HSC Public Health Agency

agenda

Title of Meeting	127th Meeting of the Public Health Agency Board
Date	19 November 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 15 October 2020		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 1.55	Finance Report	**PHA/01/11/20**	Director of Finance
8 2.05	Update on COVID-19 To include: - Launch of Digital Self Trace Platform for Contact Tracing - Self-Isolation Support Pathways	**PHA/02/11/20**	Chief Executive

items for noting

9 2.45	Update on Self-Harm	**PHA/03/11/20**	Professor van Woerden

closing items

10 2.55	Any Other Business		

11 Details of next meeting:

Thursday 17 December 2020 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

Public Health Agency

minutes

Title of Meeting	126th Meeting of the Public Health Agency Board
Date	15 October 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Professor Hugo van Woerden	-	Director of Public Health
Alderman William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Ms Christine Frazer	-	Assistant Director of Finance, HSCB *(via video link)*
Dr Aideen Keaney	-	Director of Quality Improvement *(via video link)*
Ms Marie Roulston	-	Director of Social Care and Children, HSCB *(via video link)*
Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services (*via video link*)
Mr Robert Graham	-	Secretariat

Apologies

None

98/20	**Item 1 – Welcome and Apologies**
98/20.1	The Chair welcomed everyone to the meeting. There were no apologies.
99/20	**Item 2 – Declaration of Interests**
99/20.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. Mr Clayton declared an interest during the discussion at paragraph 105/20.8.

100/20	**Item 3 – Minutes of previous meeting held on 20 August 2020**
100/20.1	The minutes of the Board meeting held on 17 September 2020 were approved as an accurate record of that meeting.
101/20	**Item 4 – Matters Arising**
	92/20.2 Trust Funding
101/20.1	Mr Stewart sought clarity on the statement made by Mr Cummings in the previous minutes that PHA would be liable for the redundancy costs for Trust staff if PHA stopped a programme that those staff were directly involved in. The Chair said that Mr Cummings had provided him with information in terms of how much money is being allocated to Trusts, but his query related to how this money is spent and what performance management arrangements are in place. Alderman Porter said that for community and voluntary sector organisations, PHA funding would cover staff costs. Mr Stewart said that further detail is needed on PHA's financial liability if Mr Cummings' statement is true, a statement backed up by Alderman Ashe. The Chair said that his specific query related to staff in Trusts but he said that he would speak to Mr Stephen Bailie in HSCB. The Chair stated that his single purpose was to discover on what the money was spent and to ensure there was effective performance management
	93/20.8 Priadel
101/20.2	Mr Clayton asked if there was a further update on the discontinuation of Priadel. Mr Morton advised that there is further information on this in the Chief Executive's Report, but to note that the decision to discontinue is now on hold.
102/20	**Item 5 – Chair's Business**
102/20.1	The Chair said that he continues to have concern that PHA is being asked to carry out functions by the Department in the absence of confirmed funding. He added that he felt it was wrong that PHA has had to scale back or stop the programmes in which staff were directly involved. Professor Rooney said she thought that there should be a separate line in PHA's budget which would record COVID-19 related expenditure, as even though existing or unspent PHA funds were now redirected to cover COVID-19 costs, this should be easily identified in the budget. She asked whether PHA knew how much it was spending in relation to COVID-19 work. Professor van Woerden explained that there are two business cases which have been submitted to the Department of Health, but have not yet been signed off. He said that all the necessary paperwork is in place and he has no reason to believe that PHA will not receive approval and the required funding. The Interim Chief Executive reiterated that there is a paper trail. The Chair sought assurance that PHA has the authority to spend on these areas and the

Interim Chief Executive confirmed that this was the case. Alderman Porter felt that no money should be spent until there is a formal authorisation to do so.

102/20.2 Mr Stewart advised that he, along with Mr Clayton and Ms Mann-Kler had spent considerable time discussing this issue at the recent Governance and Audit Committee with Mr Cummings and the representative from the Northern Ireland Audit Office. He said that he had asked if NIAO had issued any guidance for such a situation, but was advised that no guidance has been issued. He said that he followed up by asking how this expenditure would be viewed in light of the principles of the Treasury Orange Book and was advised that although the auditors fully understood the difficulties of this particular unusual scenario, there would be an expectation that there is a clear audit trail of any decisions. He went on to say that Mr Cummings had advised that various business cases have been submitted and that he had given an overview of the level of oversight and the records that in place of the decisions that were taken regarding these. Mr Clayton noted that there had been discussion about the status of one of the business cases and that it had to be revised so he suggested that there should be an update at each Board meeting on the status of the business cases. Ms Mann-Kler said that this should form part of the Finance Report **[Action – Ms Frazer]**. She added that there should be a reflection in terms of PHA's Internal Audit work this year and ensuring that PHA's processes are tight and its governance arrangements are sound.

102/20.3 The Chair asked if it would be possible to have a line on COVID-19 expenditure within the Finance Report. Ms Frazer said that this could be included, but she pointed out that for the PHA the amount is relatively small.

102/20.4 The Chair said that as part of the development of the Corporate Strategy PHA should be involving staff and service users. He asked about support arrangements for this work given there was dedicated support during the development of the previous Strategy. Miss Taylor advised that the staff member concerned has moved on, but she will be speaking to Ms Anne McMurray about support from within PHA's planning function **[Action – Miss Taylor]**.

102/20.5 The Chair advised that he has asked if it would be possible to get copies of the presentations that were delivered at the NICON conference. He said that he was impressed by the presentation delivered by Mr Joe Rafferty, Chief Executive of Mersey care and it thought it may be useful to invite Mr Rafferty to Northern Ireland. Ms Mann-Kler highlighted an issue around data about suicides. Mr Morton explained that although the data will change, the risks associated with mental health and drug use remain high. The Chair clarified that there will be a reclassification whereby deaths by suicide that also link to drug use will not be counted. Professor van Woerden undertook to prepare a short paper outlining the implications of the change in the definition **[Action – Professor van**

Woerden]. Professor Rooney agreed that Mr Rafferty's presentation was excellent and that it would be beneficial to engage further with him.

103/20 Item 6 – Chief Executive's Business

103/20.1 The Interim Chief Executive presented her Report and said that she was working on delivering the report in a format that mirrored the functions of the PHA, but that this would take time. The Chair noted that there is a huge amount of work being placed on the Interim Chief Executive, often at short notice, and that she had also been required to appear at the Health Committee earlier today.

103/20.2 Ms Mann-Kler asked about the digital self-trace. The Interim Chief Executive advised that this was launched last week and that at the next meeting she would be able to give a better summary of its effectiveness. She explained that as the numbers start to increase people will be texted to advise them to self-isolate and then there could be more focus on the higher risk cases. Mr Clayton noted that the numbers are increasing and he asked about the ability of the contact tracing centre to cope and how PHA can gauge if people are self-isolating when advised to do so. Professor van Woerden acknowledged that self-isolation can be difficult for people and that different people comply to varying extents with self-isolation. He noted that the modelling does take into the account the possibility of people not self-isolating when required and that recent research has shown that the number who actually self-isolate is quite low. He suggested that key societal figures could have an impact on the way people behave.

103/20.3 The Interim Chief Executive said that the contact tracing system is currently stretched and that PHA is competing with hospitals for staff creating a shortage of nurses. She said that an appeal has gone out for people to help and that every Saturday job interviews are taking place and people are being recruited. She added that the ability to text contacts is a boost and will help as the numbers continue to rise.

