HSC Public Health Agency

agenda

97th Meeting of the Public Health Agency Board

Thursday 16 November 2017 at 1:30pm

Conference Rooms 3+4, 12/22 Linenhall Street, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 19 October 2017		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Finance Report	**PHA/01/11/17**	Mr Cummings

items for noting

8 2.00	Family Nurse Partnership Revaluation Report	**PHA/02/11/17**	Mrs Hinds
9 2.30	Northern Ireland Diabetic Eye Screening Programme Pre-Consultation Exercise	**PHA/03/11/17**	Dr Harper
10 2.40	PHA Community Planning Update November 2017	**PHA/04/11/17**	Mr McClean

closing items

11 2.50	Any Other Business	Chair
12 2.55	Details of next meeting: *Thursday 21 December 2017 at 1:30pm* *Conference Rooms 3+4, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

96th Meeting of the Public Health Agency Board

Thursday 19 October 2017 at 1:30pm

Conference Rooms 3+4, 12-22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Councillor William Ashe	-	Non-Executive Director
Mr Leslie Drew	-	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
Mr Robert Graham	-	Secretariat

Apologies

Mr Brian Coulter	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC

75/17	**Item 1 – Welcome and Apologies**
75/17.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Brian Coulter, Alderman Paul Porter, Mrs Fionnuala McAndrew and Mrs Joanne McKissick.
75/17.2	The Chair welcomed the members of the public who had come to attend today's meeting.
76/17	**Item 2 - Declaration of Interests**
76/17.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

77/17 **Item 3 – Minutes of previous meeting held on 21 September 2017**

77/17.1 The minutes of the previous meeting, held on 21 September 2017, were approved as an accurate record of that meeting.

78/17 **Item 4 – Matters Arising**

62/17.5 AAA Screening Report

78/17.1 Ms Mann-Kler asked if the data on AAA incidence within the prison population was now available. Mr Graham agreed to follow this up with Mrs McDevitt.

68/17.6 Appointment of Non-Executive Directors

78/17.2 The Chair advised members that there was a delay of one week in the publication of the advertisement for new PHA non-executives. In response to a question from Ms Mann-Kler, he said that the advertisement would be encouraging applications from groups where the Board is currently under-represented.

57/17.3 TIG Working Group on Social Care Procurement Clauses

78/17.3 Mr Mahaffy asked if any of the outputs of the group were available as previously requested. Mrs Watts agreed to follow this up in Mrs McAndrew's office.

79/17 **Item 5 – Chair's Business**

79/17.1 The Chair circulated a paper he had received from Public Health England which related to the length of reports presented to the Board.

79/17.2 The Chair said that the recent financial training that non-executive had received was excellent and he thanked those involved in organising it, and in particular Mr Simon Christie for preparing the glossary of terms. Councillor Ashe said that the training was very important as part of members' induction. The Chair said that the Chief Executives' Forum was keen to run similar training and he suggested that a similar course in the area of strategic planning may also be useful. Members agreed that the training was very beneficial as it was specific to PHA, and that the Director of Finance was also present.

79/17.3 The Chair advised members that he had attended the UK Public Health Forum in Edinburgh and that one full day was given over to "health as a human right". He said that the meeting heard from two individuals who had been homeless and that It transpires that anyone who is homeless is not permitted to register with a GP.

79/17.4 The Board noted the Chair's Business.

80/17 **Item 6 – Interim Chief Executive's Business**

80/17.1 The Interim Chief Executive said that at the last Board workshop she had presented recommendations on the operating model for the future PHA following a request by the Permanent Secretary. She added that this model outlined which functions could transfer to PHA and that the paper had been presented at the Transformation Implementation Group (TIG). She advised that at the TIG meeting, the recommendations were noted and will form part of an overall operating model which will be presented to a new Health Minister for approval.

80/17.2 The Interim Chief Executive advised that TIG is also considering a report by Sean Donaghy regarding the transition of eHealth to the Department of Health. She said that all of this work was important in terms of looking at new integrated ways of working in any future health service model and there was a need to strengthen integration and collaboration across the HSC. She went on to say that any new system needs to be built around patients and communities, and not institutions and bureaucracy, and that it must be financially sustainable.

80/17.3 The Interim Chief Executive said that, in relation to PHA, she would continue to work with the Department of Health to support the development of policy across the public health agenda.

80/17.4 The Chair had a query about timescales, but he acknowledged that the absence of a Health Minister does not help the current situation. He asked about where the function of connected health would sit. The Interim Chief Executive said that Sean Donaghy would be looking at this as part of this work.

80/17.5 Mr Drew said that it is importance that there is a change of culture and that processes are reviewed, before looking at how IT can help.

80/17.6 Ms Mann-Kler thanked the Interim Chief Executive for the update, but said that in any cultural change it is important that people feel part of the change and it was unfortunate that there has been no role for PHA Board to play a part in the transformation process. The Interim Chief Executive said that it is intention to work with the senior management teams of both HSCB and PHA to identify a work programme as a follow on to the staff workshops that were held in April 2017. She said that the issues that staff had raised were being progressed, but that there was more work to do.

80/17.7 Ms Mann-Kler noted that the paper suggested the future PHA as having an advisory function to the Department of Health. The Interim Chief Executive clarified that this had been put into the paper as an option, but that the Permanent Secretary has made it clear that the future PHA will remain an ALB. Ms Mann-Kler said that in the paper PHA's role of promotion and protection was listed second behind its role of carrying out this advisory role for the Department. The Interim Chief Executive said that there was no priority order, and that protecting people will be the

focus of the future PHA.

80/17.8 The Board noted the Interim Chief Executive's business.

81/17 Item 7 – Finance Report (PHA/01/10/17)

81/17.1 Mr Cummings presented the Finance Report for the period up to 31 August and said that there was little variation from the previous report. He advised that there was a year to date surplus of £919k which was as a result of two factors – underspends in demand-led services and the administration budget. He said that there had been meetings with Directors to review the budgets and that he anticipated that over the next few months there would be little change as recruitment to fill key posts is taking time. Dr Harper added that a key issue was that many posts were being filled internally.

81/17.2 Mr Drew asked if it would be possible for members to see any new Investment Plans and Mr Cummings said that these could be shared. Mr Drew went on to express concern as to whether filling all the vacant posts would be sufficient to reduce the management and administration surplus given we are over halfway through the financial year, and if the funds could be used elsewhere. Mr Cummings said that PHA would do all that it could within the regulations, but there was an option to transfer funds non-recurrently to the programme budget. The Interim Chief Executive informed members that a mid-year budget review meeting with all budget managers is due to take place and decisions will be made based on the outputs of that meeting. Mr Cummings said that any surplus would be gratefully received by the Department to ease some of the pressures across the HSC as a whole. Dr Harper added that PHA always ensures that funding is spent appropriately.

81/17.3 Ms Mann-Kler asked about the additional £40m of funding allocated to health. Mr Cummings explained that all government departments regularly review their budgets and a result of the most recent review other departments had surplus funds, some of which were able to be transferred to health. He pointed out that health had submitted bids for £100m. Ms Mann-Kler said that it would be useful if strategically significant issues like this could be reported to the Board to enable members to understand the context.

81/17.4 Ms Mann-Kler asked whether there will be any surplus funds from the DoH that may be allocated to PHA campaigns. The Interim Chief Executive said that PHA is looking at how it could reduce expenditure on campaigns which will form part of the discussions regarding next year's budget. Mr Cummings cautioned that over the next two years, the pressures on the health budget are around £400m.

81/17.5 The Board noted the Finance Report.

82/17 Item 8 – Presentation by Samaritans Ireland

82/17.1 The Chair welcomed Deirdre Toner and Julie Aiken from Samaritans Ireland to the meeting and invited them to deliver their presentation on the work of the organisation.

82/17.2 Ms Toner gave an overview of the history of the Samaritans and its work as well as how it trains its volunteers. She moved on to give an overview of the work carried out in prisons and schools and its future priorities.

82/17.3 Ms Toner finished the presentation by saying that Samaritans recognise that suicide prevention is a complicated situation and that there is a broad range of issues in people's lives.

