

Inpatient Learning Disability Safety & Quality Dashboard

Summary Report

2025

Acknowledgements

We wish to express our sincere thanks for the dedication and determination of all involved in this very important work. To the members of the Oversight Group, the Consultant Nurses, the Leads and Heads of Service, members of the Learning Disability Expert Reference Group along with the administrative and nursing staff at ward level who have supported the ongoing development of the safety & quality dashboard your input has been greatly appreciated.

Introduction

This paper provides a summary of the steps taken to develop a set of standardised measures which will form the basis for a multidisciplinary dashboard for safety & quality assurance within Learning Disability Inpatient Wards across Northern Ireland. This paper will cover the background and context of the project, the timeline of events to progress the work and the measures ultimately produced for inclusion in the dashboard.

Context and Scope of the Dashboard

Following discussion and agreement at the Muckamore Departmental Assurance Group (MDAG) on 28th June 2023 the Chief Nursing Officer (CNO) commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPPEC) to lead the development of a multidisciplinary safety & quality assurance dashboard. A letter was issued by the Deputy CNO on 28th July seeking nominations with expertise to contribute to the development of this dashboard, with the initial focus on adult inpatient facilities across 4 HSC Trusts (South Eastern Trust has no inpatient beds but remained involved in the work).

The purpose of this dashboard is to enhance existing arrangements in place across each organisation and agree a standardised model which will form an integral part of future trust and regional assurance processes. The purpose of this dashboard is to enhance existing arrangements in place across each organisation and agree a standardised model which will form an integral part of future trust and regional assurance processes.

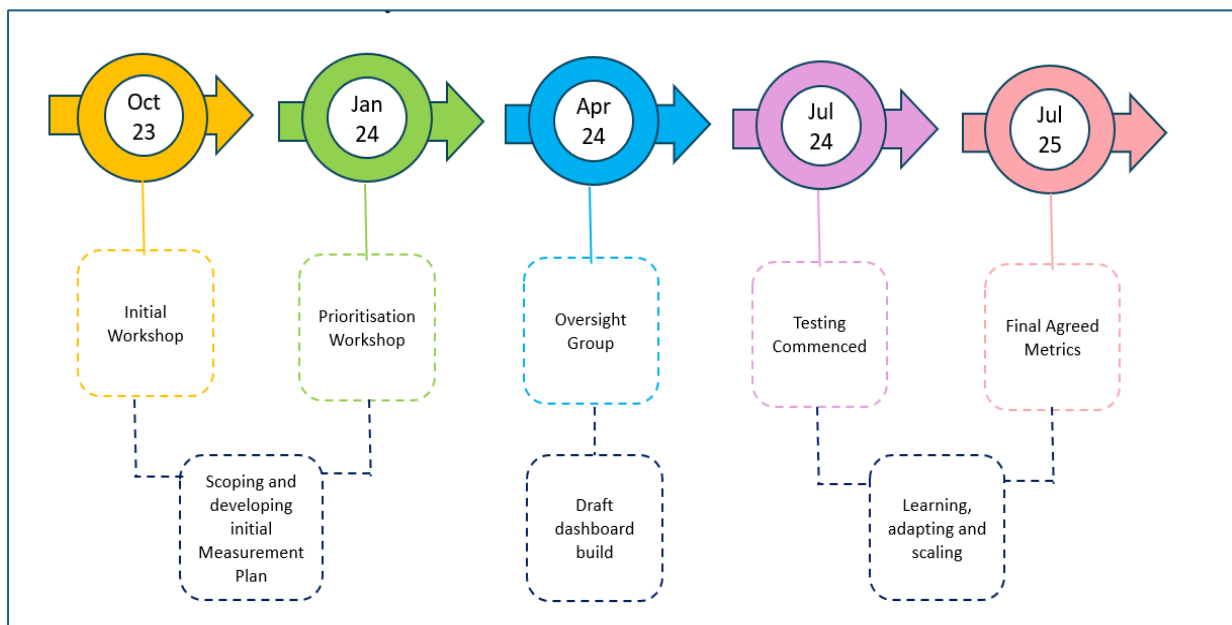
Methodology

In September 2023 a working group was established consisting of Assistant Directors for LD inpatient units/beds, Consultant LD Nurses and Assistant Directors of Nursing for Patient Safety & Governance. An initial workshop was held in October 2023 to support the identification of potential measures that were to be included within the dashboard. A total of 36 metrics were initially identified with the list continuing to grow as additional measures were put forward by the members of the group. Following a prioritisation meeting on 31 January 2024 the list was refined from 36 to the top 20 using a 2x2 matrix with the criteria of lowest - highest priority and the ease to which they could be collected (see Appendix 1). The full list of proposed metrics was shared with the Learning Disability Expert Reference Group for return of comments by Friday 1st March 2024.

