres
- 6 Training Centres
- 8 Residential Homes

We Provide Support to People in our Communities Through Approximately:

- 1,800 Residential & Nursing Home Placements
- 3,700 Domiciliary Care Services to People in Their Home
- £4.5 Million Annually spent on Community Equipment
- 218,000 Community Allied Health Professional contacts e.g. Physiotherapy, Occupational Health
- 96,000 Mental Health Outpatient Contacts
- 218,000 District Nursing Contacts
- 17,000 Social Work contacts
- 4 GP Practices

Each Year in our Hospitals we Handle Approximately:

- 55,000 Hospital Admissions
- 32,500 Day Cases
- 3,300 Births
- 23,000 Regular Day Attenders
- 126,000 Emergency Department Attendances
- 345,000 Outpatient Appointments
- 314,000 Imaging Tests

Western Health and Social Care Trust

we are west
Caring together
Committed to better

OUR STRATEGIC PRIORITIES



Quality & Safety

We put patients and service users at the heart of everything we do and provide care to the highest standard focusing on quality and safety.



Our People

We strive to be a place where we attract, retain and develop compassionate and talented people, creating an environment where they can thrive.



Performance & Access

We strive to achieve and maintain high levels of performance using our resources as effectively and efficiently as possible to improve access to our services.



Delivering Value

We aim to achieve financial stability through sound financial governance and effective use of our resources to deliver greater value and efficiency.



Our Culture

We are committed to a culture which is open, just and always learning.

Theme 1

Transforming the Culture



Trust Vision and Values

The Trust mission and vision, which is set out below, links directly to the HSC core values and has been incorporated into the Trust's three-year Corporate Plan for 2024 to 2027.



Staff Culture Survey

The Trust undertook a Staff Culture Survey in 2025 and received 3,008 responses (24.6% of staff – an increase of 4.9% from 2024). The two areas of focus were staff engagement and psychological safety. Engagement looked at the areas of involvement, advocacy and motivation. Psychological safety asked staff how they feel about sharing concerns, questions and ideas. The results were as follows:

Staff Survey Factor	Score (1- 5)2025	2024
Engagement Score	3.60	3.60
Psychological Safety Score	3.49	3.47

As this is the second Western Trust Culture Survey the organisation now has comparable data from 2024. Engagement remained the same overall and Psychological Safety declined slightly but remained stable overall. The full survey outcomes were shared at all staff forums and formal training programmes including CMT, Trade Union Consultation Group, Senior Leaders Forum, Clinical Lead Induction, Leader and Manager Framework and at all Directorate SMTs. Open staff sessions are planned in Summer 2026 to allow staff at all levels to hear about the feedback and next steps. Each Directorate has received a specific Directorate level report covering key insights and recommendations.

Engagement and Involvement continue to be a core module within the Leader and Manager Framework programme promoting the importance of engagement in developing leaders. The Trust continues to operate the Senior Leaders Forum on a bi-monthly basis. This forum provides an opportunity for engagement for senior leaders across the organisation. A coaching network has been established over the past 2 years and is available to all staff in the Trust to support culture change. In addition, group mentoring has been included in the

Leader and Manager Framework programme levels 2 & 3, with level 3 participants having access to the Trust Non-Executive Directors for their group mentoring sessions.

Team Development and Team Support

The Organisation and Workforce Development (OWD) team provide team building and support sessions to any team within the Trust who need either of these services.

- **Team Building** aims to strengthen teams enabling staff to work well together with improved communication, collaboration, and camaraderie which can ultimately increase engagement, productivity and performance. During 2025/26 the OWD team facilitated 12 sessions, covering 5 teams; attended by 252 staff.

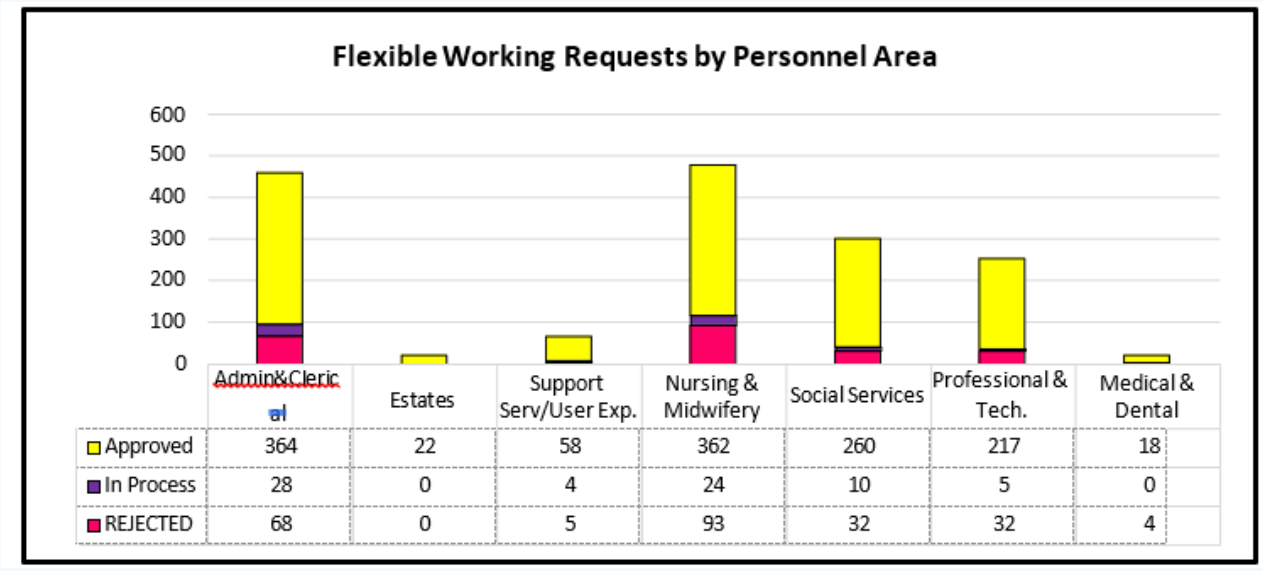
- **Team Support** provides a range of interventions to support teams in a challenging environment to continuously improve services. Bespoke intervention over a 6 month period supports teams to manage challenges, achieve goals, develop and continuously improve performance. During 2025/26 the OWD team facilitated team support sessions with 17 teams across 29 sessions supporting 381 staff.

Flexible/Agile Working Culture

The Trust continues to foster a positive and well-embedded culture of flexible working. Following the successful implementation of the WHSCT Flexible Working Policy in 2022/23, aligned to the updated Agenda for Change Terms and Conditions, the Trust has seen sustained and significant interest in flexible working arrangements across the workforce.

2025/26 applications represented the highest number of applications received indicating an increased appetite for flexible working from staff.

- 1606 Flexible working applications were submitted by 1279 individual staff between 1st April 25 and 31st March 26.
- This is an increase when compared to 1300 applications (amended to include off-line flexible retirement applications) received in 24/25 and represents the highest number of applications received in-year since the update to AFC Section 33.



	Admin&Clerical	Estates	Support Serv/User Exp.	Nursing & Midwifery	Social Services	Professional & Tech.	Medical & Dental
Approved	364	22	58	362	260	217	18
In Process	28	0	4	24	10	5	0
REJECTED	68	0	5	93	32	32	4

Staff Equality, Diversity & Inclusion

During 2025/26, the Trust continued to integrate the principles of Equality, Diversity, Inclusion & Belonging into the Trust's management development programmes via a dedicated EDIB session within Levels 1-3 of the Leader & Manager Framework.

The Trust launched its **Inclusion Calendar** to celebrate diversity and foster a sense of belonging throughout the Trust. Developed in partnership with Human Resources and the Ethnically Diverse Staff Network, it shines a light on important dates, helping staff feel informed, valued, and connected as part of a caring community.



The Trust held **free family events** in November 2025 and March 2026, organised by the Ethnically Diverse Staff Network with local councils. These gatherings encouraged community and celebrated cultural diversity within the Trust.



In March 2026, during Neurodiversity Celebration Week, the Trust's Human Resources Equality and Diversity Team launched its first **Neurodiversity at Work Toolkit**. This resource aims to raise awareness, improve team understanding, and support neurodivergent colleagues by addressing workplace challenges and providing practical solutions. The team also developed a Workplace Adjustment Plan Tool to help managers discuss and implement work supports or adjustments, which is now used regionally with the new Attendance Policy.



Throughout the year, EDIB staff continued to lead the dedicated WHSCT **Domestic Violence Staff Support Service** and to ensure the circulation of regular Trust communications to raise awareness of domestic and sexual violence and abuse and deepen understanding of supporting colleagues who experience this at home.

PATIENT AND CLIENT EXPERIENCE

Patient and Client Experience remains a key driver of quality improvement across the Western Trust. The patient and client experience team are now at full complement of staff following the appointment of a second Patient and Client Experience Facilitator in October 2025. During 2025-26, patient feedback collected through Care Opinion and the 10,000 More Voices programme informed service improvements, supported organisational learning and strengthened person-centred care across a range of services.

From the 1st April 2025 to 31st March 2026 there were *1,136 stories* (previous year 23-24 1,262 stories) posted on Care Opinion with 5 stories retracted averaging 86 stories per month with 154,168 public views and a 96% response rate. Staff are encouraged to respond in a timely manner as it is well evidenced that this approach leads to better outcomes and patient satisfaction.

Over the last six years, there has been a consistent yearly increase in extremely positive stories totalling 4,607 equating to 85% of all stories published relating to the Western Trust.

The number of strongly critical stories has decreased by one during the same reporting period to a total of four, compared to the last reporting period in 2024-2025.

Themes emerging from more critical feedback included communication, waiting times, staff attitude and behaviour, access to care, discharge information and the quality of treatment received. These themes continue to inform local quality improvement initiatives across the Trust, pressures within Emergency Departments, challenges accessing appointments, workforce pressures, concerns regarding quality of care and feeling unheard or excluded from decisions.

The Western Trust continues to show commitment to hearing, listening and prioritising the service user voice at every level evidencing this within the 24 stories which have led to either change planned and/or made. Examples of changes include enhanced communication and patient information, environmental improvements within clinical areas, improvements to meal choice and patient comfort, changes to maternity service access arrangements and service improvements supporting dementia care.

Responder training including refresher training for responders is facilitated by the Patient Client Experience team via face to face / virtual or hybrid methods. Subscription data cleanses continue biannually to ensure efficiency of the contracted subscriptions. To date there are 683 of the 750 subscriptions across Directorates that are either readers of stories or responders.

Use of Care Opinion within the Trust

Care Opinion reports contribute to the Trust's governance, assurance and equality responsibilities. Feedback is routinely reviewed to identify areas of excellence, monitor emerging concerns and support compliance with statutory equality and good relations duties. Reports are also submitted and analysed at Trust governance and accountability forums such as assurance and accountability to identify areas of excellence and where improvements may be required.

Over the past year, Care Opinion feedback has been used to influence projects within the Trust for example review of the current visiting policy as well as strategic direction within nursing and midwifery in regards to Fundamentals of care. Staff are also encouraged to use Care Opinion feedback as part of evidencing within the appraisal, revalidation and supervision processes.

Currently there are two 10,000 more voices live Projects within the Western Trust. Shared decision making and My experience of using equipment to help me live better. Both projects are live until August 2026 with sharing of results and action plan for service improvements to follow.

Other patient experience related work

Over the past twelve months the Patient Client Experience (PCE) Lead has participated in one corridor care audit, review of the current visiting policy in partnership with staff and service users, co-designed three patient information leaflets alongside services and service users, created nine MS forms for seven different services and continues to support staff and service users on an ad hoc basis regarding queries, concerns or where support is required.

The PCE team continue membership within many Trust forums to include Improvement Through Involvement, EPCO, End of life care in the hospital setting, Falls Prevention,

Fundamentals of Care Group, Disability Action Group, Engagement and Involvement Forum, Sharing for Improvement, MyCare Trust Group, QI west connect and the Trust PPI Champion Forum, The Nursing and Midwifery Group. Membership of these forums is important to ensure the service user voice is heard, prioritised and a part of everything that we do.

Patient and Client Experience activity continues to ensure that the voice of patients, service users and carers remains central to service development, quality improvement and decision-making across the Trust. Feedback gathered through Care Opinion and 10,000 More Voices has informed both local service improvements and strategic initiatives, supporting the Trust's commitment to person-centred care.

PERSONAL & PUBLIC INVOLVEMENT (PPI)

The Trust remains committed to ensuring that service users, carers, staff and members of the public have meaningful opportunities to influence its work. Personal and Public Involvement (PPI) is integral to the planning, delivery, evaluation and improvement of services and is an important means of addressing health inequalities and responding to the diverse needs of the population served by the Trust.

Throughout 2025/26, the Trust continued to strengthen the structures, processes and skills needed to embed involvement and co-production across the organisation. There has been a particular focus on strengthening lived-experience representation, improving monitoring and assurance and ensuring that involvement influences policies, action plans and strategic decisions.

Five Standards

Leadership

The Trust has an established leadership framework for PPI, with responsibility for involvement positioned at both strategic and operational levels. This enables involvement priorities to be aligned with the Trust's corporate objectives while also supporting their practical application within individual services and programmes of work.

The Directorate PPI Lead model continued to develop during 2025/26. Each Directorate has an identified point of contact through whom staff can access information, practical advice and professional support. This approach improves the visibility of PPI and helps staff integrate involvement into service planning, delivery, redesign and evaluation.

The Involvement Team continued to provide regular updates, resources and learning opportunities to Directorate leads. Work also progressed to strengthen the role of PPI Champions across Directorates, creating a wider network of staff who can promote good practice, share learning and support colleagues to meet the Trust's statutory responsibilities for involvement.

Davin Corrigan Legacy Award for Improving Patient and Service User Safety through Engagement

The Adult Learning Disability Occupational Therapy Service's Inclusive Bikes initiative was the winner of the 2025 Davin Corrigan Legacy Award for Improving Patient and Service User Safety through Engagement.

Inclusive Bikes enables people who are unable to use conventional bicycles to experience cycling, enjoy outdoor activity and participate in a safe, welcoming and inclusive environment. The initiative demonstrates how listening to service users and their carers to work collaboratively can improve access and create more inclusive opportunities.

Four projects progressed to the final stage of the 2025 award:

- CAMHS Accessibility Project;
- Inclusive Bikes within Learning Disability;
- MedPoint Solo Cancer Medication Collection Point; and
- North West Cancer Centre Easy Read Storybook.

Governance

The Trust continued to operate a comprehensive governance and assurance framework for PPI during 2025/26. The Involvement Team reports to the Improvement through Involvement Committee and also provides updates to the Corporate Management Team, ensuring senior oversight of progress, challenges and emerging priorities.

The Improvement through Involvement Committee provides a formal mechanism for championing and scrutinising involvement across the organisation. Its work is supported by the Trust's Annual PPI Action Plan, Consultation Scheme, annual reporting arrangements with the Public Health Agency and biannual updates to the Corporate Management Team.

Structured communication and reporting processes remain in place across all Directorates. These include monthly PPI updates, promotion of training and involvement opportunities, support from the Involvement Team and the collection of Directorate-level monitoring information.

The Trust remained engaged with the regional PPI assurance process throughout the year. This included preparation for and participation in monitoring, recognition and shared-learning activity with the Public Health Agency, colleagues and service user and carer representatives.

Opportunities

The Trust continued to provide and promote accessible opportunities for service users, carers and members of the public to contribute at different levels of the organisation.

The Involvement Team maintains a stakeholder database and consultee list comprising service users, carers, advocates, community and voluntary organisations, schools, universities, businesses and representatives from a wide range of communities of interest and identity.

This information supports the Trust's Register of Opportunities, through which involvement opportunities are coordinated, targeted and promoted using a central process. The approach helps services connect with relevant individuals and communities while supporting fairer and more consistent access to involvement.

The Trust also continued to work with the Public Health Agency to promote regional opportunities through the Engage website, supporting participation in involvement activities across the region.

Strategic Engagement Forum
The Strategic Engagement Forum continued to develop during 2025/26. The Forum brings together service users and carers with a range of backgrounds and lived experiences reflective of the communities served by the Trust and the different areas of Directorate activity.

The Forum provides an important route through which lived experience can inform strategic priorities, organisational change and service redesign. Its continued development strengthens the Trust's ambition to ensure that decision-making is inclusive and informed by the people who use its services.

Policy Development and Review
Service user involvement has been further integrated into the Trust's policy development and review arrangements. Involvement within the Trust's Policy Group helps ensure that the service user and carer voice is considered during the development and review of policies and incorporated wherever appropriate.

During 2025/26, service users and carers contributed to the development or review of 7 Trust policies. Their input helped ensure that policy decisions were informed by lived experience and considered the relevance and potential impact of policies on those who use Trust services.

Disability Steering Group
The Trust's Disability Steering Group provides an established and increasingly embedded approach to involving service users living with a disability and their carers in organisational decision-making.

The Group enables lived experience to inform the identification of priorities and the implementation and monitoring of action plans. This ensures that service users and carers can influence both what the Trust commits to achieving and how agreed actions are delivered and evaluated.

Knowledge and Skills
The Trust continued to build the knowledge, skills and confidence required to make involvement a routine part of practice.

Basic PPI awareness remained part of the corporate induction process, helping new employees understand the principles of involvement and their responsibilities from the beginning of their employment.

Engage, Involve and Co-production e-learning modules continued to be available and promoted across the organisation. These resources provide flexible access to learning and introduce staff to the principles, benefits and practical application of involvement and co-production.

A total of 330 completed the Engage, Involve and Co-Production online modules during 2025/2026.

Measuring Outcomes
During 2025/26, the Trust continued to strengthen how it records, evaluates and reports the impact of involvement.

The Regional Involvement Monitoring Tool has been incorporated into the Trust's reporting arrangements and is used to capture involvement activity across Directorates and programmes of work. The Involvement Team provides guidance and support to improve the quality and consistency of returns.

An internal Involvement Monitoring Implementation Plan sets out responsibilities, reporting processes and timescales for the collection and submission of information. Regular reporting through the Trust's governance structures provides assurance that involvement is occurring and that its influence is considered throughout planning, implementation and evaluation.

The monitoring approach places increasing emphasis on outcomes and learning rather than activity numbers alone. Directorates are encouraged to demonstrate:

- who was involved and how participation was supported;
- how feedback and lived experience influenced decisions;
- what changed as a result of involvement;
- how participants were informed about the outcome; and
- what learning will be applied to future work.

Clear mechanisms are in place to integrate PPI and co-production into significant projects and decision-making processes. Examples of service-user and carer involvement are captured through monitoring returns, case studies, committee reporting and shared-learning activity, providing evidence of both good practice and impact.

Good practice involvement throughout Western Trust

Involve Fest West 2025
Involve Fest West 2025 was a week-long programme celebrating Personal and Public Involvement (PPI) across the Trust. The festival highlighted examples of best practice, promoted engagement among staff, service users and carers and demonstrated the importance of co-production in the design and delivery of health and social care services.

Over the five-day period, 12 events were delivered, attracting 160 attendees, with a total of 1,667 people engaging across activities. Trust social media platforms reached 73,901 views during the weeklong festival.

Our Neuro Network
Our Neuro Network demonstrated the value of collaborative learning and cross-sector engagement. Three events were delivered in Fermanagh, Omagh and Derry/Londonderry between January and March 2026, with approximately 150 professionals attending.

Feedback was strongly positive:

* 98% of respondents rated the events as excellent or very good; and
* 96% agreed or strongly agreed that they were better informed about available services.

Reported benefits included improved awareness of services and referral pathways, new professional connections, opportunities for collaboration and the potential for more appropriate referrals.

Future Plans

The Trust will build on progress made during 2025/26 by:

- continuing to develop the Strategic Engagement Forum and strengthening representation across all Directorates;
- embedding the staff Involvement and Engagement Forum and implementing its action plan;
- strengthening the PPI Champion network across the Trust;
- increasing service-user and carer input into policy development and review;
- supporting the Disability Steering Group to influence relevant organisational action plans;
- continuing to improve the quality of involvement monitoring and evidence of impact;
- further developing regional and local PPI training resources;
- widening participation among communities that may experience barriers to involvement;
- strengthening feedback arrangements so participants understand how their contribution has influenced decisions; and
- sharing examples of effective involvement and co-production across the Trust.

These priorities will support the Trust's continued progression towards more inclusive and influential involvement. The overall aim is to ensure that service users, carers and communities continue to not only be invited to participate but are supported to make a meaningful and visible contribution to the decisions that affect them.

COMPLAINTS AND COMPLIMENTS

The Trust welcomes and encourages feedback on its services, including both complaints and compliments. We recognise the right of patients, service users, carers, families, and members of the public to raise concerns about the care and services they receive, and we are committed to ensuring that these concerns are addressed fairly, promptly, and with a person-centred approach.

In 2025/26, the Trust experienced an increase in the number of complaints received, with a particularly significant rise following the introduction of the Model Complaints Handling Procedure (MCHP) on 1 January 2026. While this has placed additional demands on services, it also indicates increased awareness of, and confidence in, the complaints process, making it easier for individuals to provide feedback and have their concerns considered.

The Trust recognises complaints as a valuable source of insight and learning. Feedback from complaints helps us better understand the experiences of patients and service users, identify areas for improvement, and implement changes that enhance the quality, safety, and effectiveness of our services. By listening, reflecting, and acting on concerns raised, we can drive continuous improvement and help prevent similar issues from recurring.

We remain committed to promoting a culture of openness, transparency, and continual learning, where feedback is welcomed and used proactively to improve the care and services we provide.

The Trust also appreciates and values compliments and positive feedback. These provide an opportunity to recognise excellence, celebrate good practice, and acknowledge the commitment and professionalism of our staff. Positive feedback not only highlights

examples of high-quality care and service delivery but also helps to boost staff morale and encourages the sharing of good practice across the organisation.

Facts and Figures

In total, **1,058** complaints were received by the Trust for the period 1 April 2025 to 31 March 2026.	**733** formal complaints were received in the period 1 April 2025 to 31 December 2025 & were managed under the former HSC Complaints Handling Procedure. 98% of the 733 formal complaints received were acknowledged within 2 working days.	**325** complaints were received by the Trust for the period 1 January to 31 March 2026. These complaints were handled under the Model Complaints Handling Procedure.	**7,583** compliments were received during 2025/26, includes **4,673** received via Care Opinion.

Response Times

Out of the 733 formal complaints received for the period 1st April to 31st December 2025, a total of 175 (24%) were responded to within 20 working days. The preparation for and transition to the new Model Complaints Handling Procedure (MCHP) during this time has had an impact on these figures and it is noted that there has been an improved trajectory since implementation of the MCHP.

The timeliness of responses to formal complaints has continued to be a challenge in 2025/26. Some delays have been attributable to the complexity of a number of complaints, many of which involved multiple service areas, as well as the time and resources required to undertake thorough investigations and develop comprehensive service-level responses.

Despite these challenges, the Trust's implementation of MCHP has made significant progress in improving its average response times over the course of the year, demonstrating a continued commitment to strengthening complaint handling processes and delivering a more responsive service for Complainants. Out of the 325 complaints received, 100 (31%) were closed within 10 working days.

Model Complaints Handling Procedure (MCHP)

The Northern Ireland Public Services Ombudsman's Model Complaints Handling Procedure (MCHP) was introduced on the 1st June 2025 with an implementation date of 1st January 2026. The purpose was to establish a consistent and customer-focused approach to complaints handling across public sector organisations. The procedure aims to ensure complaints are handled fairly, efficiently and transparently, with an emphasis on early resolution wherever possible. A key objective of the MCHP is to support organisational learning by encouraging services to use complaint feedback to identify trends, address underlying issues and implement improvements that enhance the quality and effectiveness of service delivery.

From 1st January 2026, all complaints received into the Trust are recorded as a Stage One complaint initially. Complex Complaints that require further investigation, will move to a

Stage Two Complaint. Target response times for complaints at Stage One is 5 days with an extension period of 5 days. Response time for a Stage Two complaint is 20 working days. If the Complaint has not been resolved at Stage One or requires further investigation, the complaint must be escalated to a Stage Two, with senior management approval. A record of all extensions and escalation to Stage Two must be updated on Datix.

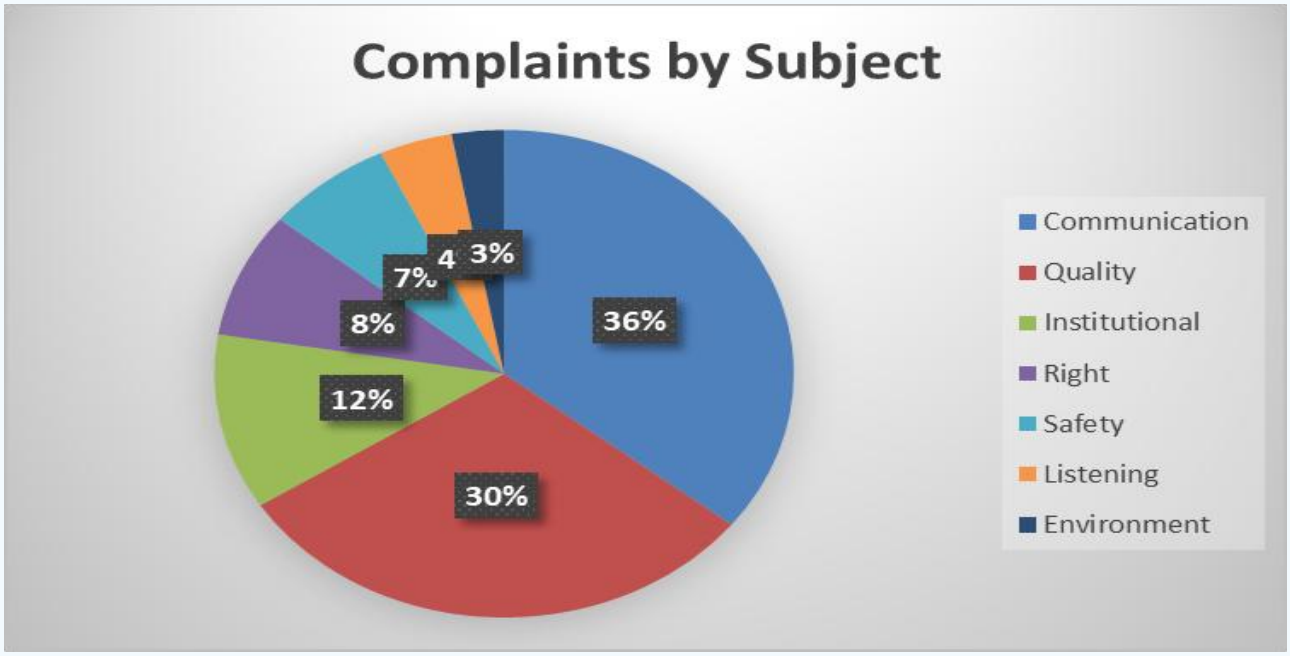
Under the Public Services Ombudsman Act (NI) 2016, The Trust was required to submit a copy of the complaints handling procedure and public-facing complaints procedure information, in line with MCHP. NIPSO has advised the Trust they have met full compliance on their procedural checks.

Reopened Complaints

Of the 733 formal complaints received between April to December 2025, a total of 23 (3%) were re-opened. This figure may seem lower in comparison to the previous year however, it is important to highlight in line with the MCHP, complaints investigated at Stage two cannot be reopened. Stage Two investigations are intended to provide a comprehensive and final review of a complaint. As such, complaints will not normally be reopened following the completion of a Stage Two investigation, except in exceptional circumstances where new and material evidence is identified. It is also important to highlight there are a number of legacy complaints that remain opened and will be managed under the extant former HSC Complaints procedure, therefore if the complainant remains dissatisfied, they may request that their complaint is reopened.

Complaints by Subject

Communication is the top subject of complaint, followed by Quality and Institutional. A breakdown of subjects during 2025/26 are set out below:



Lessons Learned and Service Improvements

We welcome complaints and feedback as valuable opportunities to learn, improve, and enhance the quality of the services we provide. Where appropriate, actions are agreed following the investigation of a complaint to address identified issues and support continuous improvement.

Themes, trends, and learning arising from complaints are reviewed through the Trust's Integrated assurance framework and shared within Directorate and service governance forums. This supports organisational learning, promotes the sharing of good practice, and helps reduce the likelihood of similar issues occurring in the future.

Learning from complaints is used to inform service development and improvement initiatives, and feedback is provided to patients, families, carers, and staff on changes made as a result of their experiences.

Complaints are discussed with the staff involved, and key learning points are shared through team meetings, supervision, training sessions, and professional forums. This encourages reflection, supports a culture of openness and accountability, and helps ensure that services continue to meet the needs of the people and communities served by the Trust.

Following the investigation of complaints during 2025/26 the following comments were captured as part of the learning: -

Complainant Said	We did
Complainant refers to the way she was spoken to by a member of maternity staff in SWAH. She states that this senior staff member said "you do realize you are not the only person on this ward".	The learning was shared with staff, emphasising the importance of communicating respectfully, sensitively and clearly with women and their partners, particularly when they may be anxious, vulnerable or tired.
Complainants colonoscopy has been cancelled on three occasions. This complainant has had difficulty contacting and receiving communication from the service.	Ward Managers to work closely with endoscopy schedulers to ensure patients get another appointment if one has been cancelled by the Endoscopy Unit. Ensure patients are kept updated on appointment details. Ensure all Endoscopy staff know the impact of cancelling a patient's procedure and how we can look at other avenues to prevent this from happening in future.
Complainant emailed about the treatment of her mother when she was a patient on Ward 40. Her mother had a stroke in December 2023.	An "intentional round chart" will be implemented for each patient. This ensures that there will be documented times when every patient will be checked on, asked if they need to use the toilet, need a drink, need moved or have any other issues.

Complainant Said	We did
Complainant states that he was not included in his meeting. He states he felt isolated, humiliated and excluded. He writes about the lack of communication from the service. He states he feels like a casefile and that he is not happy with his social worker.	Highlighted the importance of ensuring that all young people are invited to professional meetings and these should not go ahead without consent or agreement of the young person if not in attendance. We will share the learning from this complaint with all staff within the service to ensure that all young people are invited to meetings moving forward and that the level of communication is improved.
Complainant Said	We did
Complainants son has Spina Bifida and she feels like there should be a procedure in place whereby appointments could be obtained faster (e.g. emergency slots etc). Complainant advised that her son's splints which he relies on to walk had been ready for approximately 7 to 8 weeks before he was able to have them fitted.	The manager of the Orthotics Service and her team have suggested that at least one slot per clinic needs to be protected and allocated for fitting of appliances to children who require some of these orthotics to be able to stand and walk and have significant impact on child if delays occur.

Learning from a Northern Ireland Ombudsman Case

If a complainant is not happy with the Trust's final response to their complaint they can request a further review by the Ombudsman.

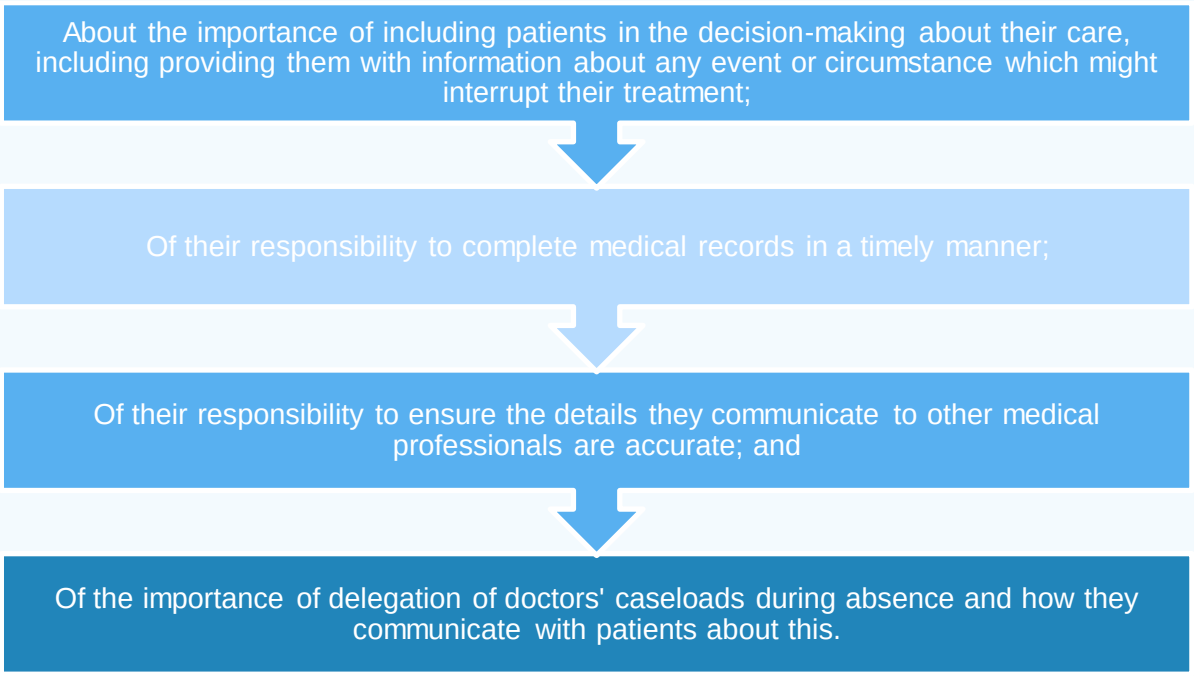
This NIPSO Case was about care and treatment the Trust provided to the complainant in relation to the provision of Eye Movement Desensitisation and Reprocessing (EMDR) therapy. The final report received from the NI Ombudsman's Office following their investigation into a complaint focused on the following issues:

(1)	The Ombudsman received a complaint about care and treatment the Trust provided to the complainant. NIPSO upheld elements of the complaint for the reasons outlined in their report. NIPSO consider this a failure in the Trust's care and treatment of the complainant.
(2)	The Ombudsman recognised the failures caused the complainant losses of opportunity to make an informed choice about his treatment; to receive care in a timely manner after the doctor's absence began; and for continuity of care. They also caused the complainant uncertainty, upset, and frustration.

The Recommendations as listed by the Ombudsman are as follows:

(a) The Trust should provide the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified (within one month of the date of this report).

(b) For service improvement and to prevent future recurrence, it is recommended that the Trust share this report with relevant staff in the Primary Care Liaison Service reminding them:



(c) Recommended that the Trust implements an action plan to incorporate these recommendations and should provide NIPSO with an update within six months of the date of the final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

LEARNING FROM INCIDENTS

Facts and Figures

- **In the year 1st April 2025 - 31st March 2026, a total of 21,252 incidents were reported, an increase of 2% over the previous year.**

Incident Reporting and Review

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”.

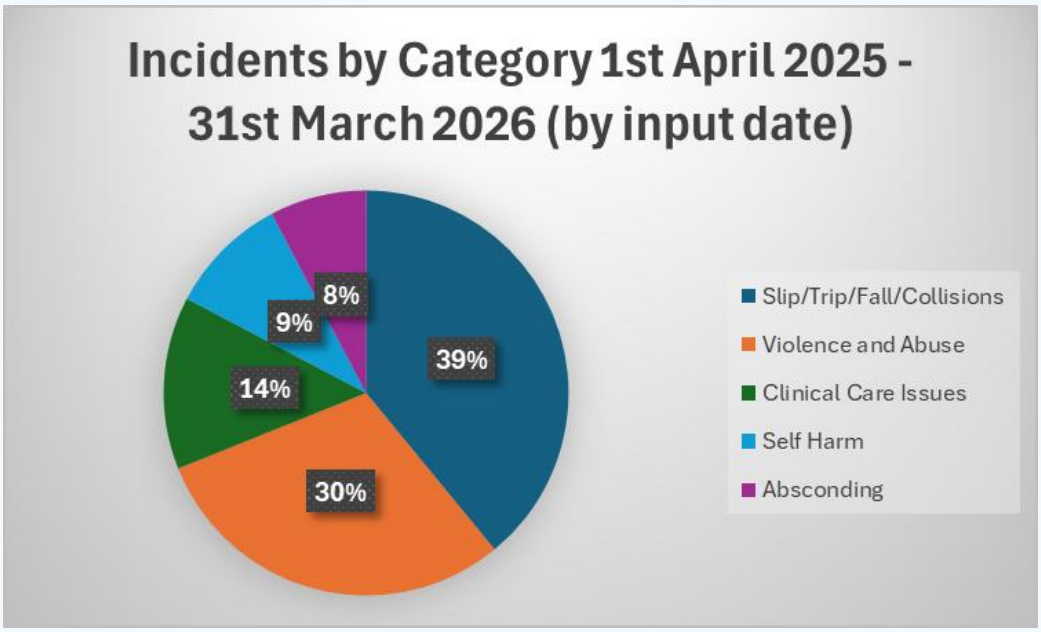
Increased reporting can reflect a positive reporting culture where there is a willingness to reflect when things go wrong and learn in an open inclusive manner. Where incidents increase due to particular issues / concerns these are highlighted in trend reports to managers and through more detailed reviews of specific incidents to identify learning and prevent / reduce recurrence.

The Trust actively encourages the reporting of incidents and the open review of incidents by the staff involved. Incident training continues to be provided for staff through eLearning modules. Incidents are reviewed and learning is identified and shared at a number of forums including – Weekly Rapid Review Group (RRG); Corporate Safety Huddle; weekly ward meetings; Directorate Governance meetings; Ward Managers Governance meetings etc.

The Trust shares learning primarily through a network of Governance forums and also through communications such as a staff newsletter called "Share to Learn" and a weekly safety message to staff, 'Lesson of the Week', accessible through a prominent icon on the Trust's intranet site. The Trust Rapid Review Group (RRG) meets weekly and identifies any urgent learning from serious incidents for sharing across the Trust and/or regionally.

Top 5 Reported Categories

The top five categories of incidents reported within the 2025-2026 period is detailed in the graph below:



Slips / Trips / Falls (39%)

- The percentage share of Incidents relating to slips, trips and falls have increased by 1% on the previous year. The Trust encourages the reporting of all falls to determine if anything could have been done to prevent what can be a distressing experience for the victim regardless of the level of physical harm.