82/17.4 Mr Drew said it was encouraging that Samaritans is providing services to employers as well as being a helpline. He suggested that changes in the digital environment must be costly. Ms Toner said that there is funding in place to ensure that Samaritans helpline is free to access. She added that it is important that all of Samaritans' volunteers are trained appropriately to deal with calls ensuring that all legislation, e.g. Data Protection is adhered to. Mr Drew asked how many calls Samaritans would deal with on an annual basis. Ms Toner said that for Northern Ireland approximately 200,000 calls would be received annually.

82/17.5 The Chair noted that 78% of calls are not linked to suicide. Ms Toner said that there are individuals who would be repeat callers who are likely to self-harm and Lady 2 noted that Samaritans offers a different type of service to the Lifeline service.

82/17.6 Ms Mann-Kler asked if demand is increasing and if refugees and asylum seekers have access to Samaritans services. Ms Aiken said that there has been a rise in the number of callers in Northern Ireland. Ms Toner said that volunteers are trained from different communities and that there is access to the wider UK team of volunteers if assistance is required for different nationalities. Ms Mann-Kler asked about developments within digital media and Ms Toner said that there is progress being made in these areas.

82/17.7 Councillor Ashe asked about the 12-week training programme for volunteers and what precautions are taken to ensure the mental health and wellbeing of staff. Ms Toner outlined how volunteers are trained and the support mechanisms that are in place. She said that in every branch there is a Safeguarding Officer and an expert in Data Protection. She added that there are services available for volunteers. Councillor Ashe asked how long individuals normally volunteer for. Ms Toner said that after 9/10 months it is possible to assess whether a person is suited to the role. She added that people can take on different volunteer roles and spend up to 15 years with the organisation.

82/17.8 The Chair asked whether repeat callers have to re-tell their story each

time they ring. Ms Aiken explained that there is a policy whereby the organisation seeks to reduce people's dependence on the service and that instead of them repeat calling, Samaritans can call them.

82/17.9 The Chair thanked Ms Toner and Ms Aiken for their presentation.

83/17 Item 9 – PHA/HSCB Annual Quality Report (PHA/02/10/17)

83/17.1 Mrs Hinds presented the Annual Quality Report which she explained is a report that PHA and HSCB are required to publish by the Department of Health. She explained that the format is also laid down by the Department, but that based on comments received by members in previous years, this year's report is more concise and is more user friendly. She said that it is PHA's intention to launch the report as part of World Quality Day in November.

83/17.2 Mrs Hinds outlined to members the five key sections within the report (Transforming the Culture, Strengthening the Workforce, Measuring the Improvement, Raising the Standards and Integrating the Care) and noted one or two of the main achievements within each section. She advised that as part of the preparation for the report different teams within HSCB and PHA were asked to highlight particular areas, which were shortlisted for inclusion in the final report.

83/17.3 The Chair praised the format of the report, but asked about 7-day working and availability of AHPs in Emergency Departments. Mrs Hinds said that through the Integrated Care Partnerships, direct access to physios is being looked at, and that there are pilots in two Trust areas.

83/17.4 Ms Mann-Kler said that the report was excellent and asked if PHA can benchmark against other parts of the UK. Mrs Hinds explained that benchmarking is difficult as different countries measure different outcomes, but she said that PHA is participating in national audits where it is possible to drill down into specific data, and that there are areas of good practice in Northern Ireland.

83/17.5 Mr Drew commended the report saying that it was easy to read. He suggested that in future reports there could be some analysis comparing performance of previous years. Mrs Hinds agreed to look at this and noted that in areas such as SAIs and complaints, comparative data is available.

83/17.6 The Chair asked that Mrs Hinds convey the Board's thanks to all of those who had been involved in the compilation of the report.

83/17.7 The Board **APPROVED** the Annual Quality Report.

84/17 Item 10 – Mid-Year Assurance Statement (PHA/03/10/17)

84/17.1 The Interim Chief Executive advised that the PHA is required to submit a

mid-year Assurance Statement to the Department of Health and that the Statement being presented today has been considered by both the Agency Management Team and the Governance and Audit Committee. She explained that the format of the Statement is set down by the Department.

84/17.2 The Interim Chief Executive drew members' attention to the Internal Control Divergences and said that that the areas covered were the same as in previous statements, but with the addition of some narrative regarding the non-recurrent removal of funding for PHA campaigns. She went on to say that following last week's Governance and Audit Committee, an insertion was made in Section 12 drawing reference to the recent finance training that members attended.

84/17.3 The Interim Chief Executive said that if members were content to approve the statement it will be sent to the Department of Health.

84/17.4 The Board **APPROVED** the Mid-Year Assurance Statement Report.

85/17 Item 11 – Governance and Audit Committee Update (PHA/04/10/17)

85/17.1 In the absence of Mr Coulter, the Chair asked Ms Mann-Kler to update members on the last meeting of the Governance and Audit Committee.

85/17.2 Ms Mann-Kler said that following the last meeting of the Committee, Mr Coulter had written to the Chair of the BSO Audit Committee passing on the Committee's concerns about Shared Services. She advised that a response was received which gave an update on the action plan, and that while some progress has been made, there remains a lot of work to be done.

85/17.3 Ms Mann-Kler said that the Committee was given an update on the latest developments with regard to cyber security. She reported that a regional Cyber Security Board has been convened by the Department of Finance, and there is an HSC Cyber Security Business Continuity Board. She added that the Committee discussed the need for clarity regarding roles, responsibilities and accountability for cyber security, and the need for an overall cyber security strategy.

85/17.4 Ms Mann-Kler moved onto the Internal Audit reports. She said that the first report considered, on research and development (R&D) gave limited assurance with governance and oversight arrangements cited as an area of concern. She added that there was a suggestion that an annual report on R&D is brought to the Board. She assured members that there are no issues with how the R&D function is carried out. The next report was on risk management and she advised that this report gave satisfactory assurance and that there was a suggestion about holding a Board workshop on risk management. She said that the Committee Chair felt that the current oversight arrangements were satisfactory. Ms Mann-Kler

advised that a report on contracts with the community and voluntary sector gave satisfactory assurance in terms of the management of contracts but limited assurance in terms of the procurement of contracts.

85/17.5 Ms Mann-Kler said that the mid-year follow up of Internal Audit recommendations showed that 86% of previous recommendations have been fully implemented and the remainder partly implemented.

85/17.6 Ms Mann-Kler updated members on fraud and said that the latest Fraud Liaison Officer Update Report showed three new cases and one completed case. She advised that the complete case did not find any fraud in relation to transactions with PHA.

85/17.7 Ms Mann-Kler moved onto corporate governance. She said that members considered the revised Corporate Risk Register as at 30 June was considered and that one new risk has been added in terms of cyber security. She added that a risk relating to the reduction in campaigns will be included at the next review at 30 September.

85/17.8 The Chair asked about the limited assurance in the procurement of contracts. Mr Cummings said that this related, in the main, to the slowness of how procurements are being progressed and the challenge of meeting the timetable with reduced staff and expertise. Mr McClean added that the procurement plan is a 3/4 year plan, and that PHA is beginning to fill gaps in capacity.

85/17.9 The Interim Chief Executive asked about the risk in relation to campaigns. Mr McClean said that in the absence of campaigns, PHA has limited means to get across the public health messages it is required to as part of its legislative remit of informing the population. The Chair said that AMR is a huge issue and that Public Health England is beginning a campaign and he was concerned that PHA does not have a plan. Mr Stephen Wilson, who had joined the meeting at this point, said that PHA has developed a plan, but one that does not involve mass media.

85/17.10 Ms Mann-Kler advised that the Governance and Audit Committee noted the updated Assurance Framework and approved the updated Risk Management Strategy and Policy. She said that the Committee received updates on the Information Governance and General Data Protection Regulations Action Plans, where there is a focus on staff training in information governance with regular reminders being issued to staff regarding this.

85/17.11 Ms Mann-Kler said that the Committee approved the Mid-Year Assurance Statement and noted the SBNI Declaration of Assurance.

85/17.12 Members noted the update from Ms Mann-Kler.