In April 2024 an Oversight Group (see Appendix 2) was set up chaired initially by Heather Trouton, Executive Director for Nursing (EDoN) for Southern HSC Trust until her retirement in the Autumn of 2024 when this role was replaced by Olga O'Neill, EDoN for Belfast HSC Trust. The purpose of the group was to provide oversight and guide the selection of appropriate quality metrics along with agreeing governance arrangements for the development the dashboard. It was also noted at this stage that there was already work underway through the Strategic Planning and Performance Group (SPPG) on the development of a dashboard across Learning Disability inpatient wards focusing on bed capacity so it was important that this work would be complementary to the wider quality dashboard.

In July 2024 trusts began to test the measures with each trust agreeing to begin with a section of the metrics within the dashboard and share the learning across the teams. Trusts continued to provide updates to the oversight group in the months that followed until the core set of thirteen metrics were finally agreed in July 2025. An excel dashboard was developed and is now in place across each trust with operational definitions included for each measure. Trusts continued to learn how to use the run chart and pareto chart as a way of visually presenting their data. A timeline of the work can be seen in Figure 1.

Figure 1: Timeline for development of Inpatient Learning Disability Dashboard



Choosing the right measures was key and a number of points had to be considered at the different stages of the journey. These included:

- Finding a shared understanding of what measures to include and why
- Getting true buy in from all involved so they could see the value of this work
- Prioritising measures that could be aligned to what matters most for both the team and the organisation
- Ensuring the measures could be used to drive improvement

In October 2025 a final workshop was held with the Oversight group members where they got the opportunity to share their learning from the development of the metrics. A data masterclass was also delivered and participants got the opportunity to learn and practice how to interpret run charts. Information was also shared with the group on the variation currently found within some of the metrics across the Trusts.

The Dashboard

Agreeing a small set of standardised measures across the four inpatient wards was the primary outcome for this work and these can be found in figure 2 below.

Engaging the staff within these wards was key to understanding what was possible

based on the aspirations of the initial set of suggested measures. It is recognised that there are other measures that can potentially be added to this in the future and that the dashboard needs to be viewed in conjunction with other data collected in these areas such as the bed capacity dashboard and patient experience feedback.

Figure 2: Final list of 13 safety & quality measures

Patient Safety (PS)	
PS1 – Patient Safety Incident Rate per 100 bed days	PS6 - Number of Seclusion Interventions
PS2 – Safeguarding referrals rate per 100 bed days	PS7 – Duration of seclusion episodes
PS3 - Number of times safety intervention hold techniques were used	PS8 - Number of Rapid Tranquilisations
PS4 - Number of patients where safety intervention hold techniques were used	PS9 - Number of PRN Medications administered per month to reduce emotional and behavioural disturbance
PS5 – Duration of Safety Intervention Holds	
Quality (Q)	
Q1 - Number of complaints reported per month	
Workforce (WF)	
WF1 – Percentage of staff absence	WF3 - Number of hours of agency staff usage per month
WF2 - Number of shifts with insufficient numbers of nursing staff to safely meet patient need	

Throughout the development of the dashboard it was important to challenge how data is traditionally collected and viewed and not aggregated or presented as a two-point comparison. This has been achieved by viewing continuous data over time using both run charts and pareto charts. It was also necessary to use rates per 100 bed days for both the patient safety incident and adult safeguarding measures. This allows teams to benchmark with each other whilst being aware of the differences in inpatient bed numbers across the trusts.

Learning

Measuring for quality can often be hard so it was important that measures chosen were both easy to collect and allowed for future cross organisational learning.

Making the dashboard real and meaningful was a fundamental aspect of its development and throughout this project there were lots of opportunities to learn.