Violence & Abuse (30%)

- The percentage share of Incidents relating to behaviour decreased by 4% on the previous year. The trust continue to see a reporting of incidents under this category. Again, staff are encouraged to report such incidents. The MOVA group is a key working group, and provides a focal point for the discussion of all relevant matters. It works to review/produce procedures for use throughout the Trust. It also monitors all security related incidents and ensure any issues with meeting standards are escalated as required.

Clinical Care Issue (14%)

- The percentage share of incidents relating to clinical care issues has increased by 2% within this reporting period. Staff are encouraged to report all incidents locally and amber incidents relating to clinical care are discussed and actioned through Corporate Safety Huddle on a weekly basis and Red clinical care incidents reviewed at RRG, on a weekly basis also.

Examples of Learning

The Trust Rapid Review Group (RRG) continued to meet weekly throughout 2025-2026 to improve the identification and sharing of learning. During that period, reviewed and authorised learning from SAIs, Complaints, Claims, Coroner's Inquests and incidents was shared trust wide where appropriate.

Serious Adverse Incidents (SAIs)

The Trust is required to report incidents that meet the criteria of a "serious adverse incident" (SAI) to the SPPG within the DoH. An SAI is an incident which meets one or more of a list of specific criteria e.g. unexpected / unexplained death or serious injury or an unexpected serious risk. They may also relate to risks to maintain business continuity or serious incidents of public interest or concern.

Each SAI is investigated and a report completed, and where appropriate, shared with the Regulation & Quality Improvement Authority (RQIA), for them to consider whether there are any issues that need to be addressed on a regional basis.

Patients/service users and/or their families are advised when an incident relevant to them is to be reviewed as a SAI to ensure they are involved in the review as appropriate. The Trust also has systems in place to ensure that learning from SAIs is taken forward.

Table of SAI deaths by Directorate

The Trust places the management of all incidents as a high priority. When an incident results in a death it is acknowledged that this is a particularly difficult process for everyone involved, not least the families and the staff directly involved in the incident, and therefore must be

prioritised for completion in a sensitive but effective way. The Trust will continue to work with all stakeholders to identify and embed the learning from these reviews to ensure the risk of them happening to someone else is reduced as much as possible.

The following table illustrates the number of SAIs that involved a death in the year 2025-2026 for the Trust.

	Unscheduled Care, Medicine, Cancer & Clinical Services	Adult Mental Health & Disability Services	Community and Older People Services	Surgery, Paediatrics & Womens Health	Children & Families	Total
4.2.1. Serious injury or unexpected / unexplained death	10	6	1	5	2	24
4.2.2. Unexpected serious risk.	5	1	0	9	2	17
4.2.6. Suspected suicide of a service user.	0	23	0	0	0	23
Total	15	30	1	14	4	64

The top 5 Serious Adverse Incident (SAI) learning themes from April 2025 to March 2026 are: -



How the Organisation Learns

The Trust utilises the following systems for sharing learning from SAIs: -

- Learning is shared with the relevant local area where the incident occurred and with staff involved following completion of SAI through their local Governance arrangements.
- Learning is shared directorate wide through a Governance report tabled at each Directorate Governance meeting quarterly.
- Learning is shared Trust wide (if appropriate) through Rapid Review Group (RRG). RRG is attended by representatives from all the service Directorates including the

Directors who decide how best to share the learning which may include through specific forums/groups.

- It is the responsibility of the SPPG to share any regional learning from the final report across the region. RRG also decide if regional learning is required to be urgently shared during the SAI review and share it with SPPG using a Regional Learning Alert prior to SAI being completed.
- Learning is also shared generally through a number of mediums including Safety Lesson of the Week (in Staff-west website); Share to Learn newsletter; Trust SAI Learning workshops.
- If appropriate, RRG will create a learning template and share with specific teams following SAI approval.

Monitoring of shared learning is reviewed through SAI Action Plans. Action plans are required to evidence how the learning has been shared and they are held open until evidence of completion is received.

Leadership Safety Culture Walkrounds

Leadership Safety Culture Walkrounds provide an informal opportunity for Executive Directors and Non-Executive Directors within the Trust to engage directly with frontline staff and discuss safety issues within their ward, department, or service area. They demonstrate the Trust's ongoing commitment to fostering a positive safety culture and continuously improving services to achieve better outcomes for patients, service users, and staff.

Making care safer for patients, clients, and service users remains a top priority for the Trust. Leadership Safety Culture Walkrounds are undertaken in facilities where staff have direct contact with patients, clients, and service users. The Trust is committed to promoting a culture of safety in which all staff feel able to speak openly about safety and quality concerns, as well as share ideas for improvement and learning. This approach ensures that staff have an active voice within the organisation. Executive Directors and Non-Executive Directors conduct Leadership Safety Culture Walkrounds to support safer care and gather valuable information that informs learning and service improvement.

Executive and Non-Executive Directors highly value these Walkrounds as they provide an opportunity to meet frontline staff and hear first-hand about both safety initiatives and concerns. In addition, they offer insights and perspectives that may not ordinarily be captured through reports presented at formal Board and Committee meetings.

Since the introduction of Leadership Walkrounds in April 2008, a total of 403 Walkrounds have been undertaken across the Trust. During 2025/26, 30 Leadership Safety Culture Walkrounds were completed, demonstrating the continued commitment of senior leaders to engaging with staff, promoting a culture of safety, and identifying opportunities for learning and service improvement.

During the year the Leadership Walkround question proforma was reviewed and rebranded as the Leadership Safety Culture Walkround Conversational Guide. The revised guide was implemented in January 2026, with feedback from senior leaders planned following the first nine months of use.

The Conversational Guide continues to capture a range of key quality and safety indicators, including performance relating to incident reporting, complaints, compliments, quality

improvement (QI) projects and clinical audit activity. In addition, information gathered from Care Opinion and local audit activity enhances preparation for Leadership Safety Culture Walkrounds and supports the identification, sharing and celebration of good practice across services.

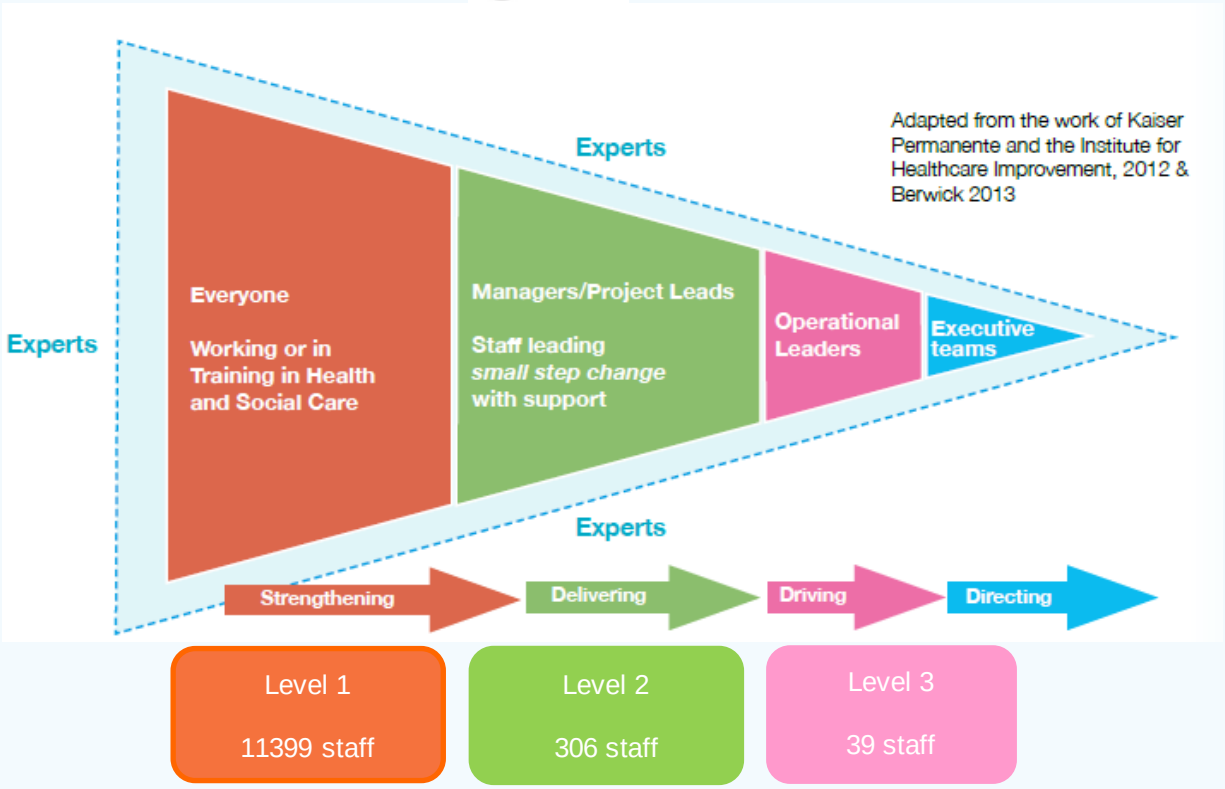
The revised approach encourages more open and meaningful conversations between senior leaders and frontline staff, providing valuable insights into the safety culture within teams and helping to identify opportunities for learning, improvement and the delivery of high-quality care. The information gathered through these conversations supports organisational learning, informs improvement activities, and strengthens the Trust's commitment to providing safe, effective, and person-centred care.

QUALITY IMPROVEMENT (QI)

Introduction

The Quality Improvement Team continued to provide support through project registration, governance reporting, mentoring, training signposting, QI Clinics, project facilitation and access to the QI Hub. Throughout the year the team maintained oversight of Quality Improvement activity through operational meetings, governance reporting structures and support for staff undertaking improvement work across all directorates.

QI Trained Staff 2025-26



QI West Connect Newsletter

The Quality Improvement Newsletter continued to support the promotion of quality improvement activity across the Trust by providing staff with regular updates, examples of improvement work, learning opportunities, and information on training and events. The newsletter serves as a key communication tool for sharing good practice, celebrating achievements, and increasing awareness of quality improvement methodologies and resources available to staff. Publication of the newsletter was paused from January 2026 while the Quality Improvement Team prioritised delivery of core operational and governance support. Following a review of priorities and available resources, publication resumed in 2026 and will continue throughout 2026/27.

QI West Connect Forum

QI West Connect continued to provide a monthly forum for staff until January 2026, when the programme was paused to allow the Quality Improvement Team to focus on priority operational and governance activity. Following review of service priorities, the programme resumed and continues to provide opportunities for staff to learn, share experiences and exchange improvement practice.

QI Events in 2025/2026

Quality Improvement was promoted through the WHSCT Annual Audit Showcase events held in SWAH during June 2025 and SWAH and Altnagelvin in June 2026. While primarily audit-focused, the showcase provided an important opportunity for staff to present and discuss quality improvement projects, share learning, display posters, and highlight examples of service improvement activity taking place across the Trust. Across both events, staff were able to view presentations and displays demonstrating the use of measurement, audit, and improvement methodologies to support better outcomes for patients and services. The showcase also provided a valuable forum for recognising staff achievements, disseminating good practice, and encouraging wider engagement in quality improvement activity.

QI Steering Group

The QI Steering Group continued to provide strategic oversight of Quality Improvement activity across the organisation. Agendas and supporting papers were circulated during the year to support discussion, governance and organisational learning.

QI Operational Group

The QI Operational Group continued to meet throughout 2025-2026 to monitor project activity, discuss support requirements and review operational priorities.

Project activity reports were reviewed, including new projects received, projects completed, projects cancelled or incomplete, and projects requiring discussion or escalation. These reports supported oversight of the Quality Improvement portfolio across the Trust.

Quality Improvement Governance

Quality Improvement remained embedded within Trust governance arrangements during 2025-2026.

QI reports continued to be provided through established governance structures including the Standards, Audit and Quality Improvement (SAQI) Group and Directorate Governance

reporting processes, ensuring organisational visibility of improvement activity and emerging themes across services.

Standards, Audit & Quality Improvement Group (SAQI)

During 2025/26, the Standards, Audit & Quality Improvement (SAQI) Group continued to support the integration of quality improvement within the Trust's assurance arrangements. By bringing together information from audits, Serious Adverse Incidents, reviews and inspection activity, the Group helped identify opportunities where quality improvement methodology could be used to support learning, service development and improved outcomes for patients and service users.

Quality Improvement Support and Resources

The QI Team refreshed a number of core resources during the year including:

- Revised QI Support and Information Overview
- Updated Quality Improvement Registration Form
- Quality Improvement Project Presentation Template
- Innovation Project Presentation Template

These resources were designed to simplify project initiation, improve consistency of reporting and support the spread of improvement methodology across the organisation.

The team continued to provide practical support to staff through QI Clinics, project registration support, mentoring arrangements and direct project facilitation.

What Matters To You? (WMTY)

The Quality Improvement Team supported WMTY Day on 3 June 2025 by promoting resources and activities designed to encourage meaningful conversations with patients, service users, carers and colleagues. The initiative reinforced the principles of person-centred quality improvement by helping staff better understand individual needs and experiences, supporting the identification of opportunities to improve the quality and experience of care.

Service User Engagement

Patient feedback continued to inform quality improvement activity across the Trust during 2025/26. Learning from patient experiences, including feedback shared through Care Opinion and other patient engagement mechanisms, was used to support improvement discussions and identify opportunities for service development. Patient experience also remained a recognised component of Quality Improvement training and improvement methodology across the Trust.

Theme 2

Strengthening the Workforce



INDUCTION

During 2025/26 **1331** Trust staff completed the Corporate Induction/Onboarding module, this included **926** new starts.

Induction

Postgraduate and undergraduate inductions are a continuous part of MedEdWest education governance. Postgraduate induction takes place twice yearly for all resident doctors. Undergraduate induction takes place at the start of each specialty placement.

LEADERSHIP PROGRAMMES

New development programmes were launched in 2025/26 and included a three-day Service Manager programme with 15 participants and a five-day Nurse Leader Development Programme with 16 participants.

The Ulster University-accredited **Postgraduate Diploma in Health and Social Care Leadership and Management**, delivered with the HSC Leadership Centre, continues to build leadership capacity continued, with 14 managers progressing to Year 2.

LEARNING AND DEVELOPMENT

Vocational Training

The **Vocational Training Team** supports 120 learners across Level 2–5 qualifications. Provision includes the Level 3 Certificate in Business and Administration, with a Level 3 Diploma in development. Health pathways enable progression to Band 3 roles, with further development planned through Level 5 Leadership and Management qualifications for non-Health and Social Care staff.

Partnerships with Intermediate Care, Primary Care, Older People's Services, Support Services and Further Education colleges continue to expand vocational provision, supporting staff progression, service quality and workforce sustainability.

COACHING AND MENTORING







The **Leader and Manager Framework** was relaunched in October 2025 with 82 managers across Bands 3 - 8B participating. Group mentoring was embedded at Levels 2 and 3, including engagement with Non-Executive Directors who mentored senior managers.

The Trust's **Coaching Network** continued to grow throughout 2025/26 with 33 trained coaches, receiving 61 referrals and achieving 47 successful matches between April 2025 and March 2026. Trust Coaches availed of significant professional support and supervision throughout the year strengthening governance and quality of the Trust coaching provision.

Clinical Education Teaching Fellows/ Teaching

Founded in 2014, the MedEdWest teaching fellowship is now in its 12th year and continues to recruit at least 8 trust clinical fellows, 6 senior fellows and 50 junior teaching fellows yearly. MedEd has continued on this innovation approach, recruiting 6 GPs on a sessional contract which help meet the continued demands in MedEdWest with the continued expansion of medical students and resident doctors.

Teach the Teacher (TTT)

The MedEdWest, Teach the Teacher (TTT) NIMDTA accredited programme remains popular. This academic year, 93 resident doctors and 16 senior medical staff completed this course. This approach expands the medical educator workforce and ensures education governance and sustainability of medical education teaching.

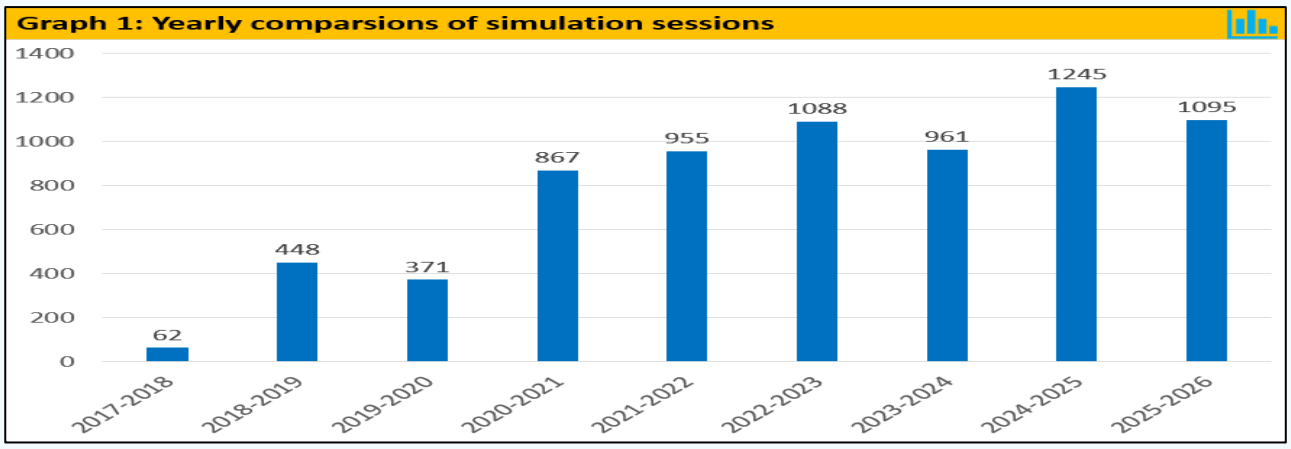
Participants	2022-23	2023-24	2024-25	2025-26
Trainees	80	62	50	93
Medical Students	21	8	0	2
Senior Medical Staff	0	14	22	16

Simulation & VR

Simulation based experiences help learners develop confidence, clinical decision-making skills, and technical competence in a safe and supportive environment. MedEdWest continues to develop and plan simulation into undergraduate and postgraduate clinical teaching programmes.

We remain committed to investing in the latest state-of-the-art simulation equipment and ensuring all existing equipment is maintained to the highest standard. Through ongoing investment and proactive maintenance, we provide reliable, high-quality resources that enhance the learning experience for students and doctors across a range of clinical settings.

Our Trustwide simulation statistics reflect the continuing value of simulation investment in terms of training provided. Our statistics show the continued expansion to simulation in medical education in the Trust, both in undergraduate and postgraduate.



Simulation continues to advance in MedEd with different buzz words. Transformative simulation is an umbrella term for simulation activities that are non-pedagogical, that is, they are not designed and structured around pre-specified learning outcomes. Instead, simulation is used to innovate, improve, intervene, involve, identify, include or influence (the 7 SBI's). It can do several of these things at once and includes specific simulation applications such as translational simulation, simulation-based improvement, and simulation-based interventions.

A strategic regional interprofessional simulation based education group has been established and overseen by DoH to explore current challenges, identify strategic priorities, and begin building consensus around the development of a formal regional SBE strategy. MedEdWest are represented on this group, in addition to the Trust's recently established interprofessional SBE group.

SUPERVISION

Medical Supervision

GMC Recognition & Approval of Trainers

Trainers carry out a vital role in ensuring safe and effective care through good clinical supervision and supporting and monitoring educational progress through education and clinical supervision. Training responsibilities are reflected in medical staff job plans. There are currently 214 GMC recognised trainers.

Nursing and Midwifery Clinical Supervision

Clinical and Reflective Supervision is a key component of professional practice for nursing and midwifery staff. It provides a safe and supportive environment for registrants to reflect on practice, strengthen professional judgement, enhance skills and support continuous professional development. Effective supervision contributes to high-quality, safe patient care and promotes staff wellbeing and professional accountability.

The Trust continues to support delivery of supervision in line with its Nursing Supervision Policy. Ward and Department Managers, Sisters, Charge Nurses, Lead Nurses and Midwives play a key role in facilitating supervision opportunities for staff. Compliance is monitored through ward and departmental reporting arrangements and through the Trust's Nursing and Midwifery Accountability and Assurance Framework.

The Trust has implemented the Northern Ireland Practice and Education Council (NIPEC) Reflective Supervision Framework, endorsed by the Chief Nursing Officer and Midwifery Officer for Northern Ireland. The development of the Trust Reflective Supervision Policy ensures alignment with regional standards and best practice. To support on-going compliance with this policy in practice, the Clinical Education Centre has provided training for 416 staff to become supervisors within the new Reflective Supervision Framework, strengthening supervisory capacity across nursing and midwifery services.

During the reporting period 1st April 2025 -31st March 2026, 80% of nursing and midwifery staff received the required two formal supervision sessions. In addition to formal supervision, staff continue to access a range of informal reflective support mechanisms, including debriefs, safety huddles and psychological support services, which further contribute to staff wellbeing and learning.

The Trust will continue to strengthen Reflective Supervision, monitoring compliance with supervision standards to support a skilled, reflective and resilient nursing and midwifery workforce.

Social Work Supervision

Throughout 2025/26, the Trust continued to strengthen and stabilise the social work workforce through the implementation of targeted workforce planning, recruitment, and retention initiatives. The **WHSCT Social Work Workforce Plan for 2023-2025** provided a strategic framework to Build, Support, Enhance, and Lead.



- Expansion of the Trainee Social Work scheme to Northern Sector; AYE Lead supporting early career Social Workers to promote job retention; Continue to support students on placement and promote Social Work as a career.



- The LDG SW Team hosted the 2025 Regional Social Work Awards where local and regional best practice was celebrated; wellbeing events; Expand Coaching Network.

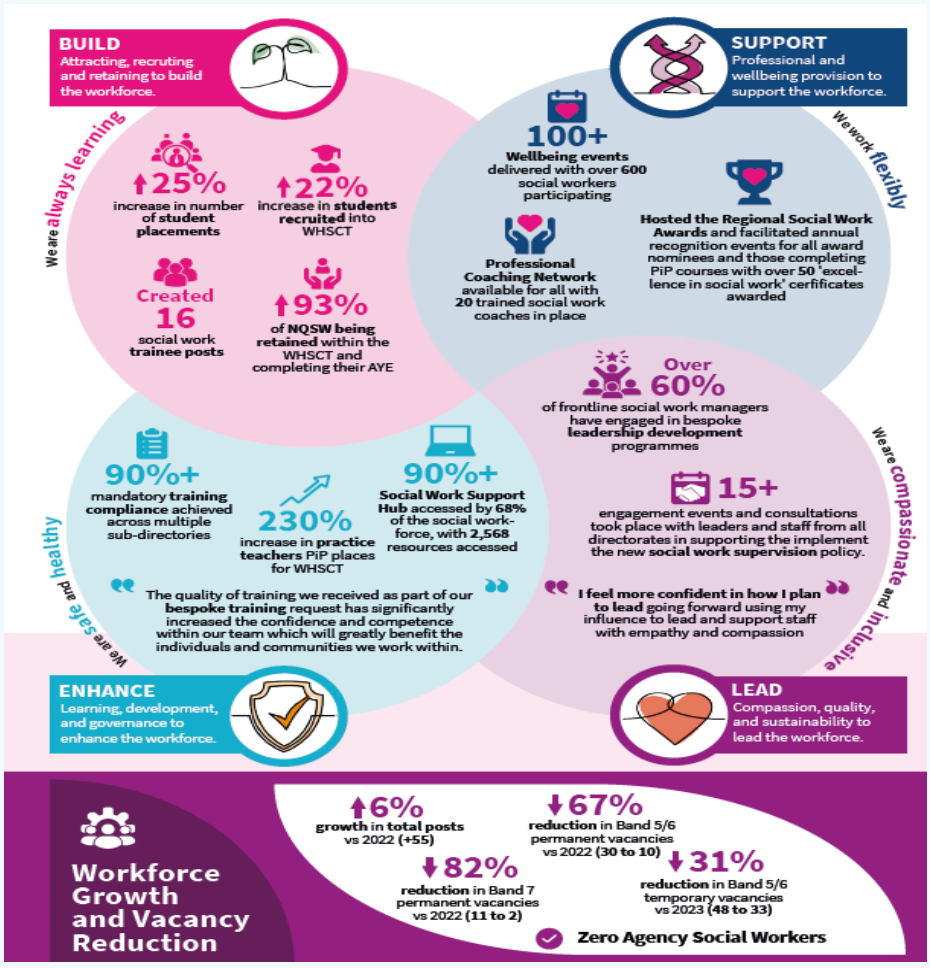


- Continue to monitor compliance to Core Mandatory Training; Increase in Practice Teacher PiP places; Promotion of postgraduate opportunities; Introduction of Phd research pathway; Develop Transfer Policy.



- Deliver leadership programme for Band 7 and 8 Social Workers; Engagement events; Support implementation of the new Supervision Policy which was launched in 2024.

Workforce growth can be evidenced by our workforce capacity increasing across most service areas, vacancy rates continuing to reduce, and stability within key practitioner and leadership grades improving. These improvements provide increased resilience across social work services and enhanced the Trust's ability to deliver safe, effective and person-centred care. A summary of the practical actions and measurable impact of the 2023-2025 plan is evidenced in this infographic:



Summary of Work currently underway:

The progress achieved across the Social Work workforce over recent years has been significant not only in terms of workforce growth, but in staff wellbeing and leadership development. The Trust's social work workforce has grown by 6% since 2022 (+55), with substantial reductions in both permanent and temporary vacancies and continued elimination of agency social worker usage. There are a number of actions from the previous plan that have been carried forward into the new plan including the development of Social Work Induction Guidance, permanency for all Social Workers, and continue work to reduce unnecessary bureaucracy.

While progress over the last year has been significant, work continues to address remaining workforce pressures and ensure sustainability across all service areas, and the recent launch of the **WHSCT Social Work Retention Plan 2026-2028**. The new Retention Plan reflects that the quality of social work practice is not sustained through policies, rather through our staff feeling valued, supported, and trusted to do meaningful work. The plan reflects regional priorities, but also recognises that retention pressures vary by service context, so outlines a number of directorate-specific priorities. Some of the key work underway includes:

Core Mandatory Training for Social Workers:

- Progress has been evident in workforce development and total compliance with Child and Adult Safeguarding training, which are core mandatory training requirements for all Social Workers, exceeding 90% by April 2026, compared with approximately 20% in February 2024. This improvement reflects a sustained organisational commitment to strengthening professional standards, safeguarding practice and workforce capability. There is currently a drive to increase the compliance of social workers with Domestic Abuse Level 2 training.
- Increasing capacity for DASH training targeting all professionals in response to the high number of recent domestic homicides in the WHSCT area, has resulted in 400 staff across social work/social care, medical, nursing and AHP services being trained. This will continue until December 2026.

Early Career Social Workers

- In terms if the recruitment of Newly Qualified Social Workers, the 2023-2025 period saw a 22% increase in students recruited into WHSCT posts.
- The bespoke support from our designated AYE Lead demonstrates our commitment to supporting early-career social workers, which promotes staff retention and wellbeing.
- The Trainee Scheme rolled out in Southern Sector during 2023-2025 period, is now being extended to Northern Sector to posts where job pressures are high.

Professional Curiosity

- LDG SW Team have developed a Level 1 Professional Curiosity digital resource that is now hosted on LearnHSCNI and is available to all staff across all Trusts.
- In partnership with other Trusts, the LDG SW Team are currently building an e-learning Level 2 programme on Professional Curiosity which demonstrates our commitment to developing critical thinking and reflective practice skills.

Social Work Leadership Programme

- The LDG SW Team have designed and facilitated a number of bespoke leadership programmes aligned to the NISCC Social Work Leadership Framework. Initially developed for Band 7/8 Social Workers within Children and Families Services, the

programme has demonstrated positive outcomes in leadership confidence, reflective practice and compassionate leadership. Building on this success, leadership development opportunities are now being extended to Band 6 Social Workers across a range of directorates.
- There is a strong emphasis on creating a space in these leadership sessions on promoting culture and psychological safety.
- Through leadership development programmes, coaching opportunities and supervision training, managers are being supported to provide reflective, strengths-based supervision that promotes learning, accountability and staff wellbeing.

Culture of Care Survey
- The 2026-2028 Retention Plan is grounded in a commitment to building an organisational environment characterised by compassion and professional competence.
- Through leadership development programmes, coaching opportunities and supervision training, managers are being supported to provide reflective, strengths-based supervision that promotes learning, accountability and staff wellbeing.
- In January 2026, the LDG SW Team undertook a Social Work Culture of Care Survey. The findings highlighted the positive impact of compassionate leadership, supportive team cultures, high-quality supervision and professional development opportunities on staff wellbeing and retention. The findings have informed a number of priorities within the Social Work Retention Plan 2026-2028 and reinforce the importance of creating environments where staff feel valued, supported and connected to their profession.

Social Work Supervision
- High-quality supervision remains a cornerstone of effective social work practice and workforce wellbeing.
- During 2025/26, the Trust continued implementation of the Social Work Supervision Policy, supporting services to develop local supervision service plans and embed consistent supervision arrangements across teams.
- This approach aligns with the Trust's ambition to develop compassionate leaders who create positive practice environments and support staff retention.
- An e-learning Supervision for Supervisees programme was launched in February 2026, aimed at raising awareness of how the current regional supervision policy can support reflective practice and professional development. The course has a number of modules which can be done at the pace of the Social Worker in their own time. LDG SW Team are currently undertaking a compliance audit of Social Work services in every directorate with 96 files to be audited for compliance to the new 2024 Supervision Policy.

Artificial Intelligence:
- The Trust launched an Artificial Intelligence Policy in 2026, and the 2026-28 Retention Plan acknowledges the potential benefits and risks to social workers in terms of access and use of AI-generated content. Whilst it can reduce administrative burden of our social workers, there are ethical practice concerns which needs further consideration. AI in Social Work will be the theme of an Executive Social Work Forum in September 2026.

Social Work Workforce Data

The Western Trust's Social Work Workforce Plan 2023-2025 was developed in response to historically high vacancy rates, with the strategic aim of stabilising and strengthening the Social Work workforce. The 2025 Data 7 Return position is informed by a range of workforce data sources, including the statutory Data 7 Return and monthly workforce returns submitted to the Strategic Planning and Performance Group (SPPG) for Children's Services.

Comprehensive workforce analysis across all Trusts, including comparative data from 2022 onwards, demonstrates a continued strengthening of the Social Work workforce within the Trust. The findings highlight growth in overall workforce capacity, significant reductions in vacancy levels, and improved workforce stability across both frontline and senior social work roles. These improvements reflect the positive impact of the Workforce Plan and associated recruitment and retention initiatives, while also identifying specific areas requiring continued focus and targeted intervention.

Data 7 Return as at 31st December 2025 Key Findings

The Data 7 Return position at 31st December 2025 demonstrates a continued strengthening of the Social Work workforce across the Trust, reflecting sustained investment in staffing and successful recruitment and retention initiatives. Overall staffing has increased from 847 in 2022 to 902 in 2025 a net growth of 6%. Growth is evident across almost all service areas, with no reductions recorded in any service area. Vacancy levels have improved significantly year on year while workforce stability within core social work grades has strengthened. Older People's Services eliminated all permanent vacancies compared to the previous year, while Family & Children's Services have reduced Band 5/6 permanent vacancies by 22 posts compared to 2022 baseline data. Overall, combined permanent and temporary vacancy rates across Bands 5/6 to 8c have reduced from 11% in 2023 to 7% in 2025. This includes a reduction in Band 5/6 vacancies from 14% to 8%, and in Band 7 from 9% to 6%. The outcomes confirm the positive impact of targeted workforce planning, recruitment and retention schemes while identifying specific local pressures.

Total Posts by Service Area (incl. Vacant Posts) – Designated and Non-Designated Posts

Total Posts by Service Area (inc. Vacant Posts)	2022	2023	2024	2025	+/- Var Vs. 2022
Adult Safeguarding & Protection Team	11	11	11	**12**	1.0▲
CAMHS/Autism/ADHD	24	21	28	**24**	0.0▶
Children's Disability Service	43	51	46	**50**	7.0▲
Family and children's services	404	439	431	**427**	23.0▲
Learning Disability	83	82	84	**86**	3.0▲
Mental Health	52	56	50	**53**	1.0▲
Older People's Services	169	166	177	**180**	11.0▲
Physical and Sensory Disability	47	49	49	**52**	5.0▲
Training and Governance	13	13	14	**14**	1.0▲
Other	1	1	3	**4**	3.0▲
Grand Totals	**847**	**889**	**893**	**902**	55.0▲

Permanent Vacancy by Service Area and Location – Band 5/6 & Band 7 Designated Posts

Permanent Vacancy by Service Area	Band 5-6					Band 7				
	2022	2023	2024	2025	+/- Var Vs. 2022	2022	2023	2024	2025	+/- Var Vs. 2022
Adult Safeguarding & Protection Team	0	0	1	**1**	1.0 ▲	1	1	0	**0**	(1.0) ▼
CAMHS/Autism/ADHD	0	0	0	**0**	0.0 ▶	0	0	0	**0**	0.0 ▶
Children's Disability Service	0	0	0	**1**	1.0 ▲	0	0	0	**0**	0.0 ▶
Family and children's services	27	14	4	**5**	(22.0) ▼	7	4	3	**1**	(6.0) ▼
Learning Disability	2	2	2	**3**	1.0 ▲	1	1	1	**1**	0.0 ▶
Mental Health	1	1	0	**0**	(1.0) ▼	0	2	0	**0**	0.0 ▶
Older People's Services	0	3	5	**0**	0.0 ▶	0	0	2	**0**	0.0 ▶
Physical and Sensory Disability	0	1	0	**0**	0.0 ▶	0	0	0	**0**	0.0 ▶
Training and Governance	0	0	0	**0**	0.0 ▶	2	2	1	**0**	(2.0) ▼
Other	0	0	0	**0**	0.0 ▶	0	0	0	**0**	0.0 ▶
Grand Totals	30	21	12	**10**	(20.0) ▼	11	10	7	**2**	(9.0) ▼

Permanent Vacancy by Location	Band 5-6					Band 7				
	2022	2023	2024	2025	+/- Var Vs. 2022	2022	2023	2024	2025	+/- Var Vs. 2022
Castlederg Area	0	0	0	**0**	0.0 ▶	0	0	1	**0**	0.0 ▶
Dromore Area	0	1	0	**0**	0.0 ▶	0	0	0	**0**	0.0 ▶
Enniskillen Area	12	14	8	**5**	(7.0) ▼	1	0	1	**1**	0.0 ▶
L 'Derry Area	13	4	1	**1**	(12.0) ▼	7	3	2	**0**	(7.0) ▼
Limavady Area	3	0	0	**3**	0.0 ▶	1	0	0	**0**	(1.0) ▼
Omagh Area	2	1	3	**1**	(1.0) ▼	1	6	2	**0**	(1.0) ▼
Strabane Area	0	1	0	**0**	0.0 ▶	1	1	1	**1**	0.0 ▶
Trust wide	0	0	0	**0**	0.0 ▶	0	0	0	**0**	0.0 ▶
Grand Totals	30	21	12	**10**	(20.0) ▼	11	10	7	**2**	(9.0) ▼

Temporary Vacancy by Service Area - Band 5/6 & Band 7 Designated Posts

Temporary Vacancy by Service Area	Band 5-6				+/- Var Vs. 2023	Band 7				+/- Var Vs. 2023
	2022	2023	2024	2025		2022	2023	2024	2025	
Adult Safeguarding & Protection Team	No Data Captured	0	0	**0**	0.0 ▶	No Data Captured	1	0	**0**	(1.0) ▼
CAMHS/Autism/ADHD		0	1	**0**	0.0 ▶		0	0	**0**	0.0 ▶
Children's Disability Service		1	1	**2**	1.0 ▲		0	0	**0**	0.0 ▶
Family and children's services		41	28	**29**	(12.0) ▼		8	11	**11**	3.0 ▲
Learning Disability		2	4	**0**	(2.0) ▼		0	1	**0**	0.0 ▶
Mental Health		1	2	**1**	0.0 ▶		1	1	**1**	0.0 ▶
Older People's Services		2	9	**1**	(1.0) ▼		2	0	**1**	(1.0) ▼
Physical and Sensory Disability		1	1	**0**	(1.0) ▼		0	1	**0**	0.0 ▶
Grand Totals		48	46	**33**	(15.0) ▼		12	14	**13**	1.0 ▲

Temporary Vacancy by Location	Band 5-6				+/- Var Vs. 2023	Band 7				+/- Var Vs. 2023
	2022	2023	2024	2025		2022	2023	2024	2025	
Castlederg Area	No Data Captured	0	2	**0**	0.0 ▶	No Data Captured	0	0	**0**	0.0 ▶
Enniskillen Area		10	11	**11**	1.0 ▲		2	4	**3**	1.0 ▲
L 'Derry Area		21	20	**14**	(7.0) ▼		8	7	**7**	(1.0) ▼
Limavady Area		2	1	**2**	0.0 ▶		0	0	**0**	0.0 ▶
Omagh Area		9	12	**6**	(3.0) ▼		2	3	**2**	0.0 ▶
Strabane Area		6	0	**0**	(6.0) ▼		0	0	**1**	1.0 ▲
Grand Totals		48	46	**33**	(15.0) ▼		12	14	**13**	1.0 ▲

Combined Permanent and Temporary Vacancy Percentage - Band 5/6 Designated Posts

Absence/Vacancy % (Designated Posts) Band 5/6	2023 Total Posts	Perm Vac.	Temp Vac.	Absence/ Vacancy %	2024 Total Posts	Perm. Vac.	Temp. Vac.	Absence/ Vacancy %	2025 Total Posts	Perm. Vac.	Temp. Vac.	Absence/ Vacancy %
Adult Safeguarding	**2**	0	0	0%	**2**	1	0	50%	**3**	1	0	33%
CAMHS/Autism/ADHD	**7**	0	0	0%	**8**	0	1	13%	**7**	0	0	0%
Children's Disability	**22**	0	1	5%	**23**	0	1	4%	**27**	1	2	11%
Family and Child Care	**272**	14	41	20%	**261**	4	28	12%	**259**	5	29	13%
Learning Disability	**49**	2	2	8%	**50**	2	4	12%	**51**	3	0	6%
Mental Health	**18**	1	1	11%	**20**	0	2	10%	**23**	0	1	4%
Older People's Services	**105**	3	2	5%	**112**	5	9	13%	**109**	0	1	1%
Physical and Sensory Dis.	**28**	1	1	7%	**27**	0	1	4%	**30**	0	0	0%
Grand Totals	**503**	**21**	**48**	**14%**	**503**	**12**	**46**	**12%**	**509**	**10**	**33**	**8%**