86/17 **Item 12 – Any Other Business**

86/17.1 There was no other business.

87/17 **Item 13 – Date and Time of Next Meeting**

Thursday 16 November 2017 at 1:30pm

Conference Rooms 3+4, 12/22 Linenhall Street, Belfast.

Signed by Chair:

Date: 16 November 2017

Public Health Agency

Finance Report, including Mid-Year Statement of Financial Position (Balance Sheet) and Capital Position

2017-18

Month 6 - September 2017

PHA Financial Report - Executive Summary

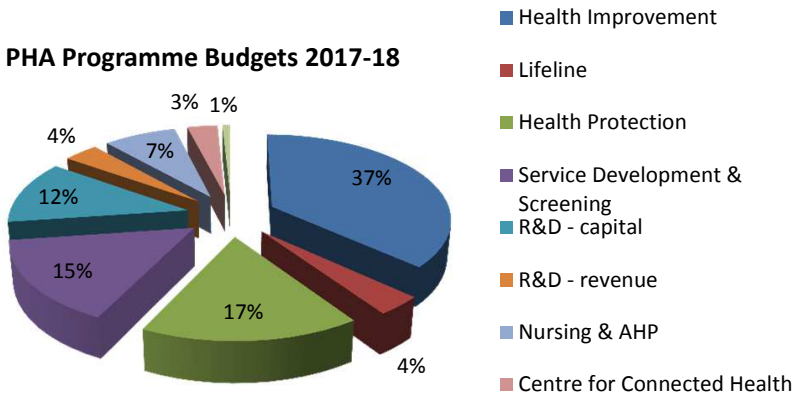
Year to Date Financial Position (page 2)

At the end of month 6 PHA is underspent against its profiled budget by approximately £1.4m. Whilst this is not unusual for this stage of the year due to the difficulty of accurately profiling expenditure, budget managers will continue to be encouraged to review their positions and take the necessary action to minimise underspends.

This underspend is primarily within Health Improvement and Health Protection budgets, combined with underspends on salaries budgets across the Agency.

Programme Budgets (pages 3&4)

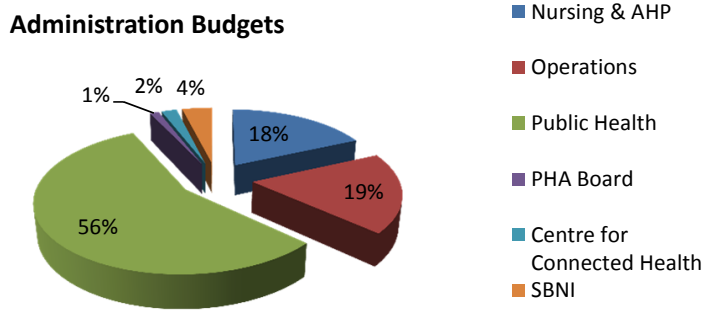
The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.



Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

There are currently approximately 30 vacant posts within PHA, and this is creating slippage on the Administration budget. It is currently estimated that this could rise to over £1m by year end, and this will be kept under close review as the year progresses.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year. Early projections indicate slippage will arise in-year from the Lifeline and Adminstration budgets in particular. Management will re-invest the Lifeline slippage in other suicide prevention and mental health initiatives where possible, however this remains an area of risk.

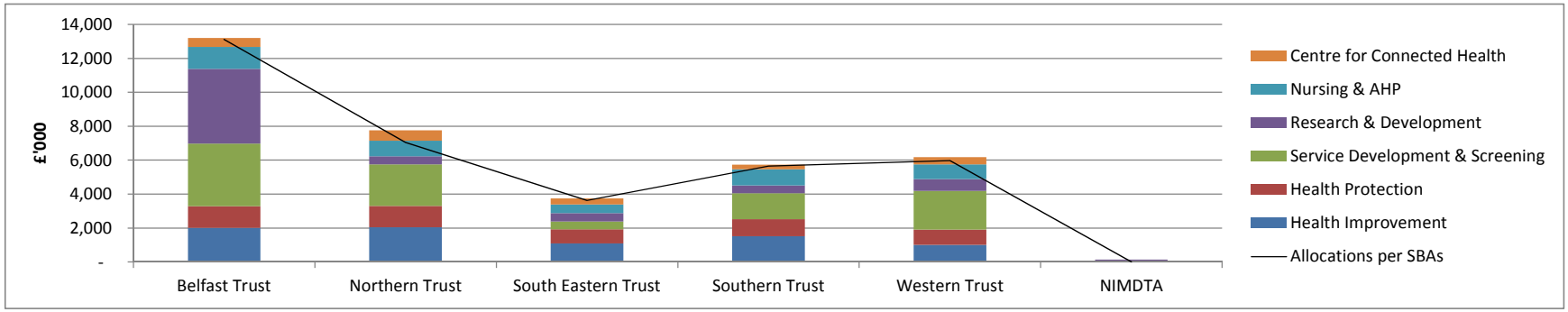
Public Health Agency
2017-18 Summary Position - September 2017

	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust	PHA Direct			Trust	PHA Direct		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Departmental Revenue Allocation	30,242	45,664	19,091	**94,997**	14,447	14,986	9,415	**38,847**
Revenue Income from Other Sources	-	150	377	**527**	-	25	190	**216**
Capital Grant Allocation & Income	6,663	3,779	-	**10,442**	3,332	323	-	**3,653**
Total Available Resources	36,905	49,593	19,468	**105,966**	17,779	15,334	9,605	**42,718**
Expenditure								
Trusts	36,905	-	-	**36,905**	18,453	-	-	**18,453**
PHA Direct Programme *	-	49,593	-	**49,593**	-	13,841	-	**13,841**
PHA Administration	-	-	19,468	**19,468**	-	-	9,048	**9,048**
Total Proposed Budgets	36,905	49,593	19,468	**105,967**	18,453	13,841	9,048	**41,342**
Surplus/(Deficit) - Revenue	-	-	-	-	(674)	1,819	557	**1,703**
Cumulative variance (%)					***-4.66%***	***12.12%***	***5.80%***	***4.36%***
Surplus/(Deficit) - Capital	-	-	-	-	-	(327)	-	**(327)**
Cumulative variance (%)					*0.00%*	*-101.19%*	*0.00%*	***-8.94%***

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

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £1.4m, mainly due to spend behind profile on Revenue Budgets within Health Improvement (notably the demand-led Lifeline contract) and also a year to date underspend on Admininstration budgets (see page 5). It is currently anticipated that the PHA will breakeven for the year.

Programme Expenditure with Trusts

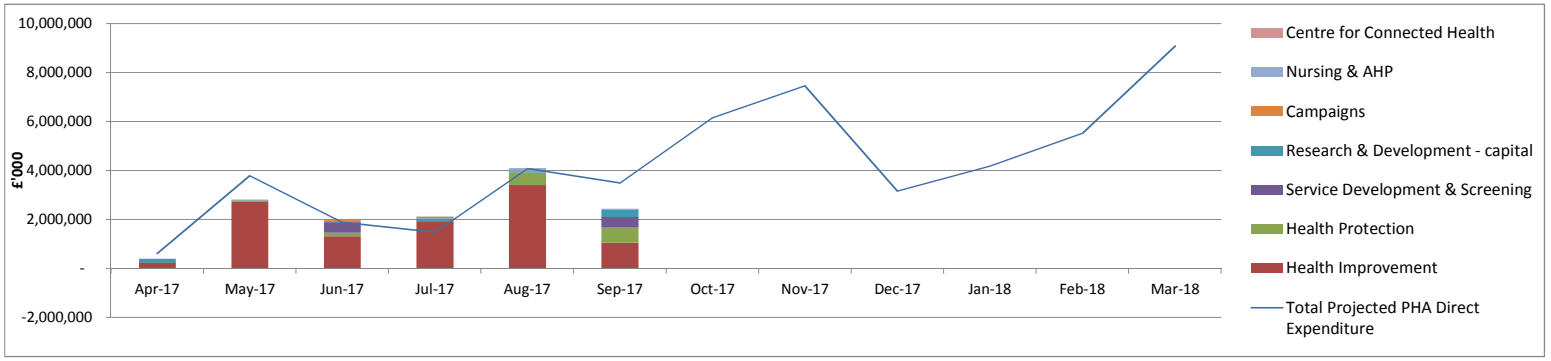


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	2,005	2,044	1,095	1,512	1,001	-	**7,657**	3,787	3,829	(42)
Health Protection	1,288	1,252	832	1,010	901	-	**5,284**	2,642	2,642	0
Service Development & Screening	3,679	2,461	465	1,536	2,293	-	**10,433**	5,213	5,217	(3)
Research & Development	4,407	479	491	447	697	143	**6,663**	3,332	3,332	(0)
Nursing & AHP	1,293	913	512	954	857	-	**4,528**	1,673	2,264	(591)
Centre for Connected Health	528	616	348	282	425	-	**2,199**	932	1,099	(167)
Chief Executive	102	- 171	70	83	56		**140**	199	70.13	129
Total current RRLs	**13,302**	**7,594**	**3,813**	**5,823**	**6,230**	**143**	**36,905**	**17,779**	**18,453**	(674)
Cumulative variance (%)										***-3.79%***

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.