Key points to note are:

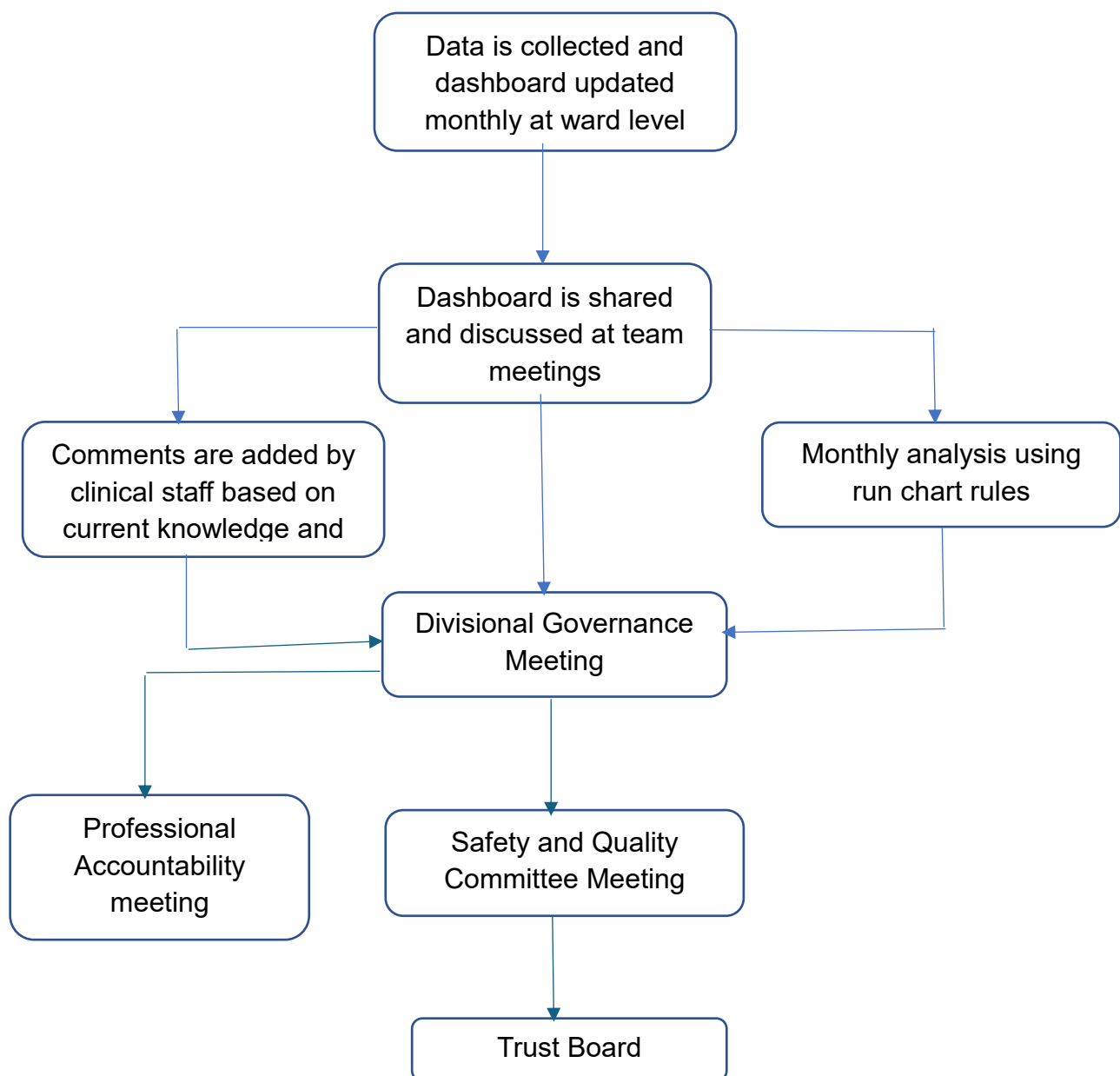
- Varying bed numbers across the inpatient units were found to cause issues when using data for benchmarking. It was agreed to change this to using a rate per 100 bed days allowing for better comparisons
- Staff who were populating the data on the dashboard were unsure of where to access bed days data
- Small bed numbers made it difficult to measure reliability using percentages in a monthly dashboard
- The health roster system Allocate was not available in all of the Learning Disability inpatient wards
- Staff absence data is normally viewed at directorate level and this needed to be made available at individual ward level
- A number of the initial measures were found to be already included in an existing audit tool but the use of this tool was variable across trusts.

