HSC Public Health Agency

AGENDA

90th Meeting of the Public Health Agency board to be held on Thursday 15 December 2016, at 1:30pm, Conference Rooms, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1.30	Welcome and Apologies		Chair
2.	1.30	Declaration of Interests		Chair
3.	1.30	Minutes of previous meeting held on 17 November 2016		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.50	PHA Financial Performance Report	**PHA/01/12/16 (for Noting)**	Mr Cummings
8.	2.00	Personal and Public Involvement Update	**PHA/02/12/16 (for Noting)**	Mrs Hinds
9.	2.25	Overview of Allied Health Professions	**PHA/03/12/16 (for Noting)**	Mrs Hinds
10.	2.45	The Northern Ireland AAA Screening Programme Annual Report 2014/15	**PHA/04/12/16 (for Noting)**	Dr Harper
11.	3.15	Corporate Risk Register	**PHA/05/12/16 (for Noting)**	Mr McClean

12. 3.25 Any Other Business

13. **Date, Time and Venue of Next Meeting**
Thursday 16 February 2017
1:30pm
Fifth Floor Meeting Room
12/22 Linenhall Street
Belfast
BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 89th Meeting of the Public Health Agency board held on Thursday 17th November 2016 at 1:30pm, Conference Rooms 3 and 4, 12/22 Linenhall Street Belfast, BT2 8BS

PRESENT:

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Mrs Julie Erskine	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director

IN ATTENDANCE:

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Mr Robert Graham	-	Secretariat

APOLOGIES:

Alderman Paul Porter	-	Non-Executive Director
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB

		Action
113/16	**Item 1 – Welcome and Apologies**	
113/16.1	The Chair welcomed everyone to the meeting. There were no apologies.	
114/16	**Item 2 - Declaration of Interests**	
114/16.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

115/16	**Item 3 – Minutes of previous meeting held on 20 October 2016**
115/16.1	The minutes of the previous meeting, held on 20 October 2016, were **approved** as an accurate record of the meeting.
116/16	**Item 4 – Matters Arising**
	Outcomes Based Accountability
116/16.1	Mr Coulter asked if there was any further update on the proposal for members to be trained in Outcomes Based Accountability. The Chair said that Diane Taylor had acknowledged his correspondence and that he had also written to Katrina Godfrey suggesting that a glossary of terms be developed for commonly used terms throughout the public sector. He added that he had also contacted Diane Taylor with regard to the facilitation of a PHA Board workshop on Board effectiveness.
116/16.2	Mr McClean indicated that PHA may be able to organise in-house training. He noted that some staff had already obtained training.
117/16	**Item 5 – Chair's Business**
117/16.1	The Chair informed members that he had attended a meeting organised by the Northern Ireland Confederation at which the Minister responded to a series of questions about her "Health and Wellbeing 2026: Delivering Together" Report and the Bengoa Report. He said that at the meeting he had expressed his hope that the various professions would be flexible with regard to proposals to allocate functions to other staff within the HSC.
117/16.2	Mrs Erskine said that there were a number of inaccuracies within the Report, for example it quoted 12,000 social care workers, but that the actual total is almost 30,000.
117/16.3	The Chair advised that he had also attended a meeting with Stephen Dalton, who had outlined a view that the present government in Westminster would not prioritise health issues to the same extent as the previous government.

117/16.4	The Chair said that he had been present at an event looking back at the 15 years' work of the Police Service of Northern Ireland. He added that presentations were also made in health and justice for the future.
118/16	**Item 6 – Chief Executive's Business**
118/16.1	The Interim Chief Executive informed members that the Minister had convened a meeting of all HSC Chief Executives with regard to resilience and winter planning. She said that the Minister had requested an update from each Trust on how their resilience plans were being developed.
118/16.2	The Interim Chief Executive said that the Unscheduled Care group, jointly chaired by PHA and HSCB, had already developed a robust plan looking at scenarios of a 2, 5 and 10% increase in admissions to emergency departments. She added that there remain some risks, and that all HSC sites would be under pressure if the 10% scenario presented itself.
118/16.3	The Interim Chief Executive advised that the Minister wishes to be kept up to date immediately with any developments and wants Chief Executives to appear in front of the media to report on any issues.
118/16.4	The Interim Chief Executive said that she had received correspondence from the Permanent Secretary regarding the establishment of a Transformation Implementation Group to take forward the work outlined in the recent ministerial statement. She said that she has been invited to join this Group, along with other HSC Chief Executives, and Alan Stout and Mark Taylor (who were members of the Bengoa Group). She added that a number of sub-groups will also be established and that the first meeting is due to take place on Monday 21 November in Craigavon.
118/16.5	The Interim Chief Executive said that she had received correspondence from the Chief Medical Officer regarding the Improvement Institute. She said that Dr Anne Kilgallen will be leading on this work and will be contacting PHA with requests for information.
118/16.6	The Interim Chief Executive advised that Dr Jackie Johnston will

	be replacing Dr Eddie Rooney on the all-Ireland Congenital Heart Disease Network Board. She said that the Permanent Secretary had written to her in this regard.
118/16.7	The Interim Chief Executive informed members that a mid-year budget review meeting had taken place on Tuesday which had provided an important opportunity to look at the implementation of the Investment Plan. She added that overall good progress is being made and there are plans in place to manage the variances.
118/16.8	The Interim Chief Executive advised that she had attended a meeting organised by the Institute of Health Equity entitled "Why Good Work Matters" in Dublin Castle. She said that a lot of learning came from the event and that there were sessions facilitated by Sir Michael Marmot and Dame Carol Black.
118/16.9	The Chair asked whether there was an information campaign to increase public awareness about only attending emergency departments in emergencies. Dr Harper said that there is a Stay Well campaign and that there will also be a Stay Warm campaign. She added that there have been health service professionals putting out information directing people to go and visit their local pharmacists in the first instance instead of GP surgeries or emergency departments.
118/16.10	Mr Drew noted that there are many departmental groups being set up and questioned whether any of them are delivering. The Interim Chief Executive noted the point, and said that with the establishment of the Transformation Implementation Group, some of the other groups are being stood down.
118/16.11	Ms Mann-Kler asked the Chair whether the Minister had indicated that this change would be the definitive change. The Chair said that he came away from the event with a sense of positivity. The Interim Chief Executive added that the Minister had also attended an event in L'derry and that she spoke with great energy and conviction. She said that the Minister will hold the Permanent Secretary, and the HSC, to account for the implementation of her vision. Mr Cummings added that in his opinion, the Minister had been given a clear mandate by her party, and will hold the post for the full term of government.

119/16	**Item 7 – Finance Performance Report (PHA/01/11/16)**
119/16.1	Mr Cummings said that the latest Finance Report showed a slight improvement in the surplus. He said that the meeting with all budget holders that the Interim Chief Executive had alluded to, had provided his staff with reassurance that there are no areas of major concern, and that members should see an improvement over the next couple of months.
119/16.2	Mr Cummings said that the £44k surplus within management and administration represented a break even position despite the challenging savings target.
119/16.3	Mr Cummings said that as this was the half-year report, there is a mid-year balance sheet. He added that a report on capital had also been included.
119/16.4	Mr Drew asked about the additional allocations. Mr Cummings explained that any additional allocation are normally non-recurrent, and are earmarked for specific activities.
119/16.5	Mr Drew asked for an update on VES. Mr Cummings explained that there are been a low take-up and the low number of suitable applicants. He said that across the Civil Service, the take-up had been low as it is not as attractive as the previous scheme.
119/16.6	Mr McClean said that PHA had received additional funding in the June monitoring round which will be put into Making Life Better and Programme for Government initiatives and this had affected how the spend profiles looked.
119/16.7	Mr Coulter said that he still had some concerns remained about slippage and getting the funding spent. Mr McClean explained that formalities such as HR processes, business case sign off etc influence the timescales it takes to get Service Level Agreements in place.
119/16.8	Mr Drew expressed concern about the timeline for the Lifeline procurement. Mr Cummings said that there is a recurrent budget, and therefore no financial implications. He said that if the current contract is extended, the PHA would seek approval from the Permanent Secretary. The Interim Chief Executive said that there should be a ministerial announcement shortly

	regarding the future of the service.
119/16.9	Members noted the Finance Report.
120/16	**Item 8 – Public Health Agency Corporate Plan (PHA/02/11/16)**
120/16.1	The Chair informed members that he, along with Ms Mann-Kler and Mr Coulter, were part of the PHA Corporate Plan Project Board. He invited Miss Rosemary Taylor to give members an overview of the development of this draft Plan.
120/16.2	Miss Taylor said that the Project Board had commenced its work in 2014, and that this Plan had been developed to take account of Making Life Better (MLB), Programme for Government (PfG), Community Planning and the current environment. She said that this Plan focused more on actions and goals that are applicable across all directorates in PHA and focused on Outcomes Based Accountability.
120/16.3	Miss Taylor advised that the draft Plan has 4 high level, external facing outcomes with strategic indicators below each theme which link to MLB and PfG. She said that the final section of the draft Plan highlighted some key achievements over the course of the last Plan, but that this needed some further work.
120/16.4	Miss Taylor said that an initial Equality Screening was also included, together with a proposed consultation questionnaire. She said that a communications plan was also in development.
120/16.5	Mrs Erskine said that the draft Plan was user-friendly and eye catching and she was very impressed. Mr Drew said that the questionnaire was excellent and he thanked the staff for their work in producing this.
120/16.6	Ms Mann-Kler said that the final Plan was excellent, following the previous draft. She suggested that some of the consultation questions be reviewed in order to maximise the quality of responses. Miss Taylor explained that the questionnaire is set out along the lines of the strategic actions. Mr McClean added that the aim is to keep the questions at a high level, but he advised that it is PHA's intention to organise a series of consultation events which will allow for more in-depth conversations.

120/16.7	Ms Mann-Kler felt that one of the questions was a leading question. Mr McClean agreed that this question could possibly be dropped.
120/16.8	Mr Coulter said that he was pleased with the final outcome. He suggested that the final section should make reference to other PHA publications, e.g. the Director of Public Health report. Mr Drew said that PHA had possibly undersold itself in this section.
120/16.9	Miss Taylor informed members that PHA would work with its Personal and Public Involvement (PPI) staff regarding the forthcoming engagement events.
120/16.10	The Chair thanked Miss Taylor and her staff for all of their work in developing this draft Plan.
120/16.11	Members **approved** the draft Corporate Plan.
121/16	**Item 9 – Performance Management Report – Corporate Plan Business Targets for Period Ending 30 September 2016 (PHA/03/11/16)**
121/16.1	Mr McClean asked Miss Taylor to present the Performance Management Report.
121/16.2	Miss Taylor indicated that of the 90 corporate targets, 76 are rated "green" at the mid-year point, with the other 14 rated as "amber". She invited queries from members on the report.
121/16.3	The Chair asked about the wording of the targets relating to suicide prevention and smoking. Dr Harper said that these targets were Commissioning Plan Directions set by the Department of Health.
121/16.4	With regard to suicide prevention, Dr Harper noted that suicide rates have reduced across the Trust areas, with the exception of Belfast, but that there is encouraging work going on. The Chair noted a recent report which suggested that females are more likely than males to use a telephone helpline, but Dr Harper noted that females are more likely to self-harm.
121/16.5	With regard to smoking, the Chair suggested that different

strategies were needed for males and females. Dr Harper agreed, and said that it was also worth considering different strategies for different ages and different communities. However, she advised that all campaigns are developed with focus groups in the first instance.

121/16.6 Ms Mann-Kler noted that some of the amber targets have highlighted workforce issues, and asked whether these would be resolved. Dr Harper said that it was unfortunate that some of the VES applications fell within certain areas of work so some work had to be either deferred or scaled back. Ms Mann-Kler also asked about the targets for C Diff and MRSA, but Dr Harper said that this would be picked up more fully in the next item.

121/16.7 Mr Coulter asked about the outworking of the Bamford Review as there had been some negative press about the state of mental health services. Dr Harper said that the joint work between HSCB and PHA is continuing and that there have been areas of improvement. She said that there is now a wider range of services available for areas such as personality disorders and eating disorders. She added that PHA is trying to work in an integrated way, but there are two key factors to be noted – the first of these is the general context of life in this time of austerity and the reduced scale of investment, and the second is the legacy of the Troubles in Northern Ireland.

121/16.8 The Chair sought clarity that the work of Bamford is still continuing. Dr Harper confirmed that the work is still ongoing. The Interim Chief Executive suggested that Mrs McAndrew could give a fuller update at a future meeting.

121/16.9 Mr Drew asked about the smoke-free initiatives in HSC settings. Dr Harper said that there remains some work to enforce this. Mr Coulter asked if there were any further developments with regard to a policy on e-cigarettes. Dr Harper reported that the most recent research has shown that the vapours are dangerous and can cause harm to the respiratory tract and that PHA's line would be for people to avail of stop smoking services.

121/16.10 Members noted the Performance Management Report.

122/16	**Item 10 – Briefing on new Healthcare Associated Infections / Anti-Microbial Resistance Improvement Board**
122/16.1	Dr Harper invited Dr Lorraine Doherty to provide a briefing for members on the new Healthcare Associated Infections (HCAIs) and Anti-Microbial Resistance (AMR) Improvement Board.
122/16.2	Dr Doherty outlined PHA's role with regard to HCAIs and how tackling AMR has now become a global priority. She said that a recent report by Lord Jim O'Neill said that by 2050, AMR could kill 10 million people a year, the equivalent of 1 person every 3 seconds. She said that a public awareness campaign was needed.
122/16.3	Dr Doherty gave members a definition of some of the key terms and outlined the terms of reference for the new Improvement Board. As background, Dr Doherty showed members trend data for both C Diff and MRSA in Northern Ireland from 2001 and explained that each year targets are set between PHA and Trusts.
122/16.4	Dr Doherty informed members that 18 November is European Antibiotics Awareness Day and she highlighted some of the activities that would be taking place. She said that there is a section of the PHA website, and gave members a link where people can make a pledge to become an antibiotic guardian.
122/16.5	Dr Doherty said that with regard to Northern Ireland, there are gaps in terms of the surveillance of antimicrobial resistance and usage, and gaps in antimicrobial stewardship activity and practice. She said that education was needed as well as a public and professional engagement approach.
122/16.6	In summary, Dr Doherty said that work in the areas of surveillance, diagnostics, communication and stewardship would form the focus of working groups for the Improvement Board and that there is a workshop scheduled for January 2017 to develop the improvement approach.
122/16.7	The Chair thanked Dr Doherty for her presentation. He asked whether Lord O'Neill's assessment of AMR being responsible for 1 death every 3 seconds was accurate. Dr Doherty said that this is a particular problem in the developing world, and this is one of

the reasons for the development of the Fleming Fund. She added that an analysis of data across Europe would show that the UK is only performing slightly better than Spain or Italy.

122/16.8 The Chair asked if there will be a strategy to change people's behaviours, attitudes and expectations. Dr Doherty said that there is work to help support medical professionals in handling the public's expectations.

122/16.9 Mr Coulter said that while progress has been made, some Trusts are struggling to sustain this. Dr Doherty explained that a patient may be administered antibiotics following an initial diagnosis, but that once test results are received, there is no way of stopping the antibiotics if they are not required. She said GPs need to be supported more at the initial diagnosis stage.

122/16.10 Ms Mann-Kler noted the presence of antibiotics in the food chain and asked what measures are being taken to reduce this. Mr Drew said that there is work being undertaken in the farming industry to reduce antibiotic use in animals. He noted that some restaurants are indicating that none of the food comes from animals that have been treated with antibiotics.

122/16.11 Members noted the update on Healthcare Associated Infections and the Antimicrobial Stewardship Improvement Board.

123/16 Item 11 – Outbreak of Serious Pneumococcal Disease in a Belfast Shipyard April-May 2015 (PHA/04/11/16)

123/16.1 Dr Doherty gave members an overview of the Report and said that it had been a challenging outbreak for PHA to deal with, given the multi-cultural workforce at Harland and Wolff. She advised that there had been 4 confirmed cases, but that there had been many challenges. She said that there had been tremendous co-operation from the shipyard and the workers' union, and that there were many lessons to be learnt.

123/16.2 Dr Doherty said that a specific recommendation had been made that all staff working in welding should receive the pneumococcal vaccine. The Chair noted that people over the age of 65 receive this vaccine. Dr Doherty noted that it is a younger workforce of people who are hard to reach.

123/16.3	Mrs Erskine thanked all member of the team for carrying out this work and preparing this report.
123/16.4	Members noted the report.
124/16	**Item 12 – Any Other Business**
124/16.1	There was no other business.
125/16	**Item 13 – Date and Time of Next Meeting**
	Date: Thursday 15 December 2016 Time: 1:30pm Venue: Conference Rooms 3+4 12/22 Linenhall Street Belfast BT2 8BS
	Signed by Chair:
	Date: 15 December 2016

HSC Public Health Agency

Public Health Agency

Finance Report

2016-17

Month 7 - October 2016

Public Health Agency
2016-17 Summary Position - October 2016

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	Non-Trust	Mgt & Admin	Total	Trust	Non-Trust	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Departmental Revenue Allocation	32,021	45,532	18,825	**96,378**	18,717	20,331	10,528	**49,577**
Revenue Income from Other Sources	-	13	384	**396**	-	13	204	**217**
Capital Grant Allocation & Income	6,822	5,556	-	**12,378**	3,979	1,224	-	**5,204**
Total Available Resources	38,843	51,101	19,209	**109,153**	22,697	21,569	10,733	**54,998**
Expenditure								
Trusts	38,843	-	-	**38,843**	22,697	-	-	**22,697**
Non-Trust Programme *	-	51,101	-	**51,101**	-	22,388	-	**22,388**
PHA Administration	-	-	19,209	**19,209**	-	-	10,634	**10,634**
Total Proposed Budgets	38,843	51,101	19,209	**109,153**	22,697	22,388	10,634	**55,719**
Surplus/(Deficit) - Revenue	-	-	-	-	-	(247)	99	**(148)**
Surplus/(Deficit) - Capital Grant	-	-	-	**-**	-	(572)	-	**(572)**

** Non-Trust Programme includes amounts which may transfer to Trusts later in the year*

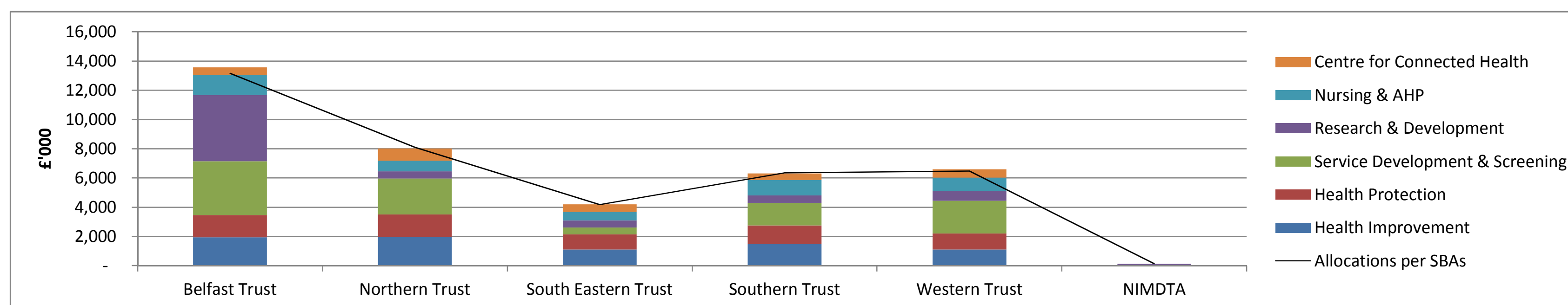
As advised in the opening Budget paper, revised Departmental guidance means the vast majority of PHA's Research & Development (R&D) expenditure will now be funded from a DoH capital budget (CRL), rather than a revenue budget (RRL) as was previously the case. Total CRL allocations received for R&D now total £11.4m, with additional receipts of £1.0m bringing the total to £12.4m. As a result of this change the majority of R&D programme will no longer form part of PHA's revenue breakeven requirement. However, total funds and expenditure will be shown within the Finance Reports in a combined manner, but the individual CRL and RRL breakeven targets will be monitored and highlighted separately.