The year to date position shows a small variance against profile, but this is a timing issue only as funds initially held within non-Trust budgets have been issued to Trusts. The Programme position across both Trust and PHA Direct budgets is a £0.8m underspend, mainly due to expenditure behind profile in Health Improvement (including Lifeline) and Health Protection (see page 3). It is expected that these budgets will break even at the end of the year.

PHA Direct Programme Expenditure



	Apr-17 £'000	May-17 £'000	Jun-17 £'000	Jul-17 £'000	Aug-17 £'000	Sep-17 £'000	Oct-17 £'000	Nov-17 £'000	Dec-17 £'000	Jan-18 £'000	Feb-18 £'000	Mar-18 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Projected Expenditure																	
Health Improvement	306	3,457	1,058	753	3,308	1,094	1,669	3,805	388	1,885	4,625	2,164	**24,512**	9,976	9,713	263	*2.6%*
Lifeline	264	264	264	264	264	264	264	264	264	264	264	264	**3,173**	1,586	937	649	*40.9%*
Health Protection	-	27	31	131	424	1,429	1,764	2,253	942	844	613	956	**9,413**	2,041	1,079	962	*47.1%*
Service Development & Screening	34	47	456	34	65	456	152	8	430	88	8	1,441	**3,219**	1,093	1,102	(10)	*-0.9%*
Research & Development - capital	-	-	64	259	-	-	-	-	-	-	-	3,457	**3,779**	323	649	(327)	*-101.2%*
Research & Development - revenue	-	-	-	-	-	-	-	1,067	1,067	1,067	-	-	**3,200**	-	-	-	*0.0%*
Campaigns	-	-	-	-	-	205	45	45	50	-	-	20	**365**	205	228	(23)	*-100.0%*
Nursing & AHP	1	1	12	35	1	22	1,840	1	7	15	5	190	**2,128**	71	133	(62)	*-88.4%*
Centre for Connected Health	-	-	-	-	20	20	425	20	20	20	20	20	**567**	41	-	41	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	584	**584**	-	-	-	*100.0%*
Total Projected PHA Direct Expenditure	**605**	**3,795**	**1,885**	**1,476**	**4,082**	**3,490**	**6,160**	**7,464**	**3,168**	**4,182**	**5,536**	**9,096**	**50,941**	**15,334**	**13,841**	**1,493**	
Cumulative variance (%)																***9.74%***	
Actual Expenditure	**433**	**2,853**	**2,054**	**2,170**	**3,845**	**2,487**	**-**	**-**	**-**	**-**	**-**	**-**	**13,841**				
Variance	**172**	**942**	**(168)**	**(693)**	**237**	**1,003**							**1,493**				

The budgets and profiles are shown after adjusting for retractions and new allocations in the Allocation Letter from DoH. The Campaigns budget has been entirely retracted, and Price Inflation has not been applied to individual budgets but rather held centrally in the Other line for further discussion in the pending Investment Plan.

Expenditure is £1.5m behind profile for the year to date, however some of this funding has been allocated to Trusts and is shown on page 2. Programme spend as a whole (Trust and PHA Direct) is £0.8m behind profile at month 6, mainly due to delays on payments within Health Improvement (including Lifeline) and Health Protection. Budget managers will continue to review variances closely throughout the remainder of the year to ensure PHA meets its breakeven obligations.

PHA Administration
2017-18 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	3,354	2,377	10,614	230	317	464	**17,357**
Goods & Services	204	1,208	337	33	72	297	**2,151**
Price Inflation				62			**62**
Savings target				(100)			**(100)**
Total Budget	**3,559**	**3,585**	**10,951**	**225**	**389**	**760**	**19,469**
Budget profiled to date							
Salaries	1,691	1,188	5,319	96	159	194	**8,647**
Goods & Services	79	605	174	10	29	61	**958**
Total	**1,770**	**1,793**	**5,493**	**106**	**188**	**255**	**9,605**
Actual expenditure to date							
Salaries	1,620	1,143	4,996	46	168	194	**8,166**
Goods & Services	84	589	148	(29)	29	61	**882**
Total	**1,704**	**1,732**	**5,143**	**17**	**197**	**255**	**9,048**
Surplus/(Deficit) to date							
Salaries	71	45	323	50	(9)	(0)	**480**
Goods & Services	(5)	16	27	39	0	0	**77**
Surplus/(Deficit)	**66**	**60**	**350**	**89**	**(9)**	**(0)**	**557**
Cumulative variance (%)	*3.73%*	*3.37%*	*6.37%*	*84.17%*	*-4.62%*	*0.00%*	***5.80%***

A savings target of £0.1m was applied to the PHA's Administration budget in 2017-18. This is currently held centrally within PHA Board, and will be managed across the Agency through scrutiny and other measures.

The year to date salaries position is showing a surplus which is being generated by approximately 30 vacancies currently within PHA. It is likely that this will continue to grow as the year progresses, and senior management will monitor this closely in the context of PHA's obligation to achieve a breakeven position for the financial year.

PHA Prompt Payment

Prompt Payment Statistics

	September 2017 Value	September 2017 Volume	Cumulative position as at 30 September 2017 Value	Cumulative position as at 30 September 2017 Volume
Total bills paid (relating to Prompt Payment target)	£3,055,823	359	£20,207,633	2,611
Total bills paid on time (within 30 days or under other agreed terms)	£3,002,846	336	£19,940,315	2,423
Percentage of bills paid on time	**98.3%**	**93.6%**	**98.7%**	**92.8%**

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 at 92.8%. PHA is making good progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 92.5% by value for the year to date, which significantly exceeds the 10 day DoH target for 2017-18 of 60%.

Public Health Agency

Statement of Financial Position as at 30th September 2017

	30th September 2017 (Month 6) £000	31st March 2017 (Published Accounts) £000	
Non-current assets			
Property, plant and equipment	417	540	
Intangible assets	153	178	
Total non-current assets	570	718	
Current assets			
Trade and other receivables	297	493	
Other current assets	43	15	
Cash and cash equivalents	448	419	
Total current assets	789	927	
Current liabilities			
Trade and other payables	(4,957)	(6,987)	
Provisions	-	(375)	This provision for one legal case is now expected to be utilised in 2017-18.
Total current liabilities	(4,957)	(7,362)	
Non-current liabilities			
Provisions	-	-	
Total non-current liabilities	-	-	
Total assets employed	**(3,598)**	**(5,717)**	
Financed by taxpayers' equity			
Revaluation reserve	35	36	The mid-year Statement of Financial Position (Balance Sheet) is displayed against the audited position as at 31st March 2017.
SoCNE * reserve	(3,633)	(5,753)	
Total taxpayers' equity	**(3,598)**	**(5,717)**	

* Statement of Comprehensive Net Expenditure

PHA Capital Expenditure Position

2017-18 - Month 6 (September 2017)