Governance and accountability

Internal

It is a requirement that all organisations have in place arrangements that will lead to good governance ensuring that decision-making is informed by intelligent information and assurance is in place to avoid problems, stabilise, and improve services by monitoring them on an ongoing basis. The flow chart in Figure 3 below sets out the expectations of the internal governance and assurance processes that should be in place in relation to the Learning Disability inpatient safety & quality dashboard.

Figure 3: Internal governance and assurance process



External

External assurance plays a key role in enhancing trust and confidence in the data reported but also enables an opportunity for cross-organisational learning. It is important that the dashboard is not viewed in isolation and instead should complement other data available within these areas in particular the bed capacity dashboard managed by SPPG and Patient Stories and Care Opinion reviews managed by the PHA. The final external assurance process has not yet been agreed.

Recommendations

This report sets out 9 recommendations listed below to ensure the sustainability of the dashboard into the future:

1. Trusts must ensure the dashboard is embedded into local ward processes providing ongoing management of continuous data
2. Narrative should be added to the comments box under each measure in the dashboard providing the story behind the data points
3. Staff must have a level of knowledge of Microsoft excel to be able to maintain and further develop the dashboard
4. A long-term digital solution must be sought to support the data input and display of matrix within the dashboard
5. Analysis must be undertaken using the Institute for Healthcare Improvement (IHI) four run chart rules therefore ensuring appropriate decision making based on statistical variation
6. Robust governance structures must be in place to ensure visibility of the dashboard from ward to board
7. Shared learning opportunities must be created across organisations to allow a collaborative approach to improvement
8. A standardised Quality Audit Tool will be agreed by the Consultant Nurses for use across all of the inpatient wards similar to the example in Appendix 3
9. Agree external assurance governance processes

Conclusion

Throughout the lifespan of this project written and verbal updates were provided to MDAG at regular intervals. In December 2025 the final dashboard was presented to the DoH, Senior Leadership Group where it was widely received. The Oversight group has now been stood down and the main objective of this work to develop a regionally agreed multidisciplinary dashboard for safety & quality assurance within Learning Disability Inpatient Wards across Northern Ireland has been completed.

This summary report, with the recommendations has been submitted to the CNO as the commissioner of this work for her consideration and onward action planning as thought appropriate. The project report will be made available on the NIPEC website

along with some additional resources. Further work is required to pursue a regional approach to internal and external assurance reporting.

Appendix 1: LD Inpatient Measurement Plan (following prioritisation)

Priority Rating key:



High priority and easy to collect



High priority and hard to collect



Low priority and easy to collect



Low priority and hard to collect

Quintuple Aim Domain	Measure No:	Measure Name	Priority rating	Operational Definition
Population Health	1	% patients who have been assessed using a validated outcome measurement tool		Numerator: The total number of inpatients with assessment completed Denominator: Total number of LD inpatients
Safety and Experience	2	Rate of Incidents per 100 patient days	 	Numerator: The total number of incidents with harm Denominator: The total number of LD inpatient bed days per month Calculating the harm rate: Divide the numerator by the denominator and multiply by 100 to give the harm rate per occupied bed days
	3	No of times Rapid tranquilization used		This is a count of times rapid tranquilization is used each month
	4	No of patients who require rapid tranquilization		This is a count of the number of patients each month who require rapid tranquilization
	5	No of Prone restraint incidents		This is a count of the number of patients in a prone restraint hold
	6	No of patients requiring prolonged restraint		This is a count of the number of patients who require prolonged restraint of greater than 10mins
	7	No of patients requiring Seclusion		
	8	% pts in Long term segregation		
	9	No of safeguarding referrals		This is a count of the total number of safeguarding referrals per month
	10	No of Safeguarding referrals escalated single agency		This is a Count of all Safeguarding referrals that have been escalated