The budget has reduced by £0.6m since September 2016 in relation to a retraction of EITP funds (£0.4m reprofiled to 2017-18) and a retraction of £0.25m related to natural slippage on programme budgets identified by PHA.

The year to date financial position for the PHA shows an overspend against profiled budget of approximately £0.7m. This position is significantly improved from month 6, where a large underspend against profile was reported, and is the a result of considerable effort in the current month to commit funds. However, it should be noted that more than half of the Non-Trust Programme expenditure remains to be incurred in the last five months of 2016-17. It is currently anticipated that the PHA will breakeven on its full year budget.

October 2016

Programme Expenditure with Trusts

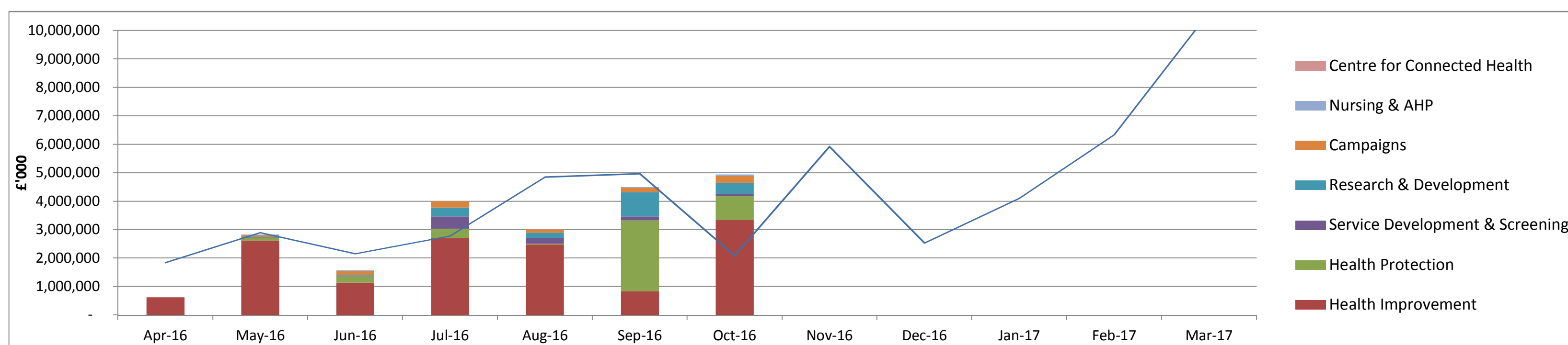


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,945	1,969	1,104	1,487	1,097	-	**7,602**	4,434	4,434	-
Health Protection	1,511	1,534	1,044	1,268	1,101	-	**6,457**	3,767	3,767	-
Service Development & Screening	3,679	2,454	465	1,536	2,252	-	**10,386**	6,059	6,059	-
Research & Development	4,546	489	477	517	660	132	**6,822**	3,979	3,979	-
Nursing & AHP	1,371	735	601	1,048	918	-	**4,674**	2,726	2,726	-
Centre for Connected Health	522	832	510	460	577	-	**2,902**	1,693	1,693	-
Total current RRLs	**13,574**	**8,014**	**4,202**	**6,316**	**6,605**	**132**	**38,843**	**22,658**	**22,658**	**-**
Opening Allocations	**12,876**	**6,816**	**3,498**	**5,798**	**5,993**	**25**	**35,006**			

The above table shows the current Trust allocations split by budget area. These amounts are primarily Revenue Resource Limits (RRL) but also include the Capital Resource Limit (CRL) for Research and Development.

During the current month, an exercise to re-align budgets between Trust and Non-Trust has been carried out, and profiles have been amended accordingly. This explains the year to date breakeven position. A breakeven position is also anticipated for the full year.

Non-Trust Programme Expenditure



	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Projected Expenditure																
Health Improvement	1,246	2,368	1,389	1,582	2,674	1,658	834	3,675	832	2,724	3,329	2,314	**24,624**	11,751	12,625	(874)
Lifeline	225	225	225	225	225	225	225	225	225	225	225	225	**2,700**	1,575	1,118	458
Health Protection	27	29	25	275	611	2,493	1,259	648	648	653	1,002	1,475	**9,143**	4,718	4,789	(72)
Service Development & Screening	217	148	392	157	102	375	(23)	113	375	127	114	425	**2,520**	1,367	1,119	248
Research & Development (CRL)	8	8	8	372	1,002	21	(193)	948	132	8	1,147	5,236	**8,695**	1,224	1,797	(572)
Campaigns	115	115	115	115	187	165	1	242	242	242	242	292	**2,076**	815	940	(124)
Nursing & AHP	4	4	4	49	49	11	(64)	18	23	76	79	205	**458**	57	129	(72)
Safeguarding Board	-	-	-	-	-	12	-	-	-	-	-	12	**24**	12	-	12
Centre for Connected Health	-	-	-	-	-	-	-	-	-	-	157	50	**207**	-	-	-
Other	-	-	-	-	-	-	50	50	50	50	50	403	**653**	50.00	(127)	177
Total Projected Non-Trust Expenditure	**1,842**	**2,897**	**2,157**	**2,775**	**4,850**	**4,959**	**2,088**	**5,918**	**2,527**	**4,104**	**6,347**	**10,637**	**51,101**	**21,569**	**22,388**	**(820)**
Actual Expenditure	**620**	**2,914**	**1,663**	**4,127**	**3,040**	**4,795**	**5,229**	**-**	**-**	**-**	**-**	**-**	**22,388**			
Variance	**1,222**	**(18)**	**494**	**(1,351)**	**1,810**	**165**	**(3,140)**	**-**	**-**	**-**	**-**	**-**	**(820)**			

The Non-Trust Programme budgets show the opening budgets plus additional allocations received subsequently. The total Non-Trust budget for the year has decreased by £1.0m during the month due to £0.3m being issued to Trusts (page 2), £0.4m of EITP funding being re-profiled to 2017-18, and a £0.250m retraction from DoH relating to natural slippage on budgets.

Expenditure is £0.8m ahead of profile for the year to date as a result of a high level of expenditure in month 7. It should be noted that 56% of the budget remains to be spent by year end. This has been examined during the recent mid-year budget review which included all budget managers and was chaired by the Chief Executive, and the PHA is still projecting a breakeven position for the full year.

October 2016

PHA Administration

2016-17 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	2,747	3,354	9,215	452	316	507	**16,591**
Goods & Services	97	1,316	388	482	49	287	**2,618**
Total Budget	**2,844**	**4,669**	**9,603**	**934**	**365**	**794**	**19,209**
Budget profiled to date							
Salaries	1,582	1,955	5,361	246	184	255	**9,583**
Goods & Services	56	771	196	18	29	80	**1,149**
Total	**1,638**	**2,726**	**5,557**	**264**	**213**	**335**	**10,733**
Actual expenditure to date							
Salaries	1,634	1,915	5,449	146	186	255	**9,584**
Goods & Services	72	734	175	(20)	8	80	**1,050**
Total	**1,706**	**2,649**	**5,624**	**126**	**194**	**335**	**10,634**
Surplus/(Deficit) to date							
Salaries	(52)	40	(87)	100	(2)	(0)	**(1)**
Goods & Services	(16)	37	21	38	20	0	**99**
Surplus/(Deficit)	**(68)**	**77**	**(66)**	**138**	**18**	**(0)**	**99**

The total PHA funding allocation from the DoH in 2016-17 has been reduced by 10%, which equates to £1.6m. Although this reduction has initially been set against Commissioning funds by the DoH as an interim measure, the PHA Investment Plan requires the Administration budgets to deliver a contribution towards this reduction to enable PHA to achieve breakeven in-year.

The Administration savings target is based on anticipated savings as a result of restructuring following the VES 2015-16 process, the implementation of which is estimated to generate a net £0.4m after funded other pressures and priorities. Salaries budgets have been updated in line with these plans.

The year-to-date salaries budgets of both Nursing and Public Health are under some pressure. This is due to a number of issues including incremental drift and in-year costs of 2015-16 VES posts. The position is expected to improve as the year progresses, and all Directorate surpluses and deficits are being closely reviewed to enable the overall PHA Administration budget to breakeven in 2016-17. The surplus shown under PHA Board relates to slippage on investments relating to Making Life Better for which implementation has been slower than anticipated in the Investment Plan.

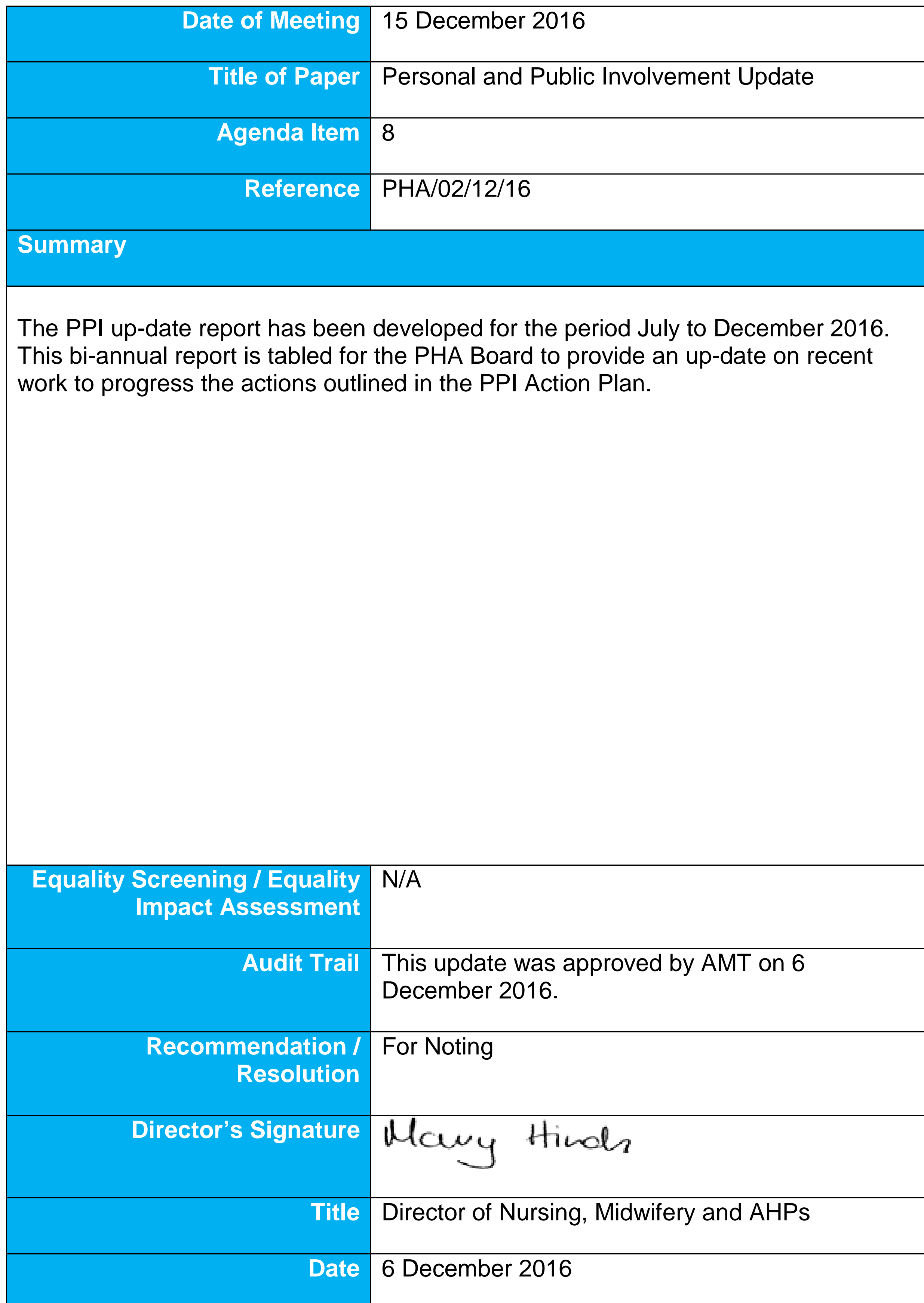
PHA Prompt Payment

Prompt Payment Statistics

	October 2016 Value	October 2016 Volume	Cumulative position as at 30 October 2016 Value	Cumulative position as at 30 October 2016 Volume
Total bills paid (relating to Prompt Payment target)	£5,279,354	454	£27,582,919	3,049
Total bills paid on time (within 30 days or under other agreed terms)	£5,261,373	426	£26,441,579	2,859
Percentage of bills paid on time	**99.7%**	**93.8%**	**95.9%**	**93.8%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95%, although on volume performance is slightly below target. This is mainly as a result of poor performance in August and September resulting in only 90.2% of invoices by volume being paid within 30 days or terms in these two months. A marked improvement in performance can be seen in the current month.

The 10 day prompt payment performance remained strong at 84% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2016-17 of 60%.



HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 December 2016
Title of Paper	Personal and Public Involvement Update
Agenda Item	8
Reference	PHA/02/12/16

Summary

The PPI up-date report has been developed for the period July to December 2016. This bi-annual report is tabled for the PHA Board to provide an up-date on recent work to progress the actions outlined in the PPI Action Plan.

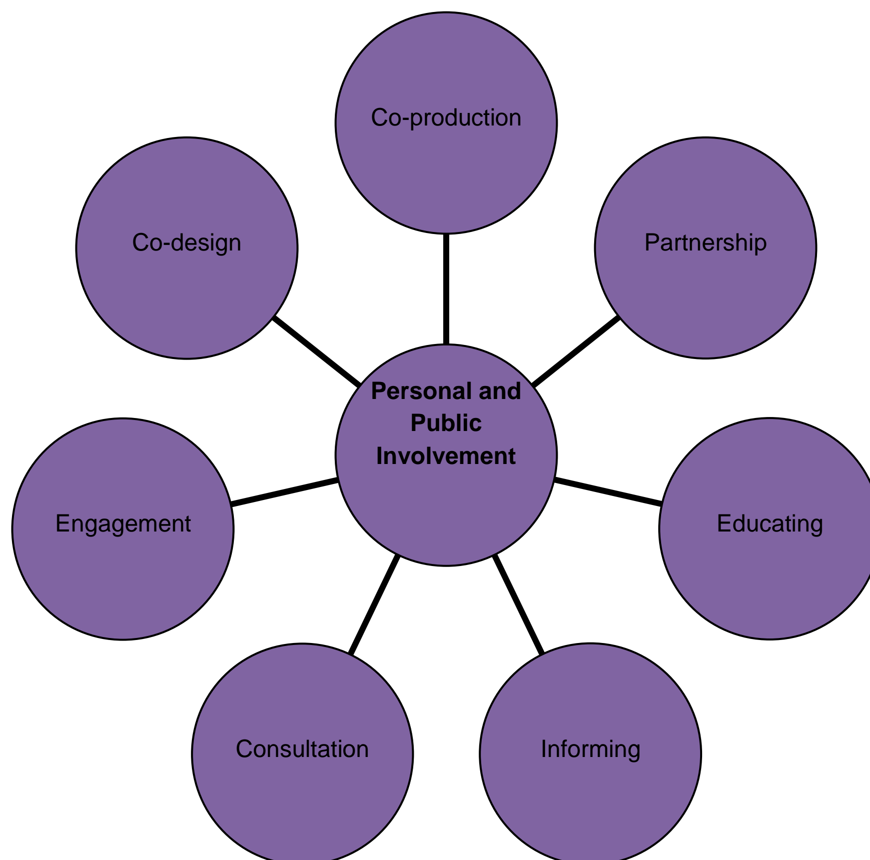
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This update was approved by AMT on 6 December 2016.
Recommendation / Resolution	For Noting
Director's Signature	Mary Hinds
Title	Director of Nursing, Midwifery and AHPs
Date	6 December 2016

HSC Public Health Agency

DRAFT

Personal and Public Involvement (PPI)

PHA Board Update December 2016



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

Personal and Public Involvement – What is it?

PPI is the active and effective involvement of services users, carers and the public in health and social care services. Involvement can range from one to one clinical or social care interactions with service users and carers, in regard to their own health, through to larger engagements to assess needs, partnership working to co-design services and influence commissioning priorities and policy development. Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement.

The rationale for PPI – Why do it?

People have a right to be involved in and consulted with on decisions that affect their health and social care. Meaningful Involvement helps to:

- effectively identify need;
- increase efficiency through tailoring services and agreeing priorities;
- improve quality, safety and patient experience;
- reduce complaints and SAIs;
- encourage self-responsibility for health and social well-being.

The PHA's role

In the 2012 PPI Policy Circular, the DHSSPS confirmed and assigned to the PHA, primary responsibility for the leadership of the implementation of this key policy area across the HSC system. It requires the PHA to provide the Department of Health with assurances that HSC bodies and in particular Trusts, meet their PPI Statutory and policy responsibilities. Additional responsibilities confirmed/assigned also included:

- ensuring consistency and co-ordination in approach to PPI;
- the identification and sharing of best PPI practice across HSC;
- communication and awareness raising about PPI;
- capacity building and training;
- development of the Engage website;
- monitoring of and reporting on PPI.

Progressing PPI

It is worthwhile briefly reflecting on the progress that we have achieved in PPI working collectively through the Regional HSC PPI Forum. Together we have designed and delivered:

1. Standards for Involvement – The first set of involvement standards for the HSC which provide a cornerstone for much of our work.
2. Engage & Involve – A comprehensive PPI training programme for HSC involving e-learning, coaching, team briefing and taught modules.
3. Monitoring Mechanisms and Systems - A system to record, monitor and assess progress in PPI across the HSC has been co-designed and implemented with service users and carers.
4. PPI Conference - A large conference of over 200 people attracting HSC staff, service users and carers, highlighting best practice in Involvement and related concepts such as co-production, was delivered in June 2016.

2016 continues to be a very productive and busy period. Key points to note:

- **Research**
  The PHA working in conjunction with the Patient and Client Council (PCC) commissioned research to examine Personal and Pubic Involvement (PPI) across Health and Social Care and to make recommendations on ways to advance it. The funding was awarded via the HSC Research & Development Division. The final report has just been submitted to the PHA.

- **Action Plan**
  The PPI Action Plan 2016-19 has been developed utilising many of the recommendations from the Research Report. It is now undergoing a period of consultation.

- **Engage Website**
  The PHA has embarked on re-establishing the Engage website resource. Working through a Project Team, comprising HSC colleagues and service users and carers, the website will be a repository for information, research, good practice, case studies, guides etc. A draft website will be in place for early 2017 and a series of User Acceptance Testing will be undertaken before the website goes live.

- **Training**
  The PHA continues to provide PPI training input through a number of courses and programmes. Social Media Training for Regional HSC PPI Forum members was organised by the PHA. The Consultation Institute hosted this session and working through the Communications sub-group, HSC organisations will begin a programme of work to maximise the use of social media for PPI through an agreed Communications Plan.