Capital Scheme	Annual Budget £000	Allocation/Spend to Date £000	Forecast Expenditure £000	Variance £000	Notes
ICT	101	-	101	-	This allocation is for ICT capital directly expended by the PHA. The amount covers 2 minor schemes and is expected to be fully utilised.
General Capital	35	1	35	-	This is the general allocation for PHA which is administered by Planning and Corporate Services. The 2017/18 forecast expenditure is for the remaining invoices relating to Linum Chambers.
Farm Families Health Check	5	-	5	-	This is a capital allocation required to fund an upgrade to the IT system used for a health check programme specifically targeting farmers and their families. The forecast position is breakeven.
Research & Development - Other Bodies	4,562	621	3,840	722	This allocation relates to the element of PHA's R&D funding that is expended with bodies other than Trusts. This is a change from previous years when all R&D funding was disseminated through resource allocations as revenue, whereas R&D is now classified as capital following changes in European legislation. The forecast slippage has been communicated to DoH and is expected to be managed within the total R&D allocation envelope, leaving a breakeven position for the year.
Research & Development - Trusts	6,000	3,332	6,663	(663)	This allocation relates to the element of PHA's R&D funding that is expended with Trusts. The forecast over-spend has been communicated to DoH and is expected to be managed within the total R&D allocation envelope, leaving a breakeven position for the year.
Research & Development - EITP	100	28	159	(59)	This allocation relates to the Early Intervention Transformation Programme (EITP), and consists of funding of £75k from Atlantic Philanthropies (see line below) and £25k from DoH. The forecast overspend has been communicated to the DoH, and will be managed within the total R&D capital expenditure limit.
Research & Development - EITP Capital Receipts	(75)	(75)	(75)	-	This relates to funding from Atlantic Philanthropies for the Early Intervention Transformation Programme which has already been received.
Research & Development - Capital Receipts	(279)	(247)	(343)	64	This allocation is for income associated with R&D which is now reported and notified to DoH as capital receipts. The increased receipts figure has been reported to DoH and an update to the allocation to "cover" the forecast figure is expected.
Total	**10,449**	**3,659**	**10,384**	**64**	

The PHA has received indicative Capital Departmental Expenditure Limit (CDEL) allocations in 2017/18 for a range of capital initiatives, both those which create assets in the PHA's accounts and those which are provided to HSC Trusts, other providers, and academic bodies. This mid-year review highlights the latest financial position and all CDEL budgets are expected to breakeven by either direct expenditure by PHA, allocations made to other organisations, or withdrawal and reallocation of surplus CDEL by DoH.

HSC Public Health Agency

board paper

Northern Ireland Diabetic Eye Screening Programme
Pre-Consultation Exercise

date 16 November 2017 **item** 9 **reference** PHA/03/11/17

presented by Dr Carolyn Harper, Medical Director

action required For noting

Summary

The Northern Ireland Diabetic Eye Screening Programme aims to reduce loss of vision caused by diabetic eye disease through early diagnosis and treatment.

In the Western Trust area the service is delivered at six fixed HSC sites. Elsewhere it is delivered as a peripatetic service at each general practice. This latter arrangement presents a number of issues:

- Inability to maintain the screening interval (at 12 months) as practices can find it difficult to provide a room for a set number of days during a specific period of time.
- The rooms provided are often unsuitable for testing visual acuity, which should be part of the programme.
- The General Practice Committee has indicated that individual practices may not be able to continue to provide accommodation to support diabetic eye screening into the future.
- People can only be screened in their own GP practice. People who can't attend during the time screening is being provided at their practice have to travel to "mop up" clinics at hospital sites.
- The screening technicians operate as lone workers and there are issues with staff satisfaction, with clinics being vulnerable to cancellation if a technician is unavailable.
- Screening efficiency is sub-optimal, as the screening technicians need to travel to multiple sites and set up the cameras each time they go to a different venue.

In addition, the UK National Screening Committee has recommended that, for people living with diabetes who are at lower risk of sight loss, the interval between screening tests should change from 12 months to two years (the current one year interval would remain unchanged for the remaining people at higher risk of sight loss). This will require a service that can guarantee an individual screening interval of 12 month

(higher risk) or 24 months (lower risk); as opposed to one based on attempting to provide screening within each practice every 12 months.

The PHA has been engaging with stakeholders on these issues, with oversight through the DESP Project Board which includes the Royal National Institute for the Blind, and Diabetes UK. The preparatory work to enable an informed pre-consultation, has been completed and Project Board are content with the options outlined and the process of pre-consultation. The attached pre-consultation paper sets out a number of options for change, noting the advantages and disadvantages of each, as well as a set of option appraisal objectives. It is accompanied by a response questionnaire.

The pre-consultation phase will run until the end of December 2016 and will include extensive engagement with people who use the DESP and key interdependent clinical services. Following this an option appraisal will be carried out to determine a preferred option which will then go out for consultation, subject to AMT and PHA Board approval.

Equality Impact Assessment

A full equality impact assessment will be carried out on the preferred option. The pre-consultation exercise will help to gather information in relation to this.

Recommendation

The Board is asked to **NOTE** the Northern Ireland Diabetic Eye Screening Programme Pre-Consultation Exercise.

PRE-CONSULTATION ON THE WAY THE NORTHERN IRELAND DIABETIC EYE SCREENING PROGRAMME IS PROVIDED

V1.3 27.10.17

1 INTRODUCTION

This document examines a range of options for the future delivery of the Northern Ireland Diabetic Eye Screening Programme (NIDESP). It describes the advantages, and disadvantages, of each option and lists the objectives that will be used to assess these options in an option appraisal. A copy of this document and the accompanying response questionnaire can be found at http://www.publichealth.hscni.net/modernising-diabetic-eye-screening-programme.

2 BACKGROUND

The NIDESP aims to reduce loss of vision caused by diabetic eye disease through early diagnosis and treatment. Screening is offered annually to everyone, aged 12 and over, with diabetes who has any light perception in either eye.

The screening test comprises two digital photographs of the back of each eye. Following expert examination of the photographs, people who are identified as having eye disease are referred to the hospital eye service (HES) for further assessment and treatment.

Everyone who has a normal screening test should (ideally) be screened every 12 months. The achievable standard for the programme is that 98% of eligible people with diabetes should be offered an appointment for routine digital screening occurring 6 weeks before or after their due date (i.e. after 12 months +/- 6 weeks).

In other parts of the UK diabetic eye screening also includes testing visual acuity (an eye examination that checks how well you can see different sized letters on a chart). This has not yet been introduced locally, as it requires suitable accommodation to do the test.

The programme is provided by the Belfast Health and Social Care (HSC) Trust which currently invites over 93,000 people a year. This is a significant increase from the approximately 50,000 people invited when the programme began in 2008. Indeed, the eligible population is expected to continue to increase as the number of people with diabetes continues to rise (currently by 5% per year).

3 CURRENT MODEL

Our programme is currently delivered through two different models. These are:

- A mobile screening service; and
- A fixed location screening service

Table 1 below provides details on how and where these services are provided.

Table 1: Current provision of digital photography for NIDESP

	Mobile	Fixed location
Staff	Screening technicians (employed by BHSCT)	Community optometrists (independent contractors)
Location	Each individual GP surgery	Six HSC locations
Area covered	BHSCT, NHSCT, SHSCT and SEHSCT	WHSCT

Both models have advantages and disadvantages, although there is no difference in uptake between these two models, with a regional average uptake of 68%.

3.1 Current Fixed Site Service

In the west, diabetic eye screening is provided by community optometrists at 6 fixed HSC sites. This service has consistently been able to maintain a screening interval of 12 months and is currently working well.

Advantages:

- participant choice on when to attend;
- the consistent screening interval, which meets the standard;
- the availability of suitable accommodation, with the ability to test visual acuity; and
- fixed cameras on site (these do not need to be moved from one screening site to another which reduces damage and manual labour).

Disadvantages:

- Although some people may have to travel a bit further for screening, compared with the mobile service, uptake (the percentage of people invited for screening who attend) is the same.

3.2 The Mobile Screening Service

Everywhere else in Northern Ireland, a mobile screening service is provided by screening technicians, employed by the BHSCT, at 284 GP practices. They visit each practice on a rotational basis as close to annually as possible. They transport the digital camera to the practice by van and establish a screening clinic in a room provided by the practice. The time the screening service is available at each practice is in accordance with the number of people in that practice who are eligible to be invited.