103/20.4 The Interim Chief Executive explained that at the outset PHA's approach had been to develop a high quality service where each contact would receive a telephone call of up to 45 minutes. She felt that this level of interaction would have helped encourage people to self-isolate and that if a different approach is taken there may be an impact on people's behaviour. She added that the focus at present is on forward contact tracing but she felt that it would be beneficial to undertake backward contact tracing in order to determine the sources of infection as 80% of the infection is caused by 20% of the population. She said that the system is under pressure and that with the numbers going up, PHA will need to flex its approach. Alderman Porter expressed concern about the impact on people who have to self-isolate on more than one occasion. Professor van Woerden conceded that as the prevalence increases people may have to self-isolate on three or four occasions. The Interim Chief Executive said if people adhere to the guidelines they

	are less likely to contract COVID-19.
103/20.5	Professor Rooney asked about work with schools. The Interim Chief Executive advised that the dedicated cell in PHA HQ has been set up with staff from health protection and nursing. She explained that if there is a positive case in a school this team will link with the school head teacher to discuss next steps and that PHA will send a letter to the school. She said that this approach has been well received.
104/20	**Item 7 – Finance Report (PHA/01/10/20)**
104/20.1	Ms Frazer began by informing members that the role of Director of Finance within HSCB, with specific responsibility for the provision of financial services and advice to the Board of the PHA, has been advertised and closes at the end of this month. She said that she, along with her other Assistant Director colleagues, will cover this role in the meantime.
104/20.2	Ms Frazer took members through the Finance Report and said that at the end of August PHA has a surplus of almost £2m. She added that the projected year-end surplus of £1m and that the Department of Health has been advised of this. She explained that the impact of COVID-19 is beginning to affect the overall position as programmes are being scaled back.
104/20.3	Ms Frazer advised that the Trust-related programme expenditure should be fully utilised and following on from the earlier conversation, she said that a lot of this funding is for permanent posts and there is a contractual obligation on PHA vis-à-vis these posts. She reassured members that these programmes are regularly monitored and she said that either she or Miss Taylor can provide more information if required. The Chair asked if the monitoring relates to the activity or to the funding. Ms Frazer replied that it would relate primarily to the activity, but that COVID-19 has meant that some staff had temporarily been moved into other work. Miss Taylor said that performance monitoring is still taking place but she acknowledged that some programmes may be undertaking different work than they were originally intended to do. She advised that programme managers are speaking to providers.
104/20.4	Ms Frazer moved onto the direct programme expenditure and said that are challenges for PHA as the underspend in this area is likely to increase but managers were currently reviewing with an objective to returning to break even by the year end. She said that the management and administration budget also has a surplus as there are challenges in not only filling posts, but in the time lag in doing so. She estimated that the surplus would be at least £1m by the year end.
104/20.5	Ms Frazer advised that there are ring fenced funds for COVID-19 and for Transformation funds. With regards to COVID-19 funding she explained there is £600m currently being held with the Department of Finance for

Health in respect of which the Department of Health has recently advised the DoF of its assessment of the full potential costs for Health and Social Care for 2020/21. This should include approved bids submitted by the PHA to the DoH and Ms Frazer stated that she would keep members updated on this area.

104/20.6 Mr Stewart suggested that the estimate of the surplus is a conservative one, and that it is likely to increase. He asked whether the Department has given an indication as to how this surplus will be treated. Ms Frazer said that £1m has already been declared for consideration by the Department for use across the whole HSC. She said that PHA is likely to be more and more challenged in terms of spending its allocation so it will be necessary to keep on top of these figures and to look at other ways of using the funding in a meaningful way.

104/20.7 The Chair sought clarity as to whether due to COVID-19 there was no discretion to reallocate funding. He also queried why the HSCQI salary budget was in deficit. Ms Frazer explained that in previous years if there was an underspend in the administration budget it could have been transferred to the programme budget, but realistically this would not be possible this year. With regard to the HSCQI, she explained that in year the HSCQI deficit would be met by surpluses in other areas of the Admin budget. Miss Taylor added that going forward there is an issue in terms of identifying recurring funding for HSCQI. The Interim Chief Executive advised that there is a number of posts across the organisation which have been vacant for over a year and she is going to review these **[Action – Interim Chief Executive]**. Dr Keaney thanked the Chair for drawing attention to the HSCQI budget.

104/20.8 The Board noted the Finance Report.

105/20 Item 8 – Update on COVID-19

105/20.1 Professor van Woerden delivered a presentation giving members an overview of the number of positive cases, ICU occupancy and deaths associated with COVID-19. He showed members a map detailing the density of cases across Northern Ireland before giving a breakdown by Local Council area. In summary, he said that the numbers are rising which will lead to an increase in the occupancy of ICU admissions and deaths and may result in further restrictions being put in place.

105/20.2 The Chair asked about the use of ventilators. Professor van Woerden advised that CPAP is now more frequently used as it is less invasive. He added that there is now greater societal awareness that if people start to feel breathless they should go to hospital.

105/20.3 Alderman Porter asked where the correlation is between the data presented and testing, and if the R number factors in the fact that more testing is being carried out. Professor van Woerden agreed that the data can only report against what is being tested and in the first wave

many more people could have COVID-19 than was known because testing was only taking place in hospitals, but now it is also taking place in the community. However, he noted that there are individuals who are being tested that do not need to be. With regard to the R number, he advised that it was previously calculated based on hospital bed usage, but now it is calculated based on community transmission. He opined that it is not an exact science.

105/20.4 Alderman Porter asked whether religious and sporting events were contributing to the number of cases. Professor van Woerden agreed that there is a link between large family events and the number of cases. The Chair asked about excess deaths. Professor van Woerden said that he did not have an exact figure but he reported that there have been 66 deaths among people under the age of 65, and 8 deaths among people under the age of 45, but many of these people may have had co-morbidities. The Chair noted that recent excess death figures showed the number of deaths in hospitals and care homes, but not in private homes. Professor van Woerden advised that older people who live on their own would still tend to die in a hospital setting.

105/20.5 Mr Stewart noted that there are now local restrictions in place in parts of Northern Ireland and that given that PHA is providing contact tracing information, he asked whether the rise in the number of positive cases is clearly linked to the hospitality sector. Professor van Woerden said that the advice given to the Chief Medical Officer is based on the situation in Northern Ireland. He explained that people may not catch COVID-19 while sitting in a bar, but visiting other people's homes before and after going to the bar is likely to contribute to the higher number of cases. He added that there is an association between people spending time together and contracting COVID-19 and that the hospitality sector is one of the reasons for people spending time together. He added that religious events such as weddings and baptisms where people spend a lot time together before and after events can also see a spread of cases. Mr Stewart asked whether the track and trace system should pick up that there may be clusters in Belfast but then they spread to other parts of the country. Professor van Woerden agreed that this could happen and cited the example of students returning home at weekends, but he said that there is limited evidence. He said that people double or treble their risk of COVID-19 when spending time in the hospitality sector.

105/20.6 Ms Mann-Kler asked about hospital admissions, noting that the number had doubled between 22 September and 6 October. Professor van Woerden agreed that over the next few weeks admissions are likely to increase so measures are being put in place. Ms Mann-Kler asked if there was any data on long COVID. Professor van Woerden said that as this is a relatively new phenomenon there is not a lot of data available, but he said that there is an overlap with Chronic Fatigue Syndrome.

105/20.7 Professor Rooney asked about the role of PHA in providing the public

health advice to the Department, as the PHA was the leading public health organisation and the Director of Public Health is the Northern Ireland expert in this area. The Interim Chief Executive said that the PHA provides the Department with a range of data every week.