- **Informing and Influencing Policy**
  The PHA was instrumental in facilitating a meeting of service users and carers with the HSC Expert Panel in May. The Expert Panel's report, 'Systems, Not Structures: Changing Health and Social Care', clearly sets out the need for change. Alongside this report, the Minister also launched 'Health and Wellbeing 2026: Delivering Together' which sets out a 10-year vision, to transform the current health and social care system. These reports are significant for PPI and positively reinforce the need for partnership working with patients, service users and families. Key points to note for PPI:

  - *'Systems, Not Structures: Changing Health and Social Care'*, calls for a fundamental reshaping of HSC service delivery to put in place a new model of care designed to meet the needs and challenges of today. The recognition of 'co-production' as a way of working to break down barriers between professionals and the people they service to recognise people who use services as assets with unique skills.

  - *'Health and Wellbeing 2026: Delivering Together',* identifies partnership working with patients, service users, families, staff and politicians to produce lasting change which benefits all. Co-production has been identified to empower patients, service users and staff to design the system, develop and expand specific pathways of care and HSC services and be partners in the care they receive. The Minister has committed to the principles of co-production and co-design

- **Leadership and Innovation**
  The PHA has provided a range of advice and guidance on involvement across the HSC system in major developments such as Unscheduled Care, Early Intervention Transformation Programme, the Electronic Health and Care Record project among others.

  The PHA will work with a range of partners to deliver a co-production masterclass in the spring of 2017 examining its role in the wider context of Involvement in the HSC.

  A small grants programme has also been operated to encourage innovative and creative approaches to meaningful involvement to be tested across the HSC.

The August 2016 up-date report outlined what we needed to do to progress work against the PPI standards. The following table outlines in a little more detail our areas of work and what we have achieved undertaken against the PPI Standards during August – December 2016.

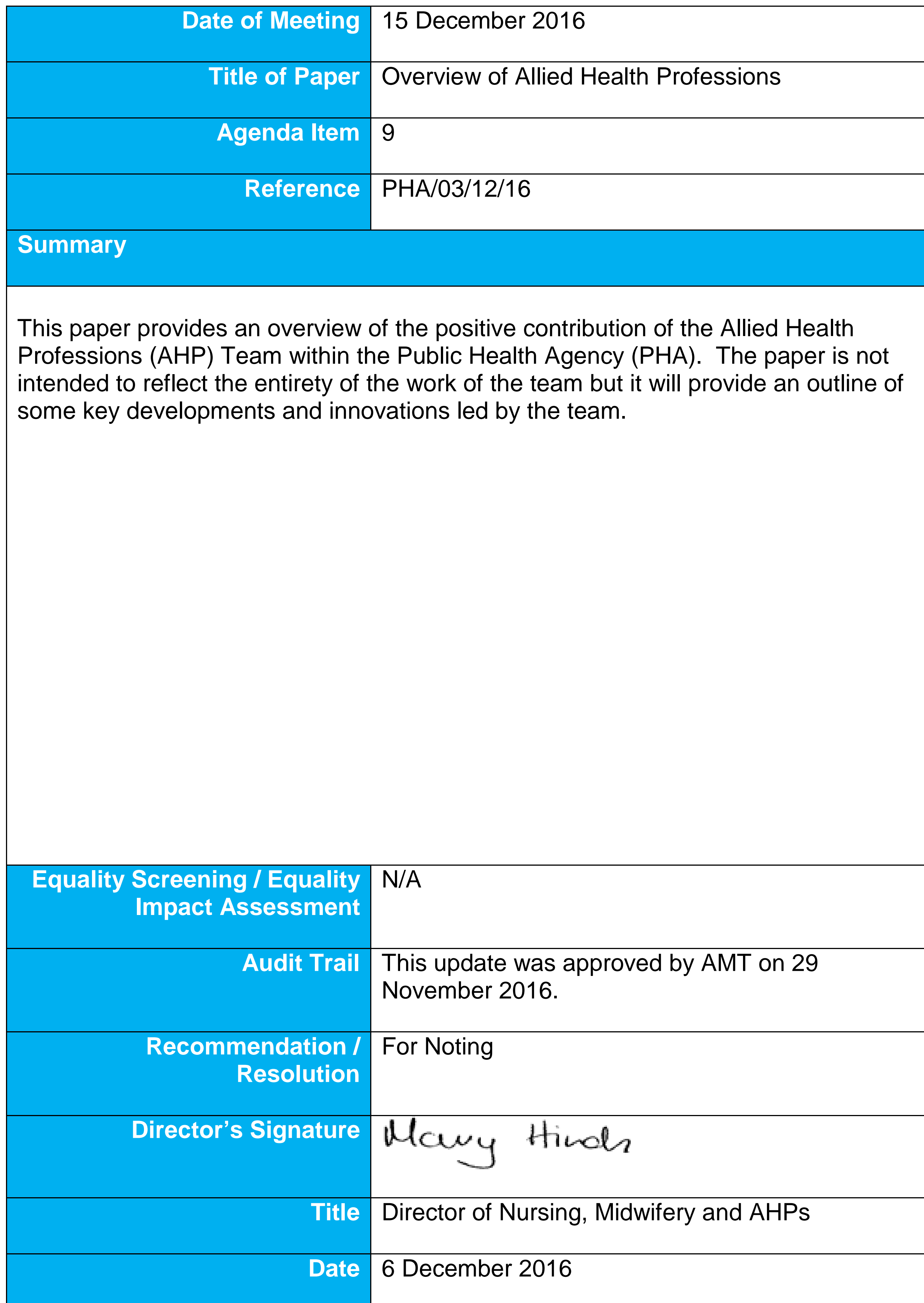
Standard	What have we achieved?
1. Leadership	**PPI Standards** The PHA continues to raise awareness and embed the PPI Standards into the culture and practice of HSC. **Advice and guidance** The PHA PPI Team provides professional leadership advice, guidance and support within the PHA and across the HSC system on PPI. During this period, the team has: • Worked with service users and carers to co-design an involvement structure for the Unscheduled Care programme of work which has been agreed by the Programme Team. This has involved shaping the format for involvement and co-designing the recruitment pack. • Supported the development of an Engagement Plan for the PHA Corporate Strategy. This involves engaging service users to co-design the engagement plan and support will also be provided to implement the plan in early 2017. • EHCR/ Medicines Management **Regional HSC PPI Forum** The PHA in its strategic leadership role, continues to Chair and facilitate the work of the Regional HSC PPI Forum: • In September, the PHA hosted the Strategic meeting of the Regional HSC PPI Forum which brings together the accountable Directors. • In November, the PHA hosted the quarterly Regional HSC PPI Forum. A key focus of the

Standard	What have we achieved?
	meeting was in relation to the recent Bengoa report and the Minister's vision for future Health and Social Care.
2. Governance	**Strategies and plans** • The Corporate Plan has committed to PPI as a key approach to how the PHA does its business and this is reflected in our Annual Business Plan. • The PPI Action Plan 2016-19 is undergoing a period of consultation. This includes internal and external areas of responsibility. The responses are currently being analysed to inform and shape the up-dated Action Plan. • The PHA has led the review and up-date of the HSC wide Consultation Scheme template. The template is currently being reviewed by the DoH. **Reporting** • The PPI Annual Report is being developed in conjunction with the Communications sub-group and a draft will be available in December 2016/January 2017.
3. Opportunities and support for involvement	**Opportunities for involvement** • A PPI small grant programme has been made available to HSC organisations to progress an identified PPI project. This allows for the testing of new and innovative approaches to PPI through the work of the HSC organisations. • The Engage website is currently being re-developed in conjunction with a Project Team. Working closely with a group of service users and carers, a specific section entitled 'get

Standard	What have we achieved?
	involved' will be developed to highlight how to get involved and what opportunities are available across HSC. The PHA is currently working with HSC Trusts to develop an agreed protocol for the sharing of information between individual websites. No recurrent funding is currently available to continue to up-date and develop this resource ono an on-going basis. • The PHA hosted social media training to enhance this method of communication for promoting involvement in HSC. A social media strand will be incorporated into the PPI communications plan. We continue to utilise #involvementstory and tweeted for the recent NHS Pledge Day #fabnhs2016 **Research** The PPI research, commissioned by the PHA and Patient and Client Council and funded by HSC Research & Development, has been completed. This work was undertaken by a research team led by QUB and includes a set of recommendations to help overcome the barriers to involvement. The research was also subject to a QUB independent audit and was commended as a model of good practice, which is an assuring layer of quality in regard to this research. We will continue to work with the research team to launch the report in 2017 and also contribute to the development of a UK wide NIHR bid for PPI.
4. Knowledge and Skills	**Awareness raising training** • 'Engage & Involve', the generic regional PPI training programme for HSC was developed and launched by PHA in February. All HSC Trusts have been asked to develop a PPI Training action plan which the PHA will support by way of providing access to materials and delivering training in specific areas such as team briefing etc. • The PHA will up-date the e-learning training to provide a resource for service users and

Standard	What have we achieved?
	carers. This will be based on the existing e-learning and will be co-designed with service users and carers. • From an internal perspective, the PHA has commenced the development of a PPI training action plan. This will ensure that training is rolled out across the divisions and a baseline will be established to identify training needs and action plan will be developed based on this. • Up-take for the PPI e-learning training remains low and an awareness raising programme has been developed to support the PHA and other HSC organisations to maximise uptake. **Engage web resource** • The development of the 'Engage' web resource has commenced. This has been undertaken with a range of stakeholders and service users/carers. The website structure is now in place and the content is being developed. This includes a section for training for staff and training for service users and carers • The PHA is currently working with HSC Trusts to put in place an agreement for minimum PPI content on Trust websites and input into the Engage content. • There remains a challenge to identify recurrent funding to further develop this resource beyond its completion and to undertake the outreach and development programme initially envisaged to accompany it.
5. Measuring Outcomes	**Monitoring arrangements** The PHA has completed the PPI monitoring reports for the HSC Trusts and formally submitted to the DoH as part of the accountability arrangements. The DoH has agreed to raise PPI as a significant issue and has written to all Chief Executives to request an up-date on how the recommendations raised by the PHA are being progressed. The PHA will commence a

Standard	What have we achieved?
	programme of work to review the monitoring process and develop a more outcomes based framework. In relation to internal PPI monitoring processes, working through the PPI Leads Group, the monitoring form has been redesigned to ensure that effective and efficient monitoring mechanisms are in place to record and capture evidence of PPI in practices.



Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 December 2016
Title of Paper	Overview of Allied Health Professions
Agenda Item	9
Reference	PHA/03/12/16

Summary

This paper provides an overview of the positive contribution of the Allied Health Professions (AHP) Team within the Public Health Agency (PHA). The paper is not intended to reflect the entirety of the work of the team but it will provide an outline of some key developments and innovations led by the team.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This update was approved by AMT on 29 November 2016.
Recommendation / Resolution	For Noting
Director's Signature	Mary Hinds
Title	Director of Nursing, Midwifery and AHPs
Date	6 December 2016

HSC Public Health Agency

Introduction

This paper provides an overview of the positive contribution of the Allied Health Professions (AHP) Team within the Public Health Agency (PHA). The paper is not intended to reflect the entirety of the work of the team but it will provide an outline of some key developments and innovations led by the team.

AHPs are a vital part of enabling the new vision described by the Minister of Health in '*Health and Wellbeing 2026: Delivering together*'. They offer a very different perspective to the planning and delivery of services and are well placed to apply their expertise in rehabilitation, enablement and leadership across health and social care as well as driving integrated approaches through robust partnership and collaborative working with other agencies such as the judicial system, housing and education.

Key Facts

The AHPs are a group of twelve professions

Dietitians	Drama Therapists
Music Therapists	Occupational Therapists
Orthoptists	Orthotists
Physiotherapists	Podiatrists
Prosthetists	Radiographers – Diagnostic &Therapeutic
Speech & Language Therapists	Art therapists

- Seven of the professional groupings are employed within Health and Social Care (HSC) in Northern Ireland with approximately 4830 professional and support staff (4095 wte) working across acute, community, education and judicial environments, primary care and in people's own homes.

- AHPs are regulated by the Health and Care Professions Council (HCPC) and are required to renew their registration on a bi-annual basis. They are autonomous practitioners and assess, diagnose, treat and discharge

independently. This autonomy is further enhanced with the ability of a range of the professions to prescribe independently or on a supplementary basis.

- An additional six AHP professions (Art Therapists, Drama Therapists, Music Therapists, Orthotists and Prosthetists) deliver support and interventions through external contracting arrangements with HSC organisations.

- Six of the AHP elective services (Dietetics, Occupational Therapy, Orthoptics, Physiotherapy, Podiatry, and Speech and Language Therapy) are monitored against the DOH 13 week access target. This work accounts for approximately 60% of the staffing resource equating to over 273,000 new patients in 2015/2016 period. This elective activity does not include work carried out in the unscheduled care pathway, Consultant Led service models or AHP work delivered through multi-disciplinary teams.

- There are approximately 230 AHPs trained in Northern Ireland every year across 7 professions

The PHA AHP team

The PHA AHP team is small comprising of an Assistant Director for AHPs and PPI and 4 permanent and one temporary AHP Consultants and benefits from having members from the following professional backgrounds, Occupational Therapy, Dietetics, Podiatry, and Radiography.

The core function of the team is the provision of professional advice and support with a value base of partnership, engagement with patients and families, person centredness, early intervention and high quality services.

This is delivered through a range of mechanisms, including:

- Delivery of PHA objectives across the life course. The team has been working to ensure that AHP approaches and service delivery models are refined to incorporate population health and wellbeing, early intervention and prevention approaches and reducing health inequalities.

- Support and advice to the HSCB including contributions to Local commissioning Groups, regional and other specialist services, performance management and service improvement and early years interventions. In addition team members work in partnership with HSCB colleagues leading strategic initiatives such as the Regional Palliative Care Programme- *Palliative Care in Partnership*
- The implementation of the AHP Strategy and RQIA AHP Governance review recommendations.
- Lead responsibility for Muscular Dystrophy and Neuro-muscular Disorders across the N Ireland and chair the N Ireland Lymphodema Network.
- Personal and Public Involvement - engaging and involving. The AD for AHPs and PPI is charged with the responsibility of driving forward the PPI agenda across HSC in Northern Ireland. The focus has been to try to push the boundaries of PPI within work remits, initiatives and service developments and to instil the widespread PPI ethos at undergraduate and professional levels across a range of organisations

The team has strong networks particularly with the voluntary sector, education department, and third level education providers along with regional and national professional networks. The AHP team fosters and leads a number of professional regional networks to ensure that the views, experiences and expertise of professional front line staff and service users and carers is valued and incorporated

Impact of AHPs across the Life Course

Whilst there has been a lot of emphasis on how efficient AHP services are at managing waiting list demands the professions have been making significant contributions along the key stages of the life cycle and this work is underpinned by a strong commitment to continuous improvement.

Early Years

Evidence demonstrates that effective intervention and support in child development brings significant benefits throughout childhood and into adult life in a range of areas such as health and well-being, educational attainment and economic status. In addition widespread evidence suggests that lack of stimulation and a poor

environment can hinder healthy brain development. To help support this the team has had a focus on supporting parents with key child development understanding and skills to help them provide a stimulating and caring environment to optimise child development.

Early Intervention Transformation Programme (EITP).

A project to develop a series of AHP key health promotion messages has been developed as part of the Early Intervention Transformation Programme (EITP). This work has involved the completion of a robust engagement and involvement process with service users and parents. The key messages aim to enhance children's health and development by encouraging more active family engagement and involvement in areas commonly seen in children referred for AHP support including: inactivity, obesity, delayed independence, motor, speech and language deficit and over reliance in technology for play ' Let's move explore laugh and play to keep us fit in every way'. The work is supplemented through the provision of health promotion materials to GPs and a wide range of early years settings.

Neonatal Network

The evidence indicates that the provision of occupational therapy, physiotherapy, speech and language therapy and dietetics in the neonatal environment improves the nutritional, respiratory, neuro-developmental, communication and sensory outcomes of children born prematurely.

Funding has been secured to appoint AHP staff in neonatal wards and to assist in driving innovation in this area through an established AHP Neonatal Network. As a result an integrated service model has been developed and AHP services will be delivered through the appointment of Dietetics, Occupational Therapy, Physiotherapy and Speech and Language Therapy staff located in all neonatal units. Their key function will be to provide advice, support and specialist interventions to the children, working closely with other members of the multi-disciplinary team alongside community and voluntary sector colleagues. This model of intervention will assist in timely and safe discharge of the child from the hospital setting and a seamless pathway of care will be delivered which includes post-discharge support and review. Ultimately this work will significantly contribute to the more timely and appropriate interventions and discharge of the child from hospital settings.

Speech and Language Therapy in Sure Start

A regional review of Speech and Language Therapy support in Sure Start to assist in standardising service provision and models of support has been completed in partnership with HSCB Social Care colleagues.

The Sure Start Programme focuses on both the needs of children and parents/families who live in the top 25% most socially deprived areas. There is strong evidence on how a child's very early experiences influence the future development of their speech, language and communication skills which impacts on their level of socialisation, establishment of peer relationships, educational attainment, employment, and general health and well-being. Language and communication play an integral link in all services offered in Sure Start settings with a focus of ensuring that all children registered in the projects receive the necessary help and support they require to develop and thrive.

As part of the regional Speech and Language Therapy review the team has worked with Trust colleagues to develop a regional speech, language and communication intervention model which will ensure equitable access to appropriate levels of specialist support to improve outcomes and work to “close the gap” for those children from socially deprived areas across the region.

A newly created post of Regional Sure Start Speech and Language Therapy Co-ordinator will drive further innovation in this area and ensure enhanced outcomes are monitored and achieved.

Review of AHP support for children with statements of Special Educational Needs (SEN)

There are approximately 15,940 children and young people identified as having a statement of special educational needs in Northern Ireland which equates to approximately 4.7% of the school population. There are also in the region of 11,072 pupils with statements of special educational needs in mainstream schools and 4,794 in special schools.

The PHA led a review of Allied Health Professions (AHP) support for children/young people with statements of SEN to establish if the current resource was being used in

the most effective and efficient way. This was in response to a number of complaints from school principals, families and MLAs.

The purpose of the review was to address the issue of how AHPs can best meet the assessed AHP needs of children with statements of SEN. This was a child and family centred review, evidencing effective PPI engagement, focusing on services meeting the assessed AHP needs of children in order to maximise their health and educational outcomes.

The views of the children were central to the review which presented a challenge give the complex communication and cognitive impairments present for many of the children. A key partnership was developed between the team and Barnardo's Disabled Children and Young Peoples Project. This partnership helped maximise the opportunities to engage with the children enrolled in special schools. In addition, the Cedar Foundation assisted with the engagement of children/young people with a statement of SEN attending mainstream schools. This approach challenged the traditional approach where engagement with this group of children and young people which was often achieved through parents, carers and teachers.

Engagement with parents/carers, health and education staff was also critical to inform decisions about the way forward and 38 special schools were visited across Northern Ireland.

The 5 key themes, identified through engagement and information gathering have been integral to the proposed regional framework and are Working Together; Informed, skilled workforce; Timeliness; Therapy environment and equipment and Best Use of Resource.

The implementation of this framework will improve the quality of the AHP service to children with statements of SEN, ensuring their needs are met in the most effective and efficient way and by the right person.