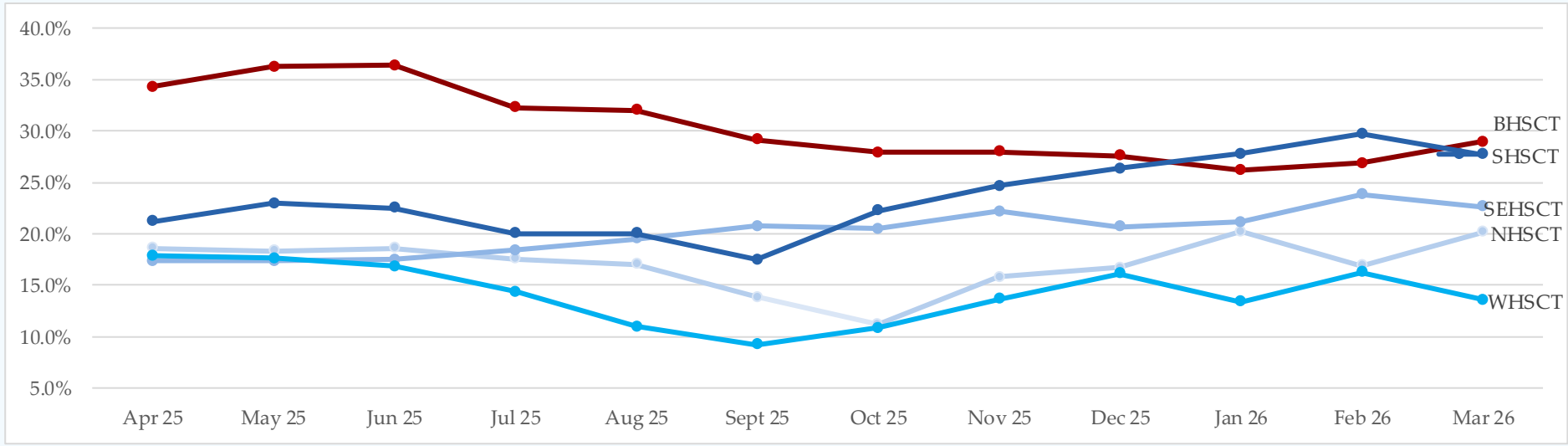
Temporary Contracts by Service Area (Bands 5–6) - Designated Posts

Temporary Contracts by Service Area (Bands 5-6)	2022	2023	2024	2025	2022-2025
Adult Safeguarding & Protection Team	0	1	1	**1**	**1.0▲**
CAMHS/Autism/ADHD	4	3	5	**4**	**0.0▶**
Children's Disability Service	6	0	2	**4**	**(2.0) ▼**
Family and children's services	21	20	6	**6**	**(15.0) ▼**
Learning Disability	6	7	8	**7**	**1.0▲**
Mental Health	3	3	4	**7**	**4.0▲**
Older People's Services	30	35	40	**38**	**8.0▲**
Physical and Sensory Disability	0	9	9	**10**	**10.0▲**
Grand Totals	70	78	75	**77**	7.0▲

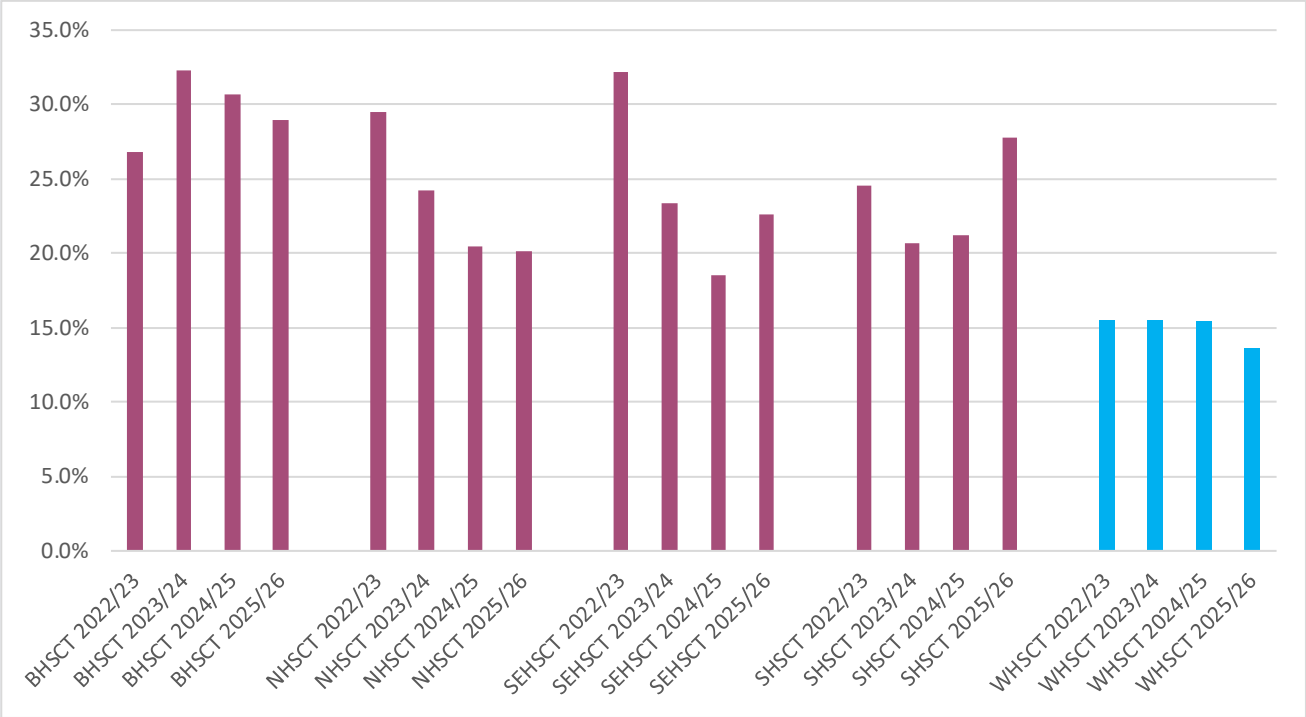
Temporary Contracts by Location (Bands 5-6)	2022	2023	2024	2025	2022-2025
Castlederg Area	0	3	4	2	**2.0▲**
Dromore Area	0	1	1	0	**0.0▶**
Enniskillen Area	8	7	4	5	**(3.0) ▼**
L 'Derry Area	39	40	38	44	**5.0▲**
Limavady Area	9	7	5	5	**(4.0) ▼**
Omagh Area	10	13	15	13	**3.0▲**
Strabane Area	4	7	8	8	**4.0▲**
Grand Totals	70	78	75	77	**7.0▲**

Monthly SPPG Regional Vacancy Data (Children Services)

	Regional Absence/Vacancy Data - Qualified Social Workers Band 5-7											
Trust	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
BHSCT	34.3%	36.2%	36.4%	32.3%	32.0%	29.1%	27.9%	28.0%	27.6%	26.2%	26.8%	28.9%
NHSCT	18.6%	18.3%	18.6%	17.6%	17.0%	13.9%	11.2%	15.8%	16.7%	20.2%	16.9%	20.2%
SEHSCT	17.4%	N/A	17.5%	18.4%	19.5%	20.7%	20.5%	22.1%	20.7%	21.1%	23.8%	22.6%
SHSCT	21.2%	22.9%	22.5%	20.0%	N/A	17.5%	22.2%	24.6%	26.3%	27.8%	29.7%	27.7%
WHSCT	17.9%	17.6%	16.9%	14.4%	11.0%	9.2%	10.9%	13.6%	16.1%	13.3%	16.3%	13.6%



Qualified Social Workers Bands 5-7, Absence/Vacancy Data as at 31st March



Across the five HSC Trusts, WHSCT has consistently recorded the lowest absence/vacancy rate for Qualified Social Workers (Bands 5–7) at 31 March over the four-year period 2022/23 to 2025/26.

Allied Health Professionals (AHP) Supervision

Professional supervision remains a core component of safe, effective and person-centred Allied Health Professions (AHP) practice across the Western Health and Social Care Trust (WHSCT). Supervision provides a structured process for professional support, reflection, learning and development, contributing to high standards of clinical care, staff wellbeing and workforce retention.

Supervision is well established across all AHP services, with staff expected to receive a minimum of four supervision sessions per year in line with the Regional AHP Supervision Policy. Supervision arrangements are tailored to individual and service needs and may include one-to-one supervision, group supervision, peer supervision or blended approaches.

The frequency and focus of supervision are determined by professional experience, role complexity and development requirements. Newly qualified practitioners and those undertaking new roles or responsibilities typically receive more frequent supervision, with increasing autonomy supported through regular review and professional guidance.

Compliance with supervision standards continues to be monitored within each AHP service through local governance arrangements, quality assurance processes and audit activity. Feedback from staff is routinely sought to inform continuous improvement and ensure supervision remains effective, meaningful and supportive.

The regional supervision training programme continues to support best practice through a blended learning model. Tier 1 training is available through the regional eLearning platform, while Tier 2 combines online and face-to-face learning. This structured framework supports

supervisors and supervisees at all career stages and promotes consistent implementation of the Regional AHP Supervision Policy (NI) 2022.

During 2026, services have continued to focus on strengthening the quality and consistency of supervision, recognising its important role in professional development, clinical governance, staff engagement and the delivery of high-quality AHP services.

STAFF ACHIEVEMENTS

Professional Awards

Trust staff were successful in obtaining a number of awards over the year such as:

Northern Ireland Healthcare Awards 2025






Congratulations to the Cardiology Team at the South West Acute Hospital, Enniskillen, on winning the Cardiology Team of the Year at the Northern Ireland Healthcare Awards 2025. The award was in recognition of their work in the Cardiovascular Renal Metabolic Space.

Regional Recognition from the Department of Health



Orthopaedic 'Prehabilitation' Programme received regional recognition from the Department of Health. The 'Link to Wellbeing' programme was awarded the Elective Care Recognition Award for its efforts to improve delivery of elective care services in Northern Ireland.

King's Birthday Honours 2025









Congratulations to Dr Anne Friel, recently retired Head of Pharmacy and Medicines Management and Hospital Volunteer Wallace Nutt on their richly deserved recognition in the Kings Birthday Honours. Also acknowledged in the honours list was Dr Roz McMullan, former Head of Orthodontics who received an OBE for services to Dentistry.

RCN Northern Ireland Nurse of the Year Awards 2025



Jacqui Lundy, Community Children's Nurse was winner of the Patient Choice Award.



Jonah Atos, International Nurse Co-ordinator, was runner-up in the Directors of Nursing Award.



Linda Britton Reid was runner-up in the Health Care Support Worker Award.



Ashley Ferguson, Health visitor was joint runner-up of the Public Health Award.



Karen Harper and Helen McCormick, Clinical Nurse Specialists for lung cancer were Runners-up in the Cancer Nurse

UK Advancing Healthcare Awards 2025

The Trust's Children and Young People's Autism Early Intervention Service celebrated their success in the annual UK Advancing Healthcare Awards. The Service won the Northern Ireland Government's award for clinical impact to address healthcare inequalities with their nomination for 'Doing Things Differently – Using a neuro-affirming approach to see beyond the label'.





HSJ Patient Safety Awards 2025

The Pharmacy Team at the North West Cancer Centre, Altnagelvin Hospital celebrated success in the annual HSJ Patient Safety Awards recognising outstanding achievements and innovations in improving patient safety across the UK healthcare sector.

European Society for Medical Oncology (ESMO) Accreditation

The European Society for Medical Oncology (ESMO) presented the North West Cancer Centre (NWCC) with ESMO accreditation as a Designated Centre of Integrated Oncology and Palliative Care for 2025-2027. The NWCC is the first cancer centre in Northern Ireland to receive this prestigious accreditation by fulfilling 13 strict criteria based on recommendations from the World Health Organisation on the provision of palliative care for patients with cancer.











Davin Corrigan Legacy Award 2025

Adult Learning Disability Occupational Therapist service 'Inclusive Bikes' initiative won the Davin Corrigan Legacy Award for Improving Patient and Service User Safety through Engagement.

National Joint Registry (NJR) Quality Data Provider Awards 2025

Congratulations to the Arthroplasty Team, Altnagelvin Hospital on receiving silver accreditation in the National Joint Registry (NJR) Quality Data Provider Awards 2025. They received the Bronze award previously for the 2023/24 audit cycle and this reflects further improvement in their performance.





Northern Ireland HFMA Awards

Yvonne Ferguson Recognised as Northern Ireland's Unsung Hero Runner-Up at the NI HFMA Awards. This recognition highlighted the exceptional value of her work within the Finance Department and the positive influence she has across our organisation.

Staff Recognition Awards 2024/25

Western Trust staff were recognised at the Trust's 2025 Staff Recognition Awards. The annual awards ceremony held in December 2025.

The Staff Recognition Awards are the highlight of the Trust's year, celebrating the outstanding contribution of staff. There are twelve main award categories and nine professional awards, each designed to acknowledge individual staff and teams and celebrate leadership, compassion, innovation, patient care and working together.















LOOKING AFTER OUR PEOPLE

Improving the Health and Wellbeing of Trust Staff

The Western Trust strives to be a *Great Place to Work* with a focus on staff wellbeing.

Investment and development into supporting staff well-being remains a priority within the Western Trust. The Wellbeing Framework, HSC Healthier Workplaces Network, the Staff Wellbeing Forum, communications with staff, cross-department and regional engagement forums help to support and guide the development and implementation of staff wellbeing initiatives within the Western Trust.

Corporate Commitment

All WHSCT Directors have been invited to support and promote the health and wellbeing of staff by actively and visibly supporting the 'We are with you Wellbeing Project' by becoming 'Wellbeing Guardians' on a topic of their choice and furthermore fulfilling a visible and supportive role to promote key wellbeing initiatives within the organisation.
To date, 12 WHSCT Directors have held the title of Wellbeing Guardian, each for a period of 3 months.
In addition, The Corporate Management Team have both contributed to and overseen the completion of The DoH Strengthening Our Core – WHSCT Workplace Assessment.

The assessment tool will allow the Trust to assess our current situation against best practice; to identify areas in which our organisation is performing well; highlight areas that require further attention; and chart future steps required in order to strengthen impact over time.

HIEI Staff Wellbeing Team- Core Services

The Staff Wellbeing Team within the HIEI Department continue to promote and enhance provision of staff health and wellbeing through a range of services to maintain and improve wellbeing at work.

The team continues to use initiatives such as; Quarterly Staff Wellbeing Menu, Monthly Staff Wellbeing Magazine, Thrive and The TRUSTed Podcast, as a vehicle to both highlight and address health inequalities.

In order to improve communication regarding service delivery for staff without access to WHSCT email, the team have developed a postal mailing distribution list to ensure all staff have access to hard copies of resources.

Monthly Thrive editions publishes a wide range of health-related topics, written by subject matter experts within WHSCT along with the continued dedicated space for a piece on Equality, Diversity and Inclusion, written by, HR Manager, Human Resources, Joanne Scott. In addition, the magazine has a reoccurring feature on spiritual wellbeing, with rotating authors representing various religious backgrounds.

Recent Podcast episodes have included; *Hidden Harm, Coercive & Controlling Behaviour* and *a Personal Story – My Journey Through Breast Cancer*.

Upcoming recordings during 2026 will deliver episodes including; *Prostrate Cancer, Prevention, Detection and Cancer Care* and *Paediatric Cardiovascular Health*.

The Western Trust values its broad and diverse workforce and is committed to supporting staff wellbeing. The Staff Wellbeing Team is dedicated to designing and delivering

accessible health and wellbeing programmes, incentives, campaigns and information initiatives for all employees.

Examples of these initiatives include, but are not limited to:

The Staff Wellbeing Team continue a working relationship with the WHSCT Occupational Health Department to develop and deliver online 20-minute Gentle Exercise for Musculoskeletal Health (MSK). A physio led, full body, chair-based exercise programme focusing on breathing, core, strength and mobility. Additionally, printed materials are provided for those without online access.

The Staff Wellbeing Team continue a working relationship with the WHSCT Perinatal Mental Health Team to co-design and deliver once per quarter, a 4-week programme for staff members who currently care for or expecting a child. Topics explored included; preparation for birth, emotions & feelings in the postnatal period, how we nurture the mother and baby connection, taking time for you.

HIEI along with representatives across all directorates coordinate and provide a monthly Menopause Cafe for WHSCT staff. The Cafes are delivered using a hybrid approach i.e. both in-person and face to face, and are facilitated by various subject matter experts along with the opportunity for participants Q&A.

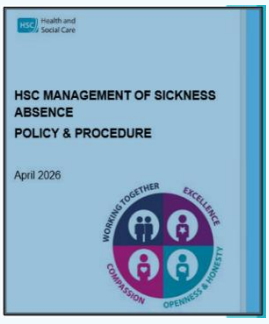
During this reporting period, November 2025-March 2026, there have been a further 5 Menopause sessions provided, with 175 staff participating.

WHSCT have developed a 'Managers Menopause Toolkit' as 'The Trust recognises that a large and increasing proportion of employees will be working through and well beyond the menopause. This policy recognises the impact of menopause on the working lives of employees'.

<u>Plans for Future Developments</u>
Driven by The Menopause working group and chaired by a member of The Staff Wellbeing Team, WHSCT have commenced on a journey to achieve accreditation to become a Menopause Friendly Employer, which will be measured against five standards, this is almost at the finish stages, with hopes of achievement during 2026/27.

The Wellbeing Team are currently developing a dedicated SharePoint wellbeing page, accessible via a direct hyperlink which will provide a centralised source of information, enhance visibility of service provision and support the Trust's commitment to promoting staff health and wellbeing. This will be launched during 2026/27.

Supporting Improved Attendance and Wellbeing



From April 2025 to March 2026, the HR Attendance Team provided consistent, proactive support to improve sickness absence management across Directorates, supporting approximately 1000 absence meetings and hearings. The team strengthened early intervention and ensured consistent application of the Attendance at Work Policy, contributing to measurable reductions in absence levels in key areas particularly within the Planning, Performance and Corporate Services Directorate. They enhanced managerial capability through targeted coaching, one-to-one support, and the

development of practical guidance and templates, while maintaining robust oversight of long-term cases in line with Trust expectations.

The team also supported Trust-wide change by preparing for the introduction of the Regional Management of Sickness Absence Policy on 1st April 2026 and delivering well-attended awareness sessions, alongside contributing to the development of regional supporting materials.

REVALIDATION

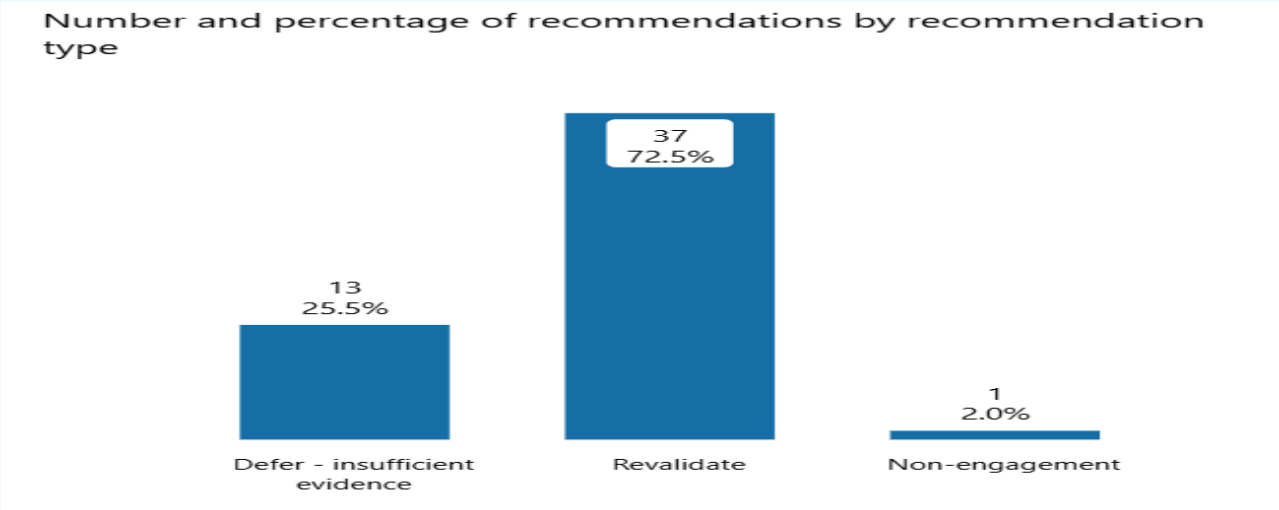
Appraisal & Revalidation - Medical Staff

The Appraisal Policy and Engagement Protocol 2025 has been finalised and circulated to all Medical and Dental staff. A key change within the updated policy is the revised appraisal completion deadline, which has been brought forward from 30 June 2026 to 30 April 2026. This change aligns the Trust with other HSCNI Trusts and will strengthen governance by supporting timely completion of appraisals and reducing the risk of doctors entering a new appraisal year with more than one incomplete appraisal.

The Regional Appraisal System has also been updated to support Clinical Academics in completing their annual appraisal. A new form has been introduced to allow Clinical Academics to include both their academic and clinical work, with input from their academic and clinical appraisers. This supports a whole-practice approach to appraisal and ensures that all relevant aspects of a doctor's role are appropriately reflected.

In relation to revalidation the Trust has submitted 35 positive recommendations alongside 13 deferrals and 1 recommendation relating to non-engagement. These outcomes are reflected in the General Medical Council appraisal and revalidation data for the period 1stApril 2025 to 31 March 2026.

General Medical Council (GMC) Appraisal & Revalidation 1st April 2025-31st March 2026



Under the theme of strengthening the workforce, 10 doctors were recently referred to the GMC under the early concern process due to incomplete appraisals and potential non-engagement. Following further engagement, 6 of these appraisals have now been

completed. It should be noted that potential non-engagement with **potential licence removal** is not captured within the revalidation table.

The Trust Appraisal and Revalidation Team continues to support Medical Practitioners with appraisal and revalidation activity by providing advice, guidance, key supporting information and training.

The Engagement Protocol remains in place to promote timely completion of appraisals and to provide a structured approach where concerns regarding engagement arise.

The team has continued to deliver appraiser and appraisee training, incorporating the principles of Good Medical Practice 2024 into training sessions. Between April 2025 and February 2026, 106 Medical Practitioners attended appraisee training and 29 attended appraiser training, all delivered via Microsoft Teams.

Further training has been booked for Autumn for New Appraisees and new appraisers.

Training	Date	Location	Attendance
Appraisee Training	April 2025 - February 2026	Microsoft Teams	106
Appraiser training	April 2025 - February 2026	Microsoft Teams	29

The Appraisal and Revalidation Team also continues to contribute to the Regional Working Group, which provides a forum for progressing regional initiatives and addressing regional appraisal and revalidation matters. This includes supporting the implementation of recommendations arising from independent inquiries and the application of GMC 2024 guidance

The working group and supporting staff will also meet in late September to review regional training arrangements and identify the best ways to support both one another and our doctors. The aim will be to ensure that system training is streamlined, there is a clear understanding on how the system works and that administrative staff are fully aware of the processes for addressing and escalating system-related issues.

Professional Registration of Nursing & Midwifery Staff within the WHSCT

All nurses and midwives working within the Western Health and Social Care Trust are required to hold an active, live professional registration with the Nursing and Midwifery Council (NMC). The Trust is required to have effective and appropriate governance and oversight processes in place to monitor professional registration status, provide assurance that registration requirements are maintained, and ensure timely action is taken where any risk or lapse in registration is identified.

As a requirement of continued professional registration, all nurses and midwives must complete NMC revalidation every three years. Revalidation supports ongoing professional development, reflective practice and public confidence that registrants continue to practise safely, effectively and in line with professional standards.

The Western Health and Social Care Trust (WHSCT) has established processes to support compliance with NMC revalidation requirements. These include individual registrant responsibility, managerial oversight, local monitoring arrangements, electronic roster alerts

and verification processes for bank and agency staff. Managers are encouraged to maintain oversight of revalidation dates to minimise the risk of registrations lapsing.

Where a registration lapses, governance arrangements are in place to ensure appropriate escalation, oversight and support. Registrants whose NMC registration has lapsed are unable to practise as a registered nurse or midwife until their registration is reinstated by the NMC. The Trust has developed supportive arrangements to minimise financial hardship for affected staff while ensuring compliance with professional and regulatory requirements.

During the reporting period 1 April 2025 to 31 March 2026, 12 lapsed registrations were reported within the Trust. While this represents a small proportion of the nursing and midwifery workforce, continued vigilance is required to minimise the risk of future occurrences and to strengthen compliance with local monitoring processes.

Professional Nursing will establish a new assurance confirmation process for roll-out during 2026/27. This will require all nurse managers to provide monthly confirmation that all nurses and midwives within their permanent, temporary staffing hold an active, live NMC registration. Existing manager-level arrangements to support staff with preparation for, and completion of, NMC revalidation will also be audited during 2026/27 to provide further assurance regarding the effectiveness of local oversight and support processes.

MANDATORY TRAINING

	April 2024	April 2025	April 2026
Onboarding (Induction)	94%	94%	96%
Quality 2020	84%	88%	91%
Fire Safety	76%	80%	78%
Information Governance	85%	86%	86%
Equality	77%	85%	84%
Moving & Handling	77%	85%	80%
Cyber Security	72%	87%	91%

STAFF TRAINING

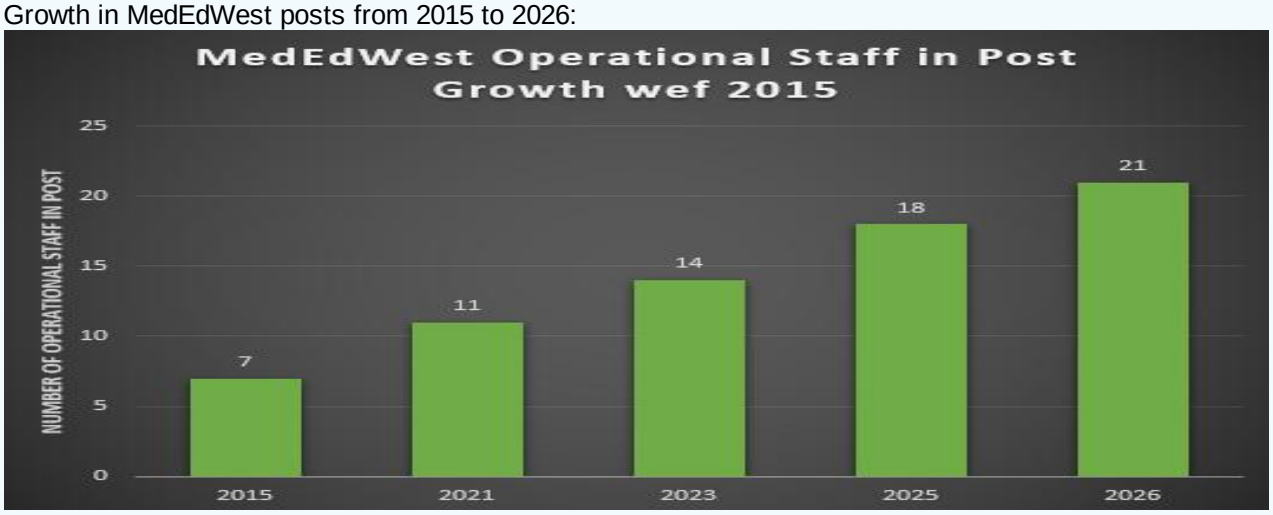
Medical Education & Training

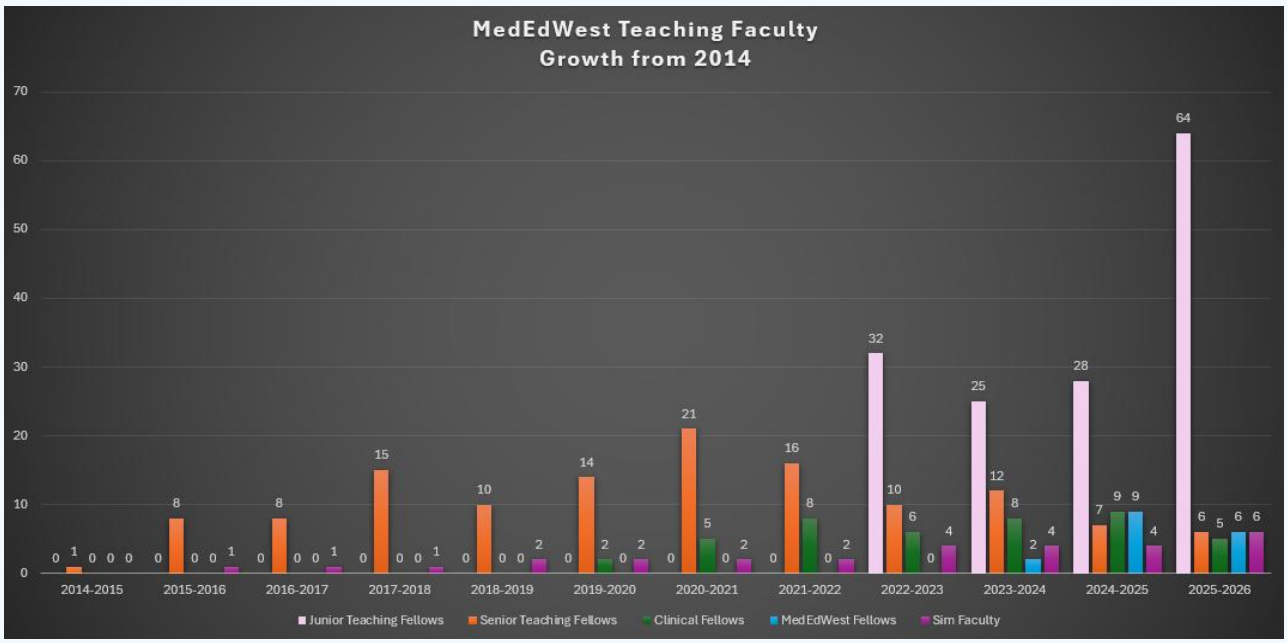
MedEdWest growth

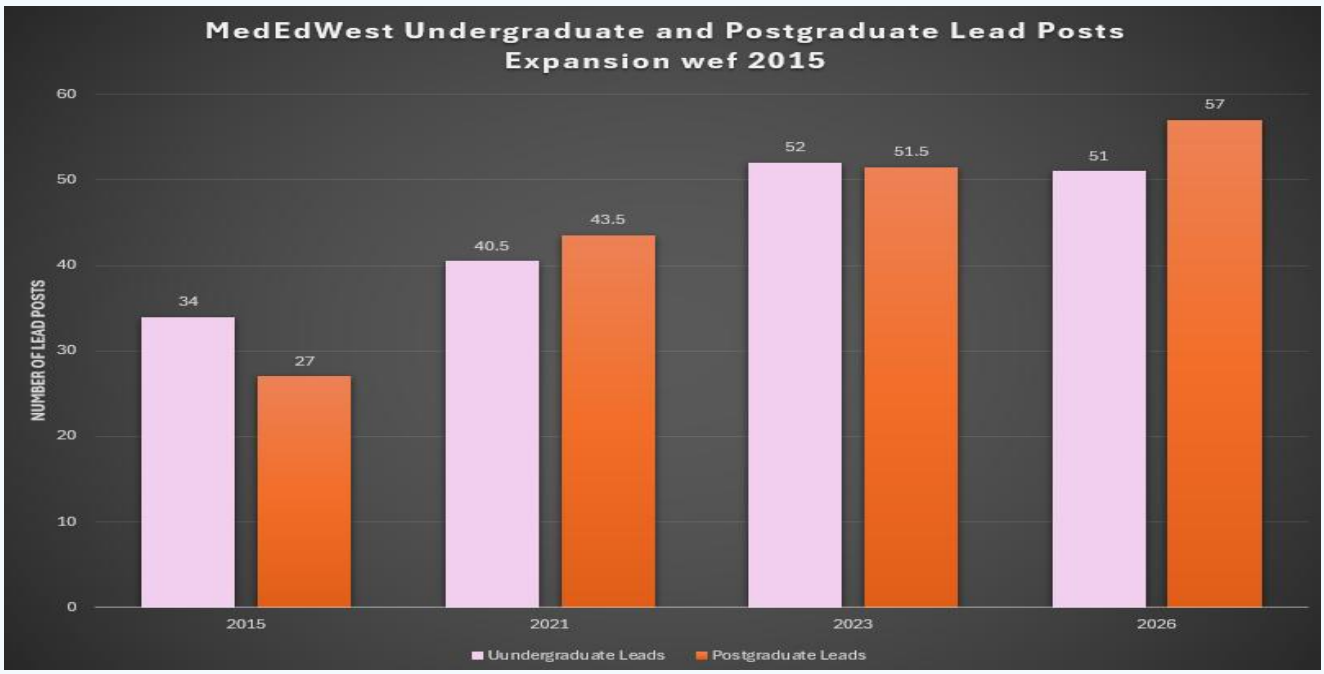
MedEdWest continues to develop and strive for excellence in medical education. MedEdWest continues to be innovative in a dynamic education facility and adapting to continued changing needs in medical education. The growth in medical student and postgraduate numbers has brought significant changes not only to the learner experience and educator provision, but also to the operational team that underpins the delivery of high-quality medical education.

As the scale and complexity of teaching and training programmes increase, so too does the demand on the administrative, technical and nursing support structures that ensure their effective delivery. The team and structure rapidly expand, meeting the changing needs of medical education.

Growth in MedEdWest posts from 2015 to 2026:







Widening Participation
Over 150 students from 28 schools across the council area attended an Open Evening for prospective medical students in the MedEdWest education centres. With the assistance of MedEdWest team, students had the opportunity to speak to professionals in over 20 different specialities, ranging from Orthopaedics, Emergency Medicine, Ophthalmology, ENT, Dentistry, Respiratory and Paediatrics to name a few. Staff hosted interactive stations where students had a chance to try their hand at skills such as laparoscopic surgery, suturing, cardiac arrest simulation, lumbar puncture, orthopaedic surgery and more. Students then attended a talk by a resident doctor who spoke of their journey into medicine. Attendees then had the unique opportunity of a Q&A session with medical students, FY1 and FY2 Doctors and other more senior colleagues.

The students have said these evenings have gone a long way in cementing their decision to follow medicine or dentistry as their career path. They have seen aspects of the career they had never heard of before and got to hear first-hand what Trust staff love about their job. The interactive stations really brought to life procedures that form a part of every-day life as a medic or dentist

Undergraduate & Postgraduate Quality Assurance Systems and Processes
Quality management processes are in place, this allows the Trust, in collaboration with QUB and UU, and to ensure DoH that SUMDE is being used to deliver appropriate outcomes in the support of undergraduate medical education. The annual QUB clinical visits to Altnagelvin and SWAH took place with excellent feedback from the medical students. Specialties achieving quality scores of greater than 80% are deemed excellent and considered to reflect high standard clinical teaching. The Trust was praised for the quality of clinical teaching provided to QUB and UU medical students.

UU:
Out of 16 specialty placements – all 16 placements scored over 80%, with 13 specialties scoring 100%.

QUB:
Out of 20 specialty placements – 17 specialties scored over 80%. 3 specialties in SWAH scored less than 80%, these specialties will be monitored in the next academic year.

Postgraduate quality assurance systems are in place between the Trust and NIMDTA. Deanery visits take place every year. The national training survey is the largest annual survey of doctors across the UK. It gathers the views of doctors in training on the quality of their postgraduate medical education and work environments. It also seeks feedback from trainers about their experiences as clinical or educational supervisors.
The GMC NTS (National Training Survey) identifies area of good practice and improvements required that are monitored as part of MedEdWest quality report returns to NIMDTA.

MedEdWest App
MedEdWest continues to make use of our space on the Eolas medical app. This valuable space is our one stop shop for all medical education resources. Combined with our major communication tool 'MedEdWest Medics', we continue to provide students and residents who cannot attend training a wealth of information including access to recorded resources. MedEdWest are able to add medical students and residents to the app, reducing delays in accessing information, enabling us to support users in their communication needs. The recording facility is incredibly time efficient in terms of staff input and enables a greater

flexibility of service provision and getting the right information to the right users at the right time, reducing the number of emails to users.

Is it BAU (Business as Usual)?
After 5 years of planning, preparing and then implementing the UU Graduate Entry Medical School and QUB change of curriculum, MedEdWest has moved into a new phase of sustainable operational delivery. Nothing has remained static, with yet more curriculum change and expansion in student and resident doctor numbers. The work continually evolves with endless meetings and more versions of timetables and rotas that we care to mention. We continue to be fully operational, dangerously efficient and a team mostly standing - no big deal just...our new business as usual!

What is BAU?

- it's not cutting the ribbon and letting momentum slip
- it's not forgetting the WHY
- it is shaping the future of medical education in the NI region
- it is maintaining sustained excellence in delivery
- it is managing student expectations across all cohorts and universities
- it is continued curriculum refinement
- it requires expanding the model --- regionally - which means being innovative

We just didn't deliver another medical school; we have changed the map. We are very proud of our delivery of medical education. We will embrace the incoming year head on and look forward to another challenging year, as we continue providing the education and training support required for medical workforce expansion as outlined by the Gardiner report in 2018.

Reducing the Risk of Hyponatraemia

The Western Trust leads the very highest standards in relation to safe fluid therapy for children and we continue to implement the Regional Fluids Policy. Professionals now can easily benchmark their own best practices in line with the Regional Competency Framework and we also promote fluids safety at our twice-yearly face to face Medical and Dental inductions. We also mandate that Medical Staff undertake the BMA and HSC online training modules on fluid therapy.

The Trust action plan arising from the Inquiry into Hyponatraemia Related Deaths continues to be monitored through the Trust's governance arrangements. Oversight of implementation is being transferred to a new Major Reviews Governance Learning & Assurance Oversight Group in 2026, which reports to CMT and provides assurance to the Patient Safety & Quality Committee and Trust Board regarding progress against learning and actions arising from major reviews and inquiries.