105/20.8 Mr Clayton asked about care homes. He noted that the number of tests being carried out in the community has risen and that the number of outbreaks in care homes is also rising. He asked whether there has been much engagement with staff side representatives as members have been contacting his trade union with regard to PPE issues. He said that while there is emphasis on reducing the R number, the current measures may merely suppress R temporarily, so he asked what the risks are of the virus coming back again in December/January and if there is a long term strategy. The Interim Chief Executive advised that COVID-19 is a reportable disease and so care homes must report any incidents to PHA and the Duty Room will then carry out a risk assessment with the home and support that home. She added that any issues of non-compliance should be reported to the regulator. Ms Roulston said that the sector is dependent on the data that it receives from Professor van Woerden's team so it can plan how to deal with outbreaks. She added that while there has been engagement with provider organisations rather than staff, the Chief Social Services Officer, Mr Sean Holland, had held an engagement session with staff. She said that she would be content to discuss this with Mr Clayton outside of the meeting.

105/20.9 Professor van Woerden remarked that people die of COVID-19, but there are also people who die as a result of unemployment. He estimated that around one in 200-300 people who lose their job will die earlier than they would otherwise have done as a result of lockdown. He also indicated that there is some evidence to suggest that the incremental cost per quality adjusted life year (QALY) for the first wave of lockdown was between £250k and £1M. He referenced the Great Barrington Declaration, which has proposed a greater focus on the potential role of collective (herd) immunity and which has stressed the importance of shielding older and more vulnerable people. He recognised that there is a debate over the best approach and that it may take a decade before research can determine which was the most successful approach to controlling a COVID-19 pandemic.

105/20.10 The Chair thanked Professor Van Woerden for responding at short notice and compiling such a comprehensive presentation. He also remarked that it was very useful to see the data presented in such a graphic manner.

106/20 Item 9 – Update from Chair of Governance and Audit Committee (PHA/02/10/20)

106/20.1 Mr Stewart advised that the minutes of the Governance and Audit Committee meeting of 1 July were available for members for noting. He

	said that there was a further meeting of the Committee on 1 October and that the agendas were broadly similar.
106/20.2	Mr Stewart reported that there was a lot of discussion on the Corporate Risk Register and that the updated Register is on the agenda for today's Board meeting.
106/20.3	Mr Stewart said that at both meetings there was discussion around procurement issues given that there are long standing audit recommendations in this area. He advised that the former Director of Operations had suggested that a sub-Committee of the Board should be established to look at the procurement plan and he said that the PHA Board should take a view on this.
106/20.4	Mr Stewart said that the Committee had received an update on outstanding audit recommendations and that Internal Audit was going to review the implementation dates of these. He added that at the meeting in July, the Committee had held a meeting with the internal and external auditors and that both sets of auditors were content with how the Committee discharges its responsibilities. He cautioned that the auditors had flagged up the issue of the gaps at senior level within the organisation.
106/20.5	Mr Stewart advised that the final "Report to those Charged with Governance" had been received and that it was a clean audit with an unqualified audit opinion. He said that the Committee had considered a self-assessment which flagged the need for some refresher training for members.
106/20.6	Mr Stewart noted that going forward the Committee will be asking relevant officers to come to update on specific matters and that the Interim Chief Executive is due to attend the next meeting. He thanked Miss Taylor and other PHA officers for their work in supporting the Committee as well as the other Non-Executive members.
106/20.7	The Chair thanked Mr Stewart for his update and acknowledged the enthusiasm and focus of those Non-Executives on the Committee. He agreed to follow up on the sub-Committee on procurement issues and to proceed with its establishment **[Action – Chair]**.
107/20	**Item 10 – PHA Mid-Year Assurance Statement (PHA/03/10/20)**
107/20.1	The Interim Chief Executive advised that the Mid-Year Assurance Statement had been completed prior to receiving correspondence from the Department of Health that it is not required.
107/20.2	In response to a query from the Chair around procurement, Miss Taylor advised that there was a particular issue for PHA in terms of progressing work in relation to the re-tendering of contracts in the field of drugs and alcohol. The Chair asked how often programmes are re-tendered. Miss Taylor said that it would normally be every 5 years but there is a balance

to be struck between getting a programme in place for a period of time, but also ensuring that it is not too long a time to enable a change. Professor Rooney asked if the work being done is taking account of Departmental policy, and Miss Taylor confirmed that this is being factored in, but a Direct Award Contract may need to be put in place in the short term. Professor Rooney felt that this area would be an important issue going forward, particularly given the change to the recording of suicide statistics in Northern Ireland and the fact that the number of deaths from drugs and alcohol will rise considerably. The Interim Chief Executive said that there was considerable discussion on this at the last meeting of the Procurement Board and good progress has been made.

107/20.3 The Chair asked whether the two senior planning posts had been filled and if these individuals will be involved in procurement. Miss Taylor confirmed that both posts have been filled, but pointed out that the work that they are required to do is more in the pre-procurement planning phase and determining what is required to be procured prior to any procurement commencing. She added that once a procurement exercise commences PHA will link with BSO PALS. The Chair asked if he could see the report of the task and finish group. Miss Taylor agreed to send him a copy.

107/20.4 Ms Mann-Kler asked about a potential divergence on staff resilience. The Interim Chief Executive advised that staff resilience is discussed regularly and also the need for staff to ensure they are taking leave as they are under constant pressure. She said that it is important that staff are supported. Professor Rooney asked whether there was more the PHA Board could do to show its support. Ms Mann-Kler suggested that a letter should issue from the Chair, on behalf of NEDs to express the appreciation of the Board for the work that staff are doing **[Action – Chair]**.

108/20 Item 11 – PHA Corporate Risk Register (PHA/04/10/20)

108/20.1 Mr Stewart advised that the Governance and Audit Committee had considered the Corporate Risk Register in depth at each of its last two meetings and that the Committee was content with the wording and assessment of each risk. He suggested that there should be a risk included on the revised HSC Framework.

108/20.2 The Interim Chief Executive said that the Agency Management Team had taken the opportunity to review the Register on a line-by-line basis.

108/20.3 The Board **APPROVED** the Corporate Risk Register.

109/20 Item 12 – ALB Self-Assessment (PHA/05/10/20)

109/20.1 The Chair noted that PHA is required to complete this self-assessment annually and although it is not required to be submitted to the

Department, it provides a useful mechanism for self-evaluation.

109/20.2 Professor Rooney noted that there is a new handbook being launched by the Department for Boards of ALBs and she suggested that following its publication, it would be useful to use it to carry out an evaluation of how our board is functioning. She also highlighted the need for feedback from stakeholders on our performance. Mr Stewart agreed with Professor Rooney's suggestion. The Chair suggested that a workshop could be organised to undertake the evaluation.

109/20.3 The Board **APPROVED** the ALB Self-Assessment.

110/20 Item 13 – Update on Population Screening Programmes (PHA/06/10/20)

110/20.1 Professor van Woerden presented the update and said that the team is carrying out its work and that there is a Screening Programme Board in place. Professor Rooney said that the Board will be kept informed of any issues. The Interim Chief Executive explained that this update was brought to the new Regional Management Board and that most of the work is the responsibility of the Trusts. She said that she brought this paper in order to keep members informed to show that this vital work is still happening. She added that PHA will be required to bring regular updates to the Management Board.

110/20.2 The Board noted the update on population screening programmes.

111/20 Item 14 – Any Other Business

111/20.1 There was no other business.