Children and Young People's Neuro-disability Service

A service model was developed in Northern Ireland to address the complex needs of children and young people with a range of neurological conditions which result in excessive spasticity in both upper and lower limbs. The level of spasticity associated with conditions such as cerebral palsy causes children excessive pain, reduced

function and poses difficulties for their parents and carers attending to their hygiene and personal care needs. To help address these issues it was essential that the right professional input was available in order to give these children the best chance in life.

The team have worked with medical and other colleagues in developing and instilling a robust tertiary neuro-disability model supported by local interventions to address a range of complex neuro-disability needs in children and young people. The staff supporting this multidisciplinary model includes specialist medical, Occupational Therapy and Physiotherapy staff. This model has achieved significant outcomes for children including enhancing their independence, reducing deformity and pain and easing their overall management.

This effective model of multidisciplinary working has been widely acknowledged at regional and national levels. The team has just been awarded the 2017 Health Service Journal (HSJ) award for 'the Most Effective Adoption and Diffusion of Best Practice' which was presented last week in London. This work demonstrates the impact of effective multi-disciplinary working and the positive outcomes AHPs can make in advanced roles such as the Physiotherapy injector role developed in this service model.

Adult Years

Breast screening

Breast cancer is the most common type of cancer among women in Northern Ireland and it is also one of the most treatable, particularly when detected early. Around 1,200 women are diagnosed with breast cancer in Northern Ireland each year.

If breast cancer is diagnosed at the earliest stage of its development, it is estimated that after five years 99 out of 100 women diagnosed will still be alive. With advances in treatment and care over recent years, there is a lot that can be done to tackle breast cancer when it appears, but early detection is extremely important.

The AHP team has been working with Trusts to further develop skill mix in the radiography mammography workforce both at assistant practitioner level and

advanced practise. The focus is on ensuring an adaptable workforce that can contribute to responsive and timely breast screening across Northern Ireland.

As a result, there has been regional agreement on the development of a new role of a Consultant Radiographer in Breast Imaging. A commissioning specification is being developed for this post as part of a 5 year plan. The aim is to have a minimum of three Consultant Radiographers within a year and to have ten within 5 years.

This role of Consultant Radiographer will ensure that patients receive high quality, safe and seamless breast imaging services, whilst delivering value for money. The Consultant Radiographer will be able to work autonomously and closely with the Consultant Radiologists, rotating with them to provide Breast Imaging Services. They will provide an exceptionally high level of expertise in the specialist clinical field of breast cancer diagnosis in a screening and symptomatic environment and will use highly advanced clinical skills, including the provision of independent clinical opinion for patient centred care.

Neurology Care Advisors

In 2012 The AHP Team undertook an ambitious and innovative engagement programme with people with Neurological conditions in N. Ireland. This is a complex group with many different and wide ranging conditions e.g. Muscular Dystrophy, Multiple Sclerosis, Parkinsons, Huntingtons and Supra Nuclear Palsy. This engagement exercise was innovative as it did not seek views on services rather on personal experiences of living with a neurological condition. The engagement was about life and therefore not restricted by e.g. health, transport and education boundaries.

One of the recommendations that emerged from the engagement exercise was that services users and carers and families wanted emotional support, (not necessarily formalised counselling programmes), effective signposting and high quality, timely information.

As a result of this work a joint project with the Belfast Trust and voluntary organisations has resulted In the development of a Neurological Conditions Care Advisor service across Northern Ireland. This is the first of its kind for this population. The newly formed team has become a single point of contact to help guide people

with neurological conditions through the range of services and for signposting and providing information about charities and voluntary services e.g. contacts for support groups and associations; links for hobbies, sports and leisure activities in Northern Ireland Information on carer support; available benefits / supports; answers to access and mobility questions.

This engagement has resulted in a very different solution to a historic problem for this population.

Diabetic foot care pathway

Diabetes and diabetic foot disease is an increasingly urgent health issue with approximately 15% of people with diabetes in the UK likely to develop a diabetic foot ulcer (DFU) during their lifetime. People with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes and are 23 times higher risk of amputation than of a person without diabetes, with evidence that a large proportion of these could have been avoided.

To help develop a responsive diabetic foot care pathway a multi-professional group comprising of lead clinical and commissioning staff from Trusts, HSCB and PHA including medical, nursing and AHP specialist staff was set up to review the delivery of diabetic foot services in NI. This group cross referenced current models available and their outcomes against NICE NG19 (2015) specific diabetic foot care guidance. The AHP team worked closely with HSCB, PHA and other key stakeholders in the development of a robust Diabetic foot model aimed at assisting early intervention and prevention, and specialist support for clients with more significant Diabetic Foot Ulcers.

This model comprises of 3 seamless levels of support with a Podiatry Lead Foot Protection Team and Podiatry Enhanced Foot Protection Team working alongside a specialist Podiatry embedded Multi-disciplinary Foot Team. This model is aimed at providing a holistic model of support operating across primary care, community and acute hospital services which would provide equity of access and a client centred approach, and has been supported through ministerial funding released in early 2016.

This model recognises and fully utilises the roles and expertise of Podiatry professions but also challenges them to ensure that their practice is cutting edge. The Podiatrists have designed, tested and are implementing a risk stratification tool which will provide an ongoing, reportable baseline of client need on a regular basis. This tool has been designed for any Podiatry patient presenting with risk of ulceration and amputation e.g. vascular, rheumatoid and neurological.

Development of a Podiatric Surgery service in Northern Ireland

Originally approved in the HSCB/PHA Commissioning Plans for 2012-13 and 2013-14, the intention is, once established, all Trusts will utilise a podiatric service for foot and ankle surgery.

In partnership with HSCB colleagues, the team has taken lead in the development of a commissioning specification for a new model of surgical intervention for foot deformities which utilises the skills of advanced practice podiatrists. This would be a new service model for Northern Ireland, similar to services delivered across the UK for over 30 years. (In the UK there are over 40 NHS Podiatric Surgery units led by Consultant Podiatric Surgeons.) The service would work as part of a wider integrated musculoskeletal team, for example, be part of an existing Integrated Clinical Assessment and Treatment Service (ICATS). The development has the potential to provide a significant contribution to reducing the demand capacity gap in orthopaedics at an improved value for money rate.

AHP 7 day working ED

The background to AHP 7 day working is within the DoH Unscheduled Care Task Group Work streams (2014). One of the 7 key work priorities identified at that time focused on patient flow in ED at the 5 large acute sites. The PHA team led the AHP element of this through Regional Unscheduled structures engaging with Local Commissioning Groups and Trusts across the region resulting in:

- Establishing physiotherapy input to maximise "see treat and discharge" within a dedicated minor injury stream in Emergency Departments. This complements the role of the Emergency Nurse Practitioner. A Physiotherapist is now in place to see treat and discharge in the minor injury streams in each of the ED units of the 5 large acute hospitals, i.e. Craigavon, Royal Victoria Hospital, Altnagelvin, Antrim and the Ulster hospital.

• Embedding Physiotherapy, Occupational Therapy, Pharmacy and Social Work support within EDs and Short Stay Wards. Both Physiotherapy and Occupational Therapy are embedded as part of a multidisciplinary team in the Emergency Departments of the 5 large acute hospitals. The posts have been appointed for all Trusts and are now in place in 4 of the 5 Trusts. These posts will be in place shortly in all five Trusts.

Under the new regional Unscheduled Care structures in Northern Ireland, AHPs are represented on the regional programme team and are working collaboratively with colleagues across Health and Social Care through the workstreams. One of the current workstreams is the discharge workstream. Discharge to Assess principles have been described by NHS England, learning from models across the UK. The key findings of this will be brought to the Northern Ireland Discharge Group with the intention of informing Discharge to Assess in Northern Ireland.

Direct Access Physiotherapy

The HSCB, in the 2015/2016 Commissioning Plan committed to the "Implementation of a Direct Access Physiotherapy pilot within South Eastern Trust, to commence May 2015 for a period of 9 months"

The aim of the project was to work in partnership to test the most efficient, least disruptive (particularly in terms of impact on waiting times) model to implement a Direct Access approach. Direct Access provides service users with the opportunity to self-refer to Physiotherapy service without seeing a GP first.

The AHP team has led the pilot to implement Direct Access and has secured very significant outcomes e.g.

- Improved patient compliance for direct access is demonstrated by a reduction in DNA and CNA rates for new patients. The reduction in DNA rate demonstrated in the project results in a reduction in lost capacity.

- Patient stories support the hypothesis of improved patient satisfaction and empowerment to self-manage. Stories were gathered through 10,000 Voices project and the trends are consistent.

- EQ5D1 data demonstrates a higher percentage of Patient Reported Outcomes for self-referred patients.

- Circa 40% referrals now coming from self referral cohort.

- A minimum of 686.75 GP hours were saved and an estimated cost saving £98,892 was made during the period of the project (Data from 15th June – 31st June 2016) for patients who would otherwise have attended their GP prior to Physiotherapy intervention. (This is based on the assumption that such patients would have had only 1 GP appointment prior to Physiotherapy referral – it is highly likely that they could have had multiple appointments along with prescription costs).

Upskilling of Sonographers in ultrasound for ovarian cancer

Ovarian cancer is the leading cause of death from gynaecological cancer in the UK, and its incidence is rising. It is the fifth most common cancer in women. In Northern Ireland around 165 women are diagnosed with ovarian cancer every year.

The outcome for women with ovarian cancer is generally poor, with an overall 5-year survival rate of less than 35%. This is because most women who have ovarian cancer present with advanced disease. The stage of the disease is the most important factor affecting outcome. The woman's general health at the time of presentation is also important because it affects what treatments can be used. Most women have had symptoms for months before presentation, and there are often delays between presentation and specialist referral. There is a need for greater awareness of the disease and also for initial investigations in primary and secondary care that enable earlier referral and optimum treatment. Despite the relatively poor overall survival rates for ovarian cancer, there has been a two-fold increase in survival over the last 30 years.

NICE guidance recommends that when symptoms such as bloating, feeling full and/or loss of appetite, pelvic or abdominal pain and increased urinary urgency and/or frequency as well as a raised blood test result (CA 125) that a trans-vaginal ultrasound may be helpful.

The PHA AHP has team worked with HSC Trust radiography services to quantify the current capacity within radiography to deliver a Trans Vaginal Ultrasound service as

per the NICE guidance and ascertained the training requirement needed to extend the current capacity,

Skills of sonographers have been enhanced resulting in the provision of a direct access radiographer led Trans-Vaginal ultrasound service with immediate same day reporting available to primary care and patients.

Twelve Sonographers are now upskilled and are in place across the region, with a minimum of two in place in each Trust area. This allows patients quicker access to appropriate investigations, more appropriate use of medical consultant time and it is hoped a quicker cancer diagnosis for patients that need urgent referral onward to the appropriate cancer team.

AHP Capacity Demand Project

The Ministerial target states that 'no patient should wait longer than thirteen weeks from referral to commencement of AHP treatment'. The AHP team and performance management colleagues in the HSCB have been working in collaboration with Trusts to complete a Demand and Capacity exercise across all five Trusts.

This work now has an agreed position in relation to the level of capacity in each AHP elective specialty (Physiotherapy, Occupational Therapy, Dietetics, Speech and Language Therapy, Podiatry and Orthoptics), taking into account levels of productivity and efficiency and the demand for each specialty on a Trust by Trust basis (Belfast HSCT underway). The outcome of this exercise has informed decisions on where available recurrent funding should be targeted in order to address identified capacity gaps within Trusts. However, given the wider HSC financial environment and the deployment of Demography pressures to Trusts in 2016/17, the pace of implementation will result in known capacity gaps not being fully addressed by Trusts in this current financial year.

Older Years

AHP Public Health Approaches to Reducing Loneliness in Older Adults

Older people are in the grip of a "loneliness epidemic" according to research. A study carried out found that 66 million hours are spent alone by people aged over 65 in

Britain each day, equivalent to each person over 65 spending more than 100 days alone each year.

AHPs are well placed to deliver public health approaches, such as the promotion of independence and general health and wellbeing, provision of early intervention techniques and provision of advice and support to prevent physical and mental ill-health as older adults as they form a large proportion of their caseloads and they frequently support clients in their own home.

This work includes:

- The development of a loneliness Aide Memoir for AHPs
- The provision of advice on the identification of the signs of loneliness or social isolation, neglect or distress
- Developing mechanisms to enhance knowledge of support sources to include an inventory of useful contact numbers e.g. Silverline, Age NI, Trust Coordinators/Community Navigators
- Development of a short leaflet/bulletin on advice for older people with tips on remaining healthy and independent in order to reduce the chance of isolation though ill health. A description of the contribution of AHPs will also be outlined.
- Early work with Translink, Age NI and others in supporting people with skills to improve confidence in the use of public transport and using public transport systems as an opportunity to help build sustainable social support systems

Dysphagia/Swallowing

Dysphagia/swallowing difficulties are a leading cause of avoidable and preventable deaths and adverse incidents. The AHP team has been working with Speech and Language Therapists across Northern Ireland with the aim of improving safety and quality for patients by raising awareness of dysphagia/swallowing problems and providing advice to staff, carers and service users.

The implementation of the Promoting Good Nutrition Strategy has identified risks in the screening and assessment for dysphagia amongst Trust staff.

The AHP team is leading work to scope the training and support currently available to Trust staff in terms of swallow awareness, screening, full swallow assessment.

Key issues will be identified and an action plan produced which will offer solutions to ensure:

- Timeliness of full swallow assessment, particularly if the patient is in the community
- Appropriate ward staff are trained and competent in swallow screening
- Agreement on the best methods of awareness training so that they are effective but not resource intensive

In partnership with the Belfast Trust a new approach to improving the awareness of choking by food was supported. The project was developed through co-production with service users. The 'Help stop Choking' DVD is an accessible DVD based on a service user's (John) experience to help increase awareness of choking, promote safe eating strategies and reduce avoidable mortality and adverse harm effects from choking. John hopes that by sharing his story it will help to improve service user experience and help other people reduce their risk of choking. In 2014 the project won the top prize at the Patient Safety and Care Awards in London. A Choking by Food website is now available and has been co-produced by Speech and Language Therapy and John. This is available at helpstopchoking.hscni.net

Medicines Management Dietitians

The joint HSCB/PHA Regional Medicines Management Dietitian initiative has been in place and undergoing ongoing refinement since September 2013 as part of the PCE Programme. The initiative involves a small team of Dietitians and Prescribing Support Assistants working as part of the HSCB medicines management team and deployed within primary care general practices to ensure the appropriate use of Oral Nutritional Supplements (ONS).

The expenditure on nutrition, including oral nutritional supplements (ONS) in Northern Ireland, in 2011/12 was approximately £18.9M. This equates to a cost per head of population in NI of approximately £10.43 compared to £5.83 in England,

£4.32 in Scotland and £6.14 in Wales. Approximately 57% of the total spend dispensing data is adult oral nutritional supplements (ONS) and thickeners.

The spend on ONS was increasing year on year with no sign of recovery when the AHP team and HSCB pharmacy colleagues agreed to test a new model whereby Dietitians undertake a core function in the prescription of ONS.

A team of Dietitians and Prescribing Support Assistants has worked with 144 of the 349 GP practices across NI to review patients on ONS and ensure appropriate prescribing and use of these supplements.

The utilisation of the skills of Dietitians including dietetic assessment has improved safety and quality for patients and demonstrated efficiencies. The patient level efficiency data captured by the MMD has demonstrated a total efficiency of £1.9million in two years.

The initiative has also received positive feedback from GPs and service users. It has demonstrated innovative working practices through the creation of an electronic database for patient assessment, clinical record keeping and outcome measure generation. The initiative was recognised at the NI Advancing Healthcare Awards 2014 where it won the award “maximising resources using evidence-based practice - maximising resources for success”.

The initiative has focussed to date on those currently prescribed ONS, however, a ‘7 step’ approach to support appropriate prescribing for all future patients has also been developed. It is also intended that a standardised training package is developed and delivered to relevant groups including GPs, practice nurses, practice pharmacists, district nurses and nursing staff in nursing and residential homes to support the sustainability of this programme.

Occupational Therapy Cognitive Rehabilitation for Dementia Care

The 2011 the Dementia Strategy ‘Improving Dementia Services in Northern Ireland was launched by DOH and is currently being implemented across the region. Evidence suggests that with the increasing age of the population the incidence of Dementia is expected to increase significantly in future years. At the time of the launching the Dementia Strategy experts in this field estimated that the prevalence of Dementia in Northern Ireland was as high as 18-19,000 with the figure predicted to

rise to 61,000 by 2051. The strategy focused on improving access to early diagnosis and evidenced based early intervention alongside the necessary carer support across all stages of the dementia journey.

The AHP team have been supported the development of an Occupational Therapy Cognitive Rehabilitation Programme to provide early intervention for clients diagnosed with Dementia. This model will provide clients and carers with an evidenced based model of support to assist in maintaining the cognitive and independent functioning of clients diagnosed at early to mid-stages of Dementia. This will ease management issues which may be experienced by carers and families and will be important in ensuring better quality of life outcomes for clients and their families.

Professional Issues

AHP Assurance framework

In partnership with HSC Trusts, the PHA AHP Team led a project to develop an HSC AHP Assurance Framework to provide professional assurance that systems and processes are in place in HSC Trusts to support AHPs to provide safe, effective and high quality care to people who use health and social care services in N Ireland.

It is the current professional direction to support the implementation of the overarching HSC Framework (2011) which details the statutory requirements placed upon the HSC by the Health and Social Care (Reform) Act (NI) 2009. The HSC Framework document clearly articulates processes, along with roles and responsibilities across existing structures, in so doing this recognises the accountability of HSC Trusts to the Department of Health (DoH) alongside the roles and responsibilities devolved from DoH which will be taken forward on its behalf through the PHA/HSCB.

The key performance and assurance roles and responsibilities are encompassed in the four dimensions of: Corporate control, Safety and quality, Finance and Operational performance.

Assurances are required across a number of professional areas including, Professional Registration, Training and Development, Safeguarding, Safe staffing

levels and skill mix, Supervision, Evidence Based Practice, Mentoring of Students, Involvement in commissioning processes, learning from reviews, inspection, enquiries etc alongside the monitoring of and learning from disciplinary actions and Health and Care Professions (HCPC) Professional Alert reports.

Trusts have now completed the first round of monitoring and next steps will include a strong focus on:

- Ensuring that processes are put in place so that assurances apply to the 12 AHP professions in all Trusts (this includes the additional 5 contracted professions)
- Engagement with LCGs in relation to any issues raised about staffing levels
- Working with Trusts with the aim of finding solutions to gathering evidence of % compliance with training and supervision. Trusts currently report that they do not capture this detail at Trust level
- Working with Trusts to meet the full requirements of the regional AHP supervision policy

Implementation of workforce model

There are approximately 230 AHPs trained in Northern Ireland every year across 7 professions (Diagnostic Radiography, Dietetics, Occupational Therapy, Physiotherapy, Podiatry, Speech and Language Therapy and Therapeutic Radiography).

In the 2016-17 academic year the number of AHP places were reduced by 13, with Occupational Therapy reduced by 5 places, Physiotherapy reduced by 5 places and Speech and Language Therapy reduced by 3 places. This equates to approximately 6% of the overall annual student places. Current approximate yearly graduate numbers in Northern Ireland are 55 for Occupational Therapy, 13 for Podiatry, 54 for Physiotherapy, 37 for Diagnostic radiography, 16 for Therapeutic radiography, 26 for Speech and Language Therapy and 29 for Dietetics. Full graduate employment in Northern Ireland has not been achieved, however trusts report significant difficulty struggling to fill short term temporary contracts.