Quintuple Aim Domain	Measure No:	Measure Name	Priority rating	Operational Definition
		Joint protocol		
	11	No of complaints		This is a count of the total number of complaints per ward per month
	12	No of compliments		This is a count of the total number of compliments per ward per month
	13	Do you have a process in place to capture Patient/Carer Experience		
	14	Do you have a process in place for medicines optimisation inclusive of polypharmacy		
	15	Nutritional Assessment		Numerator: Number of inpatients with nutritional assessment completed/reviewed Denominator: Total number of LD inpatients
	16	Dental Hygiene		Numerator: Number of patients with evidence of attendance to daily dental hygiene Denominator: Number of LD inpatients
	17	Falls rate per bed days		Numerator: Number of falls per month Denominator: Total LD inpatient bed days per month
Workforce Wellbeing	18	No of patients requiring special observations		This is a count of patients requiring special observations per month
	19	No of contingency (Escalation) beds per month		This is a count of escalation beds used each month
	20	Safe Staffing – no of shifts with unsafe staffing per week		This is a count of unsafe staffing shifts per week
	21	No of shifts in the month % of agency staff >50%		This is a count of shifts per month when agency staff usage was >50%
	22	No of SHIFTS less than X WTE registered nurses per shift per ward		
	23	No of incidents with Violence to staff		This is a count of violent incidents towards staff

Quintuple Aim Domain	Measure No:	Measure Name	Priority rating	Operational Definition
	24	Vacancy levels		Need to clarify current measure type
	25	Staff Absenteeism		Need to clarify current measure type
	26	% Staff qualified under 12 months		Numerator: Number of staff nurses who are qualified less than 12 months Denominator: Total number of staff nurses in LD Inpatient Unit
	27	% staff with Safety Intervention training		Numerator: Number of LD inpatient unit staff who have completed Safety Intervention Training Denominator: Total number of staff in LD Inpatient Unit
	28	% staff with safe guarding training		Numerator: Number of LD inpatient unit staff who have completed Safeguarding Training Denominator: Total number of staff in LD Inpatient Unit
	29	% nurses who access Professional supervision		Numerator: Number of LD inpatient unit staff who have regular professional supervision Denominator: Total number of staff in LD Inpatient Unit
	30	% staff who know how to challenge and raise concerns about a work issue if they need to?		
Value	31	ALOS in LD Inpatient Unit		Need to clarify current measure type
	32	% patients with Appropriate Admissions		
	33	No of Delayed discharges		Need to clarify current measure type
Equity	34	? equity re MDT access	Unknown	Need to clarify current measure type
	35	No of carers assessments offered?		This is a count of carers assessments offered
	36	LOT for medical review		Need to clarify current measure type

Appendix 2:

Oversight Group Members

Name	Role	Organisation
Olga 'Neill (Chair)	Executive Director of Nursing, Midwifery, AHP'S, Functional Support Services & Deputy Chief Executive	BHSCT
Katrina Hughes	Senior Manager Nursing and Midwifery Assurance and Quality	BHSCT
Colette Johnston	Learning Disability lead Social worker	BHSCT
Peter Sloan	Interim Director for Mental Health, Intellectual Disability and Psychological Services	BHSCT
Clionagh McElhinney	Trainee Consultant Nurse Learning Disability	WHSCT
Barbara Tate	Trainee Consultant Nurse Learning Disability	SEHSCT
Caroline McGonigle	Social Care Lead for Learning Disability	SPPG
Helen McNally	Regional Bed Capacity Network Manager	SPPG
Siobhan Rogan	Assistant Director of Nursing Mental Health and Learning Disability Services	PHA
Gill Murphy	Assistant Director of Nursing for Safety & Quality	NHSCT
Catherine McGovern	Senior Lead Nurse for N&M Assurance and Quality	NHSCT
Sharon Love	Head of Service for Nursing & Midwifery Patient Experience and Quality Improvement	SHSCT
Joanne Higgins	Service Manager in Children's Disability Team	WHSCT
Maureen Roberts	Trainee Consultant Nurse Learning Disability	SHSCT
Dr Lisa Brady	Consultant Psychiatrist for Learning Disability Inpatients	WHSCT
Nigel Chambers	Head of Policy for Learning Disability and Autism	DHSSPS
Lianne Kelly	Information Performance	BHSCT
Paul McAleer	Nursing Officer	DHSSPS
Owen Duly	Statistician	DHSSPS
Joe Walker	AD Acute Mental Health Services	SHSCT
Brenda Carson	Senior Professional Officer	NIPEC
Julie Ann Colvin	Nurse Consultant for Mental Health and Learning Disability	PHA
Jill Bradley	AD AHP Governance	NHSCT
Rhona Brennan	Head of Service for Assessment and Treatment & Professional Nurse Lead for Learning Disability	NHSCT
Charlotte Wells	AD of AHP Workforce, Governance and Training	SHSCT
Nikki Smyth	Lead Nurse Disability Community Services	SEHSCT
Gareth Farmer	AD Learning Disability Team	NHSCT