Infection Prevention and Control (IP&C) Training

Induction and Mandatory Update Training
During the reporting period April 2025 to March 2026, Infection Prevention and Control (IPC) Induction Training and Mandatory Update Training continued to be delivered through the regional e-learning programme on LearnHSCNI. The programme was developed regionally for use across all Health and Social Care organisations in Northern Ireland and comprises two modules: Tier 1 for non-clinical staff and Tier 2 for clinical staff.

The IPC Team also delivered a series of virtual training sessions via Microsoft Teams. These Tier 1B sessions were aimed at staff with minimal or no patient / client contact or healthcare staff with patient contact who require role specific training, e.g. Support Services, HSDU, Estates, Transport, Social Workers, Chaplains, etc. The Team also facilitated face-to-face Training for large groups of staff in departments, e.g. Support Services staff.

Attendance at IPC Training is required on a biennial basis. The attendance rate over the 24-month period ending March 2026 was 70%.

Aseptic Non-Touch Technique (ANTT) Training
ANTT is a technique to prevent micro-organisms from being introduced to sterile/ susceptible body sites during invasive procedures, such as wound care or when handling or manipulating devices (urinary catheters, peripheral and central venous cannulas).

An ANTT e-learning programme is available on LearnHSCNI. During April 2025 to March 2026, a total of 739 staff completed this training.

Ward-Based Enhanced Support/ Improvement Work
During the reporting period April 2025 to March 2026, the WHSCT IPC Team continued to provide enhanced ward-based support and improvement work across wards and departments. This support was tailored to the needs of individual clinical areas and informed by surveillance data, audit findings, identified IPC risks and the transition to Encompass/Epic documentation. The work included on the spot education, ward-based training, real time advice and targeted feedback to staff.

Examples of support included Aseptic Non-Touch Technique, insertion and ongoing care of peripheral intravenous cannulas and urinary catheters, completion of HII audit requirements within Encompass/Epic, use of the DRIFT and HOUDINI acronyms to support clinical indication and review, compliance with the WHSCT MRSA Screening and Management Policy, hand hygiene practice, transmission-based precautions, equipment decontamination and environmental IPC standards.

High Consequence Infectious Disease (HCID) Preparedness
During the reporting period April 2025 to March 2026, the WHSCT IPC Team continued to support Trust preparedness for HCID through coordination of the multidisciplinary HCID Working Group, pathway development, action log management and preparedness discussions. Work has progressed across a number of pathway areas, including Emergency Departments, inpatient ward arrangements, paediatrics, neonatal services, maternity, vaccination and supporting services.

IPCT input also supported Trust escalation of risks and engagement with clinical, operational, estates, procurement, laboratory, emergency planning and regional colleagues.

The IPC Team continued to support HCID workforce preparedness by assisting with the set up and coordination of training arrangements across key pathway areas. This included working with services to identify appropriate trainers, support access to PPE training and encourage local ownership of training delivery. Further work is still required, as some areas continue to have significant numbers of staff to train and medical engagement has remained limited.

The IPC Team continued to highlight that HCID preparedness requires coordinated organisational ownership across clinical, operational and corporate services. Further

assurance remains dependent on continued directorate engagement, pathway sign-off, local training delivery, PPE procurement and storage arrangements, strengthened medical participation, and clear regional guidance and support to inform consistent preparedness arrangements.

Haemovigilance Training

During April 2025 to March 2026, the Haemovigilance Team continued to support safe transfusion practice across the Trust through the delivery of education, training, and competency assessment programmes aligned with the *"Right Patient, Right Blood"* principles.

The Trust remains committed to meeting the requirements of Better Blood Transfusion 3 (BBT3), HSS (MD) 17/2011, and the Blood Safety and Quality Regulations (BSQR, 2005). Staff involved in the transfusion process are required to maintain valid Haemovigilance training and, where applicable, competency assessments in accordance with these standards. Compliance is monitored through routine review of Haemovigilance incidents, sample errors, and clinical practice.

Training is provided through LearnHSCNI e-learning modules and face-to-face sessions delivered by Haemovigilance Practitioners. The team also facilitates training for new Assessors and refresher updates for existing Assessors, supporting the ongoing assessment of staff competency within clinical areas.

Additional Training and Education

A significant focus during 2025-2026 was supporting the implementation of Encompass, which went live across the Trust in May 2025. Following completion of Super User training, members of the Haemovigilance Team delivered education through User Labs, face-to-face sessions, at-the-elbow support, and Encompass update sessions, helping staff safely transition to electronic transfusion workflows.

The team also delivered targeted ward-based education in response to clinical needs, audit findings, and learning arising from Haemovigilance incidents. Training topics included the WHSCT Major Haemorrhage Protocol, Blood Collection procedures, Transfusion Associated Circulatory Overload (TACO), and other transfusion-related safety topics. Annual training and competency assessments were provided for newly appointed FY0 doctors, as well as agency and locum staff, ensuring consistent standards of transfusion practice across the Trust.

Learning and Quality Improvement

The Haemovigilance Team continues to utilise a blended learning approach, combining face-to-face education with digital learning resources. Blood transfusion training videos and e-learning videos are available to support learning and reinforce key stages of the transfusion process, with positive feedback from staff regarding their accessibility and educational value.

Through ongoing education, competency assessment, incident learning, and staff engagement, the Haemovigilance Team continues to support patient safety, strengthen regulatory compliance, and drive continuous quality improvement in transfusion practice across the Trust.

Theme 3

Measuring the Improvement



REDUCING HEALTHCARE ASSOCIATED INFECTIONS (HCAIs)

When HCAIs occur, they may have a significant impact on the wellbeing of patients. The Trust has a zero tolerance for preventable infection.

Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia:

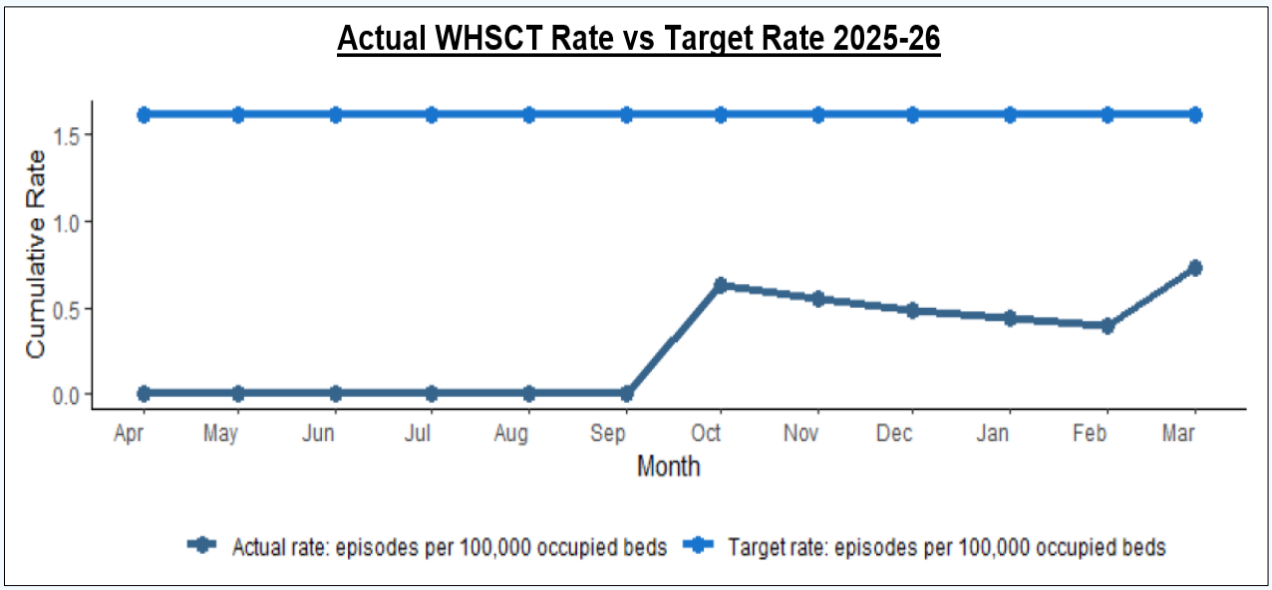
MRSA is an antibiotic-resistant organism which can be carried on the skin and not cause illness. This is referred to as colonisation. However, when a person becomes ill for other reasons, they become more vulnerable to infections caused by MRSA. The organism can cause serious illness, particularly for frail or immune-compromised patients in hospital who have a wound, or require a central line or urinary catheter. Risk factors for MRSA bloodstream infection, known as a bacteraemia, are related to the ongoing level of colonisation and vascular line care.

Facts and Figures

The reduction target set for MRSA bacteraemia in 2025-26 was an incidence rate of 1.613 cases per 100,000 occupied bed days.

The Trust reported a total of two cases for the year. Both patients came to hospital with MRSA already in their bloodstream. This equated to a rate of 0.734 cases per 100,000 occupied bed days, meaning the target was achieved.

This was a reduction of 54% compared to the baseline year of 2019-20, when four cases and a rate of 1.613 per 100,000 occupied bed days were reported.



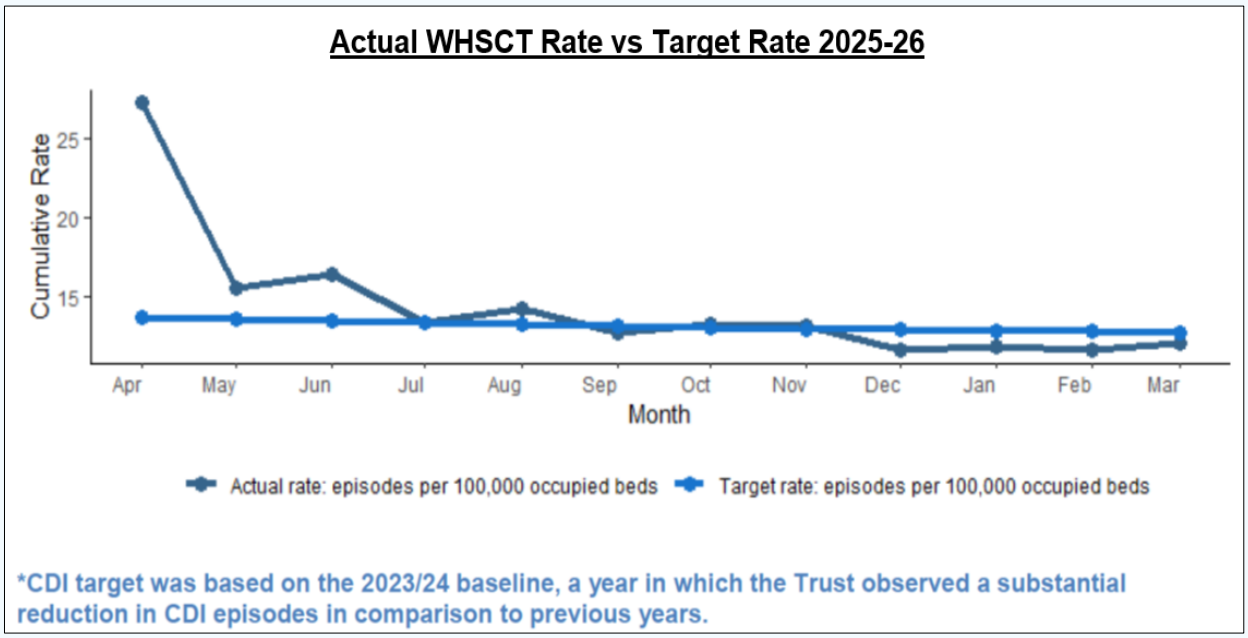
Clostridium difficile (C. difficile) Associated Disease

C. difficile is a spore-forming organism that can survive in the environment for long periods and colonisation is usually acquired by ingestion after contact with an affected person or contaminated environment / equipment. *C. difficile* is carried in the bowel. It is normally kept under control by other bacteria and patients may be colonised without displaying symptoms. The development of *C. difficile* associated disease is nearly always related to, and triggered by, the use of antibiotics prescribed either to treat another condition or given prophylactically. This is because antibiotics can change the natural balance of bacteria in the bowel, enabling *C. difficile* to multiply and produce toxins which can cause illness, including diarrhoea.

Within the Trust predisposing factors for *C. difficile* continue to be antimicrobial prescribing in primary and secondary care and the use of proton pump inhibitors (PPIs). In addition, independent audit of compliance with the *C. difficile* care bundle remains a challenge, in particular use of personal protective equipment and isolation / cohort nursing. Improvement measures have, however, helped to reduce the burden of both hospital and community-associated *C. difficile*.

Facts and Figures

The *C. difficile* reduction target set for 2025-26 was an incidence rate of 12.7 cases per 100,000 occupied bed days	The Trust identified a total of 33 cases for the year, five of which were community-associated. This equated to a rate of 12.1 cases per 100,000 occupied bed days, meaning the target was met.	This was a reduction of 16% compared to the baseline year of 2023-24, when 36 cases and a rate of 14.4 per 100,000 occupied bed days were reported.



*CDI target was based on the 2023/24 baseline, a year in which the Trust observed a substantial reduction in CDI episodes in comparison to previous years.

Gram-Negative Bacteraemia (GNB)

There are many different types of gram-negative bacteria. Some live in the intestine harmlessly, while others may cause infections with differing levels of severity and mortality. One of the most serious infections that gram-negatives can cause is a bloodstream infection or bacteraemia. Gram-negative bacteria are the leading cause of healthcare-associated bacteraemias. Gram-negative bacteria can be resistant to antibiotics, and in some cases will be multi-resistant rendering many available antibiotics unusable.

In April 2018 a mandatory enhanced surveillance programme for GNBs was introduced. The specific bacteria to be monitored were *Escherichia coli*, *Klebsiella species* and *Pseudomonas aeruginosa*. The surveillance programme is part of the Department of Health Northern Ireland's (DoH NI) response to the O'Neill Review's two ambitions for human health; namely reduction of healthcare-associated GNBs and reduction of inappropriate antimicrobial prescribing.

Facts and Figures

- Given the challenges associated with reducing healthcare-associated GNBs in secondary care to date, the DoH NI decided not to set a target for 2025-26. Rather, Trusts were encouraged to minimise risk factors for GNB infections where possible.
- The Trust reported a total of 49 cases for the year.
- This was an increase of 26% compared to the previous year, when 39 cases were reported.

Methicillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

MSSA is the same type of bacteria as MRSA. It can have the same effects on vulnerable people, ranging from minor skin infections to much more serious illness, such as if it gets into the bloodstream and causes a bacteraemia. MSSA differs from MRSA in that it is sensitive to more antibiotics and so may be more easily treated. MSSA is also much more common; approximately 30% of the population carry it on their skin. It is, therefore, more difficult to control self-exposure (meaning acquisition from sites on the patient's own body). The controls in place for MRSA go some way to also protect patients from MSSA, but do not provide the same level of safeguard because of the ubiquitous nature of the organism.

Facts and Figures

- No reduction target was set for MSSA bacteraemia in 2025-26, however surveillance remained mandatory.
- The Trust reported a total of 52 cases for the year. 42 of the patients came to hospital with MSSA already in their bloodstream.
- This represents no change compared to the previous year, when 52 cases were also reported.

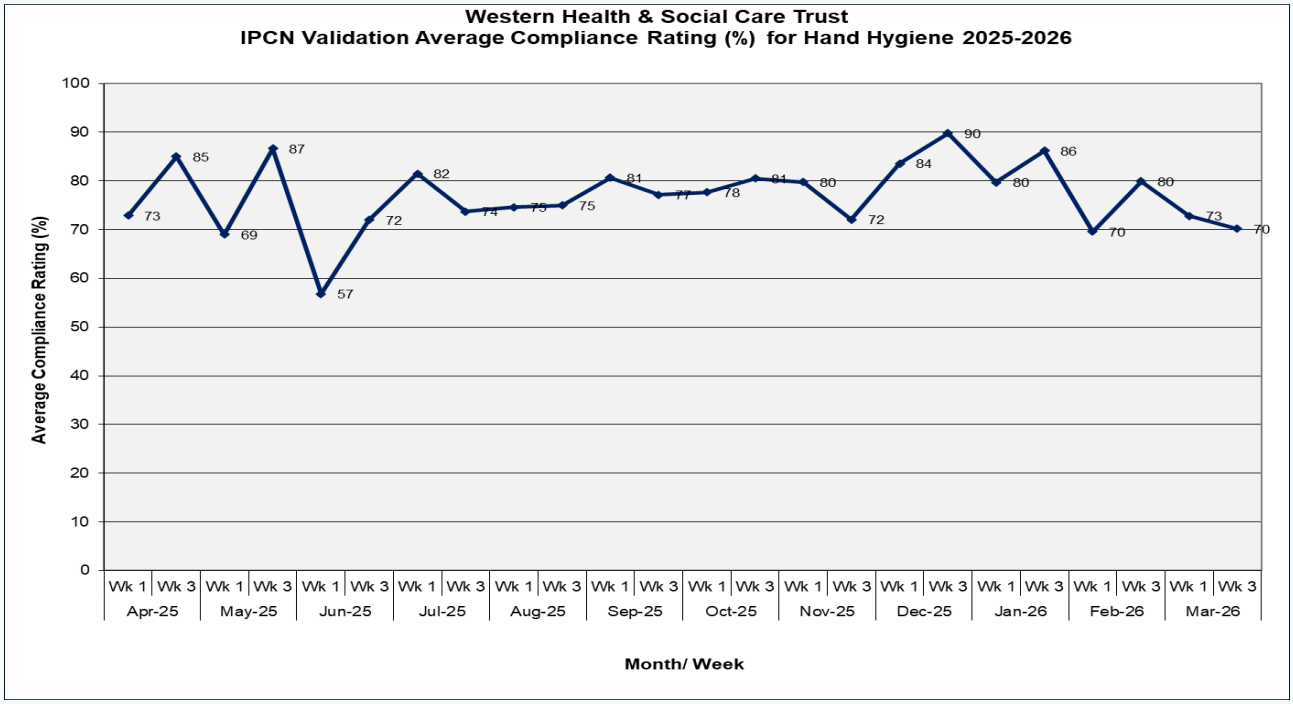
Hand Hygiene

Hand hygiene is one of the easiest and most effective ways of reducing the spread of HCAIs. While many factors can influence the risk of acquiring an infection within the healthcare setting, hands are considered a key route by which pathogens are transmitted between patients, and inadequate hand decontamination is recognised as a significant factor in transmitting HCAIs.

The Trust has improved and sustained correct hand hygiene practice since the introduction of regular and monitored hand hygiene audits in 2008. The overarching purpose of the audit is to provide performance information, to highlight good practice and to indicate precisely where improvements are required. Direct observation using a recognised hand hygiene audit tool is an effective way of assessing adherence to the evidence base.

Self-reported hand hygiene audits are carried out by core ward / department staff on a regular basis and this is validated by peer / professional lead independent audits. The Infection Prevention & Control Nurses (IPCNs) also carry out ad hoc validation audits with the aim to achieve at least 95% compliance and, if necessary, to educate and improve staff practice, with the wards / departments leading on improvement strategies. An important feature of both peer / professional lead and IPCN validation audit figures is that they are normally lower than the self-reported figures.

During 2025-26 average self-reported compliance was 99% and average IPCN validation compliance was 77%. The graph below outlines only the IPCN validation average compliance rating for hand hygiene and does not include peer / professional lead independent audit figures.

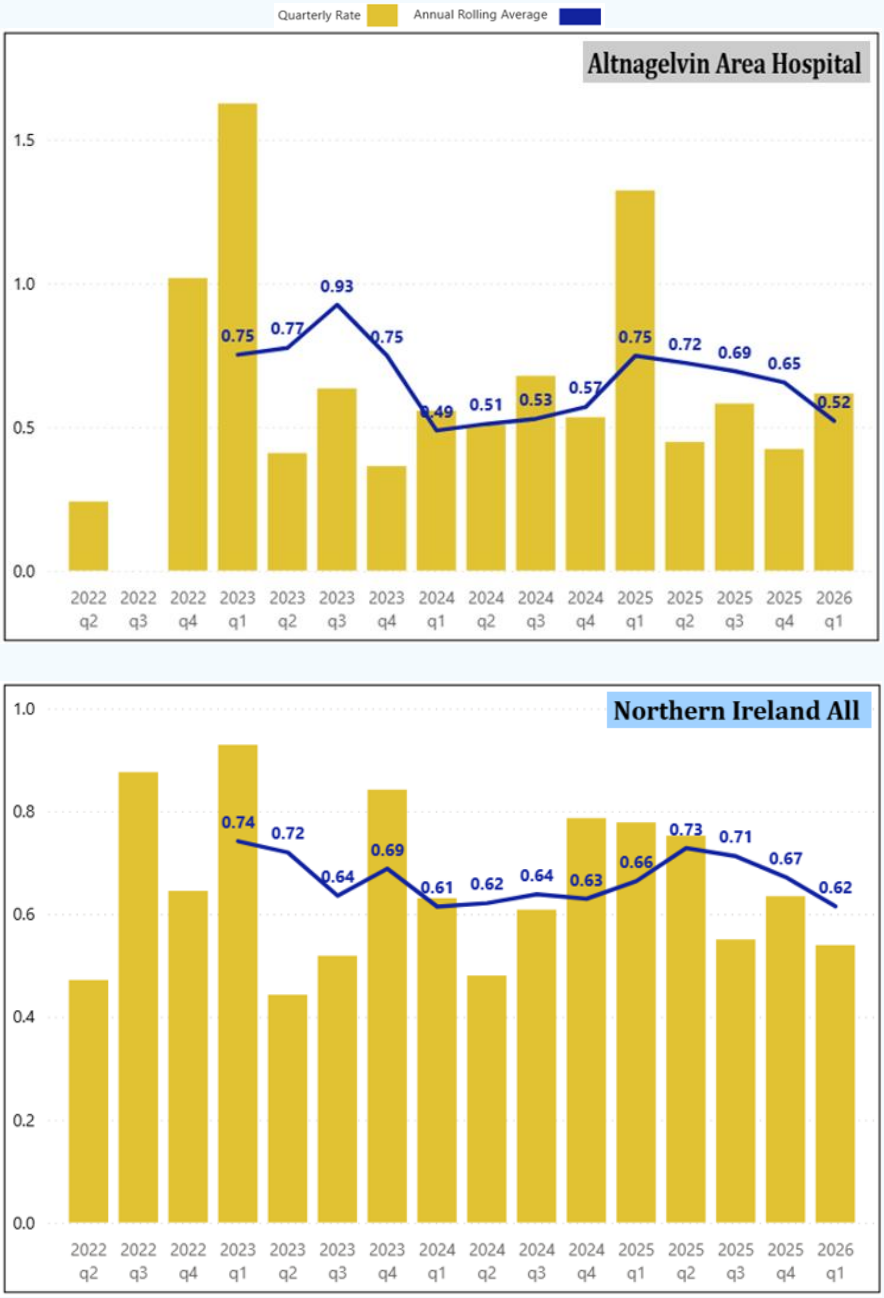


Orthopaedic Post-Operative Surgical Site Infection (SSI) Surveillance

Regional surveillance of orthopaedic post-operative infection has been continuous since July 2002. The Trust's SSI rate in orthopaedic surgery has routinely been below 1% since surveillance commenced, and the variation on the few occasions when it went above 1% was not statistically significant. The IPCNs continue to work collaboratively with the

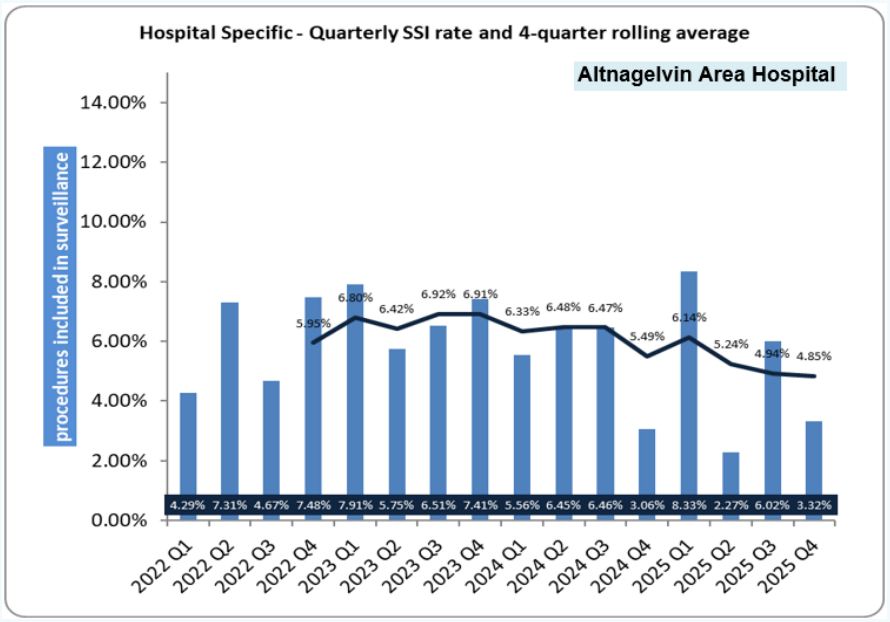
multidisciplinary team in developing further improvement strategies regarding SSI prevention.

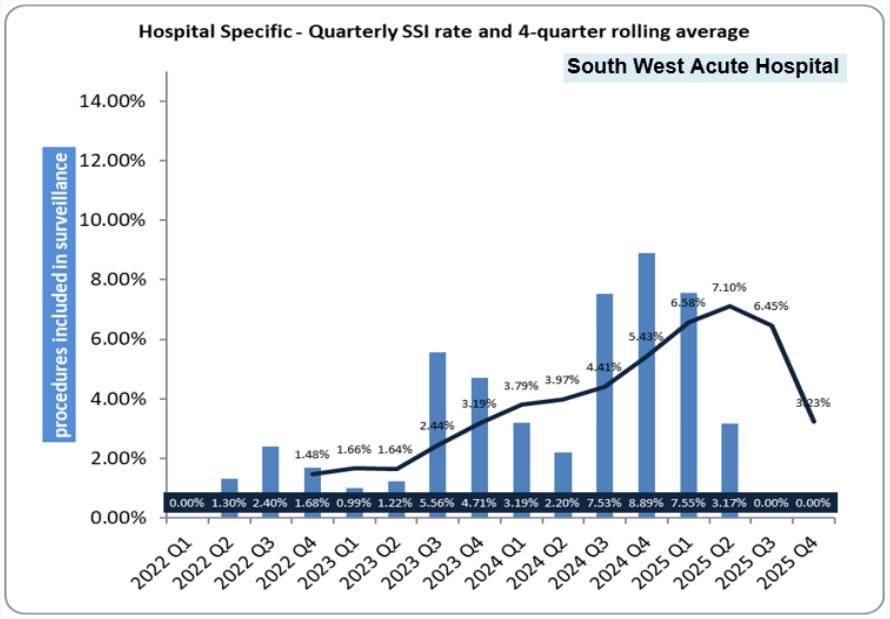
Quarterly Infection Rates and Annual (Four Quarter) Rolling Average

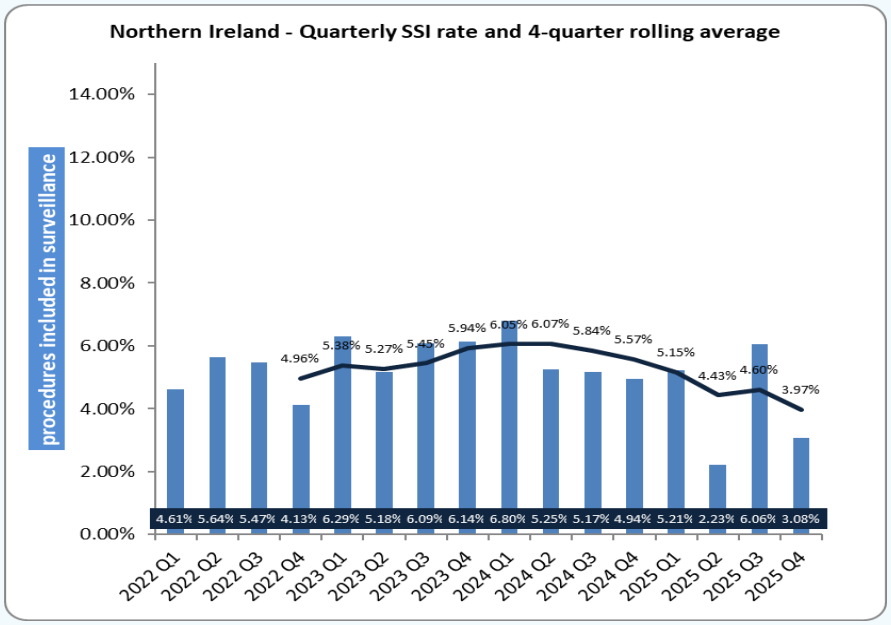


Caesarean Section Post-Operative SSI Surveillance

The Trust began contributing to the regional post-operative Caesarean section SSI surveillance programme in February 2008. The Trust performs on a par with the NI average and has seen a significant reduction in the SSI rate over time. In the previous year, 2024-25, there was a slight upward trend in the SSI rate, but this has fallen again during 2025-26. Work is ongoing with the clinical team to develop further improvement plans.

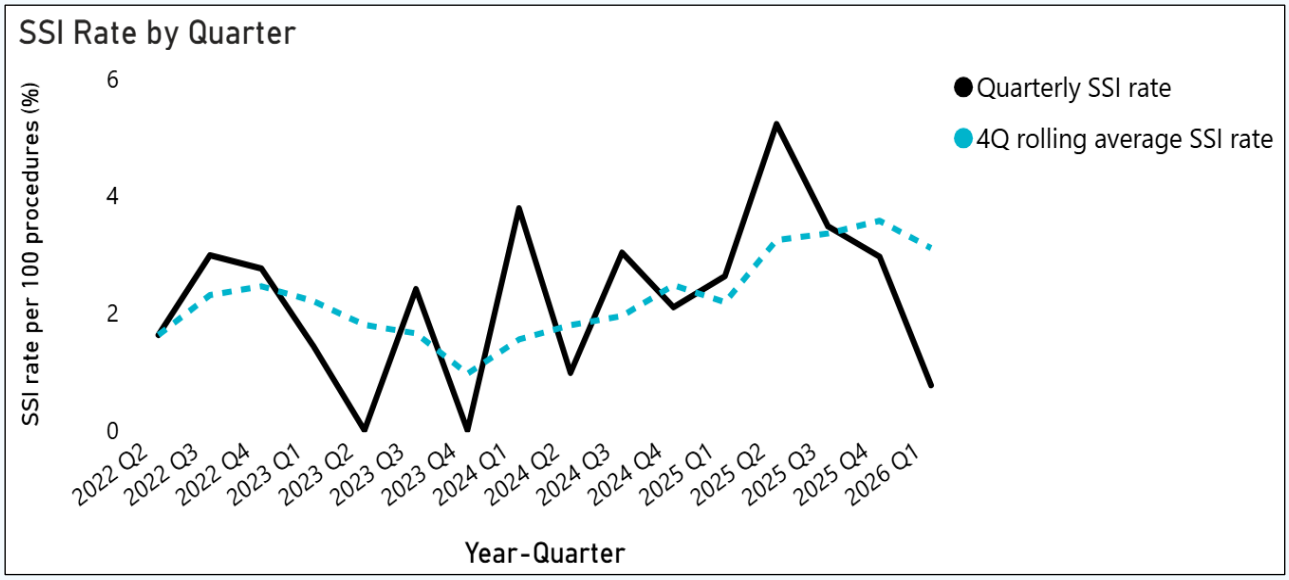

Hospital Specific - Quarterly SSI rate and 4-quarter rolling average
Altnagelvin Area Hospital
procedures included in surveillance
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
4.29% 7.31% 4.67% 7.48% 7.91% 5.75% 6.51% 7.41% 5.56% 6.45% 6.46% 3.06% 8.33% 2.27% 6.02% 3.32%
5.95% 6.80% 6.42% 6.92% 6.91% 6.33% 6.48% 6.47% 5.49% 6.14% 5.24% 4.94% 4.85%
2022 Q1 2022 Q2 2022 Q3 2022 Q4 2023 Q1 2023 Q2 2023 Q3 2023 Q4 2024 Q1 2024 Q2 2024 Q3 2024 Q4 2025 Q1 2025 Q2 2025 Q3 2025 Q4


Hospital Specific - Quarterly SSI rate and 4-quarter rolling average
South West Acute Hospital
procedures included in surveillance
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
0.00% 1.30% 2.40% 1.68% 0.99% 1.22% 5.56% 4.71% 3.19% 2.20% 7.53% 8.89% 7.55% 3.17% 0.00% 0.00%
1.48% 1.66% 1.64% 2.44% 3.19% 3.79% 3.97% 4.41% 5.43% 6.58% 7.10% 6.45%
2022 Q1 2022 Q2 2022 Q3 2022 Q4 2023 Q1 2023 Q2 2023 Q3 2023 Q4 2024 Q1 2024 Q2 2024 Q3 2024 Q4 2025 Q1 2025 Q2 2025 Q3 2025 Q4


Northern Ireland - Quarterly SSI rate and 4-quarter rolling average
procedures included in surveillance
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
4.61% 5.64% 5.47% 4.13% 6.29% 5.18% 6.09% 6.14% 6.80% 5.25% 5.17% 4.94% 5.21% 2.23% 6.06% 3.08%
4.96% 5.38% 5.27% 5.45% 5.94% 6.05% 6.07% 5.84% 5.57% 5.15% 4.43% 4.60% 3.97%
2022 Q1 2022 Q2 2022 Q3 2022 Q4 2023 Q1 2023 Q2 2023 Q3 2023 Q4 2024 Q1 2024 Q2 2024 Q3 2024 Q4 2025 Q1 2025 Q2 2025 Q3 2025 Q4

Breast Post-Operative SSI Surveillance

A pilot surveillance programme for breast post-operative SSI commenced in the Trust in July 2016. At the end of March 2026, the SSI rate was 0.77%. There is no comparative NI data as the Western Trust is the only Trust undertaking this surveillance at present. Work continues with the multidisciplinary team regarding surveillance of SSIs and the implementation of improvement measures.



Critical Care Device-Associated Infection Surveillance

Critical care device-associated infection surveillance commenced in June 2011. The surveillance looks at ventilator-associated pneumonia (VAP), catheter-associated urinary tract infection (CAUTI) and central line-associated bloodstream infection (CLABSI). The Trust performs well on this surveillance and the last recorded case of each occurred as follows:

- VAP - October 2018
- CAUTI - July 2011
- CLABSI - March 2012

SAFER SURGERY

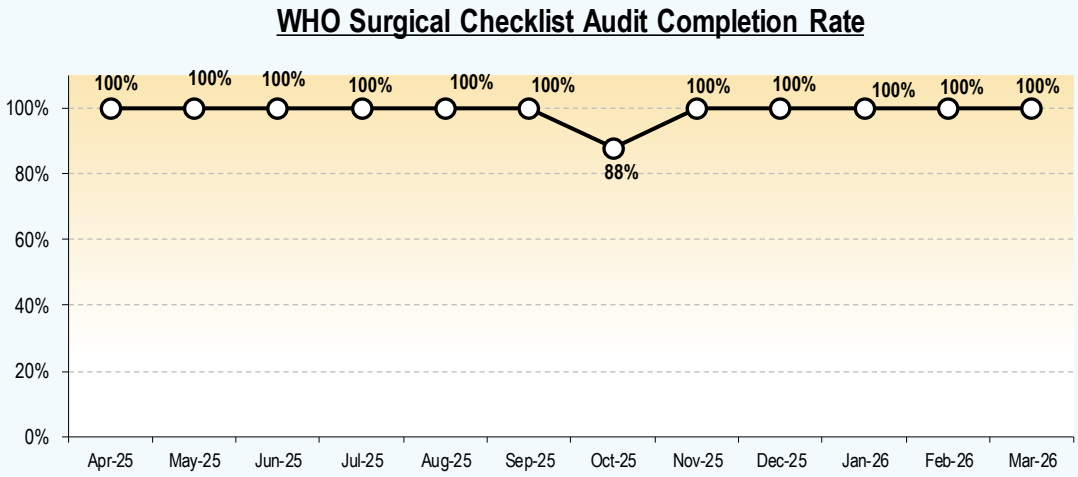
World Health Organisation (WHO) Surgical Safety Checklist

The WHO surgical safety checklist was developed after extensive consultation with key aims to decrease errors / adverse events, and increase teamwork and communication in surgery. Evidence from around the world shows that patient safety is improved during surgery if a checklist is used to ensure that the operating team adhere to key safety checks before anaesthesia is administered, before the operation begins and after the operation is complete. The WHO Surgical Safety Checklist has been adopted in all Trusts in Northern

Ireland and is an important tool to reduce the number of errors and complications resulting from surgery.

The WHO checklist has become an integral element to all surgeries carried out within the Trust. The Trust continues to promote a strong culture of safety through ongoing monitoring, feedback and education to ensure compliance with the WHO Surgical Safety Checklist remains embedded within everyday clinical practice. This provides assurance that key patient safety checks are consistently undertaken, supporting the delivery of safe, effective and high-quality surgical care

Monthly data is collected from a random selection of 20 patient case notes within each Theatre speciality. Compliance measurement is based on the percentage of surgical safety checklists filed in patients' notes and the percentage of surgical safety checklists signed at each stage of the process. The overall compliance rate for **2025/26 was 98.2%.** Monthly compliance figures were 100% apart from October 2025, demonstrating consistently high levels of compliance throughout the year and this is displayed in the graph below.



MATERNITY QUALITY IMPROVEMENT (QI)

Administration of Uterotonics during Caesarean Section / Operative Vaginal Delivery in theatre – Introducing Carbetocin

Implementation Date: 1st March 2025 following development of guidance, Drug & Therapeutics Committee approval and staff training.

Rationale: It is routine to give a uterotonic drug following delivery of the neonate during caesarean section. Carbetocin or Oxytocin are recommended uterotonic agents for routine administration after delivery of the foetus during caesarean section both as prophylaxis and also to prevent postpartum haemorrhage secondary to atony.