Advantages:

- Convenient for many patients.
- High patient and GP satisfaction rates were reported on surveys completed in 2015/16.
- Provides an opportunity to integrate diabetic eye screening with other diabetic care services; although this only happens in a minority of GP practices.

Disadvantages:

- Inability to maintain the screening interval (at 12 months, +/- 6 weeks). The average interval is normally longer and can be up to 18 months, or more, for some practices. This is because the NIDESP is not in control of the timely availability of suitable accommodation. This model requires practices to provide a room in their premises for a set number of days during a specific period of time. This can prove very challenging for practices, particularly as the size of the eligible screening population has nearly doubled since the programme was introduced, meaning that rooms are required for longer. This impacts other work in the practice.
- The rooms provided are often unsuitable for testing visual acuity. Visual acuity testing is helpful when making a decision about whether to refer someone to the hospital eye service.
- There is considerable pressure on primary care services and the General Practice Committee of the British Medical Association has indicated that individual practices may not be able to continue to provide accommodation to support diabetic eye screening into the future. Also the British Medical Association (BMA) in Northern Ireland has indicated that GPs here may vote to leave the HSC at some point. This adds a considerable degree of uncertainty in relation to this model.
- The screening technicians operate as lone workers and there are issues with staff satisfaction, with clinics being vulnerable to cancellation if a

technician is unavailable. A staff survey carried out in the summer of 2016 amongst the screening staff highlighted several common areas of dissatisfaction, including isolation (from both screening colleagues and within the GP practice setting), irregular working hours, lack of notice of rota and inability to plan around working week and lack of support e.g. equipment breakdowns.

- The UK National Screening Committee has recommended that, for people living with diabetes who are at lower risk of sight loss, the interval between screening tests should change from 12 months to two years (the current one year interval would remain unchanged for the remaining people at higher risk of sight loss). While this would reduce the numbers being screened each year by around a third, it will require a service that can guarantee an individual screening interval of 12 month (higher risk) or 24 months (lower risk); as opposed to one based on attempting to provide screening within each practice every 12 months. It would be vital to ensure that 24 months did not stretch out to 30 months and more. While the numbers being screened would initially reduce they would increase to the original level again in 8 or 9 years due to the year on year increase in the number of people with diabetes.
- People can only be screened in their own GP practice. People who can't attend during the time screening is being provided at their practice have to travel to "mop up" clinics at hospital sites.
- Screening efficiency is sub-optimal, as the screening technicians need to travel to multiple sites and set up the cameras each time they go to a different venue. Set up time means less time available for screening. These cameras are bulky items, which are transported in a container bigger than most fridges. There is also continuous wear and tear on the equipment due to the need to move them from practice to practice. This reduces their lifespan.

4 ALTERNATIVE MODELS

There are four possible main models of delivery of a DESP.[1] These are:

1. **Fixed location** screening services where the service is supplied at fixed HSC locations such as: local hospitals, community hospitals; health and wellbeing centres and selected GP practices.
2. **Mobile** screening services where a peripatetic service is provided at individual GP surgeries.
3. **High street optometry** based services where the central administration of the programme directs patients to accredited high street community optometrists.
4. **Mixed** services which may involve any or all of the above or other external agencies.

Call/recall, as well as secondary and referral grading (examination of the images), will continue to be provided centrally in Belfast and are a feature of all options.

4.1 Long list of options

A long list of seven options was identified (see table 4). Option two (a fixed location service) has two variants. In 2a the fixed locations would be in HSC settings (e.g. local hospitals, community hospitals, health and wellbeing centres) and suitable GP practices. In 2b the fixed locations would be identified through collaboration with Local Medical Committees (LMC). These would be in selected GP practices. In each case four fixed sites would be identified in each Trust area and as the current service in the western area is working well it would be retained.

In addition three sub-options were identified under option 7 (mixed model). These were:

- Option 7a - Individual GP practice based service for those practices who wish to maintain this service PLUS fixed location service for the others.
- Option 7b - Fixed site service based at HSC locations or large GP practices (e.g. 4 per Trust area) PLUS high street optometry service.
- Options 7c - Individual GP practice based service for those practices who wish to maintain this PLUS high street optometry service.

[1] Essential Elements in Developing a Diabetic Eye Screening Programme, version 4.4, 23 January 2012. Workbook Section 2: Models of Service Delivery. NHS Screening Programmes.

Table 2: Long list of options

Option	Description
Option 1	Existing model (a mixed model)
Option 2a	Regional fixed location service provided at HSC locations e.g. local hospitals, community hospitals, health and wellbeing centres, and suitable GP practices
Option 2b	Regional fixed location service with sites, in selected GP practices, identified in collaboration with Local Medical Committees
Option 3	Regional mobile service provided at individual GP surgeries throughout Northern Ireland
Option 4	Regional mobile service provided from mobile screening vans
Option 5	High street optometry based service provided at community optometrists' premises
Option 6	Photography screener based service provided at community optometrists' premises (i.e. BHSCT employees providing screening in community optometry premises)
Option 7a	Individual GP practice based service for those practices who wish to maintain this service PLUS fixed location service for the others
Option 7b	Fixed site service based at HSC locations or large GP practices (e.g. 4 per Trust area) PLUS high street optometry service
Option 7c	Individual GP practice based service for those practices who wish to maintain this PLUS high street optometry service

4.2 Preliminary Sift of Options

A preliminary sift was carried out following discussion and communication with stakeholders in Northern Ireland and counterparts in England and Wales. As a result of this the options in table 3 were ruled out.

Table 3: Options ruled out following preliminary sift

Option	Reason for ruling out
Option 4 Regional mobile service using specially equipped mobile screening vans	The only country that has experience of using mobile screening vans is Wales. The programme manager has advised that these vans are not cost-effective and are unpopular with patients. They are currently being decommissioned.
Option 6 Screening technician based service provided at community optometrists premise	No advantages over any other model, and not considered cost effective.

4.3 Shortlist of Options

This means that only the options shown in table 6 will be taken forward to assess against the objectives of the project.

Table 6: Short list of options

Option	Description
Option 1	Existing model
Option 2a	Regional fixed location service provided at HSC locations e.g. local hospitals, community hospitals health and wellbeing centres, and suitable GP practices
Option 2b	Regional fixed location service with sites, in selected GP practices, identified in collaboration with Local Medical Committees
Option 3	Regional mobile service provided at individual GP surgeries throughout Northern Ireland
Option 5	High-street optometry based service provided at community optometrists' premises
Option 7a	Individual GP practice based service for those practices who wish to maintain this service PLUS fixed location service for the others

Option 7b	Fixed site service based at HSC locations or large GP practices (e.g. 4 per Trust area) PLUS high street optometry service
Option 7c	Individual GP practice based service for those practices who wish to maintain this PLUS high street optometry service

4.4 Overview of Shortlisted Options

Option 1 – Existing Model

In this option the current models would remain unchanged.

Advantages	
Participants	• Convenience of attending at your GP practice • High degree of satisfaction
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services • High degree of satisfaction
Standards/Service	
Disadvantages	
Participants	• Restricted choice regarding date, time and location of screening appointment
Primary Care	• Continued pressure on primary care to provide suitable accommodation
Standards/Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet standards in particular the screening interval standard throughout Northern Ireland • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual. • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing

Indicative Costs

Revenue - £1.65 million Capital - £37,800

Option 2a – Regional Fixed HSC Sites

This model would provide the service at HSC locations e.g. local hospitals, community hospitals, health and wellbeing centres, and suitable GP practices. The screening technicians would provide screening clinics at 16 fixed HSC sites throughout the Belfast, Northern, Southern and South Eastern HSC Trust areas (four per Trust area). Whenever required and possible, they would work in pairs for support, making it less likely that a screening clinic would be cancelled if a screening technician was unavailable. The current model in the Western Trust area would be maintained.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened, rather than having to travel to Belfast to a "mop up" clinic.
Primary Care	• Remove pressure on primary care to provide rooms on an annual basis
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet standards, in particular screening interval • Suitable rooms are available when required • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease • Improved job satisfaction for staff, particularly screener/graders • Improved efficiencies; travel, set-up and closedown times, manual handling
Disadvantages	
Participants	• Potential for increased travel for some people
Primary Care	• No longer able to integrate retinal photography with other diabetic care services
Standards/Service	

Indicative Costs

Revenue - £1.38 million Capital - £111,700

Option 2b – Regional Fixed Primary Care Sites

This model would provide the service at a selected number of suitable GP practices, identified in collaboration with LMCs. The screening technicians would provide screening clinics at 16 fixed HSC sites throughout the Belfast, Northern, Southern and South Eastern HSC Trust areas. Whenever required and possible, they would work in pairs for support, making it less likely that a screening clinic would be cancelled if a screening technician was unavailable. The current model in the Western Trust area would be maintained.