112/20 Item 15 – Details of Next Meeting

Thursday 19 November at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7ES

Signed by Chair:

Date:

HSC Public Health Agency

Public Health Agency

Finance Report

2020-21

Month 6 - September 2020

PHA Financial Report - Executive Summary

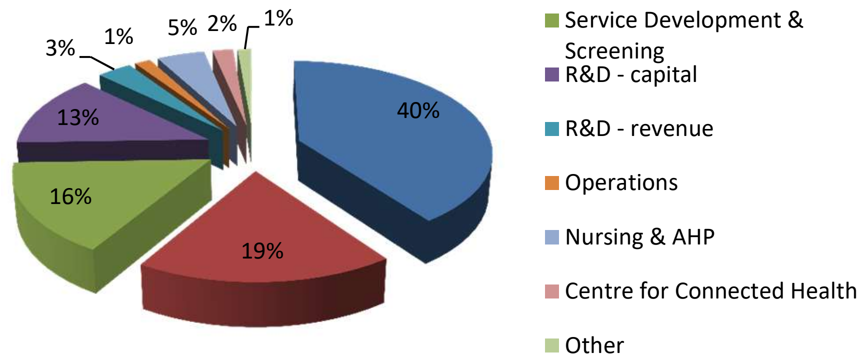
Year to Date Financial Position (page 2)

At the end of month 6 PHA is reporting an underspend of £1.8m against its profiled budget. This underspend is primarily the result of year-to-date underspends on PHA Direct budgets (page 4) and Administration budgets due to vacant posts and different working arrangements (see page 5).

Budget managers continue to be encouraged to closely review their profiles and financial positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

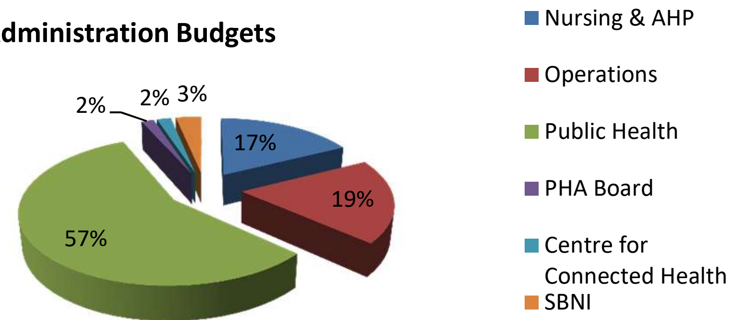
The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.



Administration Budgets (page 6)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below. A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a surplus of £1.85m for the full year. Slippage is expected to arise from Administration budgets in particular. In previous years this has been used to fund a range of in-year pressures and initiatives, however the impact of COVID-19 has reduced the potential to absorb this slippage in 2020-21. Ringfenced activities including COVID-19 and Transformation projects are assumed to be fully funded in-year, however discussions with DoH are on-going and some slippage on the baseline budget may be diverted to meet COVID-19 pressures.

Public Health Agency
2020 -21 Summary Position - September 2020

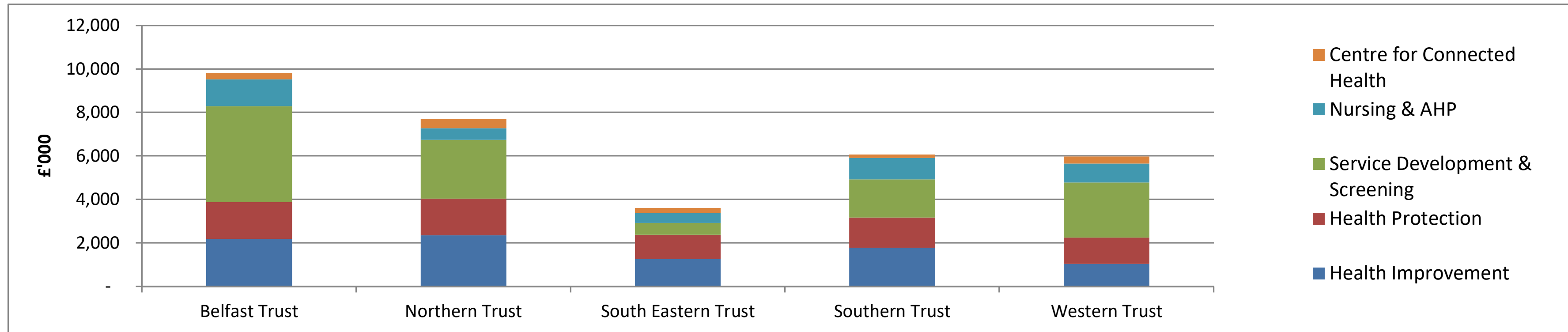
	Annual Budget					Year to Date				
	Programme Trust £'000	Programme PHA Direct £'000	Ringfenced Trust & Direct £'000	Mgt & Admin £'000	Total £'000	Programme Trust £'000	Programme PHA Direct £'000	Ringfenced Trust & Direct £'000	Mgt & Admin £'000	Total £'000
Available Resources										
Departmental Revenue Allocation	33,708	49,552	10,794	21,975	**116,031**	16,854	21,931	608	10,837	**50,230**
Assumed Retraction					**-**					**-**
Revenue Income from Other Sources	-	19	-	849	**868**	-	19	-	372	**391**
Total Available Resources	33,708	49,571	10,794	22,825	**116,899**	16,854	21,950	608	11,209	**50,621**
Expenditure										
Trusts	33,708	-	189	-	**33,897**	16,854	-	60	-	**16,914**
PHA Direct Programme *	-	49,091	10,605	-	**59,696**	-	19,966	1,374	-	**21,340**
PHA Administration	-	-	-	21,455	**21,455**	-	-		10,590	**10,590**
Total Proposed Budgets	33,708	49,091	10,794	21,455	**115,048**	16,854	19,966	1,434	10,590	**48,844**
Surplus/(Deficit) - Revenue	-	480	-	1,370	**1,850**	-	1,984	(826)	620	**1,778**
Cumulative variance (%)						***0.00%***	***9.04%***	***-135.71%***	***5.53%***	***3.51%***

The year to date financial position for the PHA shows an underspend of £1.8m, which consists primarily of year-to-date underspends on PHA Direct and Administration budgets, offset by expenditure ahead of profile on Ringfenced budgets

A year-end surplus of £1.85m is currently forecast. This is primarily the result of a forecast surplus in the Administration budget, with the impact of COVID-19 restricting the potential to utilise this funding on Programme priorities as in previous years. Ringfenced activities including COVID-19 and Transformation projects are assumed to be fully funded in-year, however discussions with DoH are on-going and some of the projected surplus may be diverted to meet COVID-19 pressures.