The PHA AHP team completed a comprehensive AHP Workforce analysis in December 2015 which was submitted to the DOH and outlined service and strategic developments, service trends and needs and a detailed analysis of current AHP workforce. This report supported the need for a regional AHP Workforce Review which is expected to commence shortly.

Enhanced governance through AHP Strategy

One of the key themes in the AHP Strategy 'Improving Health and Wellbeing through Positive Partnerships 2012-2017' was delivering safe and effective care. The PHA led the development of the AHP Strategy implementation plan which included a SMART action plan. Within this plan were a number of professional governance issues.

It was identified that the AHPs did not have a clear professional reporting route at Director level within HSC organisations. Through the strategy each organisation has identified a Director with responsibility at Board level for AHP governance, this ensures that issues relating to the full range of AHP governance is overviewed by the responsible director. In addition there are now requirements that all AHP professional services have an AHP manager in place at all times. This governance is further supported with the development of professional governance maps for all HSC organisations.

Data Definitions

As part of the drive to support AHP services to meet their target and support the HSCB to monitor same, the AHP team identified that there were a range of issues with how AHP services were recording data and variance in the actual type of data being collected. This made it more difficult to monitor waiting times within and across HSC Trusts. The team led a review of data definitions and, through this process, facilitated different ways of recording and managing AHP referrals. Of particular importance is how referrals are processed from acute and community settings within the same service and patients with more than one presenting condition. This change to how referrals are processed has resulted in a more holistic and standardised approach to patient care and reduced the number of patient 'hand overs' within services.

Undergraduate Training and PPI

The AHP team has entered into a collaboration with the Ulster University to enhance AHP practice in the area of PPI. The team has provided training to all 1st year undergraduate students at Ulster University and students were themselves have been involved in focus groups to give practical PPI experience. The team is also working with the Clinical Education Centre to maximise the contribution of service users and carers in the design and delivery of post graduate AHP training programmes.

Elective Care Pathways

The PHA has been working collaboratively with the AHP professions to establish ways to reduce variation of AHP practice across HSC Trusts. An intensive work programme has been underway to seek regional agreement on AHP care pathways for the areas within AHP elective services that constitute the highest levels of demand and or input.

This work is unique to Northern Ireland and has been driven by our motivation to ensure best use of resources to meet the population needs, to standardise practice, ensure equity of access and to assist in developing and incorporating innovative models of support which meet service user's needs.

The core areas in which regional consensus has been secured are access criteria, risk stratification including the definitions of urgent and non-urgent, referral sources, number and nature of interventions and discharge criteria.

AHP Education Commissioning (ECG)

The PHA chairs the regional AHP Education Commissioning Process for the post graduate training and development of 7 of the AHP professions (Excludes art therapy, music therapy, drama therapy, Orthotists and Prosthetists). The PHA has developed a commissioning cycle in partnership with Trusts, Ulster University and Clinical Leadership Centre (BSO).

The annual commissioning process concludes with a comprehensive, costed plan for AHP postgraduate training and development across the 7 AHP professional groups. The plan takes into account each of the professions sub specialities alongside the specific requirements from each trust.

The PHA has been driving an agenda to ensure that the training is primarily targeted at ensuring safe services and fundamental system reform.

Development of technologies to support AHP care and treatment

Making better use of technology and data is essential in order to move to more efficient and effective models that are patient centred, improve the health and wellbeing of the population, are modern and go beyond organisational and professional silos. Benchmarking within and between services both locally and nationally is important for the enhancement of effective and efficient services.

Following a regional AHP e-health stakeholder event the AHP team is establishing an AHP e-health network aligned with e-health structures in Northern Ireland.

This will encourage collaboration and act as a reference group for the region. A key partnership has been developed with NI Direct and discussions are underway to ascertain how they can support modernisation of AHP services. The AHP team is also driving links at a National level and will be NI representatives on NAHPIST (National AHP Information Strategy Team) where AHPs across the 4 Nations work to resolve similar issues such as

- Coded terminology in care records
- Care record headings
- Clinical decision support tools
- Telecare and telehealth
- Information Governance
- Digital literacy, and the wider information management agenda

AHP prescribing

In collaboration with HSCB and Trust colleagues, the AHP team has led on the implementation of AHP prescribing across the Physiotherapy, Podiatry and Radiography professions across N Ireland. The benefits of AHP prescribing are

- improved patient care without compromising patient safety
- easier and quicker for patients to get the medicines they need
- increased patient choice in accessing medicines
- make better use of the skills of health professionals

- more flexible team working across the health service

An AHP prescribing group has been established by the AHP team to implement or enhance all levels of AHP prescribing i.e. independent, supplementary, Patient Group Directives, Prescriptions Only Medicines and Letters of Recommendation. The core focus of the group is ensuring good governance and the monitoring of the effectiveness of prescribing.

Training of radiography profession for imaging

There are a number of challenges relating to the recruitment and retention of the radiology workforce and as a result the DoH carried out a review of imaging services across N Ireland. As part of this imaging review, a model has been developed to maximise the skill mix within the radiography workforce as a contribution to workforce challenges within radiology workforce.

This work involves role modernisation extending the scope of advanced radiography practice within the Diagnostic Radiography profession and the creation of a specific professional training resource within N Ireland to ensure sustainable, locally accessible education and training. This builds training capacity in Northern Ireland whereas the current model is heavily reliant on access to training in the UK. The approach is evidence based and has been endorsed by the Royal College of Radiologists (RCR) and the Society and College of Radiographers (SCoR).

As a result of this work, there are now Plain Film Reporting Radiographers in place in each Trust. There is also CT reporting radiography in one Trust.

AHPs in Specialist Palliative Care

The AHP PHA team has led the development of guidance on the *Management of Symptoms in Palliative Care- the role of Allied Health Professionals in Specialist Palliative Care.* This document has been produced by the Specialist Palliative Care Allied Health Professionals Forum which is co-chaired by the PHA. Members include clinicians who work in Specialist Palliative Care from Dietetics, Occupational Therapy, Physiotherapy and Speech and Language Therapy professions within acute and community settings from Hospice and HSC Trust organisations.

This document outlines the definition, cause, prevalence and evidence based practice for the Allied Health Professional (AHP) interventions to manage each of the

symptoms including breathlessness, fatigue, weight loss, dysphagia, communication difficulties, lymphoedema and also functional rehabilitation.

The main drivers for this document were:

- To outline evidence based practice for the symptom management which can be used regionally across all sectors and settings.
- To ensure patients with rehabilitative needs are referred in a timely manner to relevant AHP services.
- To support the Regional Specialist Palliative Care Workforce Review.
- To support the implementation of the regionally agreed Palliative Care Day Services model developed within the Transforming Your Palliative and End of Life Care Programme (currently the Regional Palliative Care Programme- Palliative Care in Partnership).

Conclusion

The HSC system in N Ireland is about to embark on one of the most significant and unprecedented periods of change with a new energised refocus on co-production and greater integration of care.

AHP practice has developed significantly over recent years, improving outcomes for service users, being more responsive to needs and promoting cost effectiveness. Advanced practice roles have emerged within a range of AHP groups, supported by the roll out of independent and supplementary prescribing. There are many opportunities for AHPs to work in partnership to ensure the delivery of new, innovative models of care across the spectrum of universal and specialist provision and deliver these in new settings at the heart of our communities.

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 December 2016
Title of Paper	The Northern Ireland AAA Screening Programme Annual Report 2014/15
Agenda Item	10
Reference	PHA/04/12/16

Summary

This is the third annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was successfully introduced in June 2012.

All men in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65 are encouraged to self-refer by contacting the screening programme office on 02890 631828.

Following on from another successful screening year, the programme experienced further consolidation and development throughout 2014-15. In the 2013-14 Annual Report the programme set out a number of core objectives. These objectives have either been met in full or are on target, as evidenced throughout this report.

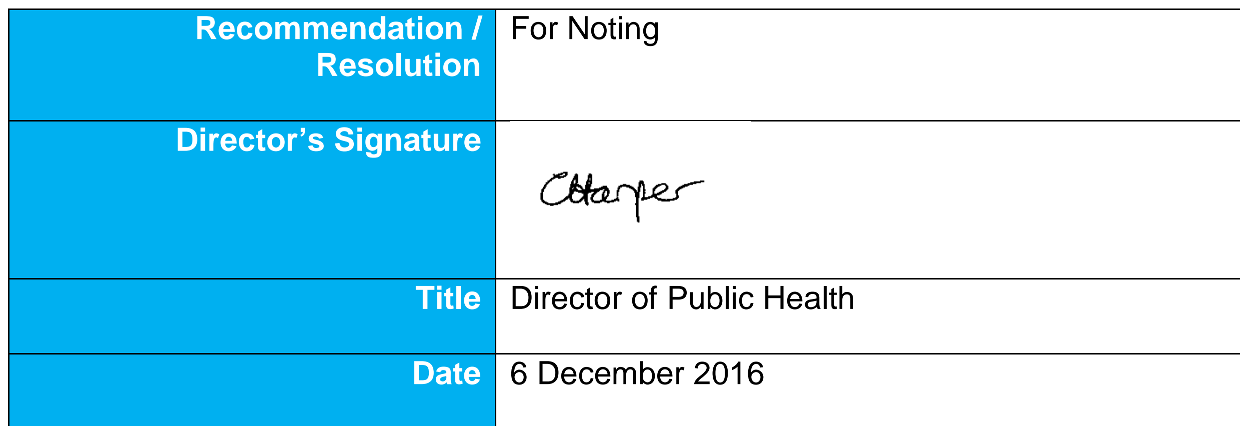
Overall performance of the programme remained high, as follows:

- almost 9,500 men were invited to attend for screening (similar to 13/14)
- uptake remained high at 83% (up a percent from 13/14)
- 583 men were screened either as a self-referral to the programme or within the prison setting (up from 447 self-referrals in 13/14)
- 126 AAAs were newly detected within the screening programme, which is 1.5%[1] of those screened (slightly down from 132 in 13/14)
- 22 men with large aneurysms were referred to the vascular team to consider treatment options (up from 16 in 13/14)[2]
- 117 men had small or medium-sized AAAs and are now being monitored under the surveillance programme (up slightly from 113 in 13/14

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was approved by AMT on 6 December 2016.

[1] Refer to table 2 on page 16 for detailed data

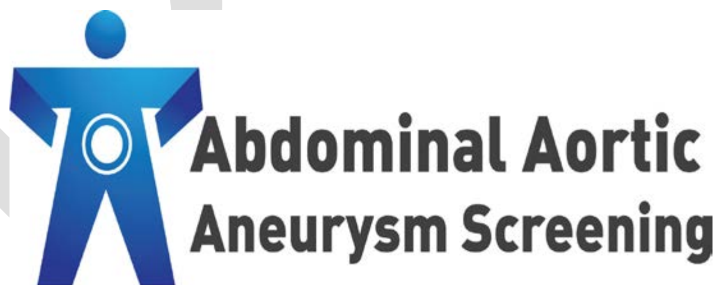
[2] This includes an additional 13 men under surveillance from previous screening years' cohorts who are counted as part of the overall number of 22 men referred for treatment in 15/16.

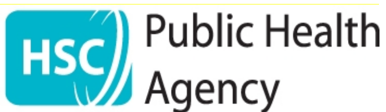


Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	6 December 2016

Northern Ireland
Abdominal Aortic Aneurysm (AAA) Screening Programme

Annual Report 2014-15





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- Members of NI AAA Screening Programme Co-ordinating Group

Draft

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Draft

Section 1:

Summary and Highlights for 2014-15

This is the third annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was introduced in June 2012.

All men in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65 are encouraged to self-refer by contacting the screening programme office on 02890 631828.

The Belfast Health and Social Care Trust is responsible for the management and delivery of the programme, whilst the Public Health Agency (PHA) is responsible for commissioning and quality assuring it. The two organisations work closely together to provide an effective, safe and accessible service.

Following on from a successful second full year of screening, the programme embarked on further consolidation and development of existing services throughout 2014-15. In the 2013-14 Annual Report the programme set out a number of core objectives. These objectives have either been met in full or are on target, as evidenced throughout this report. Overall performance of the programme remained high as follows:

- almost 9,500 men were invited to attend for screening
- uptake remained high at 83%
- 583 men were screened either as a self-referral to the programme or within the prison setting
- 126 AAAs were newly detected within the screening programme, which is 1.5%[1] of those screened
- 22 men with large aneurysms were referred to the vascular team to consider treatment options

Significant progress was also made during 2014-15 with a number of other programme developments as highlighted in the 2013-14 annual report. These include:

- Three service users recruited to sit as **Patient Representatives** on the Co-ordinating Group

- **Service user testimonial** available as a video on the programme website www.aaascreening.info, outlining the screening experience of a gentleman diagnosed with a small AAA through the programme

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[1] Refer to table 2 on page 16 for detailed data

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- **Short introductory video** by the Clinical Lead also added to the programme website, providing an overview of AAA screening and the NI AAA screening programme specifically

- **Audio versions** of the programme's general information leaflet and its three results leaflets similarly available on the website

- Production of new general **Awareness Leaflet** and **Business Card** to help promote the programme

- **Promotional Poster** updated to highlight the programme is for men aged 65 and over

- **Equality monitoring survey** undertaken across all 19 AAA screening locations in the region in the first week of June 2014. The response rate was 82%

- Screening offered to all eligible men within **Maghaberry Prison** in December 2014

- Two **additional screening venues** secured during the year for regular clinics in Bangor Community Hospital and Roe Valley Hospital in Limavady

- **Engagement with Primary Care** continued with a number of GPs actively promoting the programme as noted in section seven of this report

- The PHA Quality Assurance and Commissioning Support Manager invited to sit on the **English NHS AAA Screening Programme Quality Assurance (QA) Steering Group** (which is responsible for establishing and maintaining a QA structure and framework for English AAA screening). Membership of this group will facilitate establishment of an External QA Model for AAA screening in Northern Ireland

- **Annual reviews** for clinical and imaging leads completed for 2014-15

- **Peer review training** for participation in external quality assurance successfully completed by the programme's Public Health Lead, Clinical Lead, Imaging Lead and QA Manager

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- **Staff recognition and awards** – a number of staff within the programme were recognised for their contributions either to the programme or within the wider vascular field.

President of the Vascular Society of Great Britain and Ireland (VSGBI)

Mr Paul Blair, Clinical Lead for the programme, was appointed as the President of the Vascular Society of Great Britain and Ireland for the period November 2014 until November 2015.

Northern Ireland Advancing Healthcare Awards – November 2014

Category 2 – Seating Matters Award for Innovation and Creativity – enabling AHPs to deliver safe and effective practice and care
- Mrs Deirdre Kearns, Lead Screening Sonographer for the programme, was a finalist for this award category.

Category 5 - Award for outstanding achievement by a support worker
- The NI AAA screening technicians were finalists in this award category.

Draft

Institute of Healthcare Management (IHM) - Allied Health Professional Manager of the Year 2014

Mrs Deirdre Kearns, Lead Screening Sonographer for the programme won the award for the Allied Health Professional Manager of the Year 2014.

Section 2:

Introduction

2014-15 has been a year of firsts for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme; it also represents our third increasingly successful year of screening.

We particularly welcome the appointment of three Service Users / Patient Representatives as members of the programme's main co-ordinating group. Their individual experiences and input at meetings and related events has already made a significant and positive impact on future service delivery and improvement. You can read more about this exceptional group of men on page 19 of this report.

The year has also seen increased interaction with a wide variety of partner organisations which, like the PHA and the Belfast Trust, are keen to ensure that all men aged 65 and over within Northern Ireland who are eligible for screening, are able to easily access it in a safe and equitable manner. To this end, considerable effort has been put into raising awareness of the programme amongst harder to reach groups, while programme staff continue to engage with a wide range of men's groups and primary care.

Finally, I would like to congratulate the entire programme team at the Belfast Trust whose hard work and consistently high standards of professionalism have been recognised by their peers and health service colleagues, which we celebrate with them on page 6.

Dr Adrian Mairs
Consultant in Public Health Medicine / Public Health Lead
NI AAA Screening Programme

The third year of the Northern Ireland Abdominal Aortic Aneurysm (AAA) has been another successful one. As Clinical Lead for the programme, I am pleased to present this annual report outlining some of the achievements.

With patient safety always high on the agenda, ensuring those men diagnosed with a large AAA are treated as quickly as possible remains a priority. I am therefore delighted that during 2014-15 the programme continued to meet this key quality standard, with 86% of men diagnosed with a large AAA being operated on by a vascular specialist within eight weeks. This would not happen without significant support and co-operation from clinicians and other health care professionals and I remain very grateful to them.

Collaboration between the programme staff within the Belfast Trust and the Public Health Agency has been critical to the success of the programme. This year has seen more active engagement between service users, clinical and programme staff. I look forward to working with our three service users who are newly appointed members of the Co-ordinating Group.

Thank you for your continued interest in the programme and taking the time to read this report.

Mr Paul Blair
Consultant Vascular Surgeon / Clinical Lead
NI AAA Screening Programme

Section 3:

Background and Programme Objectives

What is an AAA?

An abdominal aortic aneurysm (AAA) is a swelling of the main artery in the body as it passes through the abdomen. The walls of the artery weaken, causing it to balloon out. AAAs are more common in men aged 65 and older. Other factors known to increase the risk of developing an AAA are smoking, high blood pressure and high blood cholesterol. Close relatives of someone who has been diagnosed with an AAA are also more likely to develop one.

AAAs usually cause no symptoms, therefore most people who have one will not feel anything. As the aneurysm grows so too does the risk of it rupturing if left untreated. Rapidly expanding or ruptured aneurysms do produce symptoms (typically severe abdominal, back or flank pain, low blood pressure or shock and a mass in the abdomen which pulsates; however only a minority of patients have all of these features). Patients with a ruptured AAA have a very low chance of survival, while those who undergo planned surgery for a non-ruptured AAA have an excellent rate of survival.

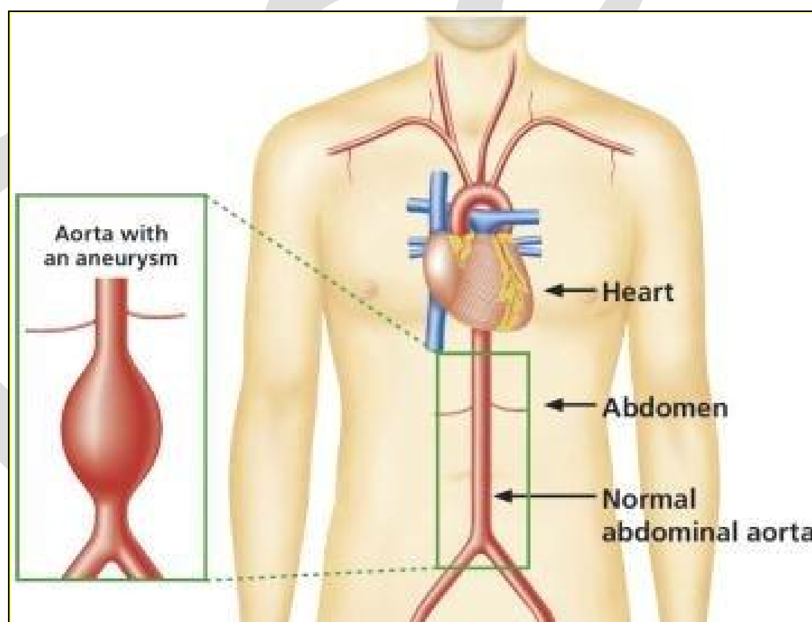

Image courtesy of English NHS AAA Screening Programme

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Aim of the Northern Ireland AAA Screening Programme

The overall aim of the Northern Ireland AAA Screening Programme is to reduce deaths from ruptured abdominal aortic aneurysms through early detection, monitoring and treatment.