Advantages	
Participants	• choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened.
Primary Care	• Would remain actively engaged in the programme, although not at individual practice level.
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet standards, in particular screening interval • Suitable rooms may be available when required • Should enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease • Improved job satisfaction for staff, particularly screener/graders • Improved efficiencies; travel, set-up and closedown times, manual handling
Disadvantages	
Participants	• Potential for increased travel
Primary Care	• No longer able to integrate retinal photography with other diabetic care services
Standards/Service	• May not be able to leave the cameras in the identified primary care accommodation permanently, meaning some degree of transportation will be required

<u>Indicative Costs</u>

Revenue - £1.38 million Capital - £111,700

Option 3 – Regional Mobile Service

This service would retain the current mobile service in the BHSCT, NHSCT, SEHSCT and SHSCT areas and expand the mobile service into the WHSCT area.

Advantages	
Participants	• Increased number of locations in the western area • Regional model, i.e. equity of service for all trust areas
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for western area GPs
Standards/Service	
Disadvantages	
Participants	• Restricted choice regarding date time and location of screening appointment
Primary Care	• Continued pressure on primary care to provide suitable accommodation
Standards/Service	• Unsustainable given the increasing diabetic population and its rate of growth • Unable to meet standards in particular the screening interval standard throughout Northern Ireland • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual. • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing

Indicative Costs

Revenue - £1.67 million Capital - £70,000

Option 5 – High Street Optometry Based Service

In this model screening would be carried out in around 60 community optometry practices throughout Northern Ireland.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened,
Primary Care	• Pressure removed from primary care to provide accommodation
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet the screening interval standard • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease
Disadvantages	
Participants	• Screening provided in commercial premises
Primary Care	
Standards/Service	• Logistical, training, standardisation and governance issues • Cost

Indicative Costs

Revenue - £2.2 million Capital - £76,800

Option 7a – Mixed Model – Mobile and Fixed Site

This model would provide the service at those GP practices who wish to maintain the service along with a number of fixed locations in areas where there is no GP service available. This retains the disadvantages of the current mobile service.

Advantages	
Participants	• Convenience of attending at your GP practice remains for some participants
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for those practices who wish to retain the service
Standards/Service	
Disadvantages	
Participants	• Restricted choice for some regarding date, time and location of screening appointment
Primary Care	• Continued pressure on participating practices to provide suitable accommodation
Standards/Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet the screening interval standard • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual as we are unable to run a programme based on individual screening intervals and practice screening intervals (the IT system can't accommodate this). • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing for some participants

Indicative Costs

Revenue - £1.65 million Capital - £37,800

Option 7b – Mixed Model – HSC Fixed Sites and High Street Optometry

This model would provide the service at a number of fixed sites and at a number of (around 30) community optometry practices.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened,
Primary Care	• Pressure removed from primary care to provide accommodation
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet the screening interval standard • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease
Disadvantages	
Participants	• Screening provided in commercial premises
Primary Care	
Standards/Service	• Logistical, training, standardisation and governance issues • Cost

<u>Indicative Costs</u>

Revenue - £1.67 million Capital - £33,300

Option 7c – Mixed Model – Mobile and High Street Optometry

This model would provide the service at those GP practices who wish to maintain the service along with (around 40) high street optometry practices.

Advantages	
Participants	• Convenience of attending at your GP practice remains for some participants
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for those practices who wish to retain the service
Standards/Service	
Disadvantages	
Participants	• Restricted choice for some regarding date, time and location of screening appointment
Primary Care	• Continued pressure on participating practices to provide suitable accommodation
Standards/Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet the screening interval standard • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual as we are unable to run a programme based on individual screening intervals and practice screening intervals (the IT system can't accommodate this). • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing for some participants • Cost

Indicative Costs

Revenue - £1.8 million Capital - £49,200

5. OPTION APPRAISAL OBJECTIVES

The six objectives that will be used to score the options are set out below. The bullet points beneath each objective help to explain it.

A. Accessibility

- Location and travelling time for service users
- Proximity to good road infrastructure/public transport links
- Sufficient car parking

B. Maximise patient choice

- Flexibility for patient re choice of site and timing of appointment
- Potential to facilitate evening/weekend appointments
- All members of community have equal access to services

C. Operational feasibility

- Availability of suitable accommodation
- IT requirements, including networking and support services
- Screening efficiency (i.e. number of screenings per day)
- Training efficiency/ease
- Ease of tracking and chasing patients who DNR/DNA (do not respond/attend)
- Ease of procurement and administering payments

D. Sustainability

- Sustainability of skilled workforce (i.e. facilitates staff retention)
- Resilience to staff absence

E. Quality

- Capable of meeting diabetic eye screening programme quality standards
- Screening interval based upon individual client appointment
- Facilitates quality assurance and performance management

F. Future proof

- Capable of screening an expanding population
- Capable of adapting to future change in screening programme i.e. changes to screening interval

6 WEIGHTING OF OBJECTIVES

Table 2 shows the weighting given to each option. Those considered to be more important are given more weight. In the option appraisal each short listed option will be scored against each objective.

Table 2: The weighted score for each objective

Objective	Weighting (%)
A Accessibility	10%
B Patient Choice	10%
C Operational feasibility	20%
D Sustainability	10%
E Quality	40%
F Future Proof	10%
Total	**100%**

PRE-CONSULTATION ON THE WAY THE NORTHERN IRELAND DIABETIC EYE SCREENING PROGRAMME IS PROVIDED

RESPONSE QUESTIONAIRE

Response Questionnaire

This pre-consultation offers an opportunity for you to consider, and comment on:

- the advantages and disadvantages of different options for providing diabetic eye screening in Northern Ireland; and
- the option appraisal that will be used to assess them.

We recognise that the various options may impact on different groups of people – in terms of their age, gender, disability, ethnicity, religion, political opinion, sexual orientation, marital status, dependant status – in different ways. Each option will have equality implications and we need to consider these carefully (see questions 7 & 8).

Following completion of the option appraisal, there will be a public consultation on the recommended model.

You can respond by email or post.

1. Email us at **claire.armstrong@hscni.net**
2. Write to us at:

   Diabetic Eye Screening Programme
   Public Health Agency
   9th Floor, Linum Chambers
   2 Bedford Square
   Belfast
   BT2 7ES

A copy of this questionnaire and the corresponding pre-consultation document can be found at http://www.publichealth.hscni.net/modernising-diabetic-eye-screening-programme.

Before you submit your response please read the annex of this document regarding the confidentiality of responses in the context of the Freedom of Information Act 2000.

Please tell us if you are responding on your own behalf or on behalf of an organisation by placing a tick in the appropriate box:

I am responding as an individual ☐

I am responding on behalf of an organisation ☐

As a member of health and social care staff ☐

Name	
Title	
Address	
Telephone	
Email	

May we contact you to get further information on your response?

Yes ☐

No ☐

OPTIONS

1 Do you agree that the current service delivery model needs to change?

Yes ☐ No ☐ (please tick a box)

If you ticked ‘No’ please tell us why.