Oxytocin administration can cause a decrease in mean arterial blood pressure (MAP) and tachycardia when given to women delivering by Caesarean Section. Rare side effects include chest pain, ECG ST segment changes and dysrhythmias.

Carbetocin is a longer acting analogue of oxytocin with similar mechanism of action and adverse effects profile. The increased duration of action of Carbetocin up to 2 hours (4 to 7

times longer than oxytocin) eliminates the requirement of an infusion after the initial bolus. Also, this avoids the antidiuretic and potential hyponatraemic effects associated with Oxytocin infusion. This is of particular relevance in patients with pre-eclampsia.

Therefore, we recommend using Carbetocin as first line uterotonic especially for high-risk Caesarean sections as per NICE recommendations.

- Carbetocin 100 micrograms by slow IV injection over 1 minute
- There is no need to commence oxytocin infusions following administration of Carbetocin bolus as it is long acting

Outcome: This has been embedded in practice. Guidance is available via the Maternity SharePoint site. A resident doctor has been allocated to do this as a service evaluation project, and the results of this will be available later this year.

Administration of Sterile Water Injections for relief of back pain in labour

Implementation Date: Staff training commenced mid/late August 2026 across both sites. This followed development of a standard operating procedure (SOP) and associated documentation at a regional task and finish group. Locally a Patient Group Direction (PGD) was drafted to support this, which was approved by both the Drug & Therapeutics Committee and Clinical & Social Care Governance Committee within the Trust.

Rationale: In September 2023 NICE updated their Intrapartum guidance (NG235) recommending the use of sterile water injections (SWI) as a non-pharmacological option for women experiencing severe back pain in labour, usually due to an occiput-posterior (OP) position of the foetus when administered by a trained midwife.

Sterile water is injected intradermally or subcutaneously at four points over the Rhombus of Michaelis which is found on the lower back/sacral area. Research suggests sterile water injections are effective due to the gate control theory: the brief, intense cutaneous stimulus (the water bleb) activates skin nociceptors/mechanoreceptors, modulating dorsal horn transmission and dampening the perception of visceral/deep back pain. The discomfort may also trigger the body's natural release of endorphins. Relief typically starts from 10 minutes post administration, and can last up to 3 hours.

Sterile Water Injections have been offered elsewhere in the UK for a number of years, with 1 of the 5 Trusts in Northern Ireland offering these as an option for the last 12 years. Therefore, we plan to provide training to midwives around sterile water injections in order to comply with the NICE recommendation and offer the women in our care a range of non-pharmacological options that are evidence based.

0.1ml of water for injection injected intradermally at each of the four points
OR
0.5mls of water for injection injected subcutaneously at each of the four points.

References:

- NICE, 2023: Intrapartum care (NG235) Intrapartum care | Guidance | NICE
- NICE, 2023: Evidence Review C – Sterile Water Injections (for NG235) NG235 Intrapartum care: Evidence review C 29/09/2023

PAEDIATRIC QUALITY IMPROVEMENT (QI)

Productive Ward Team

The Acute Children's Ward and Children's Day Case Department established a Productive Ward Team to support continuous quality improvement, enhance patient experience, and improve operational efficiency. The team is committed to ensuring that children and young people receive safe, effective, person-centred care while maximising the time staff spend delivering direct patient care. As part of this initiative, the team is currently gathering feedback from staff and service users through surveys to identify opportunities for improvement and inform future quality improvement projects.

Transforming the Culture
The Productive Ward Team promotes a culture of continuous improvement where staff are encouraged to identify challenges and contribute to solutions that improve patient care and service delivery. Key actions include:

- Promoting multidisciplinary collaboration.
- Encouraging staff participation in quality improvement initiatives.
- Supporting shared decision-making.
- Establishing regular communication forums and safety huddles.

This approach aims to create a positive working environment where staff feel valued, empowered, and engaged in service development.

Strengthening the Workforce
Recognising that staff wellbeing is fundamental to providing high-quality care, the team is engaging staff through surveys to better understand:

- Barriers to productivity.
- Opportunities to improve workflows.
- Staff wellbeing and support needs.
- Ideas for service improvement.

The findings will inform future workforce initiatives and support the development of a sustainable, efficient, and supportive working environment.

Integrating Care
A key objective of the Productive Ward Team is to improve the integration of care across children's services, ensuring seamless and coordinated care for children, young people, and their families. The department recognises that effective communication and collaboration between healthcare professionals, departments, and external agencies are essential to achieving positive outcomes.

The Productive Ward Team is therefore seeking feedback from staff and service users regarding:

- Communication between clinical teams.
- Coordination of care throughout the patient journey.
- Effectiveness of admission, transfer, and discharge processes.
- Involvement of children, young people, and families in care planning.
- Collaboration with community and specialist services following discharge.

Improving integrated care will support:

- Reduced duplication of processes.

- Improved patient flow between services.
- Enhanced continuity of care.
- Better patient and family experiences.
- More efficient use of resources.
- Improved multidisciplinary working.

The survey findings will help identify opportunities to strengthen partnerships across services and ensure care remains coordinated, patient-centred, and responsive to individual needs.

Measuring the Improvement
The Productive Ward Team has developed both staff and service user surveys to establish a baseline understanding of current experiences within the Acute Children's Ward and Children's Day Case Department. The surveys will focus on:

Staff Experience
- Productivity and efficiency.
- Communication within teams.
- Availability of equipment and resources.
- Staff wellbeing and morale.
- Opportunities for service improvement.

Service User Experience
- Experience of care.
- Communication with staff.
- Waiting times.
- Involvement in care decisions.
- Overall satisfaction with services.

Survey findings will be analysed to identify themes and priorities, enabling the team to develop targeted quality improvement projects and measurable outcomes.

Raising the Standards
The Productive Ward Team is committed to delivering high-quality, safe, and compassionate care while continuously seeking opportunities for improvement. Through active engagement with staff and service users, the department aims to:
- Improve service efficiency.
- Enhance the patient and family experience.
- Support staff wellbeing.
- Strengthen integrated care pathways.
- Promote effective communication and teamwork.
- Ensure improvements are evidence-based and informed by feedback.

Priorities for the Coming Year
Based on the outcomes of the staff and service user surveys, the Productive Ward Team intends to:
- Improve patient flow within the Acute Children's Ward and Day Case Department.
- Enhance integrated care pathways between hospital and community services.
- Increase the amount of time available for direct patient care.
- Improve communication and information sharing across teams.
- Strengthen staff wellbeing initiatives.
- Implement quality improvement projects informed by staff and family feedback.

- Monitor progress through agreed quality indicators and outcome measures.

Conclusion
The Productive Ward Team represents an important opportunity to improve productivity, patient experience, staff wellbeing, and integrated care within the Acute Children's Ward and Children's Day Case Department. By actively listening to staff, children, young people, and families, the department aims to develop meaningful and sustainable improvements that support the delivery of safe, effective, and person-centred paediatric services. The findings from the current survey programme will provide the foundation for future quality improvement work and help ensure that service developments are aligned with the needs of those who provide and receive care.

Integrating Care Through Staff Rotation and Shared Learning Between the Children's Ward and Emergency Department

As part of the Trust's commitment to improving integrated care, strengthening the workforce, and enhancing patient experience, a six-month rotational initiative was introduced between the Acute Children's Ward and the Emergency Department (ED) in Altnagelvin Area Hospital. The initiative involved two paediatric-trained nurses from the Children's Ward rotating to the Emergency Department and two Emergency Department staff nurses rotating to the Children's Ward. The programme was designed to promote shared learning, strengthen interdepartmental relationships, improve understanding of patient pathways, and support the delivery of seamless care for children and young people across both clinical areas. Recognising the importance of collaborative working and continuous professional development, the rotation programme was complemented by a joint teaching day, bringing staff from both departments together to participate in shared learning and skills enhancement activities.

The aim of the initiative was to improve integrated care across paediatric services through enhanced collaboration, shared learning, and greater understanding of the patient journey between the Emergency Department and Children's Ward.

Objectives
- Strengthen communication and collaboration between departments.
- Improve continuity of care for children and young people.
- Enhance staff knowledge, skills, and confidence across clinical settings.
- Promote professional development and workforce flexibility.
- Improve understanding of patient pathways and service pressures.
- Foster a culture of shared learning and continuous improvement.

Methodology
Over a six-month period: (September 2025 – March 2026)
- Two paediatric-trained nurses from the Children's Ward completed rotational placements within the Emergency Department.
- Two Emergency Department nurses completed rotational placements within the Children's Ward.
- Staff were supported through local induction, supervision, and ongoing feedback opportunities.
- A joint educational programme was delivered, bringing together staff from both departments for full-day teaching and development sessions.
- Feedback was sought from participating staff and departmental leaders throughout the initiative.

Joint Education and Professional Development
To further support integrated working and strengthen professional relationships, a programme of joint teaching days was introduced during the rotation period. These sessions provided staff from both departments with the opportunity to learn alongside colleagues, share expertise, and develop a greater understanding of each other's roles and responsibilities. The full-day enhancement programmes included topics such as:

- Recognise the signs, symptoms and management priorities for patients presenting with diabetes.
- Understand the structured ABCDE approach to recognise a seriously ill child
- Able to provide appropriate initial interventions
- Defib Awareness
- Develop knowledge in relation to Safeguarding Children
- Develop confidence in delivering patient centred care within paediatric clinical practice with regards to Pews, Medicine administration and IV fluids.
- Demonstrate improved communication, teamwork and clinical reasoning during simulated scenarios

Staff particularly valued the opportunity to learn together in a supportive environment, helping to build relationships and promote consistency in paediatric care delivery across both departments.

Outcomes
Feedback from both the rotational placements and the joint teaching programme was overwhelmingly positive.

Staff Feedback
Feedback from participating staff highlighted:

"Brilliant experience. I got so much from it. The staff (both nursing and medical) spoke very highly about us and were very supportive during our time in ED."

"I feel we provided an excellent learning opportunity for student nurses in ED."

"I really enjoyed my time in ED, thanks for the opportunity."

When asked what was the most valuable part of your placement response was

"Building rapport with staff in ED. I found this incredible – building trust between departments."

"Developing assessment skills. Developing knowledge of emergency care. Seeing how other teams work."

Managers from both departments reported positive engagement, increased collaboration, and enhanced professional development among participants.

Improved Understanding of Patient Pathways
Staff developed a greater appreciation of the child's journey from presentation in the Emergency Department through to admission, treatment, and discharge from the Children's Ward. This increased understanding contributed to more effective communication and smoother transitions between services.

Enhanced Interdepartmental Relationships
The rotational programme strengthened working relationships between teams, fostering greater trust, collaboration, and mutual respect. Staff reported increased confidence in liaising with colleagues across departments and a better understanding of the operational pressures experienced within each area.

Professional Development
Participants gained valuable clinical experience through exposure to different working environments, patient presentations, and care processes. Reported benefits included:

- Increased confidence in managing acutely unwell children.
- Development of new clinical skills.
- Enhanced decision-making and prioritisation abilities.
- Improved understanding of emergency and inpatient care pathways.

Benefits of Shared Learning
The joint teaching days further enhanced professional development by creating opportunities for networking, discussion, and collaborative learning. Staff reported that these sessions:

- Improved clinical knowledge and confidence.
- Strengthened communication and teamwork.
- Promoted consistency in clinical practice.
- Increased awareness of the wider patient journey.
- Encouraged collaborative problem-solving and shared decision-making.

Impact on Integrated Care
The combination of the rotational placements and shared educational opportunities has significantly strengthened integration between the Children's Ward and Emergency Department. The initiative has promoted a more coordinated approach to patient care, improved communication between teams, and enhanced continuity throughout the patient journey. By investing in both workforce development and collaborative learning, the departments have created stronger links between services, contributing to safer, more effective, and patient-centred care for children, young people, and their families.

Alignment with Quality 2020

***Transforming the Culture*:** The initiative promoted a culture of collaboration, openness, and shared learning, encouraging staff to work beyond traditional departmental boundaries.

***Strengthening the Workforce*:** The programme enhanced staff knowledge, skills, confidence, and professional development while supporting workforce flexibility and resilience.

***Measuring the Improvement*:** Feedback from participating staff and departmental leaders demonstrated positive outcomes in communication, collaboration, professional development, and integrated working.

***Raising the Standards*:** Improved understanding of patient pathways, strengthened communication, and enhanced multidisciplinary relationships have contributed to higher standards of coordinated, safe, and family-centred care.

Conclusion
The six-month rotational programme between the Acute Children's Ward and Emergency Department, supported by a programme of joint teaching and enhancement days, has successfully demonstrated the benefits of integrated working across paediatric services. Feedback from staff and departmental leaders has highlighted improvements in communication, teamwork, professional development, and understanding of the patient journey. The initiative has strengthened relationships between departments, supported workforce development, and enhanced the delivery of coordinated, high-quality care for children and young people. Given its success, consideration will be given to sustaining and expanding this collaborative model across other areas of children's services within the Trust.

Quality Improvement Project: Reducing Transfer Times from Altnagelvin Emergency Department (AED) to the Paediatric Department

As part of ongoing efforts to improve patient flow and enhance the experience of children requiring hospital admission, the Paediatric Department initiated a Quality Improvement (QI) project in collaboration with the Emergency Department (ED). Timely transfer of children from the Emergency Department to the Paediatric Unit is recognised as an important aspect of patient flow, supporting timely assessment, treatment, and admission to an appropriate clinical environment.

The project aimed to ensure that: **60% of paediatric patients requiring hospital admission to the Paediatric Unit would be transferred from AED to the Paediatric Department within 90 minutes of acceptance by the paediatric team.**

The project sought to identify delays within the transfer process and Implement improvements where required.

Methodology
Data collection was undertaken to establish a baseline measurement of the transfer process. Information was gathered on:

- Time of referral and acceptance by the paediatric team.
- Time of transfer from AED to the Paediatric Unit.
- Overall waiting times following acceptance for admission.
- Factors contributing to any delays in patient movement.

The project team worked collaboratively with colleagues in both AED and the Paediatric Department to review current processes and identify opportunities for improvement.

Findings
Analysis of the collected data demonstrated that patient transfers were already occurring in a timely and efficient manner following acceptance by the Paediatric Department. The review revealed that the average time between acceptance by the Paediatric team and arrival on the Paediatric Unit was **22 minutes**, significantly exceeding the project's original target of transfer within 90 minutes.

The data showed that the Paediatric Department consistently accepted and received patients promptly, indicating that there were no significant delays within the paediatric admission process.

However, further analysis of data collected within the Emergency Department identified a different challenge. While transfer times following acceptance by the paediatric team were consistently low, the period from a patient's admission to the Emergency Department to the decision to refer and transfer to the Paediatric Department was significantly longer.

This suggested that delays were occurring earlier in the patient pathway rather than within the transfer process itself.

Outcome
Following review of the baseline data, it became evident that the original assumption regarding delays in transfers from AED to the Paediatric Unit was not supported by the evidence collected. The findings demonstrated that:

- The existing paediatric admission process was functioning effectively.
- Patients were transferred well within the established target timeframe following acceptance by the Paediatric Department.
- The Paediatric Department was not a contributing factor to delays in patient flow.
- No specific improvement intervention was required within the Paediatric Department at this stage.

While the original Quality Improvement aim was not progressed, the project successfully identified an alternative area for investigation. Data indicated that delays were occurring prior to referral and acceptance by the paediatric team, highlighting a potential opportunity to improve the wider patient journey.

Learning From the Project
Although the project did not identify a need for service change within the Paediatric Department, it provided valuable learning and assurance regarding current practice.
Key lessons included:

- The importance of using data to understand service performance before implementing change.
- The value of collecting baseline measurements to inform decision-making.
- The need to challenge assumptions through objective analysis.
- Recognition of effective practice already occurring within the Paediatric Department.
- The importance of examining the entire patient pathway when seeking opportunities for improvement.

The project also strengthened collaborative working between Emergency Department and Paediatric teams by promoting discussion around patient flow and developing a shared understanding of admission processes. Importantly, the findings identified a potential area for future Quality Improvement work, focusing on the period between a child's arrival in the Emergency Department and the decision to refer or admit to paediatric services.

Future Priorities
The findings from this project have informed future service improvement priorities. While transfer times following paediatric acceptance were found to be highly effective, further work will be undertaken in collaboration with Emergency Department colleagues to better understand the factors contributing to delays earlier in the patient journey. Future work will aim to:

- Explore the time from attendance in the Emergency Department to referral for paediatric assessment.
- Identify potential barriers affecting patient flow within Emergency Department processes.
- Review opportunities for earlier decision-making and referral pathways.
- Strengthen collaboration between Emergency Department and Paediatric teams to further enhance patient flow.
- Improve the overall experience of children and families requiring admission to hospital.

Conclusion
This Quality Improvement project was undertaken to examine transfer times for paediatric patients admitted from the Emergency Department to the Paediatric Unit. Data collection demonstrated that the average transfer time following acceptance by the paediatric team was 22 minutes, significantly better than the target of 90 minutes. The findings provided assurance that the Paediatric Department was receiving patients promptly and that current transfer processes were effective.

While the original project did not identify a need for improvement within the Paediatric Department, analysis highlighted extended waiting times from admission to the Emergency Department to the decision to refer and transfer. This has identified a potential area for future collaborative Quality Improvement work between Emergency Department and Paediatric services. The project reinforced the importance of data-driven decision-making, enabled recognition of good practice within the Paediatric Department, and helped focus future improvement efforts on areas where they may have the greatest impact on patient flow and experience.

Alignment with Quality 2020

***Measuring the Improvement*:** The project demonstrated the importance of measurement and evidence-based decision-making. Data collection provided assurance that patients were experiencing timely transfers and that existing processes were delivering positive outcomes.

***Raising the Standards*:** The review confirmed that established admission and transfer processes were meeting expected standards and supporting the efficient movement of patients between departments.

***Transforming the Culture*:** The project promoted a culture of continuous improvement, where service performance is routinely evaluated and challenged using data and evidence.

Conclusion
This Quality Improvement project was undertaken to examine transfer times for paediatric patients admitted from ED to the Paediatric Department. Data collection demonstrated that the average transfer time following paediatric acceptance was 22 minutes, significantly better than the target of 90 minutes. While the project did not identify a need for further intervention, it provided valuable assurance that existing processes are effective and that children are being transferred promptly to the Paediatric Department. The exercise reinforced the importance of data-driven decision-making and highlighted the high standard of collaborative working already established between ED and Paediatric services.

FALLS

Facts & Figures

Between 1 April 2025 and 30 March 2026, the Trust recorded 1683 fall incidents in hospital inpatient settings, this is a decrease from 1783 falls reported in 2024/25.

Of the falls recorded 31 led to a moderate and above injury (i.e. an injury that lasted more than one month such as a fracture and/or led to an extended hospital stay over 4 days or required surgery).

The median number of falls reported from hospital inpatient wards is 137 each month.

Between April 2025 and March 2026, the Trust recorded **1683 falls incidents in hospital inpatient settings**, representing a decrease of 100 incidents (5.9%) compared with the 1,783 falls incidents reported during the same period in 2024-25. The **median number of inpatient falls reported per month was 137**.

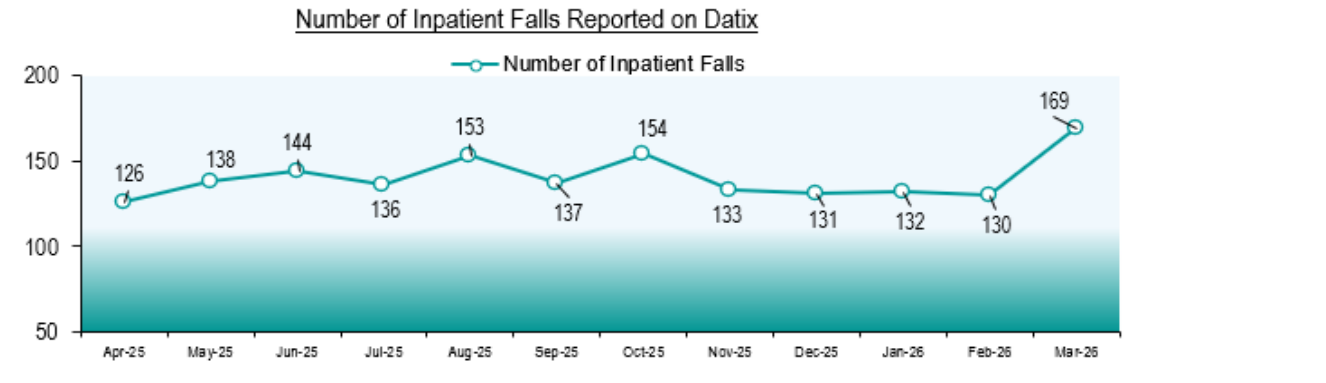
Despite ongoing falls prevention initiatives, the number of reported falls highlights the continued importance of targeted interventions, robust risk assessment, and the sharing of learning to reduce both the incidence of falls and the associated harm experienced by patients.

Harm from Falls

Of the 1683 falls reported in hospital inpatient settings between 1 April 2025 and 30 March 2026, the majority were categorised as either **'No Harm'** incidents or **near misses**, with some patients sustaining minor injuries such as cuts, bruises, and lacerations.

31 falls incidents were recorded **as resulting in moderate and above levels of harm**. Validation of data in relation to grading of incidents resulting in moderate and above levels of harm highlights the need to strengthen data quality and reporting processes.

Review of the data identified a number of opportunities to improve the quality and reliability of falls reporting. In particular, the grading of patient harm, and, the nature and severity of injuries sustained following a fall were not always clearly documented within the Datix incident reporting system, making validation and analysis more challenging. Examples included incidents resulting in fractures being classified as minor harm, while other incidents involving less severe injuries were graded as major harm. Such inconsistencies can affect the accuracy of harm reporting and limit the Trust's ability to monitor trends, benchmark performance, and target improvement initiatives effectively.



Themes Emerging from Falls Incident Reviews 2025-26

Analysis of falls incidents reported within hospital inpatient settings during 2025-26 identified a number of recurring themes. Falls continue to be predominantly concentrated within frail older adult populations, with the highest numbers of incidents occurring among patients receiving care in the Altnagelvin Emergency Department, Acute Admission Wards, Elderly Care Wards, Rehabilitation Services, Stroke Services, and Older People's Mental Health Services.

Review of incidents identified recurring themes relating to:

- Dementia, delirium, or other forms of cognitive impairment and poor safety awareness.
- Previous history of falls
- Reduced mobility, frailty and deconditioning
- Falls during toileting, transfers and unsupervised mobilisation.
- Environmental and equipment-related factors.
- Acute illness or infection
- Delays in transfer of care and prolonged hospital stays.
- Variable compliance with falls risk assessment, care planning and post-fall documentation.

These findings reinforce the strong association between falls, frailty, cognitive impairment, and complex care needs. A recurring pattern identified across incident reviews was the occurrence of repeated falls despite preventative measures being in place, highlighting the challenges of managing risk in patients with impaired cognition, poor insight, behavioural symptoms, and fluctuating clinical conditions.

Falls most commonly occurred in rooms of single occupancy, bedrooms, bathrooms and toilets, at the bedside, and during transfers between bed, chair, and standing positions. This suggests a continuing need to strengthen person-centred toileting plans, mobility support, supervision arrangements, and transfer assistance for patients identified as being at high risk of falling.

At present, updated regional benchmarking data from the Public Health Agency (PHA) is not available. Consequently, the Trust is unable to report on the **rate of falls per 1,000 occupied bed days** or the **rate of falls resulting in moderate and above levels of harm per 1,000 occupied bed days** for 2025-26. These measures will be incorporated into future reports when validated regional data becomes available.
A range of quality improvement initiatives were undertaken across high-risk clinical areas, including stroke and acute medical wards. Interventions focused on staff education, environmental safety measures, patient engagement, sensor alarms and enhanced falls prevention processes. These initiatives contributed to improved staff training compliance and continue to inform wider Trust learning.

The Trust continued to support regional falls prevention work, optimise Encompass documentation, strengthen care home falls prevention programmes and deliver public awareness initiatives. The Stepping On Strength and Balance Programme demonstrated positive outcomes, including reduced falls, improved confidence and increased independence among participants.

Key Priorities for 2026/27

- Improve the quality and consistency of falls reporting and harm grading.

- Embed falls prevention and post-fall documentation within Encompass.
- Validate and implement the Falls KPI Dashboard.
- Strengthen compliance with falls risk assessment, care planning and post-fall review processes.
- Expand strength and balance programmes and ward-based quality improvement initiatives.

Continue workforce development, patient involvement and regional collaboration to reduce falls-related harm.

PRESSURE ULCERS

Facts & Figures
In 2025/26 the Trust recorded 321 pressure ulcers compared to 328 for the previous year across the acute hospital adult sites, with 43 deemed avoidable from the 77 Stage 3 & 4 pressure ulcers investigated.

Reducing the Number of Pressure Ulcers

Pressure ulcers are recognised as an important patient safety issue due to the impact they can have on morbidity, quality of life, length of hospital stay and healthcare utilisation. Pressure ulcer prevention remains a key priority for the Western Health and Social Care Trust.

The prevention of pressure ulcers requires a multidisciplinary approach incorporating comprehensive risk assessment, regular skin inspection, appropriate support surface selection, repositioning, continence and moisture management, nutrition and hydration, and early escalation where skin deterioration is identified.

The Trust continues to use the **Regional SSKIN Bundle** as a structured approach to pressure ulcer prevention. The bundle supports staff to consider:



Pressure ulcer incidence is monitored through the Trust's incident reporting system and reviewed by the Tissue Viability Service. Surveillance is supported by Post Incident Review (PIR), clinical review, audit, education and feedback to clinical teams.

Figure 1 below illustrates the Trusts position on Pressure Ulcer development across the acute sectors since 2013 when data collection commenced.

Pressure ulcer rates per 1000 bed days Year	Rate per 1000 bed days	Hospital acquired pressure ulcers	Percentage Increase/ decrease	Hospital acquired Stage 3 and 4 pressure ulcers	Hospital acquired Stage 3 and 4 avoidable
2013-14	0.6	182	baseline	N/A	N/A
2014-15	0.6	157	-13.7	N/A	N/A
2015-16	0.8	209	+33.1	18	4
2016-17	0.9	246	+17.7	38	6
2017-18	1.2	344	+39.8	43	14
2018-19	1.4	373	+8.4	17	9
2019-20	2.2	462	+23.9	28	12
2020-21	1.7	386	-16.5	110	43
2021-22	1.1	277	-28.2	76	36
2022-23	1.2	341	+23.1	108	37
2023-24	1.1	321	-5.9	73	28
2024-25	***TBC**	328	+2.2	61	34
2025-26	***TBC**	321	-2.1	77	43

Rates for 2024/25 & 2025/26 are not yet available from the PHA

2025/26 Position

During 2025/26, 321 hospital-acquired pressure ulcers were reported, compared with 328 during 2024/25. This represents a 2.1% reduction in the overall number of hospital-acquired pressure ulcers.

Despite the overall reduction, the number of Stage 3 and Stage 4 pressure ulcers increased from 61 in 2024/25 to 77 in 2025/26. Of the 77 Stage 3 and Stage 4 pressure ulcers reported during 2025/26, 43 were deemed avoidable following investigation and review.

The Tissue Viability Service continues to focus not only on overall incidence but also on the severity and avoidability of pressure damage. Detailed review of these incidents enables identification of recurring contributory factors, areas of increased risk and opportunities for targeted intervention.

Patients presenting within acute services increasingly have complex needs, including frailty, multiple co-morbidities, reduced mobility and acute illness. These factors can significantly increase the risk of pressure damage. High-acuity and operationally pressured environments can present additional challenges in consistently implementing all elements of pressure ulcer prevention.

During 2025/26, incident surveillance identified areas requiring focused intervention. Targeted improvement work within the Emergency Department resulted in a reduction in avoidable pressure ulcers from 6 incidents in Quarter 3 to 2 incidents in Quarter 4.

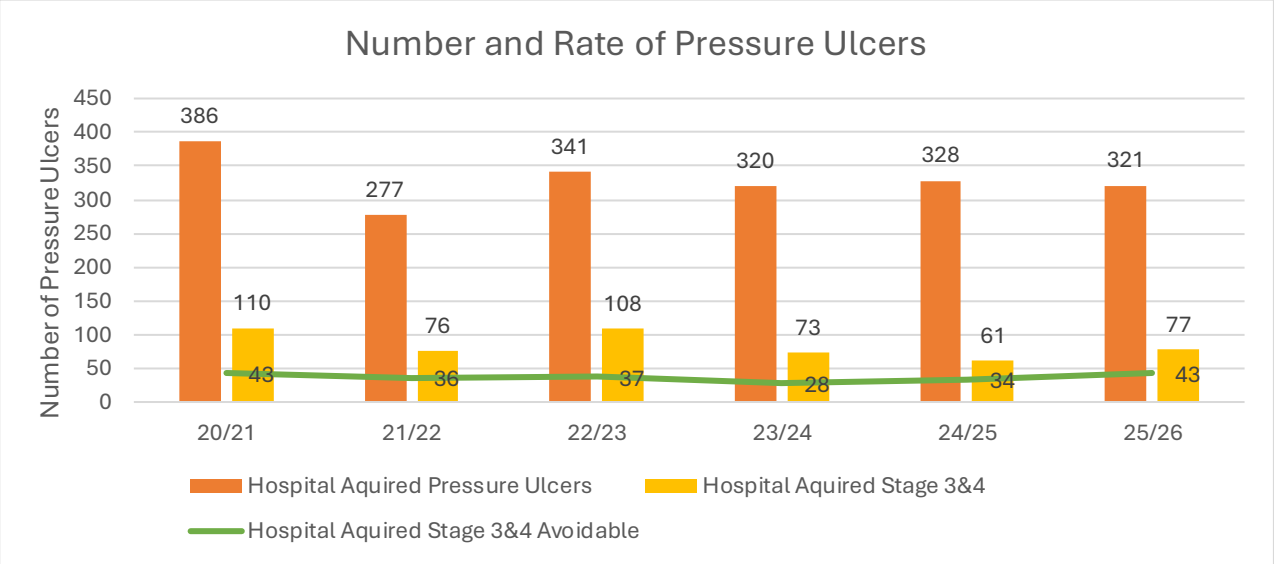
Interventions included focused multidisciplinary education, review of preventative practice and consideration of equipment provision.

Ongoing surveillance and review will continue to ensure areas of concern are identified promptly and appropriate actions implemented.

Skin Bundle Compliance

During 2025/26, the regional Skin Bundle Compliance KPI was temporarily stood down due to the implementation of Encompass; therefore, compliance data were not available. The Trust continues to monitor pressure-ulcer prevention practice through local audit, incident surveillance, post-incident review and targeted clinical review.

Figure 2: Number and Rate of Pressure Ulcers



The Tissue Viability Service continues to support staff across the Trust in the prevention, identification and management of pressure damage through a combination of specialist clinical advice, education, audit, incident review and quality improvement.

Actions taken during 2025/26 to reduce Pressure Ulcer development

- Provision of education to healthcare staff on the prevention, identification and management of pressure ulcers.
- Provision of specialist advice and guidance to healthcare professionals in the management of individual patients at risk of, or experiencing, pressure damage.
- Investigation and review of Stage 3 and Stage 4 pressure ulcers and other significant incidents to determine avoidability, identification of contributory factors and establish learning.
- Completion of Post Incident Reviews, with findings and learning shared with the relevant ward or department.
- Identification of themes and trends through ongoing analysis of incident data, enabling targeted interventions within areas of increased incidence.
- Continued collaboration with the PHA and Tissue Viability colleagues regionally to support consistency in pressure ulcer prevention and management.
- Continued contribution to regional pressure ulcer work, including sharing of learning and best practice.
- Ongoing provision of education and clinical support to areas where incident review identifies specific learning needs.
- Continued support for the Wound Care Link Nurse network across Trust services.

- Continued promotion of current regional pressure ulcer prevention guidance and the SSKIN Bundle.
- Continued support for staff in relation to pressure ulcer prevention documentation within the Trust's Digital Health Record.

Governance and Operational Monitoring

The Tissue Viability Service maintains ongoing surveillance of pressure ulcer incidents reported through DATIX.

This includes:

- Daily routine monitoring of DATIX pressure ulcer reports to ensure timely review and follow-up.
- Review of significant pressure ulcer incidents, including Stage 3 and Stage 4 pressure ulcers with involvement from Adult Safeguarding if deemed avoidable.
- Investigation and completion of Post Incident Reviews to determine avoidability and identify areas for improvement.
- Provision of feedback to wards and departments following incident review, including agreed actions where required.
- Analysis of pressure ulcer incidence to identify emerging trends, recurring themes and areas of increased risk.
- Targeted education, clinical support and review of equipment provision where areas of concern are identified.
- Ongoing monitoring and support for clinical areas in relation to pressure ulcer prevention documentation and practice.
- Liaison with senior nursing, governance and patient safety colleagues where significant or complex pressure ulcer incidents are identified.
- Continued monitoring of avoidable pressure ulcers as an important indicator of preventable patient harm.
- Sharing of learning from incidents across clinical areas to support sustained improvement and reduce recurrence.

Key examples of this approach during 2025/26:

- Focused work undertaken within the Emergency Department, where review of incident trends led to targeted intervention and a subsequent reduction in avoidable pressure ulcer incidents from 6 in Quarter 3 to 2 in Quarter 4.

- Spruce Ward QI: Targeted quality improvement work focused on pressure ulcer prevention and consistent best practice following an avoidable acquired pressure ulcer. QI poster developed to support staff knowledge and consistent pressure ulcer prevention through PURPOSE-T and SSKIN Bundle education which incorporated service user involvement to ensure information is patient-centred.

Actions Planned for 2026/27 to reduce Pressure Ulcer development

The Trust and PHA will continue to work collaboratively with the Tissue Viability Service to reduce the incidence of avoidable pressure ulcers.

Pressure Ulcer Prevention

Education

- Maintain and further develop the Trust-wide Wound Care Link Nurse network, ensuring clinical areas have access to staff with an enhanced interest and knowledge in wound care and pressure ulcer prevention.

- Quarterly Link Nurse education and meetings to support the cascade of learning throughout clinical areas.
- Continue provision of targeted education in response to trends identified through DATIX reporting, Post Incident Review and audit.
- Continue to promote the Regional SSKIN Bundle and reinforce the importance of early identification and intervention for patients at risk of pressure damage.
- Promote PHA-endorsed and regional educational resources relating to pressure ulcer prevention.
- Continue to support staff to accurately complete Tissue Viability and pressure ulcer prevention documentation within the Digital Health Record (Encompass).
- Continue multidisciplinary collaboration with ward and departmental teams to promote best practice in pressure ulcer prevention.
- Continue to participate in regional pressure ulcer prevention initiatives and share learning and best practice across Northern Ireland.
- Continue to use World Stop Pressure Ulcer Day as an opportunity to raise awareness and promote pressure ulcer prevention among staff, patients and carers.

Operational

- Continue routine monitoring of DATIX pressure ulcer incidents to support timely investigation and intervention.
- Continue specialist review of Stage 3 and Stage 4 pressure ulcers and other significant pressure damage.
- Continue Post Incident Review to determine avoidability, identify contributory factors and ensure learning is translated into improvement.
- Monitor pressure ulcer incidence and trends at ward and departmental level to identify areas requiring additional support.
- Develop targeted quality improvement plans for areas where increased incidence or recurring themes are identified.
- Continue focused improvement work within high-risk and high-acuity clinical environments, including Emergency Departments.
- Continue audit and monitoring of pressure ulcer prevention practice and documentation inline with PHA KPI stipulations.
- Continue to promote appropriate selection and use of pressure redistribution equipment.
- Continue collaborative working with nursing leadership, governance and patient safety teams to ensure learning from pressure ulcer incidents is embedded in practice.
- Continue participation in PHA led regional pressure ulcer groups and benchmarking activity.
- Continue to monitor avoidable pressure ulcer development as a key patient safety measure.

Paediatric Services

There is currently no requirement within existing regional arrangements to routinely report pressure ulcer development in paediatric patients.

The absence of a dedicated Paediatric Tissue Viability Nurse remains recorded on the Trust Risk Register as an unmet service need. The Tissue Viability Service continues to provide specialist advice and support to paediatric services as required.

PREVENTING VENOUS THROMBOEMBOLISM (VTE)

Venous Thromboembolism (VTE) is the formation of a blood clot (thrombus) in a vein which may dislodge from its site of origin to cause an embolism. Most blood clots occur in the deep veins of the legs and pelvis; this is known as a deep vein thrombosis (DVT). Dislodged blood clots may travel to the lungs; this is called a pulmonary embolism (PE). These are recognised complications of medical care and treatment.

Patients are at increased risk of Venous Thromboembolism (VTE) following admission to hospital and may experience harm or may die as a consequence of venous thromboembolism - deep venous thrombosis (DVT) and pulmonary embolism (PE). VTE is potentially preventable if patients are properly assessed and offered suitable preventative measures. To help prevent patients from developing a DVT or PE, a VTE Risk Assessment should be completed for all patients on their admission to hospital to enable healthcare practitioners to identify patients at risk of developing VTE and prescribe the appropriate therapy to reduce the risk.

The Trust VTE Working Group continue to monitor any cases of hospital acquired thrombosis as a standing agenda item to identify whether further action is required such as root cause analysis.

The Trust aims to achieve 95% compliance with VTE risk assessment completed within 24hrs of admission across all adult inpatient hospital wards. A random audit sample of 10 patient charts was completed for all adult inpatient wards during April 2025 to determine whether the VTE Risk Assessment was completed within 24hrs of admission, with 96% compliance reported. This is in line with the average compliance score of 96% reported for the previous two years. Due to the introduction of the Encompass single electronic health and care record in May 2025, official statistics are currently unavailable to report for 2025/26 as the existing paper-based audit tool is not compatible with the new system. Meetings are taking place in an attempt to establish a solution to achieving compliance with VTE Risk Assessment on the new system.

MEDICINES MANAGEMENT

Medicines are the most frequently used intervention in healthcare. Their use continues to increase due to advances in medical technology and an aging population. It is important that their use is safe and evidence-based as well as ensuring patients get the right medicine at the right time.