Research has shown that women are six times less likely than men to have an AAA and, on average, women tend to develop AAAs ten years later than men. The NI AAA Screening Programme is therefore aimed at men in keeping with the recommendations of the UK National Screening Committee.[2]

Programme Objectives

The Public Health Agency and the Belfast Health and Social Care Trust work together to meet the programme's core objectives. These include:

- Monitor delivery of the programme against national quality standards, taking appropriate action on areas where performance is not on target.
- Ensure appropriate failsafe systems are in place at each stage of the screening process.
- Ensure all staff are appropriately trained on all relevant aspects of the programme, including the Health and Social Care organisations' mandatory training.
- Actively engage with stakeholders at relevant events and opportunities, particularly in those areas where uptake rates are lower than the programme average.
- Ongoing review of information materials, with a particular emphasis on promoting the self-referral process for men aged 65 or over who have never attended for AAA screening.
- Continue to develop and formalise an appropriate quality assurance structure and function in collaboration with the English NHS AAA Screening Programme.
- Build on existing relations with the other four UK AAA Screening programmes, specifically with regard to: a review and development of current Quality Assurance Standards, updating programme information leaflets and re-tendering for the programme's IT solution.

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[2] Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: www.screening.nhs.uk/aaa Accessed 10 December 2012.

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- Identify and address health inequalities to ensure all eligible men can make an informed decision about whether or not to attend for screening.

- Continue to explore opportunities for Personal & Public Involvement (PPI).

- Identify and disseminate examples of regional and national best practice with regard to all elements of programme delivery.

- Promote and participate in research initiatives.

- Ongoing review and development of the Northern Ireland AAA Screening Programme website, engaging with stakeholders as appropriate.

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Section 4:

Programme Delivery and the Screening Pathway

The programme is run by a multi-disciplinary team of staff (see **Appendix 1**). All staff play an important role at various stages in the screening pathway.

The programme office is based in the Royal Victoria Hospital within the Belfast Trust.

Seven full-time screening technicians run clinics on a daily basis. There are currently 22 clinic locations across Northern Ireland, including health and wellbeing centres and community hospitals (see **Appendix 2**). Two of these venues were set up during 2014-15; they had been specifically identified as geographical areas with a significant population who would be eligible for screening. The new locations are Bangor Community Hospital and Roe Valley Hospital in Limavady.

Appendix 3 provides an overview of the whole screening pathway. The key stages within the pathway are:

- Screening Invitation
- The Scan
- The Result
- Surveillance
- Referral and Treatment

Screening Invitation

The programme office sends an initial invitation letter to all men during the year in which they turn 65. All eligible men registered with a GP are invited to attend a local screening clinic; men over 65, who have not previously been scanned as part of the programme or been told they have an aneurysm, can self-refer by calling the programme office (*Tel: 02890 631828*).

Invitation letters are sent together with:
- information on the informed consent process; and
- a leaflet which explains the condition, the screening process and the benefits and risks of screening.

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The Scan

At each screening appointment, the screening technician explains both the screening process and the consent process to the man. As part of the consent process, the technician explains that the man's personal information will be retained securely within the programme system and that his GP will be informed of the outcome of the scan. The screening technician is available to answer any questions that the man may have to enable the informed consent process to be completed before the scan takes place.

The screening test involves a simple ultrasound scan of the abdomen. It is quick and painless. The screening technician measures the widest part of the abdominal aorta and saves a minimum of two images per scan. The whole process usually lasts less than fifteen minutes.

The Result

All men will be informed of their results verbally at the clinic. Both the man and his GP will then be sent a letter confirming the result. If a man is identified as having an aneurysm his GP practice will also be informed by telephone the same day.

There are **FIVE** possible results from screening:

- **NORMAL**: **aortic diameter less than 3cm**

Around 98% of men will have a normal result. This means that the aorta is not enlarged (there is no aneurysm). No treatment or monitoring is needed and the man will be discharged from the screening programme. He will not need to be screened again.

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- **SMALL AAA**: **aortic diameter measuring between 3cm and 4.4cm**
Men who have a small aneurysm detected will be invited back every twelve months for a surveillance scan to monitor the size of the aneurysm. Some small aneurysms will grow in size over time and become medium or large aneurysms.

- **MEDIUM AAA**: **aortic diameter measuring between 4.5cm and 5.4cm**
Men who have a medium aneurysm detected will be invited back every three months for a surveillance scan to monitor the size of the aneurysm. Some medium-sized aneurysms will grow over time to become large aneurysms.

- **LARGE AAA**: **aortic diameter measuring 5.5cm or over**
Men who have a large aneurysm detected are referred to a vascular surgeon within the Royal Victoria Hospital at the Belfast Health and Social Care Trust for further investigation and to discuss treatment options.

- **NON-VISUALISATION**: sometimes the aorta cannot be fully visualised and a man will be invited to come back on a different day for another scan.

As part of a local protocol a small number of men presenting with a more localised or focal swelling of their aorta are discussed with the lead sonographer, radiologist and clinician. If required such cases can be presented at the weekly Vascular Multidisciplinary meeting.

As all results are kept on the programme's IT system, it will also be possible to easily identify all men who have an aorta measuring between 2.6cm and 2.9cm should further national research deem a rescreen in later years appropriate.

Surveillance

As indicated above, if a man has either a small or medium-sized aneurysm he will be invited back for surveillance appointments on a regular basis to monitor its size as follows:

- Men with small AAAs will be invited for **annual** surveillance scans
- Men with medium AAAs will be invited for surveillance scans every **three months**

Men under surveillance are also offered an appointment with a vascular nurse specialist for additional support and advice. The nurse will contact every man who has an AAA detected within two working days and offer either a face to face appointment or a telephone consultation. The nurse will explain the significance of having an AAA and offer lifestyle advice (including advice on

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smoking cessation) and advice on blood pressure control (if relevant) to help decrease the risk of the aneurysm growing. The man will also be asked to attend his GP to have measurements taken for height, weight and blood pressure and to discuss appropriate medication.

Referral and Treatment

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust. Vascular units are required to meet national standards set by the Vascular Society of Great Britain and Ireland (VSGBI). The regional vascular service in the Royal Victoria Hospital within the Belfast Trust meets these standards.

All men referred to the vascular service are seen by a consultant vascular surgeon within two weeks of the initial scan. During this period, the man will have a CT scan to confirm the size of the aneurysm. All men diagnosed with a large AAA are discussed at a weekly vascular multidisciplinary team meeting (MDT) and also undergo vascular pre-assessment by a specialist nurse and vascular anaesthetist. The vascular consultant will then discuss treatment options at outpatient review. The two main treatment options are open surgery or endovascular (EVAR) surgery. The consultant will discuss the appropriate options with the man to enable him to make an informed choice. In some men further investigation and optimisation of underlying medical issues may be required prior to treatment of the AAA.

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Section 5:

Programme Performance

During its third year, the Northern Ireland AAA Screening Programme invited all men who turned 65 between 1 April 2014 and 31 March 2015 for screening.

The current population of Northern Ireland is just over 1.8 million. Within this, the number of men aged 65 and over in 2014 was 126,662 of which 8,915 were men aged 65.

This report focuses on the performance of the programme for the 2014-15 cohort, the self-referrals and others offered screening through the programme as at end of March 2015[3].

Table 1: Numbers / categories of men to be offered screening in 2014-15

Category / Men:	**Number:**
Screening cohort 2014-15 (all men who had their 65th birthday during the year 1 April 2014 – 31 March 2015 - details for these men were automatically downloaded to the programme's IT system)	9,480
Self-referrals (men over 65 who were screened) and Prison setting (men aged 65 and over who were screened)	583
TOTAL:	**10,063**

[3] Data for the 2014-15 cohort are as at 30/06/2015 to allow time for screening episodes to be completed; all other data are as at 31/03/2015

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Overall Performance:

As shown in the table below, the Northern Ireland AAA Screening Programme had a (detection) prevalence rate of 1.5% for the 2014-15, which is similar to other AAA Screening Programmes across the UK.

Table 2: Programme performance 2014-15

			TOTAL[4]
2014-15 cohort (all) and other men over 65 screened[5]			10,063
Eligible men aged 65 and over[6]			9,864
Those screened:			
Total men 65 and over screened for the first time	2014-15 cohort screened	7,601	8,184
	Self-referrals and prison setting	583	
Uptake (calculated using 2014-15 cohort only)[7]			83%
Aneurysms detected:			
Aneurysms newly detected by programme (all)			126
Prevalence (calculated using 2014-15 cohort only)			1.5%
Number of men added to and remained on surveillance programme			117
Referrals to the Vascular Unit			22[8]

All men who turned 65 between 1 April 2014 and 31 March 2015 who were registered with a GP in Northern Ireland were sent at least one screening appointment by the end of March 2015. All men who did not attend their first appointment were offered a further appointment by the end of June 2015.

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[4] A detailed breakdown of some data is not provided to ensure no patient is identifiable

[5] This figure includes all men whose details were downloaded into the system as turning 65 in 2014-15; other men screened refers to self-referrals and those screened within the prison setting

[6] Of the 9,480 men in the 2014-15 cohort, 142 men died before being offered a screening appointment; 57 men were not eligible for screening as they were either no longer registered with a GP in NI or they informed the programme of (a) a previously detected AAA (b) previous imaging confirming they did not have an AAA; this left 9,281 men eligible for screening from the 2014-15 cohort, together with 583 men who self-referred or were screened within the prison setting.

[7] 86 men had deferred their screening appointment and a further 36 men still required a screening outcome as at the end of June 2015. The total men eligible for screening with a completed outcome therefore was 9,159 – this is the figure used to calculate the uptake rate.

[8] Figures for referrals include those men who had AAAs detected in previous years and had been on surveillance.

Table 3: Performance against Quality Standards for 2014-15:

	Programme Performance	Quality Standard - Acceptable	Quality Standard - Achievable
Uptake (initial screening)	83%	≥ 75%	≥ 85%
Timely referral (subjects with AAA ≥ 5.5cm referred within one working day)	95%	≥ 95%	100%
Timely intervention (men with aorta ≥5.5cm seen by vascular specialist within two weeks)	67%[9]	≥ 90%	≥ 95%
Timely treatment (men with AAA ≥5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within eight weeks)	86%	≥ 60%	≥ 80%
30 day mortality following elective surgery on screen-detected AAAs	0%	≤ 6%	≤ 3.5%

Surgery by Type

The Vascular Team within the Belfast Trust performed surgery on 22 men during 2014-15. Of these, 55% had an elective open repair of their abdominal aortic aneurysm, compared to 45% having endovascular surgery.

[9] The 33% of men not seen within two weeks (10 working days) were seen at the next available outpatient clinic (no man waited longer than 16 working days for an outpatient review)

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Section 6:

Personal and Public Involvement (PPI)

Personal and Public Involvement (or PPI) is about people and communities influencing the planning, commissioning and delivery of health and social care (HSC) services. It means actively engaging with the public and specifically those who use services such as screening.

The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HCS organisations within Northern Ireland.

In 2014-15, the Northern Ireland AAA Screening Programme continued to develop existing PPI projects to help ensure the programme is meeting the needs of its eligible population. A number of new opportunities were also identified to further engage with service users and learn about their expectations of the programme and how these might be met. Progress with regard to both initiatives is outlined below:

Ongoing

- The third service-user event for those men with a newly detected AAA during 2014-15 was held in April 2015. The evaluation of this event was extremely positive and resulted in a number of excellent suggestions from service users which have been implemented by the programme. These included suggestions such as greater engagement with GPs and Pharmacies.

- Draft invitation letter and easy-read version of small and large leaflets produced as part of project with health facilitators to ensure ***all eligible learning disabled men*** are able to make an informed choice about accessing screening.

- Profiles of gentlemen with a screen-detected AAA featuring in ***local and regional newspaper articles.***

- Participation of gentlemen with a screen-detected AAA in ***promotional activities*** (service user video, programme website and programme newsletter - The AAA Team).

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New

- ***Appointment, induction and participation of newly elected service users*** / patient representatives in operational meetings and PPI initiatives.

- Briefing by PHA staff at a morning workshop at the **Association of Real Change** to service providers for individuals with learning disabilities on adult screening programmes and how to access them.

- Engagement with several community groups representing older men, including Volunteer Now and Men 2 Men, leading to publication of articles in newsletters promoting AAA screening.

- Continued delivery of talks on accessing AAA screening to men's groups across the region including Probus (Bangor and Antrim), Reach (Bangor) and at Men's Sheds in Belfast, Armagh and Enniskillen.

Meet our Service User / Patient Representatives

From left: Mr Kieron McGuire, Mr Tommy Canning with Mrs Jacqueline McDevitt, Mr Peter Bullick

Mr Peter Bullick, Mr Tommy Canning and Mr Kieron McGuire have all been through the screening programme. They were each diagnosed with a large AAA and subsequently referred for treatment to the Specialist Vascular Team at the Belfast Trust. All three men have made considerable contributions to the ongoing development and improvement of the service through their membership of the programme's Co-ordinating Group and their attendance at various Service User Events. We look forward to continuing to benefit from their input and experience in the future.

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Section 7:

Role of Primary Care

The screening programme continues to engage with Primary Care teams across Northern Ireland on an ongoing basis. Since the programme began in 2012, their considerable contribution and partnership working is invaluable, particularly in the areas outlined below.

Supporting men with a screen-detected AAA

When an aneurysm is detected, the programme informs the man's GP practice by telephone on the same day. This is followed up in writing.

GPs are then asked to arrange to take measurements for height, weight, BMI and blood pressure, and consider commencing the man on anti-platelet and statin therapy (unless contra-indicated).

For men with a large AAA, GPs are also asked to make a standard referral to the Vascular Team for further intervention / treatment and to arrange an urgent blood test (U&E).

GPs are the key providers of aftercare for men who have undergone surgical repair.

Promotion of the Programme

People often rely on the advice of the primary care teams when making health decisions. It is therefore important that these teams are well informed about the programme and can discuss the benefits and harms of AAA screening to enable eligible men to make an informed choice.

GPs are informed when a man does not attend a screening appointment. Some practices identify men who do not attend and talk to them opportunistically about screening, whilst others have proactively contacted men who do not attend to discuss screening.

Primary care teams have also been actively promoting the programme to those over 65 and eligible to self-refer. Many men who call the programme to self-refer do so after being advised of the programme by their GP / Pharmacist or after seeing a poster in their waiting area. In particular, GPs have recommended screening to eligible men who have a strong family history of AAAs. Over half of all self-referrals during 2014-15 have been as a direct result of promotion by primary care. This includes emails / letters from

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GPs to their eligible patients, displaying of information within waiting areas, personal recommendation by GPs at appointments, etc.

The programme will continue build on the success of this kind of promotion by working with GP practices across Northern Ireland on an ongoing basis.

Providing information to facilitate screening appointments for eligible men

The programme continually liaises with primary care on a range of issues such as:

- ensuring patient records are accurate – information is downloaded into the programme's IT system on eligible men registered with GPs; programme staff liaise with practices on any discrepancies
- seeking information about particular needs of men coming for screening, e.g. a physical or sensory disability, limited mobility or a learning disability – this helps facilitate the screening appointment and allows appropriate arrangements to be made, e.g. extra time for the appointment if required
- organising an appropriate interpreter or signer when required to facilitate an appointment

Healthcare Professionals newsletter

The Screening Programme continued to produce a newsletter three times per year during 2014-15, aimed at healthcare professionals.

This is an important vehicle for the programme to continue to engage with primary care teams.

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Section 8:

Governance and Accountability

The Public Health Agency

The Public Health Agency has a number of key functions in relation to screening programmes including:

- Leading on the implementation of screening policy, including the introduction of new screening programmes and any changes required to existing screening programmes.
- Ensuring the delivery of high quality, safe, effective and equitable screening programmes for people in Northern Ireland.
- Supporting continuous quality improvement through programme monitoring and evaluation, and adverse incident investigation and management.

Specifically, the Agency takes lead responsibility for external quality assurance (QA) of the programme, focussing on the establishment of a robust QA structure and function to ensure it meets the responsibilities outlined above.

To help fulfil the PHA's core function of monitoring, maintaining and continuously improving upon acceptable standards of service, performance and quality across all elements of the Northern Ireland AAA Screening Programme, the PHA has ensured:

- A formalised process is in place for the timely appointment/re-appointment of a clinical lead and an imaging lead.
- The establishment of an AAA Screening Co-ordinating Committee, chaired by the Public Health lead, including PHA staff and all relevant members of Belfast Health and Social Care Trust NI AAA Screening Programme staff.
- Regular monitoring of QA data is undertaken.
- Appropriate fail-safe mechanisms are in place to ensure screening is offered to all eligible men and that those men requiring surveillance and referral are followed up in a timely and appropriate way.
- There is an agreed programme of equipment monitoring.
- A programme of formal, external Quality Assurance visits will be established in collaboration with the English NHS AAA Screening Programme.

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The Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust is responsible for the operational management and delivery of the NI Abdominal Aortic Aneurysm Screening Programme.

The Trust ensures all eligible men are invited to attend for screening in their 65th year and that they are provided with appropriate information, support and advice, particularly those men who have an AAA detected through the programme.

Staff who have responsibility for the operation of the programme are employed by the Trust and carry out all of the scans including rescans and surveillance scans.

The surveillance programme for men identified with a small or medium AAA is provided by the Trust as part of the NI AAA Screening Programme. Similarly, those men who are identified with a large AAA are referred to the vascular surgery team at the Royal Victoria Hospital within the Belfast Trust to discuss potential treatment options.

The Trust also has responsibility for:

- Setting operational policy for the programme.
- Liaising with GPs regarding secondary care, particularly when a man is detected as having an aneurysm.
- Local (internal) quality assurance of the screening process.
- Ensuring appropriate failsafe systems are in place.
- Providing reports on the performance of the programme and data for quality assurance purposes.
- Engaging with stakeholders regarding development of the programme.
- Organising and taking part in promotional activities for the programme.

Audit and Research

Both organisations take joint responsibility for developing and facilitating audit and research activities related to the programme.

Appendix 4 details the PHA's governance and accountability reporting arrangements.

Appendix 5 details the Belfast Trust's governance and accountability reporting arrangements.

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Section 9:

Future Developments

The NI AAA Screening Programme is committed to continued development of the programme to build on the achievements to date and continue to improve the AAA screening experience for service users.