Nicola McCann	Senior Inspector	RQIA
Trea Connolly	Clinical Lead SLT	SHSCT
Tracy Rogers	Head of Community Services, Disability Services	SHSCT
Billie Hughes	Co-Director Intellectual Disability Services	BHSCT
Matthew McMurray	Consultant Clinical Psychologist	SEHSCT

Appendix 3:

Quality Audit Tool

Care Plan Documentation		Yes	No
1.	Are patients' details identified in the contact section relevant and up to date?		
2.	Are care plans appropriate for patients assessed needs?		
3.	Are care plans updated weekly to reflect any changes in care and treatment?		
4.	Has SBAR been completed on admission/transfer?		
5.	Has Must been completed?		
6.	Has Braden been completed?		
7.	Has falls risk assessment been completed?		
8.	Is REDS in place and if so is most updated copy on paris?		
Promoting Quality Care			
9.	Is initial risk assessment in place or if required a Comprehensive Risk Assessment?		
10.	Does the Risk Assessment / CRA give evidence patient and family involved?		
11.	Has the RST / CRA been reviewed?		
12.	Has PQC been completed and reviewed regularly with mdt input?		
13.	Has PQC been shared with patient/family and advocate		
Patient Centred Care			
14.	Has the patient been involved in the assessment of the care plan?		
15.	Has the patient been involved in the review of the care plan?		
16.	Is there weekly-recorded 1:1 sessions with the named nurse / associate nurse?		
Adult Safeguarding			
17.	Is there a planned intervention for Vulnerable adult?		
18.	If APP1 has completed, is there evidence in the care plan regarding discussions with / MDT & family and/or APGT?		
19.	Is there protection plans in place following ASP1 incidents? (if applicable)		
20.	Is there evidence in the assessment section indicating the patient is a Vulnerable Adult?		
21.	Are the patient's level of observations indicated?		
22.	Are the patient's detention status identified? Check if detention care plan has been updated.		
23.	Is there evidence of on-going communication in relation to the patients care and treatment? (I.e. with MDT and family, if appropriate, regarding safeguarding issues.)		
MDT Meetings			
24.	Does patient have the opportunity to make request prior to meetings?		
25.	Is the patient / relative given feedback on outcome of MDT discussion? (if applicable)		
26.	Does the patient have the opportunity to attend MDT?		

27.	If patient cannot attend and/or does not have capacity to fully understand outcomes is family involved		
28.	Are advocates invited to MDT?		
Record Keeping			
29.	Are notes legible?		
30.	Are care plans received in a timely manner?		
31.	Are reviews of assessments evidenced in the progress evaluation section???		
32.	Are all entries dated / time / signature & grade?		
33.	Are care plans compliant with the NMC guidelines for record keeping?		
Restorative Practice / DOLS			
34.	Is there a plan of care for restrictive practice?		
35.	Has the patient been involved in the restrictive practice review?		
36.	Has the MDT/Family/Advocate been involved in the restrictive practice review?		
37.	Is there evidence that the restrictive practice is reviewed at MDT meeting?		
Capacity & Consent			
38.	Does the assessment section of the care plan reflect issues pertaining to capacity & consent specific to each activity of living?		
39.	Is there evidence in the case notes of capacity being considered on a daily basis?		
40.	Is there evidence that easy read material has been used to enhance the patient's understanding of their care plan?		

For further Information, please contact

NIPEC
4th Floor James House
2-4 Cromac Avenue
BELFAST
BT7 2JB

Tel: 0300 3000066
enquiries@nipec.hscni.net