Medicines Reconciliation

The Clinical Pharmacy team undertakes medicines reconciliation for patients admitted to wards across the Trust where a clinical pharmacy service is available. The Clinical Pharmacy team currently cover approximately 80% of inpatient wards. Medicines reconciliation is a key component of safe and effective patient care, ensuring that accurate medication information is reviewed and verified on admission.

The National Institute for Health and Care Excellence (NICE) recommends that 95% of patients should have their medicines reconciled by a pharmacist within 24 hours of admission, highlighting the importance of timely intervention in reducing medication errors and improving patient outcomes. Due to ongoing flow pressures, many patients remain in

the Emergency Department (ED) beyond 24 hours before being transferred to an inpatient ward. As a result, achieving the NICE target of completing medicines reconciliation for 95% of patients within 24 hours of admission is particularly challenging. This is further compounded by significant pharmacist recruitment and workforce pressures, which impact the capacity available to undertake timely medicines reconciliation across the Trust.

Another key challenge in measuring medicines reconciliation activity is the lack of validated reporting within EPIC. Differences in documentation practices and system limitations make it difficult to produce reliable performance data, monitor compliance with targets, accurately benchmark services, or fully demonstrate the impact of medicines reconciliation on patient safety and quality of care. Data collected from a snapshot audit showed:

- 55% (Altnagelvin) and 98.9% (SWAH) of patients within wards covered by pharmacy services had a completed medicine reconciliation on admission. It should be noted these snapshot audits were collected on Fridays which minimise the weekend effect of no clinical pharmacy cover.

A cohort of Pharmacy Technicians will begin medication counselling accredited training through NICPLD in October 2026, expanding their role in delivering patient-centred medicines education. This initiative will support patients' understanding of their treatment, improve adherence after discharge, and contribute to better patient outcomes and more efficient use of pharmacy resources.

Insulin Safety

Insulin is recognised as a high-risk medicine, making its safe use a key patient safety priority. The Trust has a multidisciplinary diabetes team comprising of Consultants, Diabetes Nurses and Specialist Diabetes Pharmacists who are independent prescribers.

Several Trust colleagues from a range of professional roles have been involved in the regional development of the “Safer use of Insulin, Northern Ireland Framework”, an ongoing collaboration with Department of Health, Medication Safety Strategy - Transforming Medication Safety Northern Ireland.

Insulin-related incidents are reviewed at the monthly Trust Medicines Governance working group as well as the Insulin Safety working group, which met twice during this period. The Insulin Safety Group has a remit to review insulin incidents, identify key learning points and promote safer practice through education, training and communication of good practice, including through newsletters and safety awareness campaigns.

In December 2025, a **Lesson of the Week** was issued to remind staff how to safely use an insulin pen and to avoid the inappropriate withdrawal of insulin from pre-filled cartridges using an insulin syringe. This communication was intended to raise awareness of the associated risks and reinforce safe administration practices.

The Trust continued to take a proactive approach to improving the safe use of insulin throughout the year. Insulin safety has remained a recurring theme within the Med Safety West newsletter, issued to promote learning, raise awareness and support safe practice, as illustrated below. This ongoing work supports the Trust's commitment to reducing insulin-related harm and improving the safety of insulin prescribing, dispensing and administration.

Western Health and Social Care Trust

17 December 2025

NEVER withdraw insulin from a pen device or prefilled cartridge

Patient Safety Alert

Risk of severe harm and death due to withdrawing insulin from pen devices or refill cartridges
NHS/PSA/W/2016/011

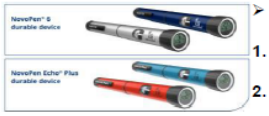
Insulin syringes are only calibrated to measure units of insulin for 100 unit/ml strengths of insulin (supplied in vials).

There are a number of **prefilled pens** and **cartridges** which now come in different strengths e.g. **200units/ml**, **300units/ml**

✘ Using an insulin syringe to withdraw from a prefilled pen or cartridge could result in a **fatal overdose**

Discontinuation of the Tresiba® Flextouch 100unit/ml prefilled pen has resulted in some patients being switched to the prefilled cartridge and reusable Novopen®

Prefilled pen (administer with screw on pen tip needle)	Prefilled cartridge (administer with reusable Novopen® and screw on pen tip needle)
	
✓ Tresiba 200unit/ml pens are still available (can be prescribed as alternative since prefilled device delivers unit doses)	



- Reusable Novopen® devices **must** be used to administer prefilled cartridges
1. Ask for the patient's own supply to be brought in including their Novopen® device.
2. If this is not possible within 4hrs, contact Diabetes team for Novopen® supply
3. Out of hours / bank holidays: a small supply of Novopens® are available in **Alt A&E / Wd41** or **SWAH A&E / Wd1 / Wd2** within the diabetic starter kits.
4. Novopens® are single patient use and should stay with patient throughout their journey. Do not dispose of after use. Do not use for other patients.

(Diabetes Network office plan to communicate how independent departments can order their own supply)

Patient Safety Alert	Link: Patient_Safety_Alert_-_Withdrawing_insulin_from_pen_devices.pdf
2 minute video	Link: NHS England » Patent safety alert: Risk of severe harm and death due to withdrawing insulin from pen devices

This is included in the NHS Improvement Never Event List 2018

Med Safety West

Western Health and Social Care Trust
Issue 24 - September 2025
Page 1 of 4

INSULIN SAFETY

Patient prescribed & received 3 doses of the wrong insulin.
On the 4th dose the patient was asked to confirm it was correct & error was identified

Take care to select correct insulin in order set

Always check with the patient:

- ✓ **Right person**
- ✓ **Right time**
- ✓ **Right insulin**
- ✓ **Right device**
- ✓ **Right dose**
- ✓ **Right way**

OMITTED & DELAYED DOSES

Since the publication of the National Patient Safety Agency's (NPSA) Rapid Response Report "Reducing harm from omitted and delayed medicines in hospital" in 2010, there has been a regional focus to promote good practice in reducing harm from omitted and delayed medicines.

Within the Trust, a multi-professional medicines governance group has been established to review and improve the processes around management of medicines to achieve the best outcome for patients. The group meet monthly and review all incidents reported via Datix related to medicines management, including omitted doses. In addition, a Task & Finish group meet monthly to review medication incidents including the omission and / or delay of critical medications in both Emergency Department (ED) sites within the Trust. The aim is to avoid any critical medication being omitted whilst a patient is in the ED.

From 8 May 2025, reporting of the Omitted / Delayed Doses KPI was suspended following the implementation of the regional digital system, encompass. The existing paper-based audit tool is not compatible with the digital prescribing and medicines administration process, which uses patient and medication barcode technology.

Work is ongoing with representatives from the HSC Trusts and the encompass team to develop reporting capabilities that will enable this data to be captured directly from the digital system. In parallel, a regional improvement programme has commenced to review omitted and delayed doses, with a particular focus on critical medications.

Within encompass, the medicines administration build includes embedded prompts and reminders to clinical staff, primarily nursing staff, involved in the administration of medicines. These prompts are aligned to the electronic prescription and appear within each nurse's workflow for their allocated patient list, helping to support timely medicine administration in accordance with the prescribed schedule. In addition, safety dashboard and reporting functions are available within encompass and are currently being highlighted for use in practice by shift leads. These functions provide an opportunity to strengthen real-time oversight of medicines administration ahead of the development of any structured, regionally agreed formal reporting arrangements.

REDUCING CARDIAC ARREST RATES IN HOSPITALS

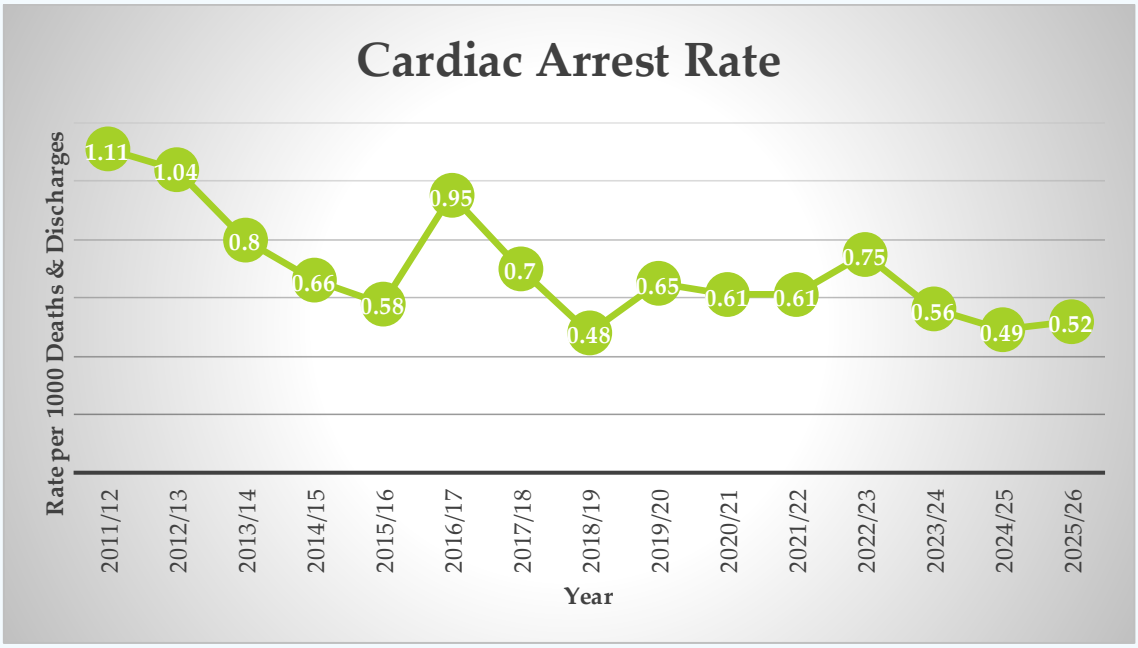
The Trust remains committed to improving patient safety through the early identification and management of deteriorating patients.

During 2025/26, there were 96 in-hospital cardiac and respiratory arrests, compared with 104 in 2024/25. This comprised 94 cardiac arrests and two respiratory arrests, representing a continued reduction in these events across the Trust.

The cardiac arrest call rate for general wards (excluding Cardiology, Emergency Department, Critical Care and Theatres) was 0.52 per 1,000 deaths and discharges in 2025/26. This represents a small increase from 0.49 in the previous year, reflecting changes in patient activity despite a reduction in the number of arrest events.

The Trust's cardiac arrest rate remains significantly lower than the latest national average reported by the National Cardiac Arrest Audit (0.52 compared with 0.9 per 1,000 deaths and discharges)

The graph below details the Trust crash call rate to general wards (excluding Cardiology, Emergency Department, Critical Care and Theatres).



Resuscitation training programmes, including Advanced Life Support (ALS), Advanced Paediatric Life Support (APLS), Immediate Life Support (ILS), Paediatric Life Support (PILS) and the Acute Life-Threatening Events and Treatment (ALERT) courses, continue to emphasise the assessment and management of the deteriorating patient. These programmes are supported by Trust-wide training pathways, Critical Care Outreach Services, Hospital at Night teams and regular ward-based simulation exercises.

All cardiac arrest calls are audited against local and national standards to identify learning opportunities and support continuous improvement.

Survival following cardiac arrest
Overall, 35% of patients survived to leave hospital following a cardiac or respiratory arrest. This compares positively with the latest national figure of approximately 26%.

Survival was highest among patients whose heart was in a rhythm that could be treated with an electric shock from a defibrillator. Of the 26 patients in this group:

- 85% had their heartbeat restored, compared with 78% nationally
- 69% survived to leave hospital, compared with 55.2% nationally

Survival was lower among patients whose heart rhythm could not be treated with a defibrillator, which is also seen nationally. However, the Trust's outcomes remained above the latest national figures:

- For patients whose heart had stopped completely, 18% survived to leave hospital, compared with 11% nationally.
- For patients whose heart still showed electrical activity but was not pumping effectively, 22% survived to leave hospital, compared with 17% nationally.

These results are encouraging, particularly alongside the reduction in the overall number of cardiac and respiratory arrests.

Continuing improvement
The continued reduction in arrest events demonstrates the impact of sustained improvement work across the Trust, including staff education, effective use of early warning scores and strengthened multidisciplinary escalation processes.

Audit findings continue to emphasise that while clinical warning scores are valuable, they should complement rather than replace clinical judgement. Some patients experienced cardiac arrest despite low warning scores, highlighting the importance of comprehensive clinical assessment and prompt escalation of concerns.

The Resuscitation Service will continue to review cardiac and respiratory arrest events to identify learning opportunities and support ongoing improvements in patient care. Key areas of focus include early recognition of deterioration, timely escalation, high-quality cardiopulmonary resuscitation, early defibrillation where indicated, and appropriate treatment planning discussions.

Overall, outcomes continue to compare favourably with national benchmarks, providing evidence of sustained improvement in patient safety and resuscitation care across the Trust.

Theme 4

Raising the Standards



EMERGENCY DEPARTMENT (ED)

Facts and Figures

135,759 people attended ED during 2025/26. This was a 2% increase from the previous year.

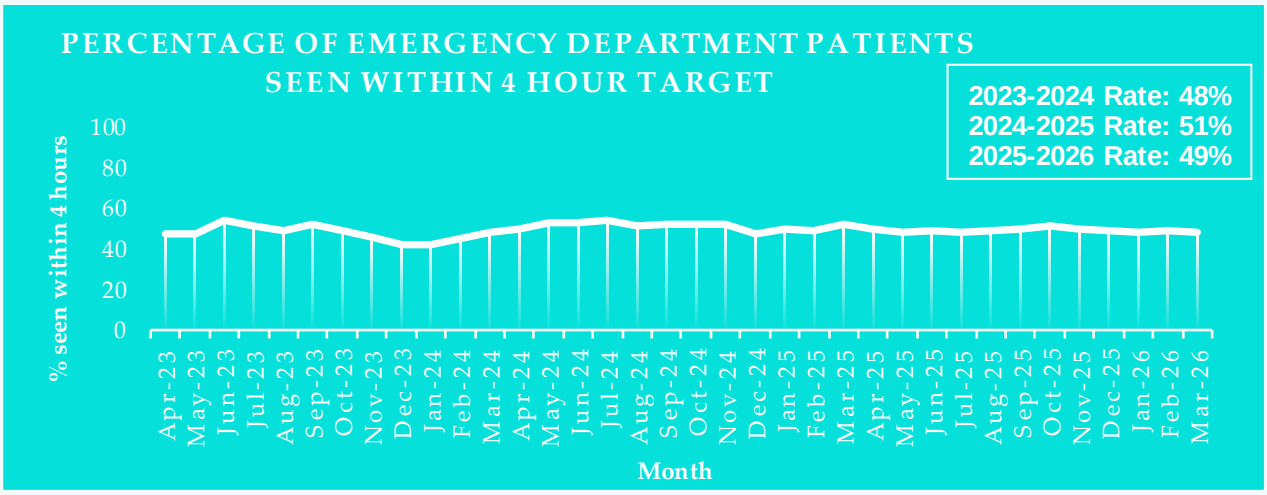
49% of these patients were seen within the 4hr target which is a 2% decrease from the previous year.

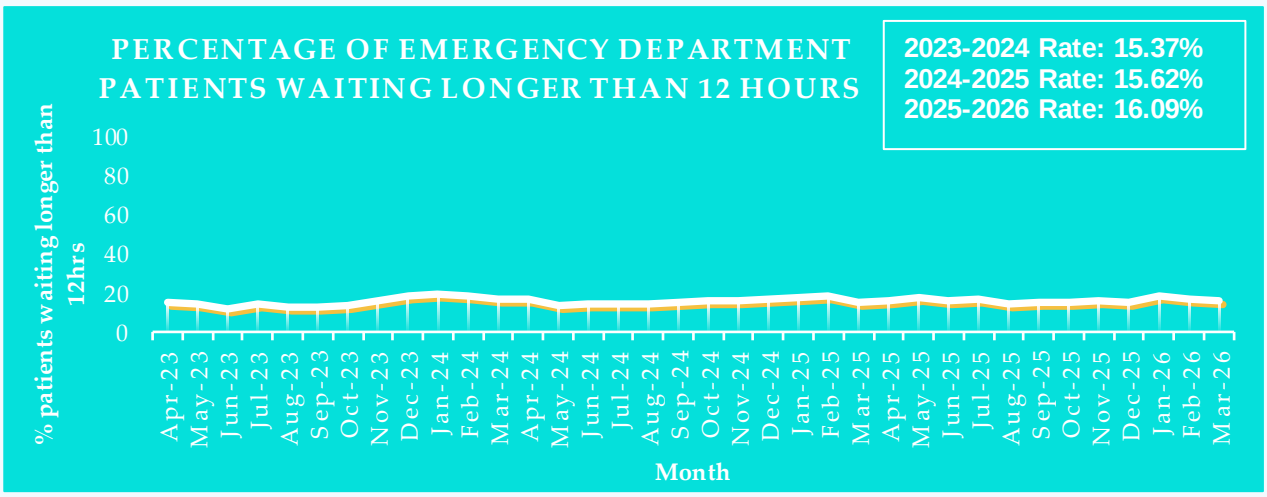
16.09% of these patients waited longer than 12hrs which is an increase of 0.47% from the previous year.

5.23% of these patients were unplanned re-attenders

4 Hour and 12 Hour Standards

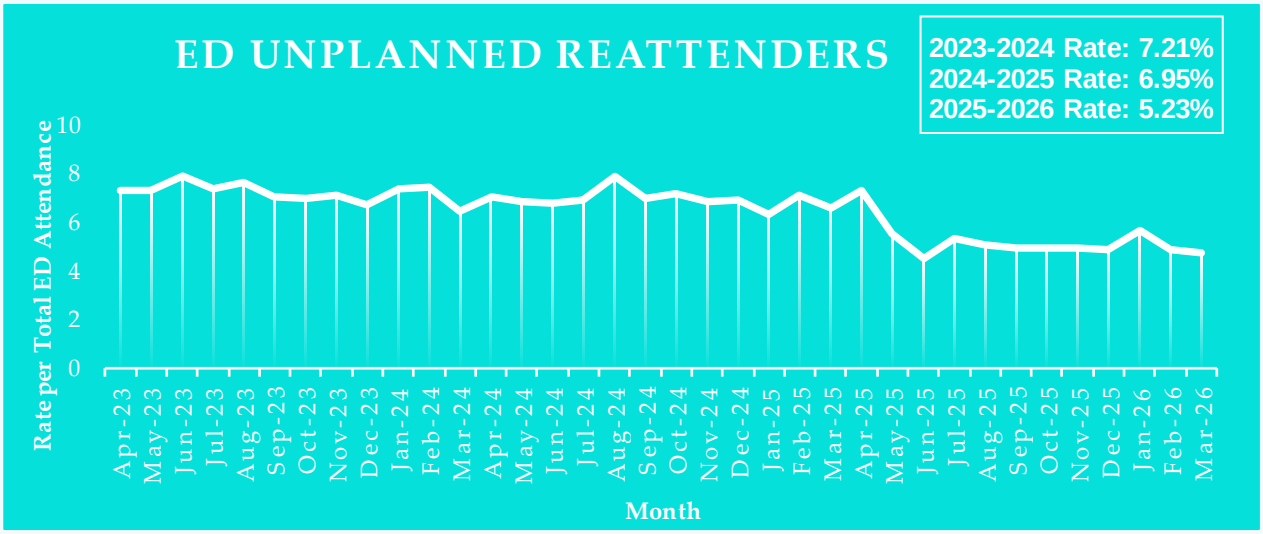
Both our Emergency Departments, similar to other EDs across the region, continue to experience challenges with congestion and long waits for our patients, alongside a 2% increase in attenders. This is reflected in our performance against both the 4 and 12 hour standards over the past 3 years.





Unplanned Re-attendance 2025/26

The Unplanned Re-attendance Rate indicator looks at unplanned follow-up attendances to the Emergency Department. The target for this is less than 5% and focuses on avoidable re-attendances and improving the care and communication delivered at the original visit. There has been a marked reduction compared to the previous year.



People who leave without being seen

Western Trust

Total number of attendances during 2025/26 - **135,759**

Percentage of patients who did not wait to be seen - **4.1%**

4.1% of all attendances did not wait to be seen, which is a reduction of 1.6% compared to the previous year. This is also reflective of the long waits patients are experiencing in ED.

Actions Taken to Improve the Trust's Provision of Emergency Care

The ED nursing workforce secured funding through Growth Fund monies that were delivered in September 2025. This allowed funding to operationalize ED ambulance offload and provide senior nursing leadership in ED to stabilize a 24/7 Rota. Funding was also provided to the night management team to again reinforce and support senior decision making in the out of hours period.

Nursing workforce stabilization across both SWAH and Altnagelvin will be reviewed again in November 2026 with the use of the Safer Care Nursing tool.

In March 2024, a Minor Injury Unit was opened in Altnagelvin Hospital as part of the No More Silos programme. This successfully delivered dedicated minor injury space, Radiology provision and an alternative pathway from ED through a Phone First Led triage process. 2025/26 has seen a significant increase in attendances from 14,000 to 17,000 attendances noting the success of the unit and a safer care journey for the patient.

The Acute Care Unit (ACU) was expanded to include eight short-stay beds, supporting admission avoidance and same-day emergency care.

Capital investment is delivering additional Same Day Emergency Care capacity as South West Acute Hospital and progressing ED improvement works at Altnagelvin Hospital.

Mortality Ratio and Emergency Readmission Rates

Encompass, implemented in May 2025, is now the source of patient administration activity and work has yet to be completed on the development of a suitable formatted data extract to inform the production of CHKS benchmarked indicators. For that reason, the WHSCT is unable to provide the standard Risk Adjusted Mortality Indicator (RAMI) and Re-Admission rate data for 2025-2026.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) GUIDELINES AND ENSURING COMPLIANCE

The National Institute for Health & Care Excellence (NICE) is an independent body responsible for producing:

- Evidence-based guidelines for the treatment of specific conditions
- Rigorous evaluations of new drugs and treatments as they become available
- Guidance for clinical, social, and public health services on how best to support people in improving their health and well-being

The Department of Health (DoH) reviews NICE Guidelines, Technology Appraisals, Public Health Guidance and HealthTech Guidance for their applicability to Northern Ireland and, where appropriate, endorses them for implementation within HSC Trusts.

The arrangements for the endorsement, implementation, monitoring and assurance of NICE Guidelines in Northern Ireland are set out in the DoH Circular HSC (SQSD) 9/26.

Within the Trust, a lead Directorate is identified for each NICE Guideline received for implementation. The lead Directorate, with input from other relevant service areas where required, is responsible for assessing current practice against the recommendations and determining the actions required to achieve implementation.

Implementation may include the development and monitoring of action plans, changes to clinical practice or pathways, business planning and/or other improvement activity. Where guidelines are considered to be fully implemented, assurance may also be sought through audit of all or part of the guideline.

Where a NICE Guideline cannot be fully implemented, the responsible Directorate is required to identify and assess the associated risks and ensure that these are appropriately managed and escalated through the Trust's internal governance arrangements and risk management process.

The Standards, Audit and Quality Improvement Group (SAQI) oversees the Trust processes for the implementation and monitoring of NICE Guidelines. Compliance and identified areas of non-compliance are shared with relevant Directorates, with implementation and associated risks monitored through the Trust's governance and assurance arrangements.

Reports on NICE Guideline Implementation are provided to the Quality & Standards Sub-Committee and Patient Safety & Quality Committee.

NATIONAL AUDITS

Clinical audit has been defined as

"*a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

Healthcare Quality Improvement Partnership (HQIP)

A total of 371 audits were carried out by Trust Staff in the year 2025-26. Reasons for these audits varied from Compliance Assurance; Accreditation, Complaints/SAI, Risk or were a Directorate Priority.

Our Trust participates, where possible, in National audits allowing us opportunities to

- Compare our performance with other participating Trusts in Northern Ireland and/or England, Scotland and Wales
- Measure our healthcare practice on specific conditions against nationally accepted standards
- Receive benchmark reports on performance, with the aim of improving the care provided
- Provide patients, the public, clinicians and health service managers with a clear picture of the standards of care being achieved by our Trust.

Examples of national audits that the Trust participated in which were published during the 2025/26 year are outlined below:

National Audit – Intensive Care National Audit and Research Centre (ICNARC) 2024/2025

Background:
The Case Mix Programme (CMP) is the national clinical audit of admissions to adult critical care in England, Wales & Northern Ireland. Critical care units that participate in the CMP submit data to ICNARC for each patient admitted to the unit.

Aims & Objectives:
To support health care providers by:
1) Measuring patient care and outcomes.
2) Benchmarking with other providers across the UK.
3) Identifying and addressing areas that could be improved.

Criteria:
Eligibility criteria for inclusion in the CMP Public Report for NHS adult critical care units are as follows:
1) Adult critical care units located in NHS hospitals in England, Wales and Northern Ireland participating in the CMP; and
2) If analysis reveals a participating unit as a potential outlier, ICNARC follows a clear 'Detection and management of outliers' policy.

Areas of good practice:
1) There is a lower than average % of patients with a potential mis-triaged to the ward
2) Average amounts of high-risk sepsis admissions from the ward
3) Average amount of unit-acquired infections in blood
4) Average amount of discharges to the ward out of hours (Not delayed)
5) Average amount bed days of care post 4-hour delay
6) Above average numbers of non-clinical transfers to another unit
7) Average amount of readmissions within 48hours
8) Average risk- adjusted acute hospital mortality

Areas where improvement is needed:
1) Above average amount of high-risk admissions from the ward
2) Less than 60% of eligible data recorded for delayed admission so unable to compare units
3) Above average (very high) number of discharges direct to home

Recommendations:
1) Decrease the number of high-risk admissions from the ward.
2) Record data for delayed admissions to our unit.
3) Reduce the number of discharges directly to home.

Actions:
1) Decrease the number of high-risk admissions from the ward. Medical team to discuss ways of reducing the number of high-risk patients that are admitted to ICU. Responsible person: Anaesthetic Team. Timescale 6 months
2) Record data for delayed admissions to our unit. Data needs to be documented when a decision to admit a patient to ICU is made. Responsible person: Nursing and Anaesthetic Team. Timescale 1 month
3) Reduce the number of discharges directly to home. Due to the wards not having beds available patients end up being discharge directly from home to ICU. A Datix incident report is completed where a delay exceeds 48 hours, and the circumstances are reviewed by the relevant managers. Responsible person: Patient Flow Team. Timescale 1 year

Lessons learned:
Data collection needed to be improved for recording delayed admissions to the unit.

We need to improve the flow of patients from ICU to the ward by not discharging patients directly to home from ICU, due to a reduced patient flow in the hospital this may be difficult, this is managed by patient flow and not controlled by ICU.

Medical team need to review their admissions and try to reduce the number of high-risk patients admitted.

Dissemination of learning:
Audit results shared with ICU team through staff meetings and email.

National Audit of Cardiac Rehabilitation 2025

Background:

The National Audit of Cardiac Rehabilitation (NACR) collects comprehensive audit data to support the monitoring and improvement of cardiovascular prevention and rehabilitation services in terms of access, equity in provision, quality and clinical outcomes.

The NACR dataset consists of a number of data fields which are collected via a set of questionnaires completed by the patients themselves, and at clinical appointments/rehab sessions with the patient. The data collected includes demographics, clinical, quality of life and mental health.

Aims & Objectives:

1) Monitor quality of:
    a. service provision
    b. cardiovascular rehabilitation (CR)
    c. service provision across Integrated Care Boards (ICBs) and Clinical Networks to support delivery of good quality and effective services, to evidence-based standards, for the benefit of all eligible patients.
2) Map the extent and quality of CR provision and report on inequalities in delivery against key service indicators for over 320 programmes in the UK.
3) Support improvement of service provision of CR via targeted research to determine the effectiveness of routinely delivered CR services on patient agreed outcomes, cardiovascular disease risk profiles and health and social care utilisation.
4) Use the audit to benchmark CR programmes to agreed standards via the National Certification Programme for Cardiac Rehabilitation (NCP_CR), run in partnership with the British Association of Cardiovascular Prevention and Rehabilitation (BACPR)
5) Tailor and evaluate NHS funding for CR Identify inequalities in service delivery and use this data to inform NHS England spending on CR. Evaluate the impact of NHS funding for CR service delivery

Criteria: National Certification Programme for Cardiac Rehabilitation standards developed with the British Association for Cardiovascular Prevention and Rehabilitation.

Areas of good practice:

1) NACR audit of 2025 reports improvement in the uptake, quality of service and benefit to patients completing cardiac rehabilitation. Whilst this is a national audit it recognises that with implementation of encompass to NI there is limited presentation of data this year.
2) The Trust reports that its Cardiac Rehabilitation Service operates with a multidisciplinary team and that previously vacant posts have been filled. Temporary staff absences continue to present challenges.
3) We also align to regional NACR report with regards CR team containing staff prescribers. We now have 2 nursing staff who have completed non-medical prescribing (NMP) with an aim of training another two staff members 2026/27 as well as lead consultant cardiologist as part of CR team. This allows us to support patients with CVD and optimise medications efficiently rather than referring to GPs. Challenges remain however with getting staff released to attend NMP course, time involved in training, selecting suitable candidates to complete course when competing with work/life balance issues.
4) We are completing data on Assessment 1 (pre-CR) where we assess CVD risk factors, complete psychosocial assessment and fitness test. We align with regional findings in using group-based CR particularly for education sessions.

Areas where improvement is needed:

1) As data flow improves into NACR audit, following implementation of Encompass in Northern Ireland, it is hoped there will be an improvement in data on uptake of CR and service quality reporting.
2) Need to get all nursing staff trained as NMP. In order to do this, we need access to NMP course, dedicated time to attend course and practice hours as well as adequate staffing levels to backfill staff whilst undertaking this study.
3) With regards completing fitness test for all CR patients entering program, we are aiming to increase testing for all patients regardless of whether they are completing face to face, hybrid or home program. With optimal recruitment of physio staff and return of long-term sick leave we feel this will be achievable provided patient is deemed suitable to undertake test.
4) We need to make better use of digital technology to include educational resources. Work is underway in NI to improve this, however there will still be challenges with regards inequalities in access to resources, technical barriers and infrastructure.
5) The waiting time from referral to the start of core rehabilitation is an area for improvement in all three nations.
6) With regards submission of complete and full data across the entire pathway with specific focus on assessment 2 (post-CR), currently due to limitations in the current Encompass build we are unable to collate full data on assessment 2. This aligns with issues within NI.

Recommendations:
1) Where required, increase pharmacology related support as part of the CR service.
2) Ensure that assessment 1 (pre-CR) is inclusive of all three core areas of risk factors, exercise test and psychosocial wellbeing.
3) Increase CR completion rates across all modes with a primary focus on Home based/Self-managed CR.
4) Review service provision in light of incorporating more digital components into the CR pathway.
5) Improve wait time (referral to start of core) and capture assessment 2 activity on NACR.

Actions:
1) Enable appropriate CR staff to upskill to become non-medical prescribers.
2) Work alongside NACR to identify missing components within assessment 1 (pre-CR) in order to target measurement and recording. Ensure all eligible patients have fitness test completed pre and post CR program.
3) Planned “Definition of Completion” due to be published in late 2026 in collaboration with the BACPR and the NCP_CR Steering Group. Pre-book assessment 2.
4) Using the findings from this report to highlight barriers in utilisation of digital modes/content and support solutions e.g. staff training, patient literacy and funding. Where new technologies are being introduced refer to NICE Early Value Assessment.
5) Aim to reduce wait time to NACR KPI of 2 weeks. Complete build for assessment 2 on Encompass.

Lessons learned:
1) We have made great improvement with regards recruitment and stabilisation of workforce which overall demonstrates improved patient outcomes and service delivery.
2) Need to continue to promote NMP role within nursing team.
3) Improve NACR data collection with regards assessment 2 once encompass build completed.

4) Aim to meet all 7 standards of National certification program for CR to achieve green status.

Key performance indicators (KPIs) NCP_CR key performance indicators.

1. Multidisciplinary team.
2. Patients starting Core CR from all priority groups.
3. Duration of CR.
4. Assessment 1 (pre-CR).
5. Wait time (Referral to start of Core) (CABG).
6. Wait time (Referral to start of Core) (post MI/PCI).
7. Assessment 2 (post-CR).

The service currently reports meeting KPIs 1 to 5. Further improvement is required in relation to KPI 6, the waiting time from referral to the start of core rehabilitation following MI/PCI, and KPI 7, completion of Assessment 2.

5) We need to improve wait time (referral to start of core) (post MI/PCI) and the required Encompass build for capturing Assessment 2 data remains under development.
6) Ongoing work on rolling out a new country-wide database in Northern Ireland is currently impacting data entry levels.

Dissemination of learning: Audit results to be shared with CR team, Clinical Lead Consultant Cardiologist and Service Manager.

ACCESS AND PERFORMANCE TARGETS

Performance Overview

This section provides an update on the changes to the commissioning and performance management framework for Northern Ireland Health & Social Care, which introduced an Integrated Care System for Northern Ireland (ICS NI). The ICS NI Framework Document - May 2024 provides an overview of the new model, strategic direction and expected outcomes to be achieved and incorporated a Strategic Outcomes Framework (SOF) and System Oversight Measures (SOM). This then superseded the requirement to develop a Commissioning Plan, a Commissioning Plan Direction (CPD) and Trust Service Delivery Plans (SDP). In 2025, DoH began work on new Planning Guidance for HSC, and this will form a key part of the performance management framework in 2026/27.

The SOF provides the strategic outcomes to be achieved in respect of the health and wellbeing of the population in the long term. It incorporates nine key themes as set out below. The associated SOM metrics will measure how the HSC system is contributing to the achievement of the outcomes. The SOMs have been developed around six key domains which include Performance, Safety & Quality, Finance & Governance, Efficiency & Productivity, Access Improvement & Tackling Health Inequalities and Workforce.



System Oversight Measures (SOM) – 2025/26

There are 101 SOM metrics across Acute, Community and Primary Care, Safety and Quality and Access Performance. The finalised SOMs were issued by Strategic Planning and Performance Group (SPPG) on the 26 June 2025.

The Western Trust are responsible for reporting against 51 (47 quantitative and 4 qualitative) of the 101 metrics to the Strategic Planning and Performance Group (SPPG). The remaining 50 metrics are reported by other Trusts or leads in DoH, SPPG and PHA.

A new Single Healthcare Record (Encompass) has been implemented progressively across the Trusts since November 2023. The Trust went live on Encompass on 8 May 2025, and as a result, review and reporting of data confidence levels as part of the stabilisation of this new system has been introduced. HSC Trusts now report a data confidence level (High, Medium or Low) for each SOM on a monthly basis, up to Board Committee level.

The Trust activity stabilisation phase was formally monitored from 8 May 2025 to 28 November 2025, comparing activity delivered against the same period of 2024/25 to provide assurance to the Trust and the Programme. Overall, the cumulative activity delivered across Hospital and Community services during this period reflects positively with the majority of service areas delivering activity above, in line with or just below baseline data.

During the year, all Trusts adopted the new SOMs and Regulatory reports developed on Encompass, which proved to be a considerable programme of work. The suite of reports for the 2025/26 SOMs have been developed with the exception of two metrics which remain a work in progress and will need tested for planned availability later in 2026/27.

Trust Board reports during the year have excluded those SOMs where data confidence remained low and reported on all other SOMs where data confidence was assessed as High or medium, or where data was drawn from non-Encompass sources. By year-end, 8 SOMs remained unreported and work continues to validate the data in these areas.

The Trust Board Performance Report is presented to Trust Board on a quarterly basis, and each month the Director of Planning, Performance & Corporate Services can highlight any significant issues which need to be drawn to the attention of the Board. The report is published on the Western HSC Trust website at Our priorities and performance | Western Health & Social Care Trust (hscni.net).