Whilst delivering on the core objectives of the programme as outlined in section 3 of this report, during 2015-16 the programme plans to:

- Set up a pilot External Quality Assurance (EQA) Desktop Review Exercise with the Trust to take place in late 2015
- Undertake a review of information materials involving input from a wide range of stakeholders including service users
- Develop the website further to make it more user friendly for accessing via mobile devices; also add other useful resources such a video animation outlining what an AAA is, an update of the screening locations map, etc.
- Continue to work with appropriate prison healthcare providers to facilitate screening clinics for eligible men
- Identify further opportunities to raise general awareness of the programme and encourage further self-referrals, e.g. promotional opportunities within healthcare facilities, shopping centres, etc.
- Continue engagement with GPs and other primary care teams to raise awareness of the programme and continue to promote the self-referral pathway in local areas
- Identify additional appropriate venues within local areas to enable the screening to be provided as local as possible

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Appendices

1 NI AAA Screening Programme Staff

2 Map of Screening Locations

3 The Screening Pathway

4 Governance and Accountability Structure: Public Health Agency

5 Governance and Accountability Structure: Belfast Health and Social Care Trust

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Appendix 1 – NI AAA Screening Programme Staff:

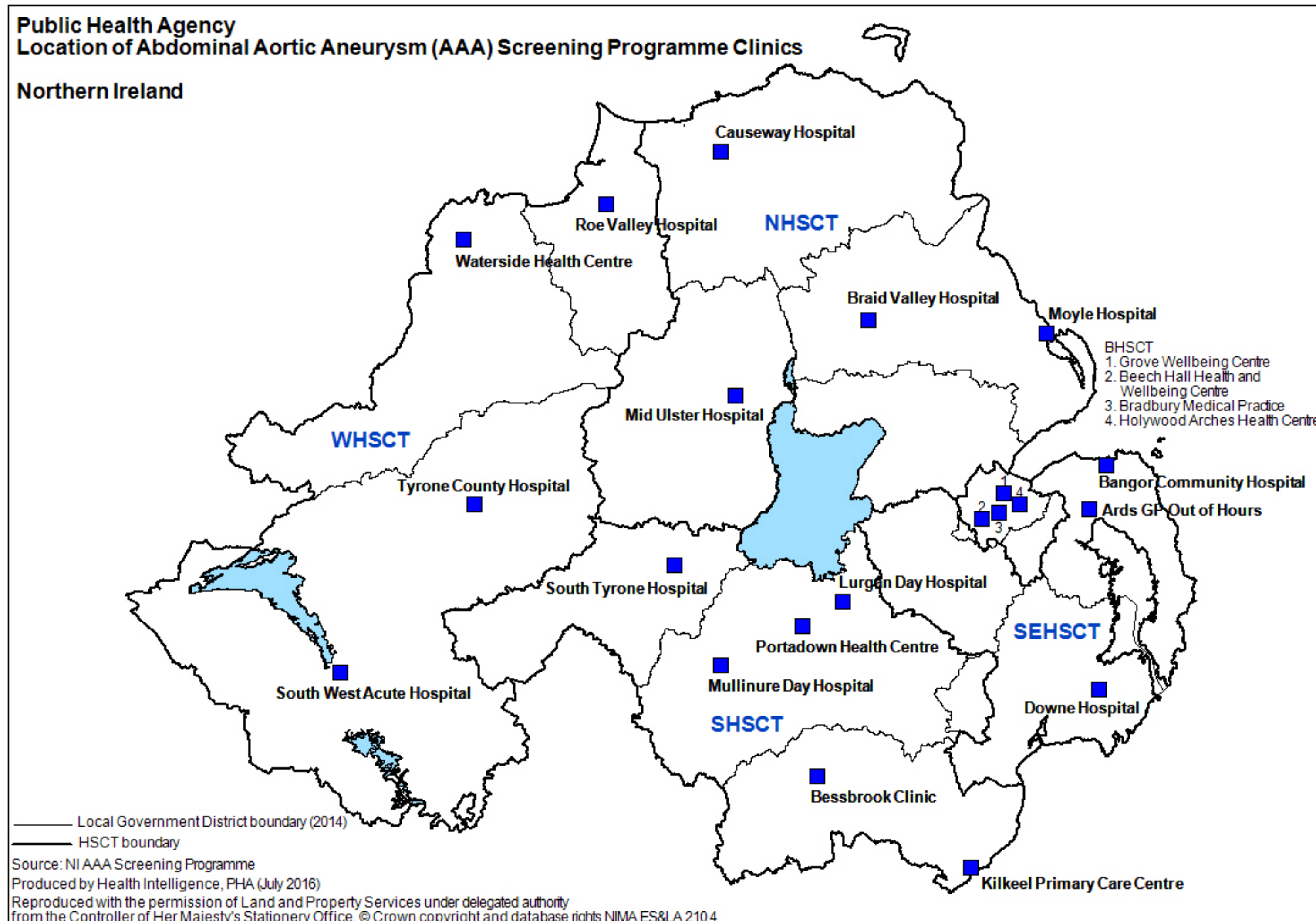
Belfast Health and Social Care Trust

Paul Blair	Clinical Lead
Janet Callaghan	Clinical Co-ordinator
Lisa Campbell	Administrative Assistant
Ciara Conway	Screening Technician
Linda Cox (until Feb 2015)	Screening Technician
Sarah Davidson	Administrative Assistant
Trez Dennison	Vascular Nurse Specialist
Elaine Donnelly	Screening Technician
Peter Ellis	Imaging Lead
Deborah Galloway (from Dec 2014)	Screening Technician
Paula Heaney (from Sept 2014)	Screening Technician
Deirdre Kearns	Lead Screening Sonographer
Pauline McMahon	Screening Technician
Roisin Monan	Assistant Programme Manager
Karen McClenaghan	Specialist Surgery Services Manager
Kathy McGuigan	Vascular Nurse Specialist
Gillian Newell	Screening Technician
Diane Stewart	Programme Manager
Gill Swain	Vascular Nurse Specialist

The Public Health Agency

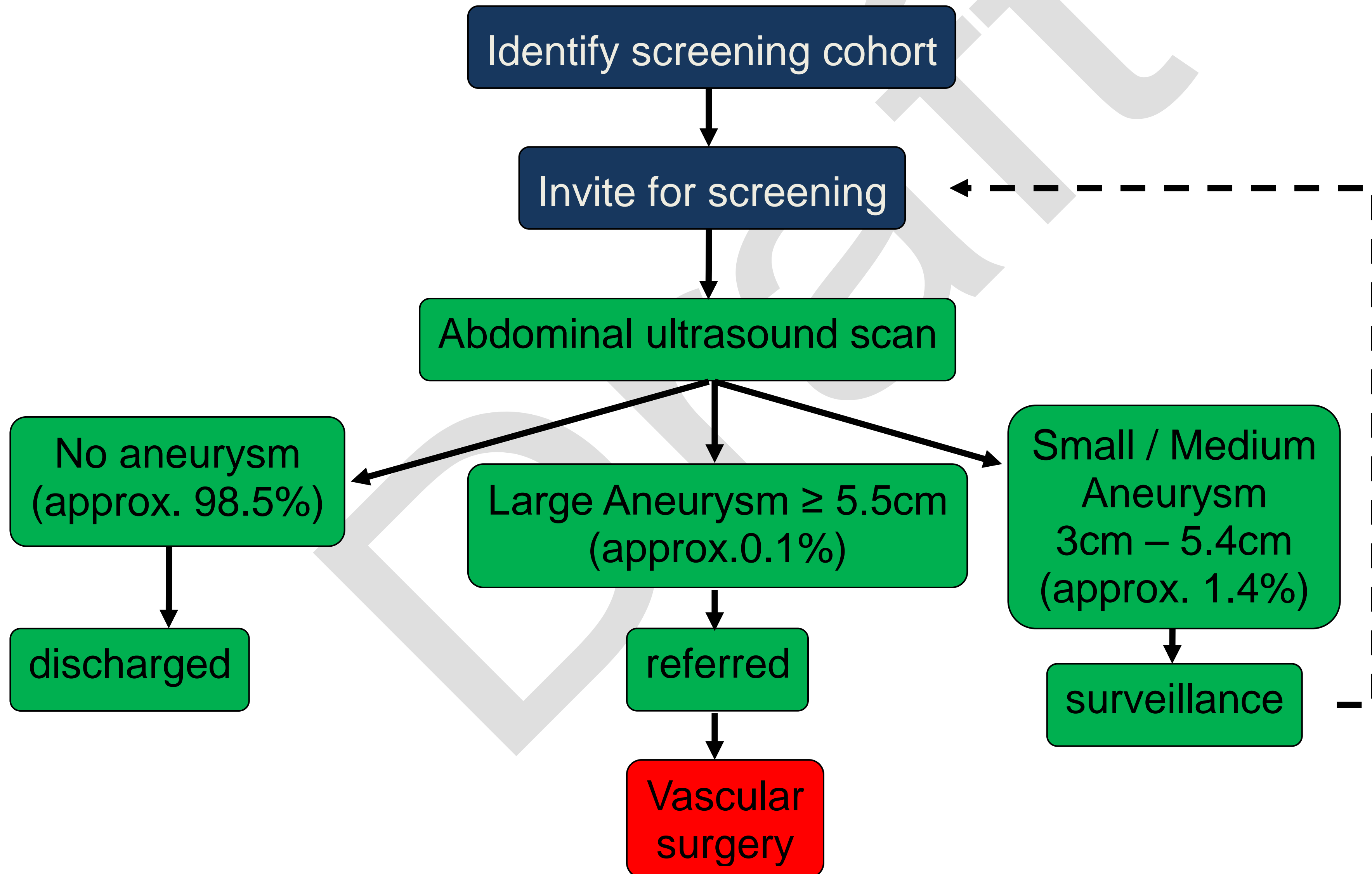
Adrian Mairs	Public Health Lead
Jacqueline McDevitt	QA and Commissioning Support Mgr
Helen McCann	Administrative Support

Appendix 2 – Map of Screening Locations



In addition, screening has been provided in Maghaberry prison

Appendix 3 – The Screening Pathway



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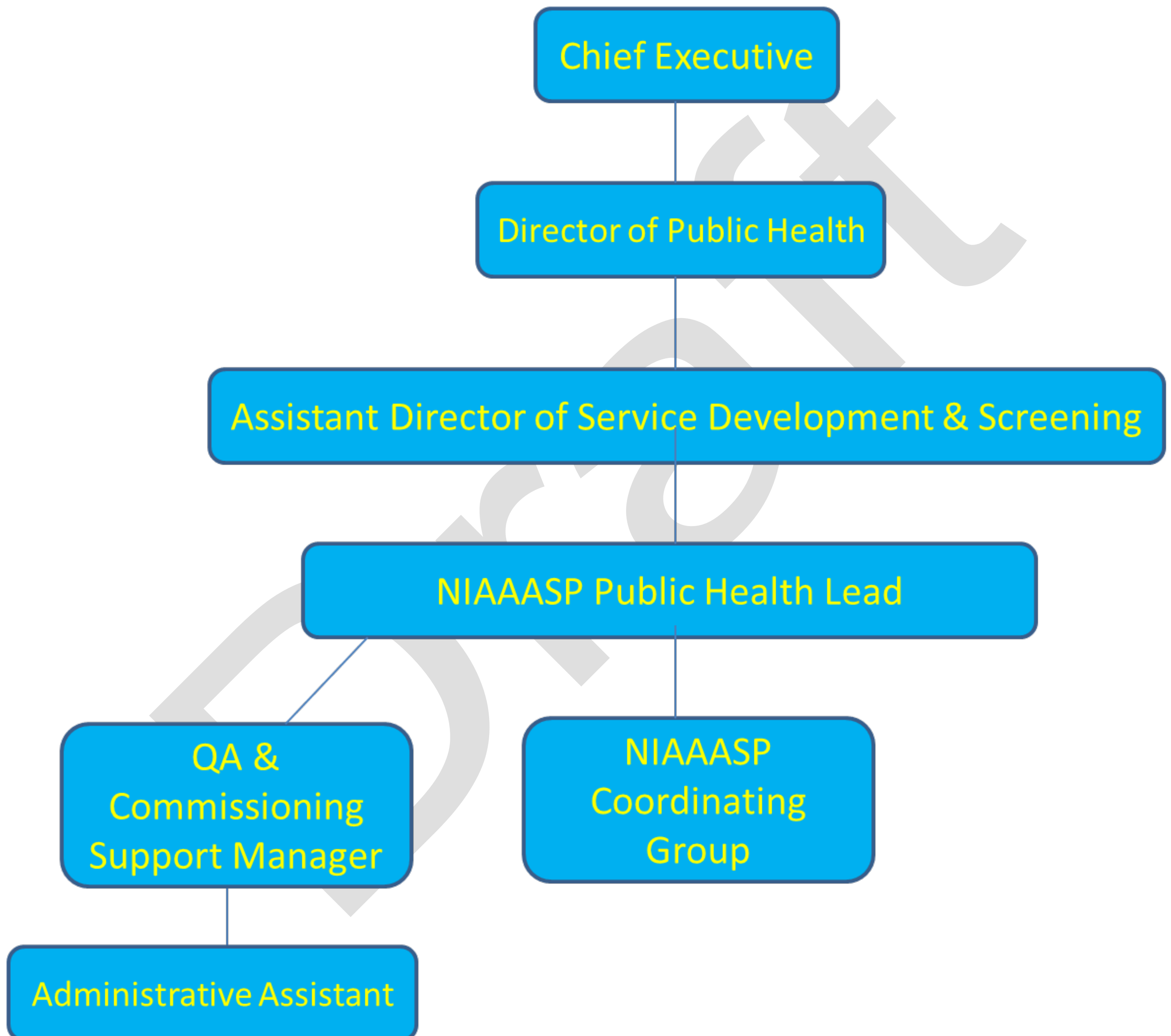
Appendix 4 – Governance and Accountability Structure: Public Health Agency



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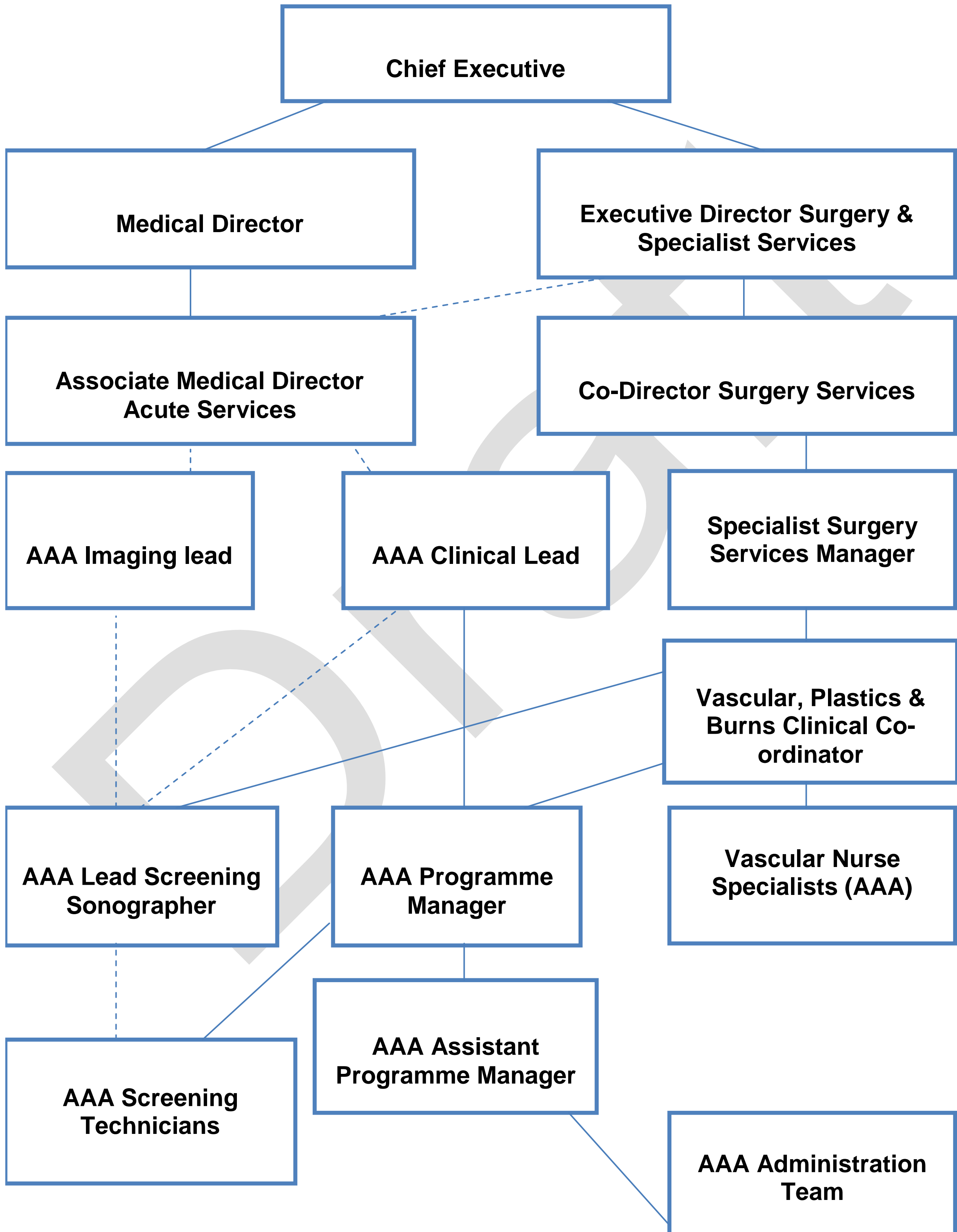
Appendix 5 – Governance and Accountability Structure: Belfast Health and Social Care Trust



If you are interested in finding out more about being screened please contact the Screening Programme Office on 02890 631828.

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Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 December 2016
Title of Paper	Corporate Risk Register
Agenda Item	11
Reference	PHA/05/12/16

Summary

Context

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the corporate register is to provide assurances to the Chief Executive, AMT, the Governance and Audit Committee and the PHA board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

Process

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The previous review was undertaken as at 30 June 2016 and was approved by AMT on 23 August 2016 and forwarded to the Governance and Audit Committee for approval at its next meeting which took place on 6 October 2016.

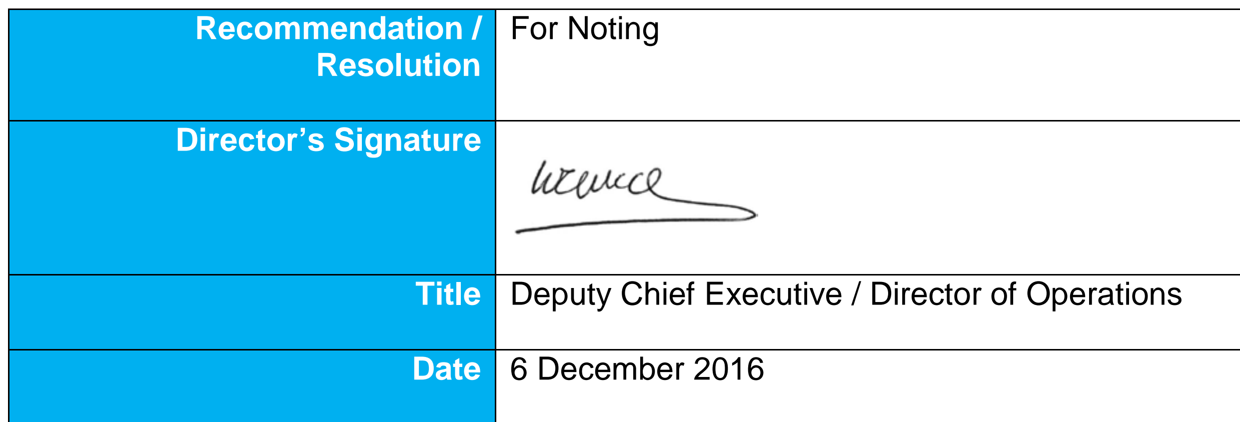
The attached corporate risk register reflects the review as at 30 September 2016 and has been carried out in conjunction with individual directorate register reviews for the same period. AMT approved this corporate risk register at its meeting on 25 October 2016.

The next review will be undertaken as at 31 December 2016.

Outcome

There were no risks added to or deleted from the Corporate Risk Register this quarter.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Corporate Risk Register was approved by AMT on 25 October 2016.