** PHA Direct Programme includes amounts which may transfer to Trusts later in the year*

Programme Expenditure with Trusts

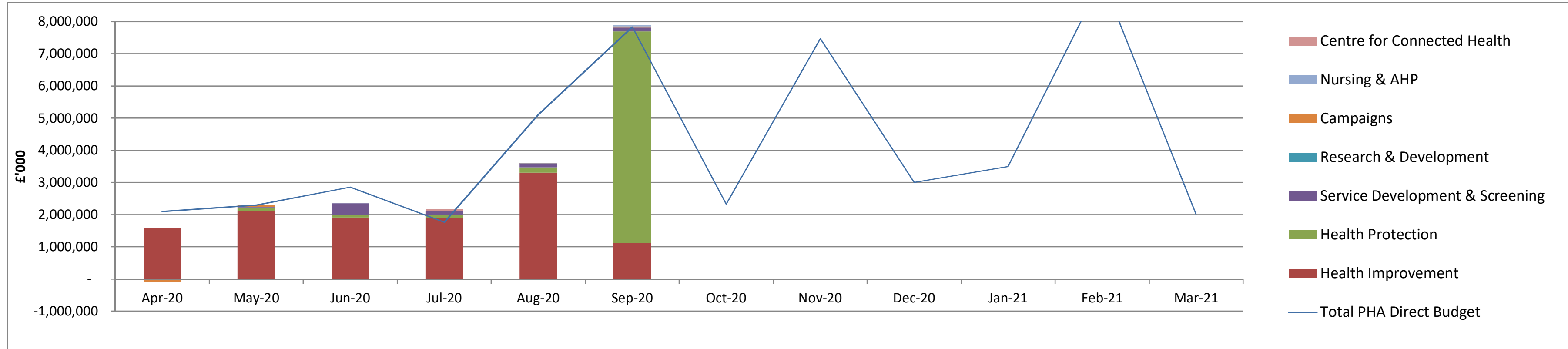


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	2,184	2,350	1,252	1,773	1,040	**8,599**	4,300	4,300	-
Health Protection	1,697	1,686	1,121	1,393	1,208	**7,105**	3,553	3,553	-
Service Development & Screening	4,408	2,702	555	1,751	2,538	**11,954**	5,977	5,977	-
Nursing & AHP	1,241	544	446	990	868	**4,089**	2,044	2,044	-
Centre for Connected Health	295	423	236	165	326	**1,445**	723	723	-
Other	152	122	56	91	95	**516**	258	258	-
Total current RRLs	**9,978**	**7,827**	**3,665**	**6,164**	**6,074**	**33,708**	**16,854**	**16,854**	-
Cumulative variance (%)									***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

The Other line relates to general allocations to Trusts for items such as the Apprenticeship Levy and Inflation.

PHA Direct Programme Expenditure



	Apr-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	2,096	2,096	2,096	1,239	4,555	972	1,206	6,152	564	980	7,070	543	**29,569**	13,054	11,940	1,114	*8.5%*
Health Protection	-	100	160	192	186	6,577	827	826	798	393	270	283	**10,611**	7,215	7,026	189	*2.6%*
Service Development & Screening	-	95	562	215	364	215	215	364	215	215	391	352	**3,203**	1,451	972	479	*33.0%*
Research & Development	-	-	-	-	-	-	-	-	1,000	1,000	1,211	-	**3,211**	-	-	-	*0.0%*
Campaigns	-	-	-	10	20	45	60	85	350	539	332	30	**1,471**	75	0	75	*100.0%*
Nursing & AHP	-	-	39	39	- 21	27	19	39	39	39	39	41	**303**	86	47	39	*100.0%*
Centre for Connected Health	-	-	-	70	-	-	-	-	38	330	-	-	**437**	70	70	0	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	766	**766**	-	(88)	88	*100.0%*
Total PHA Direct Budget	**2,096**	**2,291**	**2,857**	**1,765**	**5,105**	**7,836**	**2,327**	**7,467**	**3,004**	**3,496**	**9,314**	**2,013**	**49,571**	**21,950**	**19,966**	**1,984**	
Cumulative variance (%)																***9.04%***	
Actual Expenditure	**1,504**	**2,380**	**2,394**	**2,219**	**3,594**	**7,874**	**-**	**-**	**-**	**-**	**-**	**-**	**19,966**				
Variance	**592**	**(89)**	**463**	**(454)**	**1,510**	**(38)**							**1,984**				

The year-to-date position shows an underspend of approximately £2.0m, mainly consisting of underspends on Health Improvement and Service Development & Screening budgets due to the impact of COVID-19 on activity levels. The large spend in Health Protection in the current month relates to the prioritisation of the Flu vaccination programme in both adults and children this year.

The budgets and profiles are shown after adjusting for retractions and new allocations from DoH.

An full-year underspend of approximately £0.5m is expected to arise on PHA Direct budgets due to the impact of COVID-19 on service delivery levels. This slippage will be kept under close review in the comng months, and the impact on PHA's breakeven obligation will be closely monitored. In addition the organisation expects a surplus to arise on Administration budgets. In previous years this would have been absorbed through PHA Direct budgets to address programme priorities, but this is unlikely to be an option in 2020-21 and therefore represents a risk which will be kept under close review.

Public Health Agency
2020-21 Ringfenced Funds

	Annual Budget				Year to Date			
	COVID-19 £'000	Transformation £'000	Other £'000	Total £'000	COVID-19 £'000	Transformation £'000	Other £'000	Total £'000
Available Resources								
DoH Allocation	2,363	4,072	311	**6,747**	-	482	127	**608**
Assumed Allocation	4,047	-	-	**4,047**	-	-	-	**-**
Total	6,411	4,072	311	**10,794**	-	482	127	**608**
Expenditure								
Trusts	-	121	68	**189**	-	60	-	**60**
PHA Direct	6,411	3,951	243	**10,605**	973	298	103	**1,374**
Total	6,411	4,072	311	**10,794**	973	358	103	**1,434**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**(973)**	**124**	**23**	**(826)**

PHA has received a COVID allocation of £2.4m to date, which is primarily for Child Flu Vaccine. As at 30 September no costs had been incurred against these allocations, with the expenditure expected during quarter 3. A further £4.0m is expected to be received from DoH on the basis of COVID bids submitted to date, and this funding is included in the full year position shown above. The costs incurred for the year to date are the initial costs in relation to Track & Trace, COVID Communication Campaigns and Staff overtime. An exercise is currently underway to establish the full cost of running the Track & Trace Service and other anticipated COVID-related costs, however initial estimates have been included at this point.

A number of Transformation projects are also on-going, and separate ringfenced funding has been received for these totalling £4.1m. These projects are being monitored and reported on separately to DoH, and are currently expected to breakeven for the year.

The Other category includes EITP and DAERA ringfenced funds, which are also expected to breakeven at this stage.

Sep-20

PHA Administration

2020-21 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	3,801	326	2,957	12,345	304	348	467	**20,549**
Goods & Services	148	18	1,322	408	54	58	269	**2,276**
Total Budget	**3,949**	**344**	**4,279**	**12,753**	**359**	**406**	**735**	**22,825**
Budget profiled to date								
Salaries	1,866	163	1,478	6,169	114	174	233	**10,198**
Goods & Services	74	9	661	168	27	29	43	**1,011**
Total	**1,940**	**172**	**2,139**	**6,337**	**141**	**203**	**276**	**11,208**
Actual expenditure to date								
Salaries	1,867	186	1,358	6,011	123	186	200	**9,931**
Goods & Services	61	2	512	42	16	2	24	**659**
Total	**1,928**	**188**	**1,869**	**6,053**	**139**	**188**	**224**	**10,590**
Surplus/(Deficit) to date								
Salaries	(1)	(23)	120	158	(9)	(12)	34	**266**
Goods & Services	13	7	149	126	11	27	19	**352**
Surplus/(Deficit)	**12**	**(16)**	**269**	**284**	**2**	**15**	**52**	**619**
Cumulative variance (%)	*0.62%*	*-9.19%*	*12.59%*	*4.48%*	*1.47%*	*7.26%*	*18.92%*	***5.52%***

PHA’s administration budget is showing a year to date surplus of £0.6m, which is being generated by a number of long standing vacancies. Although efforts continue to fill vacant posts as far as possible, this has proved to be challenging, and the surplus on the salaries budget continues to be high. In addition in 2020-21 many staff are largely working from home, and this has driven a downturn in Goods & Services expenditure in areas such as travel and courses, which is expected to lead to increased slippage at year-end. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £1.3m.