A summary of the March 2026 SOMs performance is provided below:

STRATEGIC PRIORITIES 2025/26 - SYSTEM OVERSIGHT MEASURES (SOMs)

This data is management information. Performance against SOMs must be viewed alongside Data Confidence Level			MARCH 2026					
			BASELINE	EXPECTED	ACTUAL	VARIANCE Actual - Baseline	% PERFORMANCE	DATA CONFIDENCE LEVEL
ACUTE CARE								
UNSCHEDULED CARE								
PATIENTS NOT WAITING IN EMERGENCY DEPARTMENTS	ALTNAGELVIN	TOTAL ATTENDANCES	5,038		5,056	18		High
		PATIENTS NOT WAITING	402	398	246	-156		
1% REDUCTION OF 2024/25 BASELINE		% DID NOT WAIT	**8.0%**	**7.0%**	**4.9%**	**-3.11%**	**-3.11%**	
	SOUTH WEST ACUTE	TOTAL ATTENDANCES	3,643		3,629	-92		
		PATIENTS NOT WAITING	142	141	152	-117		
		% DID NOT WAIT	**3.9%**	**2.9%**	**4.2%**	**0.29%**	**0.29%**	
12 HOUR EMERGENCY DEPARTMENT DELAY *10% REDUCTION OF 2024/25 BASELINE BY MARCH 2026*	TOTAL COMPLETED WAITS		8,681		**8,685**	4		
	NUMBER WAITED > 12 HOURS		1,716	1,544	**1,910**	194	**11.31%**	
NECK OF FEMUR FRACTURES	TOTAL TREATED		95%	95%	**53**			
	TREATED WITHIN 48 HOURS				**39**			
	% TREATED WITHIN 48 HOURS				**73.58%**	**-21.42%**	**-21.42%**	
OTHER FRACTURES	TOTAL TREATED		95%	95%	**81**			
	TREATED WITHIN 7 DAYS				**77**			
	% TREATED WITHIN 7 DAYS				**95.06%**	**0.06%**	**0.06%**	
SCHEDULED CARE : OUTPATIENTS								
DNA / ON THE DAY CANCELLATION RATES	NEW OUTPATIENTS	TOTAL ACTIVITY (ATT + DNA/CND)	5.0%	5.0%	**8,204**			Medium
		TOTAL DNA / CND			**779**			
		%			**9.50%**	**4.50%**	**9.50%**	
	REVIEW OUTPATIENTS	TOTAL ACTIVITY (ATT + DNA/CND)	8.0%	8.0%	**11,868**			
		TOTAL DNA / CND			**1,166**			
		%			**9.82%**	**1.82%**	**9.82%**	
ELECTIVE AVERAGE LENGTH OF STAY	Specialties above CHKS peer group levels		CHKS PEER VALUE					
	CARDIOLOGY		3.40		**3.91**	0.51	**3.91**	
	GENERAL SURGERY		4.30		**3.21**	-1.09	**3.21**	
	GYNAECOLOGY		1.91		**2.29**	0.38	**2.29**	
	HAEMATOLOGY		10.20		**7.64**	-2.56	**7.64**	
	UROLOGY		2.26		**2.00**	-0.26	**2.00**	
SCHEDULED CARE : THEATRES / INPATIENTS / DAYCASES			FEBRUARY 2026 - THEATRE DATA REPORTED ONE MONTH IN ARREARS					
THEATRE : DNA / ON THE DAY CANCELLATION RATES	MAIN	TOTAL ACTIVITY	5.0%	5.0%	468			Medium
		TOTAL DNA / CND			52			
		%			**11.11%**	**6.11%**	**11.11%**	
	DPU	TOTAL ACTIVITY	5.0%	5.0%	630			
		TOTAL DNA / CND			63			
		%			**10.00%**	**5.00%**	**10.00%**	
	ENDOSCOPY	TOTAL ACTIVITY	5.0%	5.0%	1,057			
		TOTAL DNA / CND			84			
		%			**7.95%**	**2.95%**	**7.95%**	

STRATEGIC PRIORITIES 2025/26 - SYSTEM OVERSIGHT MEASURES (SOMs)

Western Health and Social Care Trust

This data is management information. Performance against SOMs must be viewed alongside Data Confidence Level

		MARCH 2026					
		BASELINE	EXPECTED	ACTUAL	VARIANCE Actual - Baseline	% PERFORMANCE	DATA CONFIDENCE LEVEL
COMMUNITY CARE							
MAXIMIZE HOME CARE CAPACITY							
UNMET NEED HOURS *10% DECREASE OF MARCH 2025 BASELINE BY MARCH 2026*	FULL PACKAGES, ALL POCS	2,679	2,411	5,468	2,789	104.11%	High (Non-Epic Data Source)
	PARTIAL PACKAGES, ALL POCS	2,145	1,931	1,997	-148	-6.90%	
DIRECT PAYMENTS *5% INCREASE OF MARCH 2025 BASELINE BY MARCH 2026*	NO. OF CLIENTS IN EFFECT AT MONTH END	1,405	1,475	1,396	-9	-0.64%	
CHILDREN'S SOCIAL CARE							
UNALLOCATED CASES *10% DECREASE OF MARCH 2025 BASELINE BY MARCH 2026*	FAMILY SUPPORT CASES ONLY	28	25	34	6	21.43%	
ACCESS PERFORMANCE / WAITING TIMES							
1st NEW CONSULTANT-LED OUTPATIENT APPOINTMENT	% OF PATIENTS WAITING <9 WEEKS		50%	15%	-35%	15%	Medium
DIAGNOSTIC TESTS	% OF PATIENTS WAITING <9 WEEKS		75%	55%	-20%	55%	
INPATIENT/DAYCASE TREATMENT	% OF PATIENTS WAITING <13 WEEKS		55%	33%	-22%	33%	
SUSPECT BREAST CANCER - 14 DAY TARGET (WT)	% OF PATIENTS SEEN <14 Days		100%	8%	-97%	8%	High
CANCER - 31 DAY TARGET	% OF PATIENTS TO RECEIVED FIRST DEFINITIVE TREATMENT <31 DAYS	Feb 26: reported one month in arrears	98%	97%	-1%	97%	
CANCER - 62 DAY TARGET	% OF PATIENTS RED FLAG TO BEGIN DEFINITIVE TREATMENT <62 DAYS		95%	35%	-60%	35%	
ED ATTENDANCES WAITING <4 HOURS	% OF PATIENTS WAITING <4 HOURS		95%	30%	-65%	30%	
ALLIED HEALTH PROFESSIONALS (AHP)	NUMBER OF PATIENTS WAITING > 13 WEEKS		0	11,802		55%	Medium
CHILD & ADOLESCENT MENTAL HEALTH APPOINTMENT	NUMBER OF PATIENTS WAITING > 9 WEEKS		0	69		27%	High
ADULT MENTAL HEALTH APPOINTMENT	NUMBER OF PATIENTS WAITING > 9 WEEKS		0	169		25%	
DEMENTIA APPOINTMENT	NUMBER OF PATIENTS WAITING > 9 WEEKS		0	1		0.4%	
PSYCHOLOGICAL THERAPIES APPOINTMENT	NUMBER OF PATIENTS WAITING > 13 WEEKS		0	1,383		82%	Medium

Support and Intervention Framework (SIF)

The SIF was introduced by SPPG in November 2024 as the primary mechanism for performance oversight and escalation. This process involves continuous review of performance for areas of concern; these areas can be escalated, de-escalated, added or removed throughout the year. In addition, early stage discussions can be held for other areas of concern which may result in these areas being included on SIF at a later date. The Trust works collectively with SPPG/PHA colleagues to address these 'watching brief' areas of concern, resolve emerging issues and prevent escalation onto the SIF.

The SIF bi-lateral meeting with senior SPPG officers, Chief Executive and Director of Planning, Performance and Corporate Services took place on the 23 February 2026. The Western Trust position at year end included: **Level 1: 3 escalations**, **Level 2: 4 escalations** and **Level 3: 1 escalation**.

A summary of the Western Trust escalations at the 16 April 2026 (reflecting year end position) is provided below:

Level 1
ENT services - (originally escalated as Complex Head and Neck Cancer) *(previously de-escalated from Level 2, continues to be assessed as Level 1)*
Omagh Theatre scheduling *(de-escalated from Level 2)*
Child and Adolescent Mental Health Service (CAMHS) waiting lists *(De-escalated from Level 2)*
Level 2
Gynaecology Performance *(previously re-escalated to Level 2 from Level 1, maintained at Level 2)*
Non-compliance with timescales for the Regional Procedure for the reporting and follow-up of SAIs *(Re-escalated from Level 1 to Level 2)*
Ongoing inability to provide short breaks for children with disabilities *(Maintained at Level 2)*
Ambulance Handover *(de-escalated from Level 3 to Level 2)*
Level 3
Reducing Time Spent in ED for patients (with a particular focus on >12 hours) *(Maintained at Level 3)*

Unscheduled Care remains a significant area of concern for the Trust and the factors affecting performance are multi-factorial, and include Investment in alternatives to hospital pathways, hospital bed capacity, the pressing need for and ED capital scheme at Altnagelvin, and the expansion of community (homecare and nursing home) capacity, due to the changing demographics and healthcare needs of the Western Trust population.

Cancer Services

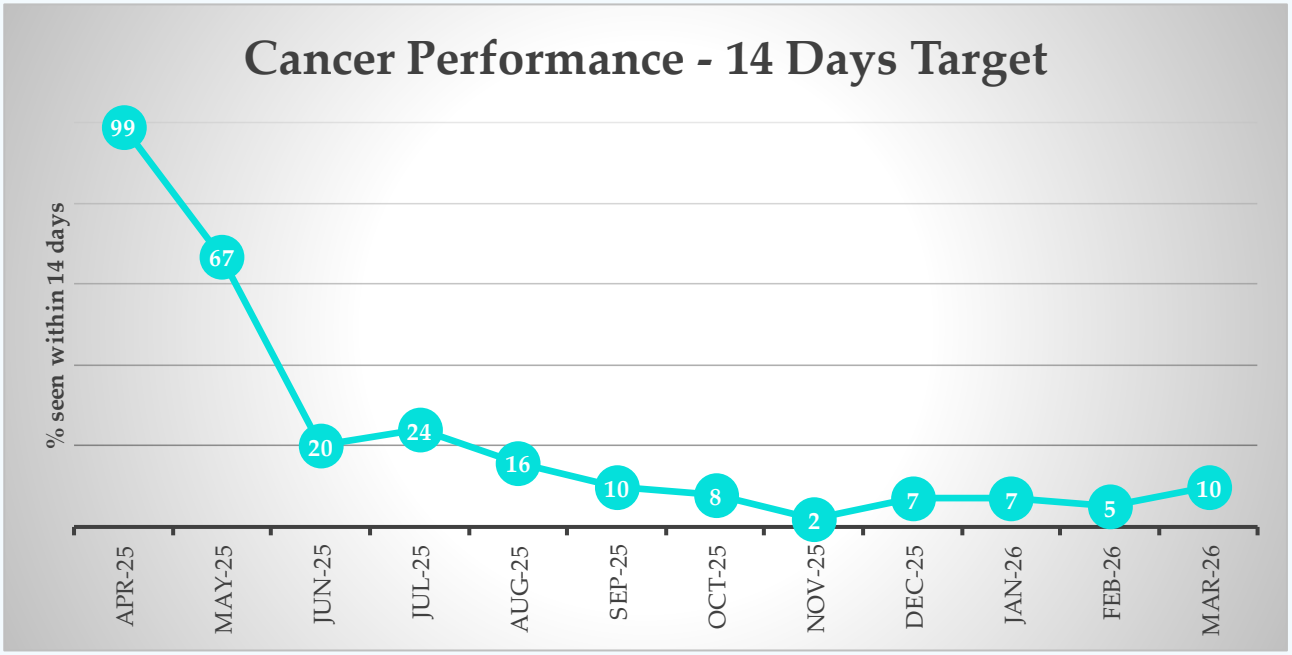
The Cancer and Diagnostics Hospital Management Team worked collaboratively to deliver high quality effective cancer diagnosis and treatment for the benefit of all patients. The Directorate continues to maintain accreditation across Pathology, Radiology, Radiotherapy and Medical Physics. The service continues to work closely with our colleagues in the Republic of Ireland to deliver cross border radiotherapy.

Despite rising demand and sustained pressure on cancer waiting time, particularly the 62-Day pathway, services prioritised red-flag and unscheduled care to ensure patients at greatest risk were managed safely. Consultant workforce challenges persisted within Radiology and Pathology, with active engagement ongoing with the Strategic Planning and Performance Group (SPPG) and Department of Health (DoH) to address recruitment gaps.

A significant achievement during the year was the global accreditation of the North West Cancer Centre (NWCC) by the European Society for Medical Oncology as a designated centre of Integrated Oncology and Palliative Care for 2025-2027. The NWCC became the first cancer centre in Northern Ireland to achieve this status, having met 13 internationally recognised criteria aligned to World Health Organisation recommendations.

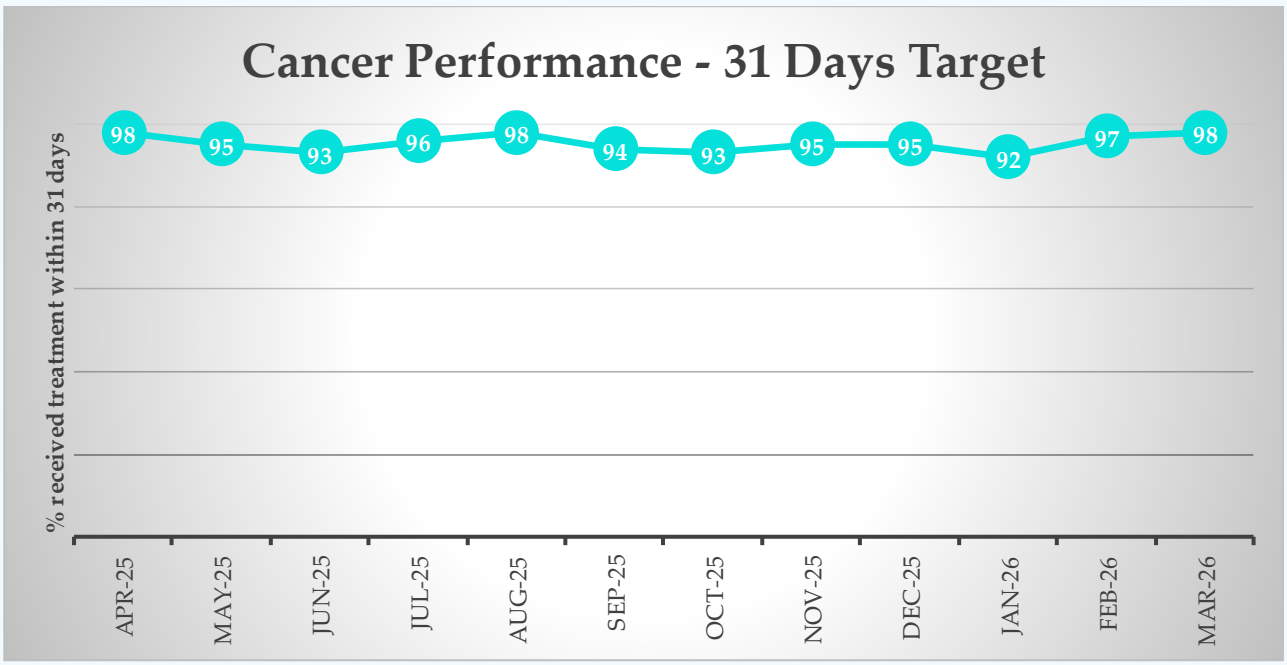
Performance against the 14-day breast target reduced to 23% for 2025/26. The 14-day cancer performance is lower due to the introduction of a Regional Breast Waiting List in May 2025. Performance against the 31-day target for 2025/26 was 95%. Achievement against the 62-day target remains challenging across the region. Monthly performance in relation to these three cancer pathways are included below:

14-day Breast target 2025/26 – 23% urgent suspected breast cancer referrals seen within 14 days

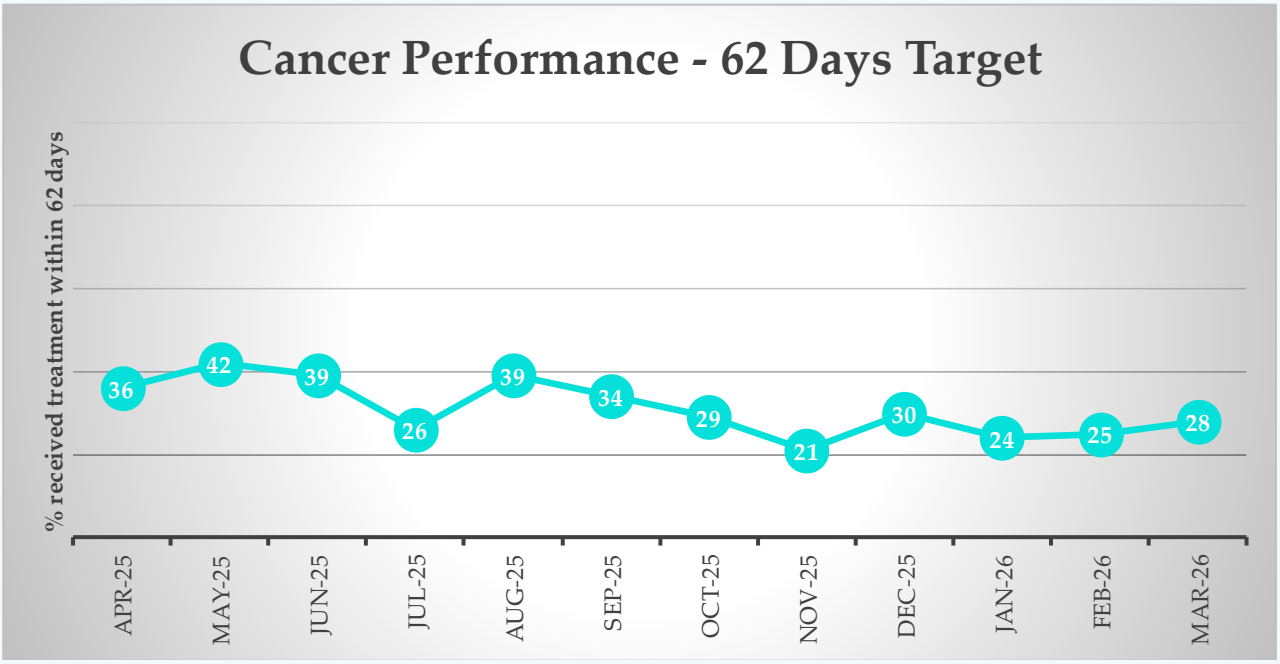


14-day breast cancer is now a regional service with one regional waiting list

31-day target 2025/26 – 95% of patients diagnosed with cancer who received their first definitive treatment within 31 days of a decision to treat.



62-day target 2025/26 - 31% of patients urgently referred with a suspected cancer who began their first definitive treatment within 62 days.



Theme 5

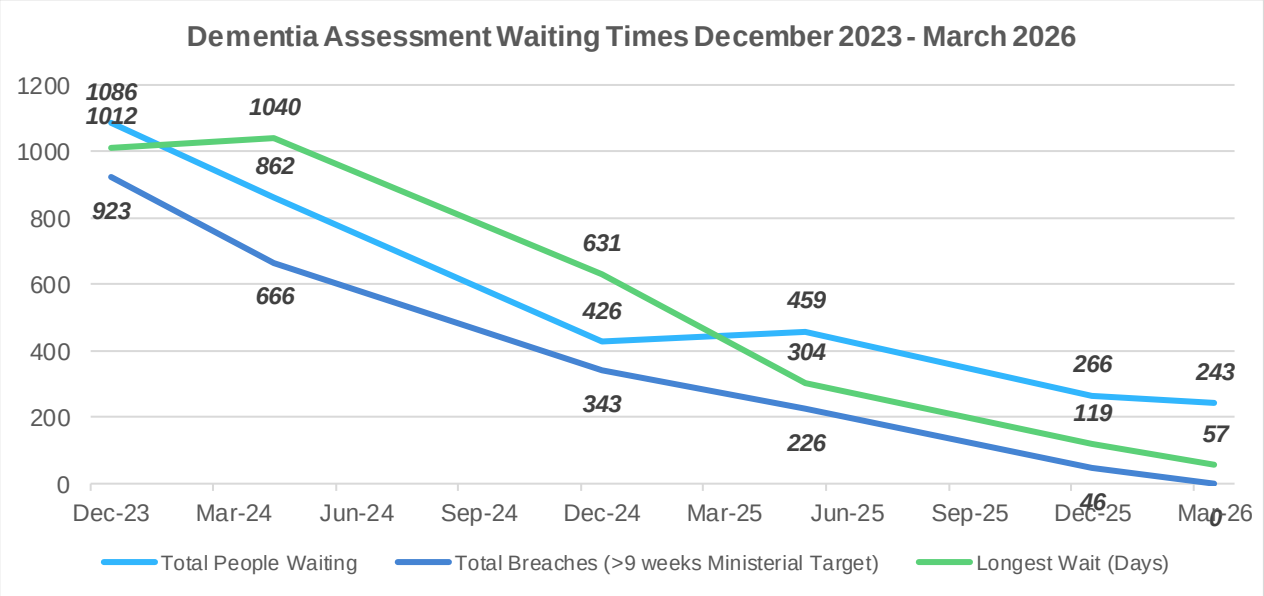
Integrating the Care



COMMUNITY CARE – SUPPORTING PEOPLE IN THE COMMUNITY

The Directorate established the Trust-wide **Community Discharge Co-ordination Team** (CDT) in May 2025, which is responsible for delivering on the strategic priority relating to the delivery of safe and effective complex discharge targets from acute hospitals. Since its formation, the team has triaged over 4000 referrals. Integrated working with Hospital Social Work and Allied Health Professional colleagues has progressed well to ensure the safe discharge of patients.

Reduced Dementia Assessment Waiting Times – Memory Service Quality Improvement work continued throughout the year to reduce the waiting times for those waiting on a dementia assessment appointment to meet the 9-week Ministerial target. The chart below shows the significant improvement made between December 2023 (923 breaches of 9-week target) and March 2026 (0 breaches of 9 week target).



The **Homecare Optimisation Project** was fully implemented across the Trust in June 2025. The Western Trust currently provides domiciliary care via an In-House service and tendered contracts with independent sector providers. Tendered contracts are provided on a block rota-based model and time specific model. The Rota Based Model is made up of Guaranteed Hours and operates on a repeating work schedule. By contrast, the Time Specific Model is variable in hours and duration (also known as spot purchasing). The Provider is paid for Guaranteed Hours every month whether or not the Trust has allocated all the Provider's Guaranteed Hours to a Rota.

The Homecare Optimisation Project was set up to ensure maximum utilisation of the guaranteed hours process and to minimise the use of "spot purchasing".
The following outcomes were achieved

- **746 cases of unmet need were accommodated** totalling **7611 weekly hours**
- **7538 weekly net hours** purchased through a spot purchasing arrangement were absorbed into existing block purchasing contracts

The **Community Respiratory Team** (CRT) undertook a quality improvement project to improve waiting times for the delivery of the Community Pulmonary Rehabilitation (PR) Programme to respiratory patients. Completion of the quality improvement project saw the **waiting list reduced by 54%** at March 2026 from the starting point at April 2025.

The Respiratory Team also undertook to produce an improvement in the timescale of the delivery of the Trust's **Tuberculosis (TB) service** to referred patients. The improvement work yielded a **31% reduction** in the waiting list between August 2025 and March 2026.

Review of Older People's Social Work Service started in 2025 with the aim of ensuring services are fit for the future and delivered by a sustainable and valued workforce. A key focus for the review is to address the number of unallocated and uncovered social work cases. This work will continue in 2026/27. A number of "tests of change" are being implemented across the social work teams including Single Point of Contact (SPOC) Assessment Model demonstrating good improvements.

Primary Care - The Trust continues to manage 4 GP Practices (having successfully handed over to a new contractor on 1st Jan 2026) with a combined population of nearly 31,000. The Trust has now stabilised the practices with GP rotas ensuring adequate cover each day. Locum cover has been substantially reduced following salaried GP recruitment exercises - 8 Salaried GPs (4.4 WTE) have been appointed to work in 2 of the 4 GP Practices. Patient access to these services is very important and all surgeries remain open during lunch time and do not close a half day during the week.

- A women's health clinic has been established in the **Fintona Surgery** to provide women's health services to the 3 GP Practices in the area managed by the Trust. The Service complements GP care provide by offering specialist services in menopause and peri-menopause management, contraceptive procedures and pelvic health
- The Practice GP and Pharmacist **Brookeborough & Tempo *GP Practice*** have been undertaking a clinical and medication review of all their patients and a treatment plan developed that includes reference to end of life wishes. The GP works closely with a range of Trust services in treating patients including Hospital @ Home Team, Rapid Response and District Nursing Team.
- A lipid management project has been established in partnership with Consultant Cardiologist, SWAH, GP Partners and Lead Pharmacist for GP Practices in **Dromore & Trillick GP Practice**. The focus is on lipid management of patients with secondary cardiovascular risks and is being taken forward initially in Dromore & Trillick GP Practice with a plan to implement in the other GP Practices. The practice has also been involved in the pro-active identification of patients with Urinary Tract Infection (UTI) and providing early treatment to avoid reaching crisis point and attendance at Emergency Department (ED).
- **CVRM Quality Improvement Project**: CVRM stands for Cardiovascular, Renal, and Metabolism. It is an umbrella medical term and therapeutic area used to describe the interconnected relationship between heart disease, kidney disease, type 2 diabetes, obesity, and related metabolic conditions. In June 2025 Dromore & Trillick GP Practice commenced this new way of managing patients with Type 2 diabetes. The project team includes a Consultant Cardiologist, a GP, Pharmacist and Practice Nurse.

Early Frailty Intervention Team (EFIT) – Co-operation and Working Together (CAWT) Peaceplus Frailty Intervention Project - Funding has been secured to commence a cross-border community-based EFIT team to provide early intervention for people over the age of 55 years living with or at risk of developing early frailty. The aim of the project is to slow down or reverse this process. The project will provide clinical support and episodes of health and social care.

Advanced Nurse Practitioner in Specialist Palliative Care – The Trust now has one of the first Advanced Nurse Practitioners (ANP) to work in palliative care in Northern Ireland to support and care for patients who have palliative and end of life care needs, with the focus on the community setting across the Omagh and Fermanagh areas of the Trust.

Stoma Health & Preventative Exercises (SHAPE)

The Community Nursing Stoma Team has collaborated with social work colleagues within GP Practices to implement a 6 week exercise programme for new patients. The programme has formed an important part of the recovery process and promoted living well with a stoma.

Community Equipment & Continence Home Delivery Service

The community equipment delivery model, which has been in place since 2016 is built around a retrieve, recycle and reissue approach. The model has served us effectively, ensuring that resources are used efficiently and responsibly. A text messaging service was introduced early in 2026 with the main aim of encouraging the return of community equipment and continence products that are no longer needed. By focusing on these returns, the aim is to further enhance recycling efforts and make sure that valuable equipment can be reissued where necessary.

MENTAL HEALTH

UPDATE ON QUALITY IMPROVEMENT INITIATIVES WITHIN MENTAL HEALTH (AMH&DS)

Regional TOWARDS ZERO SUICIDE PROGRAMME – 2026-2029

The Towards Zero Suicide (TZS) Strategic Framework and Regional Action Plan, 2026 to 2029, has been produced following an inclusive review process to determine TZS's future strategic direction of travel, priorities for action and measures of success to guide our work together over the next few years.

The process was led by the TZS Collaborative Board and co-designed and delivered with the Service Improvement Managers (SIMs). It involved structured engagement with colleagues across all Trusts including clinical leads, psychology, social work, nursing, healthcare in prison and service user consultants representing people with lived and living experience. This included a regional workshop held on 17th April 2026.

This document provides an overview of the new TZS Strategic Framework and Regional Action Plan, 2026 to 2029. It has been informed by TZS outcomes, impacts and learning, the reflections, suggestions and ideas from our Trust and Healthcare in Prison colleagues, and ongoing analysis of relevant population and service-based information available at local, regional and national level.

It was presented, by TZS Service Improvement Managers team, to the TZS Collaborative Board at their meeting on 29th June 2026 for discussion and approval for SIMs to commence delivery of the Regional Action Plan on behalf of and in co-partnership with the Collaborative Board. The Action Plan provides a clear basis for strengthening TZS engagement with the community and voluntary sector partners, and with service users, families, carers who provide lived and living experience and perspectives to inform TZS's work.

The Action Plan will commence implementation across all Trusts in Autumn 2026.

Western Trust Local Implementation Update

Suicide Prevention Care Pathway (SPCP)

SPCP is fully implemented across both Northern and Southern Sectors across the Crisis Response Home Treatment Services, Primary Care Liaison Teams and Mental Health Liaison Teams and Addiction Services. Implementation of the SPCP across adult mental health Recovery Services is complete.

Regional Task and Finish Groups were established to develop questionnaires for the evaluation of the SPCP. The evaluation commenced in January 2026. There was a low response rate to the evaluation process. TZS regional plans are in place to approach the Universities in September 2026 to explore the option of students carrying out the evaluation. A paper outlining Phase 2 of the SPCP will be shared with Regional TZS Collaborative Board in September 2026.

Safety Planning

A rolling training schedule will take place for 2026/27 for the delivery of Safety Planning training across all Adult Mental Health teams/services for all multidisciplinary mental health staff including refresher training for existing staff. A regional Safety Plan SOP has been developed and will be operational towards the end of 2026 to ensure a consistent approach across all Trusts.

Early Post Discharge

Early Post Discharge Workstream has fully implemented the 3 day follow up post discharge for all patients discharged from mental health inpatient units. The 80% target was achieved. A regional target of 100% has been set for all patients to be offered a Post Discharge 3 day follow up. The local EPD workstream will be carrying out an audit that will focus on the quality of 3-day appointments. A questionnaire has been developed and the audit will commence on 1st September – 30th September.

Minimising Restrictive Practice

A Regional MRP Workshop took place on 16th June. Each Trust shared progress to date and MRP data. There has been a reduction in MRP over the past year however need to do some more work around the data i.e. multiple RP for individuals.

Regional Priorities 26/27

- Trusts is spread and scale MRP across all wards. Western Trust spread and scaled in 2023 across both sectors of the Trust.
- Implementation of Safe Wards

A Dashboard developed to collate Restrictive Practice data i.e. incidents of Physical Interventions, Violence and Aggression and Rapid Tranquilisation. This data is collected on a fortnightly basis on a SPC QI Chart.

SafeWards Model

The SafeWards model aims to reduce levels of conflict and containment in the ward environment. A Safe Wards Group has been established consisting of ward staff and chaired by the Advanced Nurse Practitioner from both sectors of the Trust. The group will ensure full implementation of the 10 SafeWards Interventions across both inpatient units;

- TZS procured activity equipment and materials for both Grangewood and T&F. Ward Activities patients (including OT staff involvement) commenced in May 2026. Feedback from ward staff is very positive.
- Safety Cross and Therapy Cross well embedded in all wards.
- Building Safer Wards Audits. Leads identified to carry out the monthly, quarterly and yearly audits
- Regional 6 weekly check in meetings were set up. Western Trust AMH ward staff leads are represented at the meetings.

Use of de-escalation techniques promoted (and formally reported on) within inpatient units. De-escalation Techniques continue to be monitored via Therapy Cross in Grangewood Mental Health Unit and Elm and Lime wards T&F.

Implementation of Regional Post-incident Debrief/Defusion Principles

Debrief folders implemented on all inpatient wards and CRHTT and defusion sessions monitored via the therapy cross and Practice Educator.

Workforce

Workforce workstream has developed a database for recording all staff training (mandatory, essential and desirable) will be uploaded on Sharepoint for all Team Managers. System was presented at the AMH Governance meeting at the end of May 2026.

Work continues with HSC Learn team in developing a dashboard for all mental health SPCP training i.e. Pisani, Safety Planning and other essential training on the HSC Learn platform. Practice Educator completing the Autism and Suicide Training course (funded by Regional TZS). Training will be cascaded to mental health staff.

AMHDS Psychiatry Workforce

Psychiatry remains the specialty presenting the greatest workforce stabilisation risk.

A number of indicators continue to demonstrate the vulnerability of the Psychiatry medical workforce, including:

* The largest consultant vacancy position across specialties.
* Significant dependence on agency medical staff.
* A limited future training and recruitment pipeline.
* The introduction of Recruitment and Retention Premia (RRP), which to date have resulted in only limited improvement in substantive recruitment.

Despite these challenges, all Psychiatry consultant posts are currently filled through a combination of substantive consultants, Trust locums and agency locum doctors. However, during 2025 and 2026, additional pressures have arisen as a consequence of regional workforce stabilisation initiatives, particularly given Psychiatry's comparatively high reliance on agency staff to maintain service provision.

The new Medical and Dental Agency Framework has been introduced with the aim of reducing reliance on off-contract agencies, achieving greater consistency in agency arrangements and supporting stabilisation of the medical and dental workforce across the region.

Adult Mental Health & Disability Services has actively engaged with locum doctors regarding transition to the new Framework. Seven doctors have agreed to transition, with further discussions planned with those who have not yet agreed to move to Framework

arrangements. In parallel, work has commenced on the WHSCT Medical Agency Contingency Arrangements Process for doctors who do not agree to work within the new Framework rates. A draft process has been developed and is being progressed for review and approval by the Directors of Adult Mental Health.

Senior Mental Health leadership, including Assistant Directors and the Clinical Director, continues to meet regularly with Human Resources to review the workforce position, assess emerging risks and identify potential solutions.

Recruitment activity remains ongoing, with rolling advertisements continuing. All Psychiatry consultant posts currently attract a 20% Recruitment and Retention Premium, with the exception of the Omagh Community Mental Health Team post, for which a 10% RRP has been approved by the Department of Health.

During 2026 and moving towards 2027, further longer-term workforce solutions continue to be explored. These include International Medical Recruitment and potential reform and expansion of Specialty and Associate Specialist (SAS) roles. Divisional directors and clinical leads have arranged and met with other divisional leads that have successfully utilised these approaches in anticipation of further exploring these options. Alongside continued efforts to recruit, efforts to support and retain the existing substantive workforce continue.

Mental Health Improvement Board July 2026

The focus of the Adult Mental Health Improvement Board since October 2024 has been on Community Adult Mental Health Services. A deep dive review of AMH Recovery Services has been completed with a robust action plan in place to support this work. A deep dive review has also been completed within Primary Care Liaison Service (PCLS) with process mapping also completed to give a more comprehensive understanding of how Community Teams are functioning and how this connects with the wider Crisis and AMH inpatient system.

- **Primary Care Liaison (PCLS)** are currently meeting the 9-week IEAP Target. The deep dive recommendations are being taken forward through a Task & Finish Group. In addition, Fermanagh PCLS are establishing Exit meetings as there remains many long-term clients on the outpatient list.
- **Personality Disorder Services** service review has been completed and review report is being finalised for implementation. A Task and Finish Group will be established to take this forward.

Recovery Services

Recommendations for improvements to Recovery Services has been developed and Task and Finish Groups are established across teams to take forward the recommendations which report to AMHDS Directorate Improvement Board.

- **Development of Key-working Guidance (All Recovery Teams) -** completed for AMH Governance approval in August.
- **Adult Mental Health Care Management group** established with professional nursing and social work leads along with Heads of Service to review current Care Management processes within Adult Mental Health.
- **Testing of a Physical Health Monitoring Team (PHMT):**
  - Rossdowney & Slievemore PHMT has been established from 2 June 2025 to improve adherence to practice standards and create capacity in core teams. Clozapine and Lithium Monitoring pathways have been adopted as custom and practice, with further

test of change focusing upon anti-psychotic monitoring pathways. Learning for scale and spread Trust-wide is also underway within this area.
  - Southern Sector PHMT group established to consider potential scale and spread of Northern Sector PHMT work already completed to date. Data has been captured and analysed to identify priority areas for implementation.
- **Testing of a Management Oversight Tool** (Strabane Recovery Team) has commenced to strengthen governance, reduce case drift and improve flow.
- **Testing of a multidisciplinary Exit Meeting** to bring a more positive risk-taking approach to discharge (Fermanagh, Limavady, Strabane and Rossdowney). Slievemore is planned for roll out in September 2026. Omagh Recovery Exit meetings commenced May 2026.
- **Revisiting the Transition Pathway with CMHOPS/COPS** adopting a 'needs based' approach to support safe and timely transition. New Test of Change commenced in May 2026, with learning identified within areas such as Clozapine/Lithium Pathways, Memory Assessment Pathways and Critical Care Management criteria. Work is ongoing within this area.
- **Co-Occurring Mental Health and Substance Use**. WHSCT AMH have been working closely with SPPG and PHA colleagues to develop pathways to support optimum pathways for patients experiencing both mental health and substance use issues. The Scottish Four Quadrant Model has been the basis of this work with further consideration to the Scottish Multi-Agency Collaboration Hub (MACH). WHSCT have held events on 31 May 2025 and 31 July 2026 to include attendees from Community and Voluntary agencies, NIHE, CAMHS, Emergency Department, Personality Disorder, Forensics, Community Mental Health teams, Addictions, PSNI- with a clear action plan developed and agreement to pilot a MACH model in Fermanagh area with an identified Community and Voluntary lead And WHSCT support. Event on 31 July 2026 has been led by WHSCT AMH with further Regional Roll out of format in Q3. This work will also support Mental Health Collaborative work.
- **CAWT/WHSCT Community Addiction Detox +.** Funding has been secured in 2025 through PEACEPLUS to be utilised within WHSCT, SHSCT and HSE to develop a collaborative Detox Pathway between Statutory agencies and Community and Voluntary agencies to reduce repeat Detoxes and to widen and simplify Detox pathway. Recruitment has been successful in Northern Sector of WHSCT with on-going recruitment in SS. Pathway has been agreed and is implemented with best practice utilised from already established WHSCT Addiction Community and Voluntary Data Sharing Agreement and Hostel Detox pathway. Procurement for Community and Voluntary Contracts is nearing completion.
- **Forensic Service** review of Psychology commenced June 2026 which is due to be completed by September 2026 and a deep dive into the wider Forensic service is being taking forward.

Scoping is also underway to consider:

- Testing of a service to provide intensive wrap around support for 18-25 year olds. Initial discussions have commenced with Children and Families Directorate. Outcome of funding application to NIHE awaited to support same.
- Introduction of Signs of Safety Training to promote a more systemic approach to practice including how Family/informal supports can support safe discharge. Meeting to be arranged in September 2026.
- Test if introducing Structured Clinical Management (SCM) model will reduce the number of crisis assessments required for a group of six service users with personality disorder (reducing attendances for this cohort in Emergency Department and the need for an AMH inpatient admission).

Crisis Planning Update July 2026

Improvement Project ongoing to improve compliance with 7 practice standards in Care Plans within in the 5 in- patient wards through training, development, revised processes and improved systems. This is to ensure all admissions have a Care Plan (v6 format) in place that meets required standards.

In Grangewood this is now accepted as normal practice on the wards.

Elm Ward:

- The average compliance of care plans being initiated on admission was 74%, this has increased to 80%.
- The average compliance of all standards met when completing care plans was 40%, this has increased to 79%.

Lime Ward:

- The average compliance of care plans being initiated on admission was 55%, this has increased to 100%.
- The average compliance of all standards met when completing care plans was 27%, this has increased to 80%.