Recommendation / Resolution	For Noting
Director's Signature	
Title	Deputy Chief Executive / Director of Operations
Date	6 December 2016

Public Health Agency

PHA Corporate Risk Register

Date of Review:
30 September 2016

Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has commenced a systematic and unified process to develop a fully functioning risk register at both corporate and directorate levels that complies with the Australian/New Zealand (AS/NZS) 4360:2004 standard.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
1 – Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Overview of Risk Register Review as at June 2016

Number of new risks identified	0
Number of risks removed from register	0
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

CONTENTS

Corporate Risk		Lead Officer/s	Risk Grade	Page
26	Lack of market testing for roll forward contracts	Chief Executive	→ **MEDIUM**	5
30	Management of Lifeline Contract	Medical Director/Director of Public Health	→ **HIGH**	8
34	£2.8m (15%) Reduction in Management and Administrative Funding	Chief Executive	→ **HIGH**	12
35	Property Asset Management	Director of Operations	→ **HIGH**	14
36	Service Development & Screening Division Staffing Issues	Medical Director/Director of Public Health	→ **HIGH**	16
37	Organisation's web development and web maintenance function	Director of Operations	→ **HIGH**	18
38	Review of functions and Reorgansation	Chief Executive	→ **HIGH**	21
APPENDIX				

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Corporate Risk 26

RISK AREA/CONTEXT: Lack of market testing for roll forward contracts and lack of staff capacity to appropriately procure services in a timely way to address this.

DESCRIPTION OF RISK: Due to roll forward of many legacy contracts, PHA has not undertaken market testing of all baseline contracts as required under procurement regulations. This primarily impacts on the community and voluntary sector contracts under Health Improvement. PHA staff do not have the capacity (time) or skills, knowledge and experience in what is a technically specialist area, and also requires significant management of the process. Additionally there are constraints on BSO PALS and DLS to support and advise.	**DATE RISK ADDED:** September 2012 (Amalgamated with Corporate Risk 28, September 2013)

LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension

LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 6

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Possible	Moderate	**MEDIUM**

LEAD OFFICER: Dr E Rooney, Chief Executive

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Procurement Plan has been developed and agreed by AMT setting out the timescales for achieiving the re-tendering of baseline contracts. Revised processes and documentation-developed for PHA in liaison with PALS to ensure tender process is applied where required in line with Procurement regulations Training has been provided for relevant staff, including legal	Progress reports on implementing the Procurement Plan will be provided to PHA Procurement Board and annually to PHA board Leadership at AMT and Assistant Director level via ~~a~~ PHA Procurement board.	Legacy contracts may not be providing value for money Lack of capacity within BSO PALS Temporary additional capacity in Operations Directorate to support PHA social care procurement at risk due to financial constraints.	Continue to monitor input of additional capacity through PALS framework (~~September~~ December 2016) (Change in timeline of process) On-going review of Procurement Plan deliverability in light of reduced resource capacity across PHA ~~(September 2016)~~ December 2016	~~September~~ December 2016

aspects of procurement. Additional staffing resource to provide dedicated support for procurement within PHA. (Sept 2013) External support secured by PALS to provide dedicated resource to PHA. (August 2013) Internal management structures established to oversee implementation of the Procurement Plan.(August 2013) Suite of documentation and guidance for tendering developed. (Sept 2013) Review of Procurement Plan and wider support requirements on agenda of Procurement Board that meets every 2 months. Procurement awareness briefing sessions held (Nov 2013) Tenders for several work areas now awarded - Drug and Alcohol services MH Training ;		Significant skills, knowledge and capacity. may be lost due to financial constraints (temporary support currently only approved to 30/9/16). No regional HSC agreement on management of social care procurement. Clarification required on the implications and impact of the new Procurement Regulations (2015)		

LGB&T ; RSE Core admin resources in Operations has been diverted on a temporary basis to cover gap in procurement resource. Additional Training on new Procurement Regulations for relevant staff has been provided. Review of procurement processes and future approach undertaken taking into account lessons learnt from experience over the past 2 years and the introduction of the new Procurement regulations in Feb 2015 and the introduction of a Light Touch Regime. (October 2015) Temporary arrangement from core Ops admin to support social care procurement, kept under review, with Director of Operations. PHA membership and attendance at HSCNI Regional Procurement Board				

Corporate Risk 30

RISK AREA/CONTEXT: Management of Lifeline Contract

DATE RISK ADDED:
December 2013
Refocused – March 2016

DESCRIPTION OF RISK: The current contract will end by March 2017. Following extensive consultation, the PHA has revised the business case for the future service, preparing the way for re-tendering. The timescales for the new procurement will however mean that the new service is unlikely to be in place until–April 2017. There is therefore a risk of service provision and continuity.

LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension

LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 2

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Possible	Major	**HIGH**

LEAD OFFICER: Dr C Harper, Medical Director/Director of Public Health

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Existing monitoring of Lifeline Contract. Lifeline Steering Group (chaired by Assistant Director of Public Health) meets regularly. Regular meetings between the provider and commissioner to	Improvements have been seen in demand management, however, work continues to examine challenges to contract delivery regarding demand, data quality, accountability, clinical and governance review.	Deficiencies in original contract controls. Business case for the new service to be approved, and subsequent specification etc to be prepared.	Additional internal project will take place on a monthly basis and a clear data log of decision making continues to be held. (ongoing) PHA will continue to work with Department of Health (DoH) to seek approval of	~~Sep 2016~~ Dec 2016

monitor all aspects of the contract, through the following sub-groups: • Clinical and Social Governance • Performance management and Evaluation • Communications PHA internal Lifeline Project Management Group meets regularly to co-ordinate management and monitoring of all aspects of the contract. DoH has been advised of issues. Staff continue to work on addressing the issue of 'demand management', the action plan emerging from the clinical review, review of raw data on performance and matching with key performance indicators. Performance is now on target and continues to be monitored by the PHA. A strategic outline business case and Public Consultation Questionnaire were approved by PHA Board. A series of public events were	Rigorous monitoring of performance of existing contract, and continuation of meetings with provider (Clinical Governance, Performance & Evaluation and Communications groups). Clear communication channels and reporting to CE, Directors, AMT and PHA board on progress.		the Lifeline Crisis Response Service Public Consultation Report and PHA recommendations prior to publication. Procurement timeline prepared and is subject to change, dependent on Ministerial decision (ongoing). Procurement documentation (including specification) to be developed and agreed following feedback from Health Minister on the proposed Lifeline Crisis Response Service Public Consultation Report and PHA recommendations. (ongoing)	

held as part of the public 12 week consultation on the proposed future service and delivery model. Notice was issued to over 600 organisations registered on the PHA and HSCB databases, as well as promoting consultation through the five Protect Life Implementation Groups (PLIGs) and Regional suicide Strategy Implementation Body. In addition, 9 public workshops were held throughout the region and a further 26 meetings/events were held in response to requests. In addition, some 160 written responses using the consultation questionnaire were received. Findings of the independent clinical audit have been shared with Contact and ourtcomes of the audit continue to be monitored through the Clinical and Social Care Governance Subgroup. (ongoing). A letter was issued to Contact seeking confirmation of their				

financial viability in accordance with Clause 17 of the Special Conditions of Contract. PHA sought advice from BSO PaLS, DLS and HSCB Finance; confirmed that the organisation is sustainable to deliver the current contract As a result, the current contract has been extended until September 2016. A proposal for further independent clinical audit has been postponed due to the original delays in gaining approval and the fact that the current contract will conclude in September 2016. Independent clinical audit will be an integral element of the new service contract for Lifeline Service. PHA board approved the proposed new service model, taking account of the consultation responses at January 2016 board meeting. Procurement timeline prepared. On 18 May 2016 the current service provider accepted an offer of a further contract extension from 1 October 2016 until 31 March 2017.				

Work has commenced with BSO and HSCB to develop a technical specification for a future Lifeline Client Information System.				

Corporate Risk 34

RISK AREA/CONTEXT: Reduction in PHA budget	**DATE RISK ADDED:** **March 2015**

DESCRIPTION OF RISK: Potential inability to discharge all functions, departmental, corporate and statutory responsibilities as a result of the potential impact of £2.8m reduction in management and administration funding (2015/16) and subsequent impact of VES. In addition, the 10% reduction in the 2016/17 PHA budget, which the allocation letter states “has been applied against the PHA’s commissioning budgets ***as an interim measure*** whilst further work is progressed in relation to the “Getting Structures Right” programme” may further impact on the ability of the PHA to discharge its functions.

LINK TO ASSURANCE FRAMEWORK: Operational Performance

LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 1, 2, 4

GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**

LEAD OFFICER: Dr E Rooney, Chief Executive

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Chief Executive and Executive Directors engaged in discussion with DHSSPS on the impact this would have and potential flexibility in how it is achieved. • Establishment of scrutiny committee • Reporting to PHA board. • Staff update sessions undertaken by Chief Executive, and Directors in each PHA office (March 2015) • Finance reports to AMT and PHA board	• AMT in discussion with DOH to seek to obtain best result to allow PHA to discharge its functions • Regular briefings to board members	Uncertainty about implications and impact until final plan agreed within PHA and with DOH; Potential that budget reductions makes it impossible to discharge all functions as required in a safe and effective manner. Potential for loss of key staff and timescales in recruitment resulting in delays in programme budget expenditure	• Ongoing discussion at AMT and senior level within PHA (ongoing) • Discussion ongoing with DOH (ongoing) • Liaison with other HSC bodies on potential implications and means of mitigating these (ongoing) • Review of health improvement function structure underway • Review of secretarial/admin support ~~to be initiated by~~	~~Sept 2016~~ Dec 2016

• HR provided awareness sessions on Voluntary Exit Scheme • Allocation to cover VES received (September 2015) • Decisions made on Nursing/AHP Operations and Public Health VES and staff notified • Phased leave agreed (up to end June 2016) to facilitate business continuity • Review of Nursing & AHP directorate structure completed and management of overspend due to Unscheduled Care posts under discussion.			~~HR (to commence, August 2016)~~ underway, to report Nov 2016 •	

Corporate Risk 35				
RISK AREA/CONTEXT: Property Asset Management			**DATE RISK ADDED: June 2015**	
DESCRIPTION OF RISK: There are increasing expectations and requirements from DOH in respect of property asset management (in terms of increasing levels of detail, technical expertise and quantity), including business cases for approval of lease extensions, annual property asset management (PAM) plan and asset performance monitoring. The lease for Ormeau Baths is due to end February 2017; a business case setting out future options is now required. PHA was never resourced to undertake this work (and therefore does not have the capacity, nor the technical expertise); in trying to cover this work, other core work can not be undertaken.				
LINK TO ASSURANCE FRAMEWORK: Corporate Control				
LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 6				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	Major	**HIGH**	
LEAD OFFICER: Mr E McClean, Director of Operations				
Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
• Management of leases and licenses; • Limited support from DFP CPD Health Division • Issue discussed at Accountability Review meeting (August 2015); further discussions held with sponsor branch (September 2015); • Templates (new requirement) submitted to Reform Property Unit (September 2015) • Business case for extension	• PAM plan approved by AMT annually; • Regular reports to chief Executive	• Lack of capacity/resources to undertake the increasing property asset management requirements; • Lack of resources/capacity to take forward work to plan and implement for Ormeau Baths lease end (Feb 2017) • Resources to be identified for accommodation in Lisburn Health Centre	• Continue to work with DOH AEMB regarding future Belfast accommodation (Dec 2016) • ~~Liaison~~ Continue to liaise with SEHSCT regarding lease for staff currently located in Lisburn Health Centre (~~Sept 2016~~ March 2017) ; • Liaison with HSCB regarding potential	~~Sept 2016~~ Dec 2016

of Alexander House license for 2 years approved by DHSSPS (Jan 2016); new license agreed with landlord (March 2016); • Business case to vacate Anderson House and relocate on Tyrone and Fermanagh Hospital site approved by DHSSPS (Feb 2016) • Anderson House vacated April 2016, and staff relocated to 'Hilltop', Tyrone and Fermanagh Hospital site. • Advice and support for management of end of Ormeau Baths lease agreed with DOF • Business case for accommodation at the end of lease for Ormeau Baths (including Alexander House, submitted to DOH 30 June 2016 and approved by DOH & DOF Aug 2016; • PAM plan for 2016/17 submitted (AMT approved) July 2016 • DOF PD support with implementation of business case			accommodation/space for PHA to relocate to in 12-22 Linenhall street (~~Sept 2016~~ December 2016); • ~~Preparation and submission of PHA PAM plan by 1 August 2016;~~ • ~~Continue to liaise with DOH AEMB and DOF AMU regarding approval of business case (Sept 2016);~~ • Work with DOH and DOF to implement the approved preferred option (February 2017)	

Corporate Risk 36				
RISK AREA/CONTEXT: Service Development & Screening Division Staffing Issues			**DATE RISK ADDED:** December 2015	
DESCRIPTION OF RISK: Potential inability to discharge all functions within the screening programmes in Service Development and Screening Division. Risk to the delivery of the majority of Screening Programmes due to staff absences including sick leave, maternity leave, vacancy control and potential impact from VES due to planned reduction in management and administrative funding (can be linked to Corporate Risk 34, but not exclusively).				
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension				
LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 6				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Possible	Major	**HIGH**	
LEAD OFFICER: Dr C Harper, Medical Director/Director of Public Health				
Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
• Secondments in place to cover posts. • Temporary staffing approved through scrutiny panel and attempt at re-profiling other posts. • 2 ADs have been appointed since the retirement of the previous SD&S AD. • A ~~Temp~~ Permanet Band 8A Screening Manger has now been appointed to maintain continuity of the Screening Programmes.	• HR and Occupational Health aware of underlying issues. • Prioritising work to ensure essential screening programmes are being delivered.	• Reduction in activities supporting Screening Programmes including ~~pause to modernisation of Diabetic Eye Screening Programme~~ ceasing the production of annual reports and work to promote informed choice and postponement of a number of regional meetings. • Insufficient staff to carry out full range of programmes. • If posts removed due to VES,	• Review of staffing support to screening programmes. (Ongoing) • Stand down other programme support work and seek Chief Executive approval for further mitigation. Recruitment process for SD&S consultant in progress. Appointment should be confirmed by late Nov. (Rvw Dec16) • Re-skilling staff.	~~Sept~~ Dec 2016

• A permanent Band 7 Cancer Screening Coordinator has also recently been appointed. • ~~A Notification of Vacancy(NOV) has gone through Scrutiny Committee~~ Interviews will be held in December for a PH Consultant who will have 5 PAs devoted to population screening.		these cannot be replaced.		

Corporate Risk 37

RISK AREA/CONTEXT: Organisation's web development and web maintenance function

DESCRIPTION OF RISK: Loss of full complement of web development team (manager and two developers) due to combination of VES and career progression. Loss of significant skills, knowledge, experience and capacity represents a significant risk to PHA digital assets and online presence - including corporate site, intranet, and public health sites - and impacts on business continuity. Remaining PHA staff do not have the skills, knowledge, and experience in what is a technically specialist area, nor is there any capacity (time). Web hosting service is managed under a managed platform contract with external supplier, ie service is not supported by BSO.

DATE RISK ADDED: March 2016

LINK TO ASSURANCE FRAMEWORK: Operational Performance

LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 6

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Likely	Major	**HIGH**

LEAD OFFICER: Mr E McClean, Director of Operations

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Preliminary audit carried out of roles/responsibilities, and all web related assets and issues under the team, eg maintenance and management and development of online content; security updates; domains; passwords; software; credit card payments; video editing; hosting tender In-house resource from comms team identified for basic editing and updates	Leadership at AMT and Assistant Director level	~~Unable to meet expectations from other Directorates.~~ ~~No new website development, limited maintenance of existing sites, with potential that sites could crash~~ ~~Entirety of issues cannot be covered under maintenance contract, eg credit card payments, domain registrants~~	~~Risk management through AMT; include communication on NI Direct project. Prepare paper for AMT. (Sept 16)~~ ~~Continue to communicate issue acoss PHA and manage expectations - Communication on NI Direct project to follow AMT decision. (Sept 16)~~	Dec 2016

Initial planning underway for re-presentation of health site content to HSC Online Maintenance contract tender process concluded - third party supplier appointed to cover management, maintenance and limited update support (May 16) Renewal of hosting contract with Memset (initially for a year, with six-month extension option) (May 16) Existing credit card payment arrangements cancelled on 15 April. AD to take over as Finance are unable to offer an alternative option. (April 16). ~~Communicate issue acoss PHA – manage expectations.~~ ~~Email on management/maintenance of sites issued to ADs.~~ Risk management through AMT; included communication on NI		~~Lack of experience, skills and knowledge etc~~ Maintenance contract arrangements have proven to be less resilient than in house capacity Managing impact of departure of key staff resulting in admin workload further upstream	Confirm action plan for transfer of site content to NIDirect HSC online. Contingent on AMT approval for programme of eComms work. ~~(Sept 16.)~~ Action plan confirmed but implementation fluid; dependent on HSCB capacity. (Dec 16) Procure external company to re-develop corporate site onto Word Press, and transfer hosting to BSO (Dec 16). On hold at request of AMT. Scope web requirements of organisation, and associated staffing resource, eg Band 7 digital media manager to manage/coordinate all electronic platforms. ~~(Sept 16)~~ JD development underway. (Dec 16)	

Direct project. Paper considered at AMT. Communication on NI Direct project followed AMT decision. Continue to communicate issue acoss PHA and manage expectations				

Corporate Risk 38

RISK AREA/CONTEXT: Review of functions and Reorgansation

DESCRIPTION OF RISK: The Department have initiated a reform of HSC structures and a number of other associated reviews (eg shared services). While the Minister has stated that the PHA will be retained, with a renewed “focus on early intervention and prevention”, the detail of the reform and the timescales are unclear at this stage, resulting in uncertainty. There is a risk that during this period of uncertainty, staff will be lost, resulting in difficulties in sustaining core PHA functions and delivering our business objectives and that as shared services models are being explored, that these will impact on how the PHA does its business.

DATE RISK ADDED: March 2016

LINK TO ASSURANCE FRAMEWORK: Operational Performance

LINK TO ANNUAL BUSINESS PLAN 2016/17: Corporate Objective 6

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Possible	Major	**HIGH**

LEAD OFFICER: Dr E Rooney, Chief Executive

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Workshop for all PHA staff held in November 2015; Chief Executive is a member of the Department led Programme Board; Senior Management input to design; Joint AMT/SMT meetings; PHA board workshop held (April 2016)	AMT meetings Regular updates to PHA board	Uncertainty while reviews under way	Active engagement in the reviews (ongoing –to be reviewed ~~September~~ December 16) Chief Executive input to Reform Programme Board (ongoing –to be reviewed ~~September~~ December 16) Chief Executive report to PHA board to address this issue as necessary (ongoing, as and when necessary) Ongoing communications to staff (ongoing - to be	~~September~~ December 2016

Input to Communications capacity review engagement (April 2016) Input to Business Intelligence review engagement (April 2016) Senior officers involved in individual reviews being undertaken by DoH in respect to Business Intelligence and HSC Communications); Scrutiny Committee Senior Officers involved in DoH Transition Risk Meetings Revised structures agreed, reflective of redefined budget availability. Reprioritised and deferred some areas of work.			reviewed ~~September~~ December 16) Changes as a result of reprioritised areas of work will be reflected in the revised PHA Corporate Strategy and Business Plan (April 17)	

Public Health Agency

APPENDIX

RISKS ADDED TO THE CORPORATE RISK REGISTER AS AT 30 September 2016

NIL

Public Health Agency

APPENDIX

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 30 September 2016

NIL