DoH has required PHA to meet the cost of the first 1% of the pay award in each of the last 2 years (2019-20 and 2020-21). The impact of this is currently being masked by high levels of vacancies.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

Sep-20

Public Health Agency
2020-21 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	PHA Direct	Mgt & Admin	Total	Trust	PHA Direct	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Capital Grant Allocation & Income	7,996	4,113	-	**12,109**	3,998	1,642	-	**5,640**
Expenditure								
Capital Expenditure - Trusts	7,996			**7,996**	3,998			**3,998**
Capital Expenditure - PHA Direct		4,113		**4,113**		331		**331**
	7,996	4,113	-	**12,109**	3,998	331	-	**4,330**
Surplus/(Deficit) - Capital	-	-	-	-	-	**1,311**	-	**1,311**
Cumulative variance (%)								

PHA has received a Capital budget of £12.1m including income in 2020-21, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £4.3m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	Sep-20 Value	Sep-20 Volume	Cumulative position as at 30 September 2020 Value	Cumulative position as at 30 September 2020 Volume
Total bills paid (relating to Prompt Payment target)	£8,711,690	393	£26,514,161	2,160
Total bills paid on time (within 30 days or under other agreed terms)	£8,604,147	334	£25,958,409	1,960
Percentage of bills paid on time	**98.8%**	**85.0%**	**97.9%**	**90.7%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although performance on volume is below target cumulatively in September and cumulatively to date. Overall PHA is making progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 94.2% by value for the year to date, which significantly exceeds the 10 day DoH target for 2020-210 of 60%.

HSC Public Health Agency

item 8

Title of Meeting	PHA Board Meeting
Date	19 November 2020
Title of paper	Launch of Digital Self Trace Platform for Contact Tracing
Reference	PHA/02/11/20
Prepared by	Jennifer Lamont
Lead Director	Olive MacLeod
Recommendation	For **Approval** ☐ For **Noting** ☒

1. Purpose

The purpose of this paper is to update members on the launch of a digital self-trace platform for contact tracing.

2. Introduction

On 9 October PHA launched its digital self-trace (DST) platform to enhance the covid-19 Contact Tracing Service (CTS). DST is an online platform where index cases are invited to input the details of their close contacts in lieu of telling a contact tracer on a telephone call. The purpose of the service is to reduce the number of calls required to be made from the CTS.
The launch of the platform had been planned for the end of October but was brought forward due to the pressure brought on the CTS due to the sustained rise in positive cases in early October.
After the initial text or email to tell a person they have tested positive for Covid-19 they receive a further two messages – one with a code for them to enter into the stopCOVIDNI app if they have it; and one with a code to use the DST platform.

3. Progress to Date

As at 10 November 22,653 people have been sent an SMS inviting them to use DST since launch of the service on 9th October. Of this a total of 4,537 have completed DST (20%). In total (as at 10 November) 8,598 contacts have been collected by DST. 7,651 of these contacts have been successfully contact by SMS comprising a

full end to end digital journey. Where a contact has not received a text it will usually be because the telephone number has been incorrectly added.

4. Next Steps

Increasing the uptake of DST is a key part of our plan to reconfigure the Tracing Service to cope with increased case numbers. A mass media communications campaign is planned. The launch of DST is also central to the Digital First direction for TTP. We are currently considering how to support people who are unable or prefer not to use the digital platform themselves – potentially using a proxy service such as that provided by NI Direct for test booking an symptom checking.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	19 November 2020
Title of paper	Update on Self-Harm
Reference	PHA/03/11/20
Prepared by	Denise O'Hagan
Lead Director	Professor Hugo van Woerden
Recommendation	For **Approval** ☐ For **Noting** ☒

1. Purpose

This paper aims to update the PHA Board in relation to the issue of self-harm and suicide. Key data from the Self-harm Registry and the implications for services will be presented as well as an update on recent changes to the definition of suicide in Northern Ireland. The paper also highlights the work of the Toward Zero Suicide collaborative to minimise suicides among patients known to mental health services and refers to wider quality and safety issues of importance to the PHA. Issues relevant to the future PHA commissioning of services in this field are highlighted. There are many more initiatives led by the PHA under the Protect Life Strategy which address the issue of suicide prevention more generally, but these are not the focus of this report.

2. Incidence of suicide in NI and recent changes to definitions

In recent years there have been approximately 300 deaths registered as suicide each year and despite significant suicide prevention investment and efforts there appeared to be little change in these figures. These figures are now being reviewed by NISRA and are expected to be revised downwards by 20-30% bringing the NI suicide rate more in line with other UK countries. The revised figure for 2019 is 197 compared to 307 for 2018. A review is ongoing between the Coroners' Service and NISRA which will focus on additional scrutiny of drug related deaths with undetermined intent. As a result, some of these may be retrospectively reclassified as 'accidental' and removed from the suicide count. Refer to Appendix 1 for NISRA statement on this issue.

While this may be good news in relation to suicide prevention and provides some indication that suicide prevention efforts may be paying off, the same number of people are still dying each year but now attributed to a different cause. There needs to be continued efforts to address suicide prevention and enhanced focus on providing joined up preventative and intervention services for mental health and alcohol and drug misuse issues, as well as addressing the underlying determinants of both issues as they are closely related.

3. Incidence of Self-harm

3.1 Self-harm in the community

There is an iceberg effect in relation to the visibility of self-harm. A study in the Lancet in 2019 reported that the incidence of self-harm among adolescents in the community in England was just over ten times the incidence of self-harm that presents to hospitals. Similar principles may be true of other age groups, particularly for men who are reluctant to seek support. This has important implications for our commissioning of services which will be discussed later in this paper.

3.2 Self-harm presenting to hospital

People who present to hospital with self-harming behaviour are at increased risk of suicide with studies reporting 1-2% die by suicide in the year after presentation and this group having 50-200 times the risk of suicide of the general population. Risk of suicide is highest in the month after hospital attendance with self-harm highlighting the importance of early access to assessment, intervention and support following hospital attendance with self-harm. These issues will all be discussed in this paper. In NI and the Republic of Ireland (RoI) we have unique surveillance system for monitoring self-harm that presents to hospital. The Self-harm Registry in NI is led by the PHA and is a partnership with the National Suicide Research Foundation in Ireland and the local HSC Trusts. Since 2012 there is full data capture across NI from all 12 emergency departments.

The PHA produces quarterly returns to the Department of Health in relation to Registry findings. Annual reports are published with the next report due to be published in the near future on the PHA website. We aim to keep a low profile in relation to the PR around these reports to avoid normalising the issue.

3.3. Data regarding presentations of self-harm and ideation to EDs in NI 2018/19

Key findings from the 2018/19 annual report from the Registry of Self-harm which is due to be published soon include:

- there were 9,242 presentations of self-harm and a further 5,403 presentations with ideation (without an act of self-harm) to EDs in 2018/19

- together these account for 40 attendances each day and represent almost 2% of all ED attendances during 2018/19. These issues are therefore a significant burden on HSC resources.
- approximately 21% of self-harm presentations repeated self-harm within the 2018/19. Repetition rates have shown a slight reduction in 2018/19 but show a slight increase from the baseline of 19% documented in 2012/13.
- There have been some changes in methods of self-harm during the period 2012/13 to 2018/19. The proportion of cases involving drug overdose has reduced from 75% to 63%. The PHA has worked with pharmacy colleagues regarding access to medication but there is scope for further work in this area. The proportion involving attempted drowning has increased from 1% to 6% over the seven year period and this is particularly a concern in the Western Trust area where it is very significantly higher than other Trust areas.
- The proportion of cases where alcohol was involved in the act of self-harm has fallen from 51% in 2012/13 to 44% in 2018/19.
- Almost half (46%) of self-harm cases were discharged from ED following treatment without the need for admission.
- The proportion of patients who left the ED without being seen varied from 1% in the South Eastern HSCT to 6% in the Belfast HSCT.
- NICE recommends that all people who present with self-harm are offered a specialist psychosocial assessment. There has been good improvement in this over recent years with currently 83% of people who self-harmed having a record in their ED notes of either having had a psychosocial assessment carried out in the ED prior to discharge, or a referral made to have this carried out either next day in the community under the Card Before You Leave Scheme or subsequently in the wards or other location.