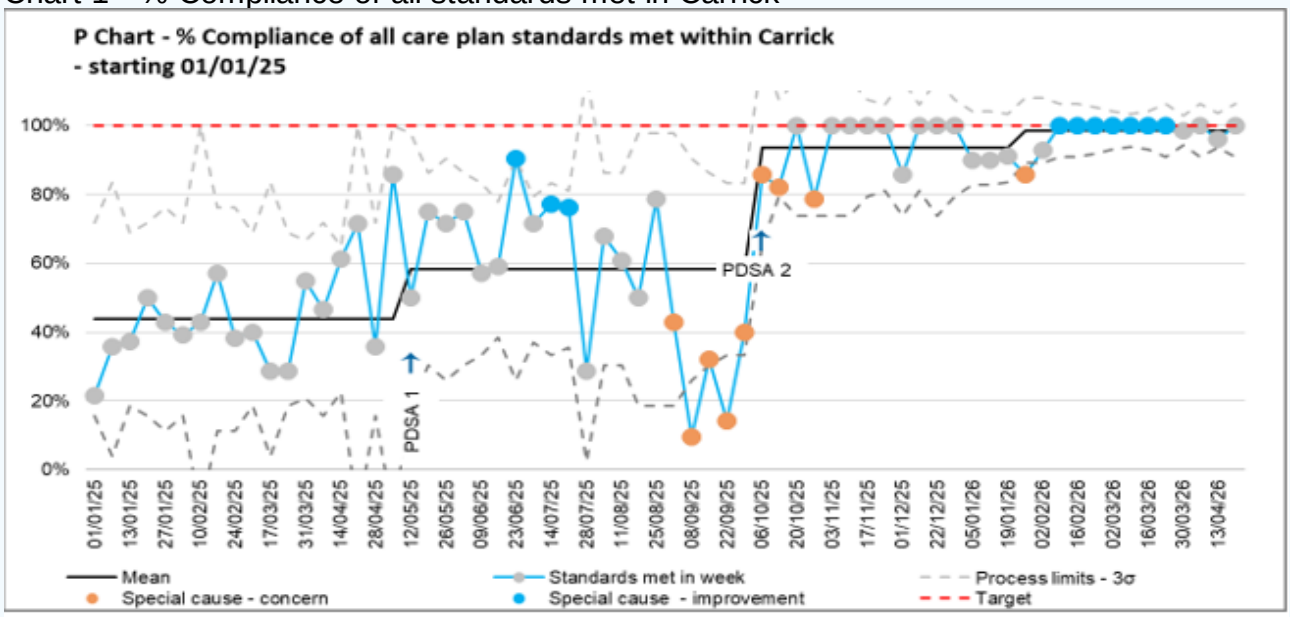
Rathview Assessment Centre:

- Data collection tools developed and set up.
- Service gathering baseline data at present.

The Team have developed;

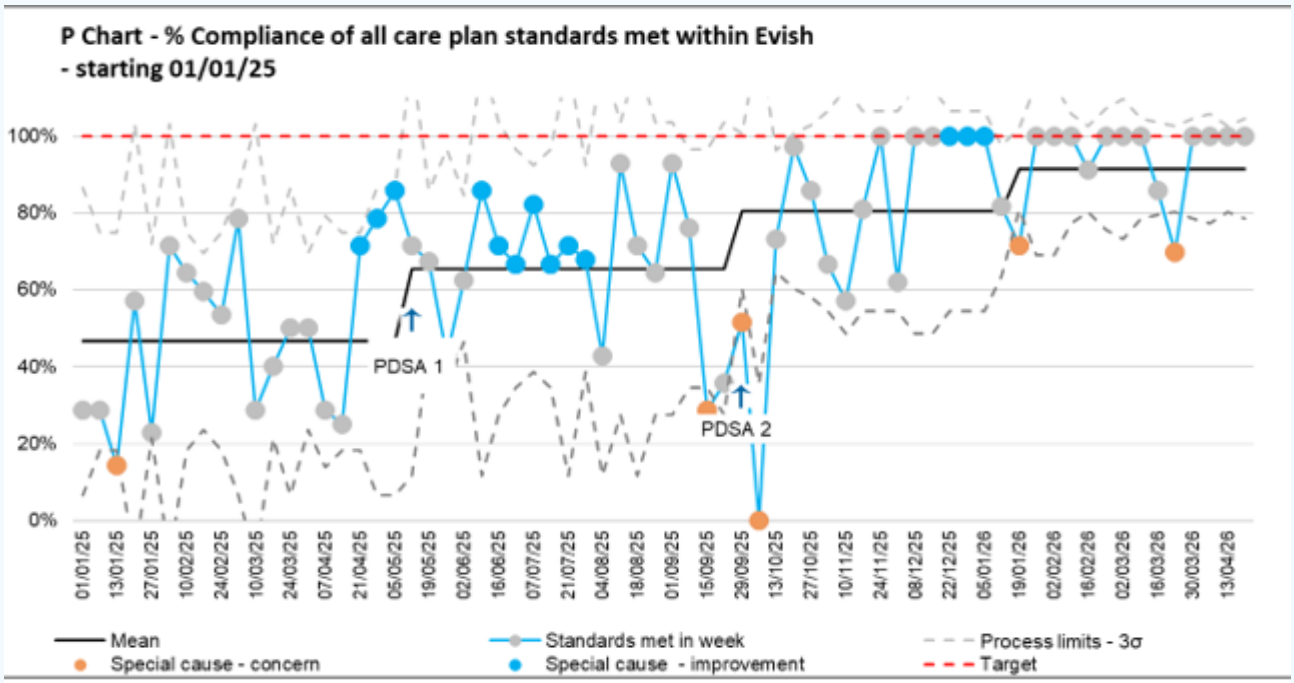
- Recording tools to capture baseline data
- Sharepoint site to centralize and record data collation tool for care plans across all wards
- Go Live on Encompass 06/10/26 and updating v6 care plans using smart phrase
- Training for staff on Smart Phrase for updating Care plans on Encompass
- Guidance documents developed for staff

Chart 1 - % Compliance of all standards met in Carrick



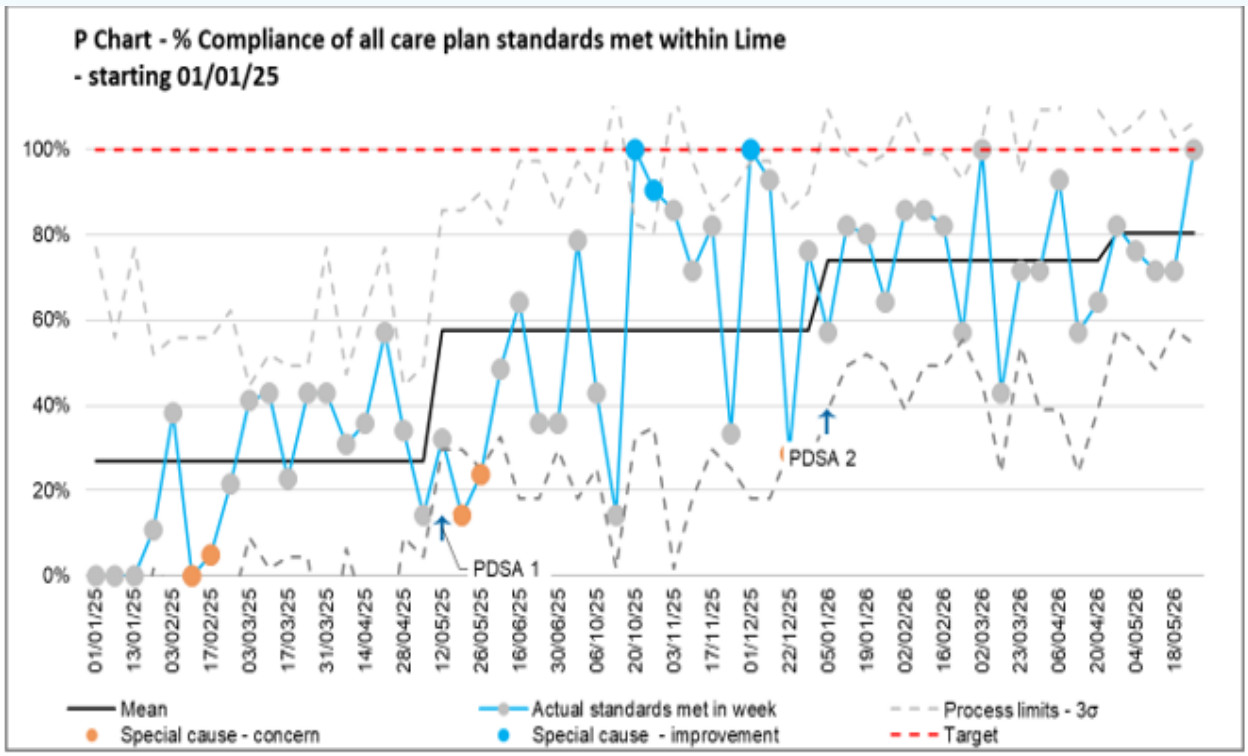
Evident that all care plans standards being met is embedded as normal practice

Chart 2 - % Compliance of all standards met in Evish



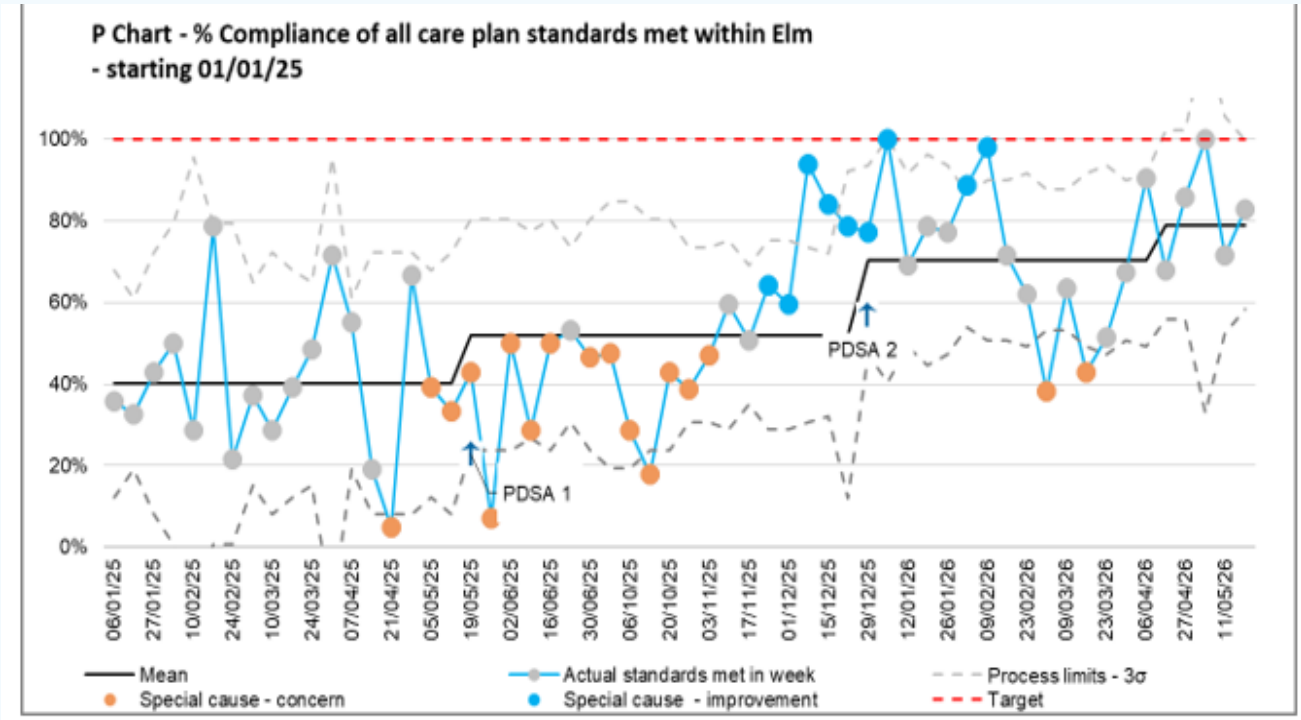
Evident that all care plans standards being met is embedded as normal practice

Chart 3 - % Compliance of all standards met in Lime



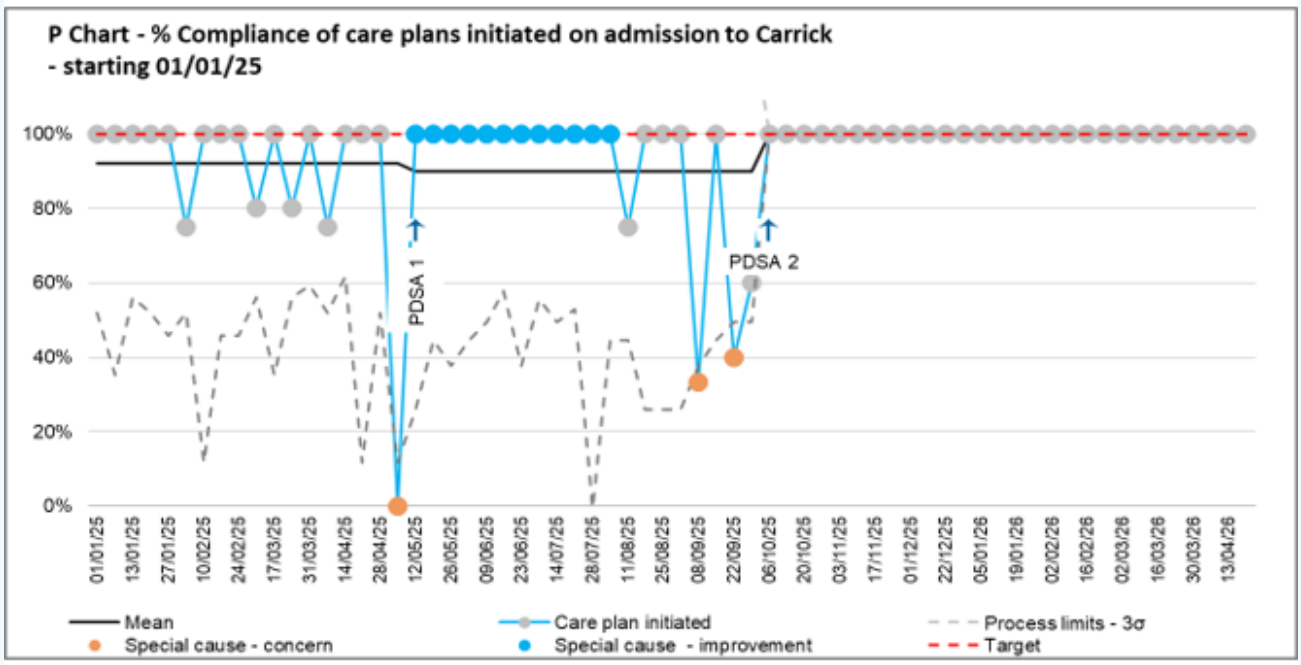
The average compliance of all standards met when completing care plans was 27%, this has increased to 58% following PDSA 1 and increased further to 71.4% following PDSA 2. **The average rate has increased further to 80.4% following a period of improved compliance.**

Chart 4 - % Compliance of all standards met in Elm



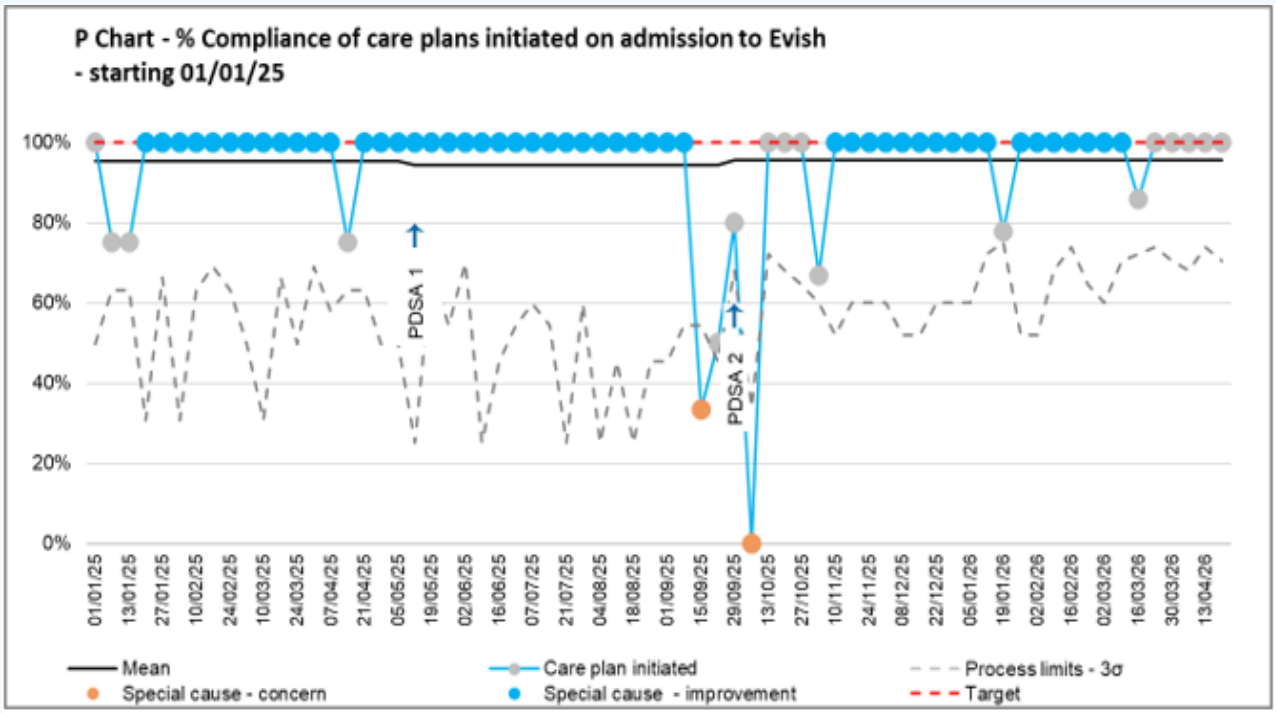
The average compliance of all standards met when completing care plans was 40%, this has increased to 50% following PDSA 1 and increased further to 69.2% following PDSA 2. **While there was a notable period during March below average, however there has been considerable improvement since, increasing the compliance rate further to 79%.**

Chart 5 - % Compliance of care plans initiated on admission to Carrick



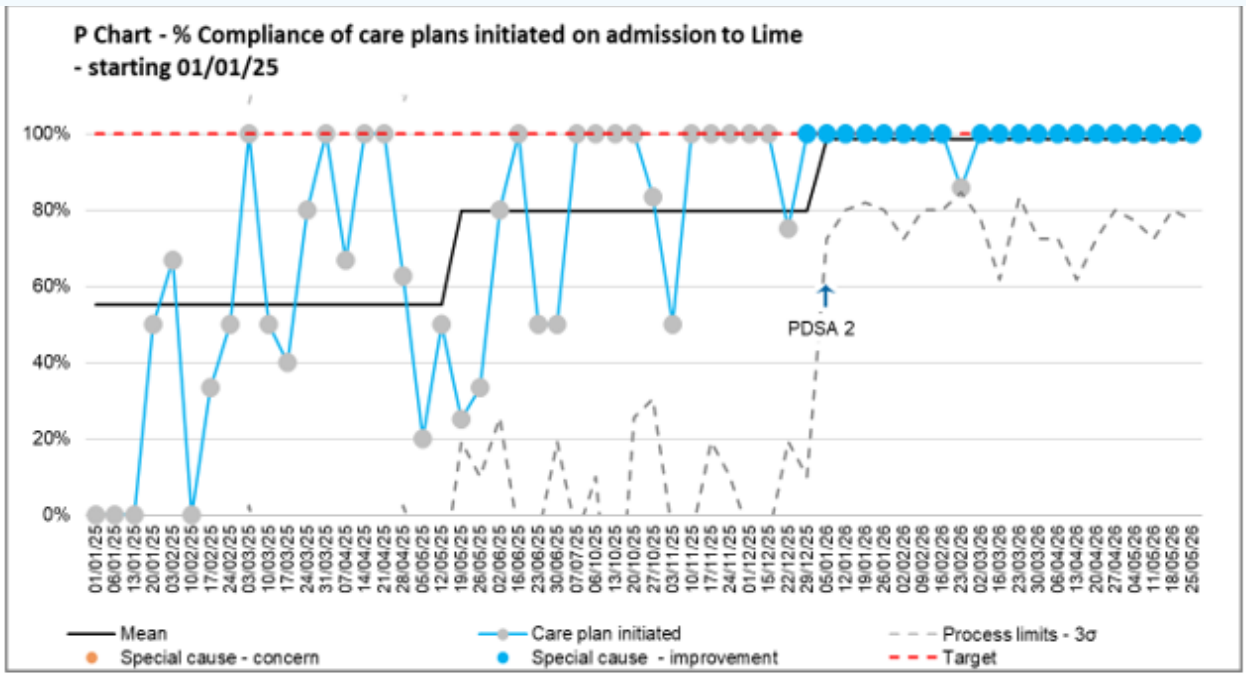
Evidence of all care plans being initiated embedded as normal business practice.

Chart 6 - % Compliance of care plans initiated on admission to Evish



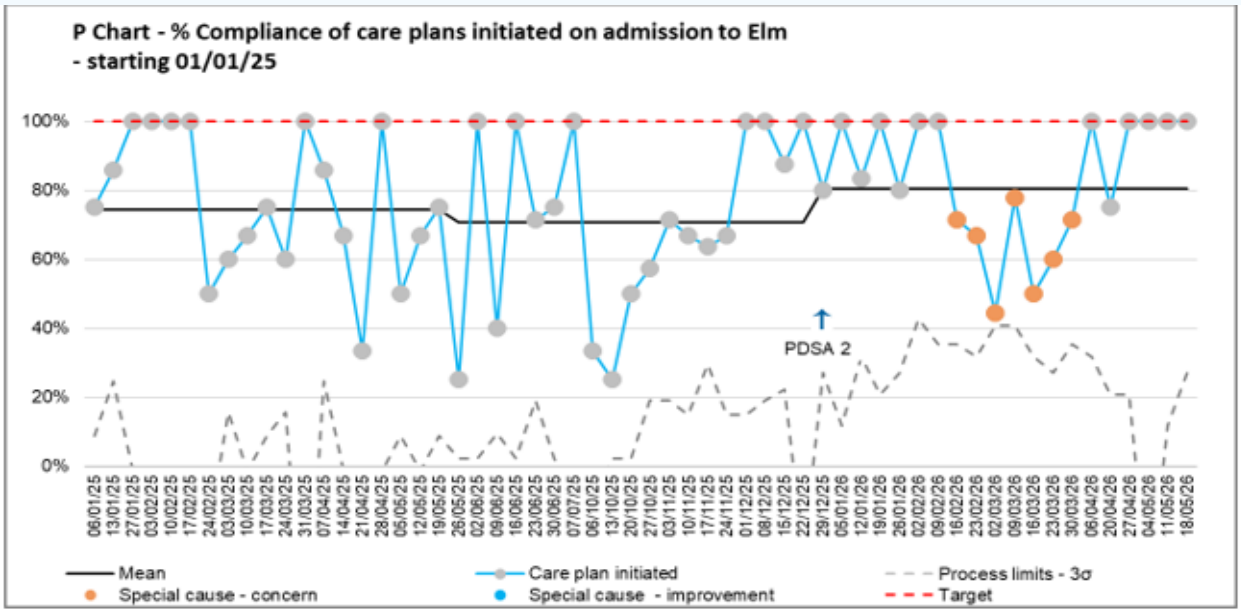
Evident that care plans being initiated is embedding as normal business practice.

Chart 7 - % Compliance of care plans initiated on admission to Lime



The average compliance of care plans being initiated on admission was 55%, this increased to 79.7% following PDSA 1 however increased to 96.8% following PDSA 2.
The data evidences sustained compliance with initiating care plans within Lime as normal business practice.

Chart 8 - % Compliance of care plans initiated on admission to Elm



The average compliance of care plans being prior to PDSA was 74.2%, following PDSA 2 this has only increased to 76.8%. There was noticeable improvement Dec to Feb, however a shift in Feb indicating lower than average compliance. **From April this trend has reverted to an improved position, increasing compliance rate to 80.4%**

Nurse Recruitment

Service has experienced significant staffing challenges and has been unable to recruit to the new funded establishment. Recruitment remains a priority for the service with 18 new graduate nurses now allocated to posts. A mental health nurse stabilisation group has been established and the work is being supported by AMH Senior Management, Recruitment, Workforce planning and the professional nursing team.

SOCIAL WORK / SOCIAL CARE

During 2025/26, Social Work and Social Care Services strengthened partnership working across disciplines, agencies and care settings to improve the delivery of integrated, person-centred support. Improvements were evident across children's and adult services, including positive outcomes in child protection, looked after children, permanency planning, adult safeguarding and support to carers. Ongoing investment in integrated models of practice has enhanced the Trust's ability to respond to increasingly complex needs, helping individuals and families achieve positive and sustainable outcomes within their local communities.

Children & Young People Potentially at Risk

Where concerns arise regarding the safety or wellbeing of a child or young person, a prompt social work response is critical to ensure risks are assessed and appropriate protective measures are considered. In line with Regional Child Protection Procedures, children assessed as potentially at risk should be seen within 24 hours. The Trust has continued to consistently achieve this standard throughout the reporting period. As of 30th April 2026, there were 385 children on the Child Protection Register within the Western Trust, a slight decrease from 397 as of 30th April 2025.

Looked After Children

At the end of April 2026, there were 674 Looked After Children in the Western Trust, compared with 688 at the end of April 2025. Children entering care require regular review of both their placement arrangements and care plans to ensure their needs are being met. These reviews are fundamental to safeguarding children's rights under the United Nations Convention on the Rights of the Child and Article 8 of the European Convention on Human Rights (ECHR). Securing permanence and long-term stability remains a key priority for Looked After Children. Permanency planning begins from the point a child enters care and seeks to identify the most appropriate long-term arrangements to support their safety, wellbeing and development.

Data for 2025/26 indicates that 41% of Permanency Panels were convened within the target three-month timeframe, a decrease from 70% last year. While this performance is below the Trust's desired standard, the position may be influenced by the reporting period, particularly given the higher number of children becoming Looked After during the early months of 2026. This may have impacted the timeliness of some panel considerations recorded within the year.

The Trust's aim remains that all children who have been Looked After for longer than three months receive formal consideration through the Permanency Panel process, helping to ensure that children achieve stable and enduring care arrangements at the earliest opportunity. During 2026/27, continued emphasis will be placed on strengthening permanency planning processes, supporting timely decision-making, reducing unnecessary delay, and promoting better long-term outcomes for children and young people in care.

Facts & Figures

100% of children or young people found to be at risk were seen within 24 hours of a Child Protection referral being made.

91% of Looked After Children had their living arrangements and care plan reviewed within regionally agreed timescales.

41% Looked After Children in care for more than 3 months had a Permanency Panel Recommendation.

Young People Leaving Care

Care experienced young people can face additional educational and social challenges which may impact their transition into further education, training or employment. It is good practice for schools to start talking about a transition plan when a Looked After Child turns 14 years old, and regularly review these plans when they reach 16 and 17 years old. Social Work teams work alongside young people, families and partner agencies to support effective planning and preparation for adulthood. Given most young people known to the Western Health and Social Care Trust’s disability services stay in school until they reach 19 years old, no children known to WHSCT disability services left school as a child in 2025/26.

Facts & Figures

82% of young people known to leaving and aftercare services are engaged in education, training and employment.

100% of disabled children have a transition plan in place when they leave school.

Adult Social Care Indicators

Adult safeguarding arrangements play a vital role in protecting individuals who may be at risk of abuse, neglect or exploitation, ensuring appropriate protection planning is implemented where required. Changes to procedures means that those people identified as at risk and who require an ASP3 (Adult Safeguarding Protection Plan) is only included in data reporting when submitted to the Adult Safeguarding Team. Performance improved significantly during the year, with 87% of adults requiring an Adult Safeguarding Protection Plan having one in place, compared with 62% reported back in 2023/24.

Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities. Recognising the essential contribution carers make to supporting vulnerable individuals, 2,355 adult carers were offered an individual assessment during 2025/26 to identify support needs and improve access to available services.

Facts & Figures

87% of adults referred for investigation and identified as at risk of abuse, neglect or exploitation during 2025/26 had an adult protection plan.

2355 adult carers were offered individual carer assessments including 1,729 new assessments, and 626 re-assessments during the period of 2025/26.

Direct Payments

Health and Social Care Trusts can provide direct payments to people who are assessed as needing social care. Direct Payments promote choice, and provide greater flexibility by enabling individuals and carers to arrange support that best meets their circumstances and personal outcomes. The number of carers receiving direct payments has been increasing year by year, from 19 in 2021/22 to 1066 in 2025/26. Growth in the uptake of Direct Payments has mirrored increased levels of carer assessment activity, demonstrating continued progress in delivering personalised and outcome-focused support.

Facts & Figures 5.8c - 1104

1066 adults and received direct payments during 2025/26.

Mental Health

Mental Health Social Workers are frequently required to make complex decisions where there are concerns regarding an individual's wellbeing or potential risks to themselves or others. Approved Social Workers (ASW's) are specially trained, and under the Mental Health

(NI) Order 1986, can recommend hospital detention for assessment. A nearest relative can also request this assessment. In fulfilling their statutory role, Approved Social Workers explore all viable community-based and least restrictive alternatives before recommending hospital admission. All decisions must always be considered alongside an individual's human rights enshrined in the European Convention of Human Rights (1998), particularly Article 5 and Article 8.

Facts & Figures

100% of requests for assessment under the Mental Health Order were completed by approved Social Workers in 2025/26.

Learning Disability

The Learning Disability Service Framework Standard 20 outlines the importance of adults with a learning disability receiving an annual health check. Evidence continues to demonstrate that Annual Health Checks contribute to improved health outcomes by identifying unmet need earlier and helping address the health inequalities experienced by people with a learning disability. In 2025/26, 39.7% of people of learning disability offered annual health assessment within the Northern Sector. However, out of the possible 851 people registered with GP's who took part in health assessment clinics 50.2% were completed. This is compared with 32% in both sectors in 2024/25. Within the Northern Sector, 119 service users did not attend scheduled appointments during the reporting year.

Facts & Figures

39.7% of adults with a learning disability in the Northern Sector were offered an annual health check in 2025/26.

Summary

Throughout 2025/26, Social Work and Social Care Services continued to play a pivotal role in delivering integrated, person-centred care across the Western Trust. Strong partnership working, effective safeguarding arrangements, and a continued focus on early intervention and prevention have supported positive outcomes for children, adults, carers and families.

Performance across a range of key indicators demonstrates sustained progress, including consistent achievement of child protection response standards, a reduction in the number of children requiring child protection registration, improvements in adult safeguarding protection planning, increased support for carers, and continued growth in the uptake of Direct Payments. Ongoing developments in permanency planning, transition support for young people, and the promotion of annual health checks for individuals with a learning disability further reflect the Trust's commitment to improving experiences and outcomes for some of the most vulnerable people within our communities.

While challenges remain in responding to increasing complexity of need and service demand, the progress achieved during the year demonstrates the value of integrated working, strong professional leadership, and a continued focus on quality, rights-based practice. The Trust remains committed to building on these achievements during 2026/27, ensuring that services continue to be responsive, person-centred and focused on delivering the best possible outcomes for those who access support.

NEXT STEPS

During 2026/27, the Trust will focus on moving forward with our key strategic priorities as set out in the Trust Corporate Plan. These include Quality and Safety; Our People; Performance and Access; Delivering Value; and Our Culture. Some examples of improvement work planned are highlighted below.

Quality and Safety

Serious Adverse Incident Reviews following a death: The Trust will continue to work with all stakeholders to identify and embed the learning from these reviews to ensure the risk of them happening to someone else is reduced as much as possible.

Patient Safety & Quality Committee: Work will continue to establish a Patient Safety and Quality Committee during 2026 as proposed by the Department of Health in December 2025.

Paediatric Quality Improvement Priorities for 2026/27: Based on the outcomes of staff and service user surveys, the Productive Ward Team intends to:

- Improve patient flow within the Acute Children's Ward and Day Case Department.
- Enhance integrated care pathways between hospital and community services.
- Increase the amount of time available for direct patient care.
- Improve communication and information sharing across teams.
- Strengthen staff wellbeing initiatives.
- Implement quality improvement projects informed by staff and family feedback.
- Monitor progress through agreed quality indicators and outcome measures.

Key Priorities to Reduce Falls during 2026/27 include:

- Improve the quality and consistency of falls reporting and harm grading.
- Embed falls prevention and post-fall documentation within Encompass.
- Validate and implement the Falls KPI Dashboard.
- Strengthen compliance with falls risk assessment, care planning and post-fall review processes.
- Expand strength and balance programmes and ward-based quality improvement initiatives.

Key Priorities for Pressure Ulcer Prevention during 2026/27 include:

- Maintain and further develop the Trust-wide Wound Care Link Nurse network, ensuring clinical areas have access to staff with an enhanced interest and knowledge in wound care and pressure ulcer prevention.
- Continue provision of targeted education in response to trends identified through DATIX reporting, Post Incident Review and audit.
- Continue to promote the Regional SSKIN Bundle and reinforce the importance of early identification and intervention for patients at risk of pressure damage.
- Continue to use World Stop Pressure Ulcer Day as an opportunity to raise awareness and promote pressure ulcer prevention among staff, patients and carers.
- Continue focused improvement work within high-risk and high-acuity clinical environments, including Emergency Departments.

Medicines Reconciliation: A cohort of Pharmacy Technicians will begin medication counselling accredited training through NICPLD in October 2026, expanding their role in delivering patient-centred medicines education. This initiative will support patients' understanding of their treatment, improve adherence after discharge, and contribute to better patient outcomes and more efficient use of pharmacy resources.

Mental Health Safety Planning: A rolling training schedule will take place for 2026/27 for the delivery of Safety Planning training across all Adult Mental Health teams/services for all multidisciplinary mental health staff including refresher training for existing staff. A regional Safety Plan SOP has been developed and will be operational towards the end of 2026 to ensure a consistent approach across all Trusts.

Our People

Growing for the Future: Engagement and Involvement continue to be a core module within the Leader and Manager Framework programme promoting the importance of engagement in developing leaders.

Looking After Our People: The Organisation and Workforce Development (OWD) team will continue to provide team building and support sessions to any team within the Trust who need either of these services.

Emergency Care Nursing Workforce: Nursing workforce stabilization across both SWAH and Altnagelvin will be reviewed again in November 2026 with the use of the Safer Care Nursing tool.

Nursing and Midwifery Clinical Supervision: The Trust will continue to strengthen Reflective Supervision, monitoring compliance with supervision standards to support a skilled, reflective and resilient nursing and midwifery workforce.

Professional Registration of Nursing and Midwifery Staff: The Professional Nursing Team will establish a new assurance confirmation process for roll-out during 2026/27. This will require all nurse managers to provide monthly confirmation that all nurses and midwives within their permanent, temporary staffing compliment hold an active, live NMC registration. Existing manager-level arrangements to support staff with preparation for, and completion of, NMC revalidation will also be audited during 2026/27 to provide further assurance regarding the effectiveness of local oversight and support processes.

WHSCT Social Work Retention Plan 2026-2028: The new Retention Plan reflects that the quality of social work practice is not sustained through policies, rather through our staff feeling valued, supported, and trusted to do meaningful work. Some of the key work planned for 2026/27 includes: continue to increase compliance with Domestic Abuse Level 2 training for social workers; continue to increase capacity for DASH training targeting all professionals; rollout Early Career Social Worker Trainee Scheme to northern sector posts where job pressures are high; Learning Development Governance Social Work Team will build a Level 2 e-learning programme on professional curiosity; and the Social Work Leadership and Development Programme opportunities will be extended to Band 6 social workers.

Review of Older People's Social Work Service: This review aims to ensure that services are fit for the future and delivered by a sustainable and valued workforce. A key focus for the review is to address the number of unallocated and uncovered social work cases and this work will continue in 2026/27.

Staff Wellbeing Team: Driven by The Menopause working group and chaired by a member of The Staff Wellbeing Team, the Trust have commenced on a journey to achieve accreditation to become a Menopause Friendly Employer, which will be measured against five standards, this is almost at the finish stages, with hopes of achievement during 2026/27.

The Wellbeing Team are currently developing a dedicated SharePoint wellbeing page, accessible via a direct hyperlink which will provide a centralised source of information, enhance visibility of service provision and support the Trust's commitment to promoting staff health and wellbeing. This will be launched during 2026/27.

Psychiatry Workforce: During 2026 and moving towards 2027, further longer-term workforce solutions will continue to be explored. These include International Medical Recruitment and potential reform and expansion of Specialty and Associate Specialist (SAS) roles. Efforts to recruit, support and retain the existing substantive workforce will continue.

Performance and Access

Access and Performance Targets: During the year, all Trusts adopted the new System Oversight Measures (SOMs) and Regulatory reports developed on Encompass, which proved to be a considerable programme of work. The suite of reports for the 2025/26 SOMs have been developed with the exception of two metrics which remain a work in progress and will need tested for planned availability later in 2026/27.

Trust Board reports during the year have excluded those SOMs where data confidence remained low and reported on all other SOMs where data confidence was assessed as High or medium, or where data was drawn from non-Encompass sources. By year-end, 8 SOMs remained unreported and work will continue during 2026/27 to validate the data in these areas.

Cancer Targets: Consultant workforce challenges persisted within Radiology and Pathology, with active engagement ongoing with the Strategic Planning and Performance Group (SPPG) and Department of Health (DoH) to address recruitment gaps.

Delivering Value

The programme for delivering value has included work streams in relation to reducing dependency on medical locum agency usage; nurse stabilisation which has focused on replacing agency with substantive and bank nursing staff; a further roll out of the domiciliary care rota optimisation project; energy efficiency schemes; and patient-centred reviews of enhanced care packages. The Trust will continue to build on this work into 2026/27.

In the knowledge that our major financial challenge in 2026/27 will be the delivery of significant savings targets, we have reviewed our planning assumptions and adopted a risk-based approach to 2026/27. In relation to capital expenditure, the Trust will continue to prioritise the use of available funding to maintain the stability of our core services.

Our Culture

Staff Culture Survey: Open staff sessions are planned in Summer 2026 to allow staff at all levels to hear about the feedback and next steps from the 2025 Staff Culture Survey.

Patient Client Experience: There are two 10,000 more voices live projects within the Trust – 'Shared decision making' and 'My experience of using equipment to help me live

better'. Both projects are live until August 2026 and the results and action plan for service improvements will be shared during 2026/27.

Patient and Client Experience activity will continue to ensure that the voice of patients, service users and carers remains central to service development, quality improvement and decision-making across the Trust.

Patient & Public Involvement: To support the Trust's continued progress towards more inclusive and influential involvement, the Trust will build on progress made during 2025/26 by:

- continuing to develop the Strategic Engagement Forum and strengthening representation across all Directorates;
- embedding the staff Involvement and Engagement Forum and implementing its action plan;
- strengthening the PPI Champion network across the Trust;
- increasing service-user and carer input into policy development and review;
- supporting the Disability Steering Group to influence relevant organisational action plans;
- continuing to improve the quality of involvement monitoring and evidence of impact;
- further developing regional and local PPI training resources;
- widening participation among communities that may experience barriers to involvement;
- strengthening feedback arrangements so participants understand how their contribution has influenced decisions; and
- sharing examples of effective involvement and co-production across the Trust.