Key population subgroups

- *Under 18s:* self-harm presentations by those under 18 years of age contributed to 10% (n=968) of all presentations during 2018/19. This has been a fairly consistent pattern since 2012.
- *Homeless:* approximately 5% (n=454) of self-harm presentations involved persons who were homeless at the time of attendance.
- *Prisoners:* Approximately 1% (n=71) of self-harm presentations recorded by the Registry were made by persons who were in prisons at the time of the self-harm act.
- *Children's Residential Homes*: A total of 92 self-harm presentations (1%) were made by 38 residents of residential children's homes. This reflects one in four residents of children's care homes highlighting the importance of staff training and access to interventions for young people in these settings.

Self-harm rates

- The overall age-standardised rate of self-harm in 2018/19 for Northern Ireland was 361 per 100,000. This is 8% higher than the rate in 2012/13. The male rate of self-harm increased by 6% during this period while the female rate increased by 9%. The rates are highest in 15-24 age group.
- Comparisons between rates for those aged over 15year in cities in the UK and Ireland were made in earlier reports from the Registry based on data from around 2013-14. It found that rates in Derry and Belfast were significantly higher than all other regions included, with rates of 708 and 701, respectively. Limerick had the highest rate in ROI, with a rate of 453 per 100,000 while Derby had the highest in England, at 434 per 100,000.

4. Service implications of Registry findings

The Registry report is a statistical report and as such does not try to interpret the findings in depth or explore the implications for services. A brief exploration of these issues is considered below. A Self-harm Steering Group, co-chaired by PHA and HSCB was established to try to bring together health improvement and service development initiatives on this issue and ensure the registry data was utilised to inform service developments. A suite of resources (care pathway, assessment tool, education programme, patient literature, ED staff fact sheets) was developed. The education programme was not fully implemented as intended and much of the other work should now be reviewed and updated. The SHSG has not met for some time and has been stood down temporarily due to Covid pressures.

4.1 Increasing demand on services

Overall since 2012/13 there has been a 28% rise in self-harm and ideation presentations when these two issues are considered together. Among <18 year olds there has been a 45% increase in presentations, and a 26% rise in adult presentations. This highlights the increasing pressure on the services responding to these issues i.e. ED services, CAMHS services, adult mental health services and partners involved in follow-up services in the community such as the Self-harm Intervention Programme (SHIP) which will be referred to later.

The rise in ideation presentations (69%) has been greater than for self-harm presentations (12%). It is not clear how this should be interpreted. It may suggest a trend towards help-seeking at an earlier stage before an act of self-harm takes place but requires further exploration. There have been a range of public health and service initiatives over this period of time which may have had some impact on these figures. Increased awareness of services among the public and professionals as well as reduced stigma may have resulted in more people being willing to seek help and being therefore visible to services.

4.2 Avoidance of use of ED where possible

While many cases of self-harm require physical care, the fact that some people in distress appear to be unable to access services in the community and need to present to / be brought to the ED with thoughts of self-harm /suicide is quite concerning. If people are already under the care of mental health services it would be preferable to be able to access crisis support without having to attend the ED unless absolutely necessary.

It is therefore important that there are joined up pathways with emergency services to avoid bringing such patients to the ED unless essential. A good example of where this has worked well is the Multi-agency Triage Team (MATT) led by the PHA which has been operating the SE Trust area and subsequently Belfast Trust. In other UK countries this is referred to as 'Street Triage'. This partnership between the emergency services and mental health services aims to manage people in the community setting as far as possible. This reduces demand on ED services and on NIAS and PSNI resources waiting at ED but more importantly provides a more appropriate and timely intervention for the patient with 80% of patients being seen within one hour of calling the MATT service, avoiding considerable waiting time at ED and the patient potentially leaving before being seen. Referrals to MATT are twice as high from the top 20% most deprived areas. From 1st February to 30th September 2020 there have been 155 referrals to MATT and an estimated 77 ED presentations diverted. Most of these patients receive a mental health assessment by the MATT service reducing the need for mental health assessment in ED or next day follow up by mental health services.

4.3 Access to specialist psychosocial assessment following ED attendance

Across NI there are different service models in place in each Trust relation to the mental health teams that respond to people attending the ED with mental health issues and there isn't full coverage across services for all age ranges. These services are currently being mapped out. A new Psychiatric Liaison model has been proposed following a successful pilot in the Northern HSC Trust. Transformation Funding had been identified towards this but progress has been slow and longer term funding would be required to fully implement this model. If fully operational this would enable all people with self-harm and other mental health presentations to have a psychosocial assessment at the time of presentation to the ED and potentially to have some short term follow-up crisis care.

5. Follow-up interventions for people who self-harm

5.1 Access to interventions following ED attendance with Self-harm

Services available within mental health teams in Trusts vary across Trusts. This paper does not seek to describe these services. A sub-group of the HSCB /PHA Mental Health Commissioning team oversees the range of psychological therapies commissioned by HSCB for a range of problems.

The PHA commissions one specific psychological service in the community aimed at those who self-harm who do not need input from Trust mental health services i.e. the Self-harm Intervention Programme (SHIP). SHIP was commissioned as tendered service in 2015. There are three key service providers across NI and there is full coverage across the region. Re-procurement will be informed by the review of Crisis Services that the Chief Medical Officer has requested to be undertaken. An evaluation of SHIP is ongoing. The SHIP service accepts referrals of people aged 11+ who have engaged in self-harm either currently or in the past. In 2019/20, 3433 people who self-harm were referred to SHIP. That reflects over half of those who present to the ED, although there are also other routes of entry. Referrals decreased by 40% in the period April-June 2020 during the pandemic compared to same period last year but are steadily rising again. There were also 909 psycho-educational and support sessions were offered to families/carers of people who self-harm during 2019/20. An important aspect of SHIP is the timely response with people referred being contacted within 24 hours and offered an appointment within a week thus providing support in the high risk period immediately after ED attendance.

Currently GPs, school nurses etc. cannot make a direct referral to SHIP services and the patient must be triaged by a mental health professional to ensure that they are accessing the appropriate level of support. If access was opened wider there would be likely to be considerable resource implications.

As self-harm is often a hidden problem there is an argument that there is a gap in services and that it may be appropriate to create self-referral options and open referral to a wider range of referral agents. There are also potentially more linkages that could be made with drug and alcohol services. This will be considered following evaluation of the service, review of crisis services and as part of the re-procurement exercise.

It is important that there are initial sources of help and support available in various formats that can provide people who self-harm or their carers with appropriate educational materials and if appropriate self-management advice. The PHA has developed a range of literature and has some information of our website at www.minding your head.info. There are also a range of help-lines available including Lifeline.

6. Safety within services

The Northern HSC Trust is currently leading on the Towards Zero Suicide collaborative to reduce suicide in mental health services utilising Transformation funds. This work has been heavily influenced by the approach undertaken in Merseyside led by Mr Joe Rafferty for Merseycare.

There is also work underway in NI to develop a Suicide Care Pathway to ensure early access to the right level of support. Data from the PHA Self-harm Registry is very useful to inform this work. When complete this pathway will influence future commissioning by PHA to provide services at the early steps in the pathway.

As part of the Quality and Safety responsibilities of the PHA, the PHA is involved with HSCB colleagues in reviewing Serious Adverse Incidents (SAIs) relating to suicide and serious self-harm that occur among patients who are currently or have recently been under the care of mental health services or suicides that occur in in-patient settings. A review of the SAI processes by RQIA is currently in progress. It is important that careful consideration is given to the definitions used to ensure all appropriate cases are included. Consideration should be given to whether serious self-harm and suicide that occur in settings such as prison, primary care or following discharge from ED should be included. Consideration should also be given to how best to handle incidents that occur in commissioned services such as Lifeline and SHIP.

7. Research

The Registry will continue to engage in producing peer reviewed research papers. In addition the Registry data is being utilised by researchers from Queen's University to link self-harm presentations with mortality data and social services data. This will shed more light on how we can help prevent suicides. NI is in a unique position to contribute to research in the area of self-harm and suicide prevention given the existence of our Registry of Self-harm and this should be supported given our high rates of self-harm.

8. Future direction

This paper has outlined a range of services that are in place for people who self-harm. PHA should continue to work with the HSCB and Trusts on ensuring access to a range of services dependent on the level of need and presenting issue and ensuring safety within services. The current work on developing a suicide care pathway will be very important going forward. It is also important that future commissioning addresses the very closely related issue of substance misuse as people in distress often also have issues with alcohol and drugs. Future services should try to ensure a more holistic approach to these issues to avoid people being continually passed around services and falling between the cracks. It is also important that the wider public health societal issues continue to be addressed via the Protect Life Strategy e.g. suicide prevention at bridges.

While it is important that there are services in place for people in immediate crisis it is also crucial that there is a focus on preventing self-harm occurring in the first place and ensuring that there are a range of preventative services accessible in schools

and communities to promote positive mental health and wellbeing and early detection of problems. There are currently a range of universal services accessible to families and young people and it is important that staff working in these services have access to training in relation to self-harm and suicide prevention and can access higher levels of support when required. Services currently working with people who are known to be in high risk groups e.g. Looked After Children should have access to training and support and have good awareness of how to access high levels of support if required.

The issue of self-harm is complex and straddles health improvement and service development boundaries within the PHA. Decisions need to be made in future regarding where commissioning of services (such as SHIP, MATT and other counselling services) should sit and whether they should sit alongside the commissioning of other clinical type services. These decisions are often dictated by the funding streams which may not be the most appropriate rationale and risks these services becoming disjointed from other clinical services. However there are risks in losing the upstream public health focus if such services become integrated with the wider commissioning of other services. It is a high risk and complex area of work.

Significant investment may be required to further open up self-harm services and provide education and training to a wider audience. New NICE guidance on self-harm is expected in 2022 and will help guide our future direction.

Appendix 1

Guidance Note to Users on Suicide Statistics in Northern Ireland updated October 2020

Issue

Provisional 'cause of death' statistics for Q4 2019 were published by NISRA on 30th June 2020 (https://www.nisra.gov.uk/publications/registrar-general-quarterly-tables-2019) and along with the previous quarterly releases, enable users to form a provisional 2019 total for suicides.

The 2019 provisional total (197) is a significant fall on previous years (307 in 2018). This decrease has been primarily driven by improvements in the statistical collection and collation process, including the quality of the suicide data at source. This has ultimately reduced the number of deaths coded with a finding of 'undetermined intent', while increasing the numbers coded as 'accidental' which fall outside the definition of suicide (see below).

In light of these refinements to the 2019 data, NISRA is working with the Coroners' Service to review and revise, as necessary, drug related deaths within the 'undetermined deaths' category from 2015 to 2018. At this stage revisions further back are not considered necessary due to different processes being in place at that time (see below); however if a break in the series is evident on completion of the review this will be assessed and a course of action agreed in conjunction with the Coroners' Service.

This note provides further detail for users, including guidance on the most reliable series to refer to in the meantime.

Background

Suicide deaths in Northern Ireland are defined as deaths from Self-inflicted Injury as well as Events of Undetermined Intent. This is consistent with the UK National Statistics definition. The codes used to define the suicide figures are shown below:

Table 1: ICD10 codes relating to Suicide Deaths

ICD-10 Underlying Cause Code	Description
X60-X84, Y87.0	Self-inflicted Injury
Y10-Y34, Y87.2	Events of Undetermined Intent

Where a person has died from any cause other than natural illness for which they have been seen and treated by a registered medical practitioner within 28 days prior to the death, the death must be referred to the Coroner. A death which is suspected to be suicide must therefore be referred to the Coroner and can only be registered after the Coroner has completed his/her investigation.

The information provided by coroners at registration of the death is used to code

the underlying cause of death. In some instances, it can be difficult to establish whether the cause of death was suicide. If it is not clear, or the Coroner has not specifically stated that it is a suicide, these are coded as 'Undetermined'.

What has changed?
The recently published 2019 provisional total is a significant fall on previous years as shown in series B below. The change in the numbers of undetermined cases (series D) is an issue closely aligned to the number of drug related deaths increasing over time (series E).

Why review from 2015 onwards?
Prior to 2015 ICD 10 coding of deaths was done within the GRO by a dedicated coder which allowed for case by case scrutiny, including a process by which further information could be sought from the Coroner in relation to 'undetermined deaths'. ICD 10 coding was then transferred to ONS, working in conjunction with the NISRA Vital Statistics Unit. All drug related deaths registered after being referred to the Coroner were statistically classed as 'undetermined', unless NISRA received specific documentation from the Coroner which indicated that the death was the result of self-inflicted injury or was an accident and therefore not within the definition of suicide.

Table 2: Analysis of Suicide Deaths and Intent Over Time

A	B	C	D	E
Registration year	**Total number of suicides**	***Of which:*** **Self-inflicted**	**Undermined**	**Proportion of undetermined deaths which are also drug related**
2011	289	220	69	81%
2012	278	203	75	81%
2013	303	243	60	78%
2014	268	191	77	82%
2015	318	204	114	96%
2016	298	149	149	71%
2017	305	173	132	78%
2018	307	184	123	93%
Provisional 2019	197	187	10	-

Following a quality exercise between NISRA and the Coroners' Service, to better understand drug- related deaths and intent, improvements have been made in order to reduce the number of deaths coded as 'undetermined':

1. Since 2019, all documentation received by NISRA and going back to Q3 2018, which involved a drug-related death without an indication of intent, was flagged to the Coroners Service, in order for a verdict of accidental/ suicide or undetermined intent to be provided. Of 86 cases reviewed, 66% were deemed accidental.
2. In late 2019, the Coroners' Service introduced a new I.T. system within which all drug- related deaths must be assigned as either accidental/suicide

or undetermined intent at point of processing.

Together, these changes have resulted in a discontinuity in the statistical series, with the number of ‘undetermined’ deaths reducing from 132 in 2017 to 10 in 2019. There has also been a small impact in 2018 due to checks carried out at (1) above.

Timeline
The timeline for the review to complete is estimated to be around May 2021. Once complete, NISRA will prepare a dedicated official statistics output based on the new time series, including key background information on why and how this review was undertaken.

Advice to Users
NISRA recommends that until this review has completed users should refer to the sub-series relating to self-inflicted injury only (series C above) (*ICD-10 codes X60-X84, Y87.0*), as this is unaffected by the discontinuity outlined above and remains a reliable indication of the trend in suicides over recent years. Published figures on deaths due to self-inflicted injury are available at: https://www.nisra.gov.uk/publications/registrar-general-annual-report-2018-cause-death

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