2 Are there any other options we should consider?

Yes ☐ No ☐ (please tick a box)

If you ticked ‘Yes’ please describe the option(s) below

3 Have all the advantages and disadvantages of the different models been identified?

Yes ☐ No ☐ (please tick a box)

If you ticked 'No' please comment.

OPTION APPRAISAL

4 Are the option appraisal objectives appropriate?

Yes ☐ No ☐ (please tick a box)

If you ticked 'No' please comment.

5 Do you agree with the weighting given to the objectives?

Yes ☐ No ☐ (please tick a box)

If you ticked ‘No’ please tell us why.

6 Do you agree with the short list of options?

Yes ☐ No ☐ (please tick a box)

If you ticked ‘No’ please tell us why.

EQUALITY

7 When you think of the range of people in need of this service, can you identify any equality groupings that may experience particular difficulties under any of the model options?

Yes ☐ No ☐ (please tick a box)

If you ticked 'Yes' please explain which groupings and what are the difficulties or needs.

8 What do you suggest we could do to address those difficulties or needs?

RURAL IMPACT

9 Are there implications for rural areas we need to consider?

Yes ☐ No ☐ (please tick a box)

If you ticked 'Yes' please comment on the implications and how we could ensure a fair rural outcome.

FINAL COMMENTS

10 Do you have any other comments?

Yes ☐ No ☐ (please tick a box)

If you ticked 'Yes' please comment.

Thank you for your comments.

Annex

Freedom of Information Act (2000) – Confidentiality of Consultations

It is expected that we will publish a summary of responses following the completion of this engagement exercise. Your responses and all other responses may be disclosed on request. We can only refuse to disclose information in exceptional circumstances.

Before you submit your response, please read the paragraphs below on the confidentiality as they will give you guidance on the legal position about any information given by you in response to this pre-consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Public Health Agency (PHA) in this case. This right of access to information includes information provided in response this pre-consultation. The PHA cannot automatically consider as confidential information supplied to it in response to this pre-consultation. However, it does have the responsibility to decide whether any information provided by you in response to this pre-consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to this pre-consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

The PHA should not agree to hold information received from third parties "in confidence" which is not confidential in nature. Acceptance by the PHA of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact The Information Commissioner's Office, or see website at: https://www.gov.uk/government/organisations/information-commissioner-s-office.

HSC Public Health Agency

board paper

PHA Community Planning Update November 2017

date	16 November 2017	**item**	10	**reference**	PHA/04/11/17

presented by Mr Ed McClean, Director of Operations

action required For noting

Summary

The attached paper provides an update on PHA's input and the progress of community planning to date with a focus around 6 questions:

- What is proposed and to what extent are PHA leading or supporting?
- How developed is the plan and how does it build on good practice or evidence?
- How do the actions relate to the 4 key areas of focus (early years, age-friendly, physical activity and mental health)?
- What is the expected contribution from other partners?
- Are there opportunities for upscaling across council areas?
- Are there any budget/investment implications?

The responses to these questions are drawn from PHA experiences in each council and also from discussions at the recent HSC Community Planning Forum held on 27 October which included representation from PHA, Health and Social Care Board, LCGs, Health and Social Care Trusts and Mr Nigel McMahon and Mr Gary Maxwell from the Department of Health.

While specific actions and overall action plans are still developing and emerging, PHA continues to play a key role in community planning strategy and delivery. PHA has also been the driver behind closer working alignment with HSC and Local Government through the facilitation of the joint Chief Executives meetings and the HSC Community Planning Forum. The experiences to date have been mostly positive across councils and opportunities are emerging to improve health and wellbeing through community planning processes.

Equality Impact Assessment

N/A

Recommendation

The Board is asked to **NOTE** the update on Community Planning.

HSC Public Health Agency

Community Planning Update – Board Update November 2017

Introduction

Local Government has always been an important partner for the PHA in working to address the wider determinants of health inequalities and to improve and protect health and social well-being more generally. This relationship has been given added focus with the PHA identified as one of the statutory partners that each of the 11 Councils must work with in taking forward Community Planning under the Local Government (Northern Ireland) Act 2014.

As a statutory partner, the PHA has been very involved in the development of community planning and early steps very much centred on the establishment of community planning governance arrangements e.g. Strategic Partnership boards (these sought input from Chief Executive/Director level tiers of statutory partner organisations) and thematic or action planning tiers (typically informing leads for functional or thematic areas within partner organisations). All 11 community planning processes have now established or in the process of establishing a health and wellbeing subgroup with representation from all HSC statutory partners.

All 11 councils have now agreed their final community plans and are embarking on the action planning phase. Derry City and Strabane District Council is the last council to launch its community plan and will do so in November 2017.
The approaches taken to and timescales for the development of the plans have differed somewhat across Councils. Each Plan has as its focus three broad areas: Social (including health and well-being), Economic and Environment. The action planning process is following a similar pattern in that all councils are taking different approaches ranging from being highly prescriptive to more iterative processes.

PHA with HSC and working through Making Life Better, agreed 4 key areas of focus for health within community planning:

- Improvements to the early years of life
- Increased opportunities for physical activity
- Improved mental health and wellbeing
- Older people will maintain healthy, active lives; and promotion of age friendly communities

These themes are reflected across each of the eleven plans and as well as providing a foundation on which health and wellbeing actions will be agreed, they align clearly with Making Life Better and the draft Programme for Government (PfG) outcomes and actions. Further to this, the draft PfG Delivery Plan for Outcome 4 (We live long, healthy, active lives) includes these four themes as areas for action within its Healthier Lives Programme which is being progressed by PHA.

PHA has not only been working on strategic alignment with Making Life Better and Programme for Government within community planning but also on facilitating good system wide cohesion.

HSC continues to work closely together and PHA recently established the HSC Community Planning Forum to facilitate and encourage alignment and collective action for HSC organisations involved in community planning. The joint meetings between HSC Chief Executives and Local Government Chief Executives also continue regularly and provide an opportunity to maintain the excellent links between HSC and Local Government but also to discuss key areas of joint working and any potential challenges before they should arise.
Recent conversations for example, based on a paper written and presented by Ms Mary Black on opportunities for working together (PHA and Local Government) raised the potential for a regional initiative between HSC and Local Government. This paper, which was well received by all chief executives, set out a number of areas of emerging work which offer particular joint working opportunities including the Community Development work through TIG and Delivering Together, PHA Workplace Health and Wellbeing Service, Active Travel, Breastfeeding Welcome Here Schemes and opportunity to improve the food offering in the public sector. More recently, the Department for Communities (DfC) has commented that the paper offers the strategic engagement collaboration DfC envisage within community planning and have encouraged other partners to consider similar approaches.

While specific actions and overall action plans are still developing and emerging, PHA continues to play a key role in community planning strategically and in delivery, in facilitated system wide cohesion and ensuring that health is a key focus for the plans both in terms of the wider determinants of health inequalities and to improve and protect health and social well-being more generally.

Community Planning Updates

The following section provides a regional overview of community planning based around 6 questions:

- What is proposed and to what extent are PHA leading or supporting?
- How developed is the plan and how does it build on good practice or evidence?
- How do the actions relate to the 4 key areas of focus (early years, age-friendly, physical activity and mental health)?
- What is the expected contribution from other partners?
- Are there opportunities for upscaling across council areas?
- Are there any budget/investment implications?

The responses to these questions are drawn from PHA experiences in each council and also from discussions at the recent HSC Community Planning Forum held on 27 October which included representation from PHA, Health and Social Care Board,

LCGs, Health and Social Care Trusts and Mr Nigel McMahon and Mr Gary Maxwell from the Department of Health.

What is proposed and to what extent are PHA leading or supporting?

PHA is a statutory partner within community planning and supports each process across the councils through membership at each level of the community planning structures, including appropriate subgroups and in some instances, as Chair of the health and wellbeing subgroups. All of these structures include a subgroup with a focus on health and wellbeing through which work is beginning to develop and agree the action plans that will pursue the stated health and wellbeing outcomes. PHA and all HSC Statutory Partners in Community Planning continue consistent liaison to ensure coordinated HSC responses and input.

The processes vary in speed and approach between councils but PHA continues to provide a consistent and committed input. Fermanagh and Omagh for example have taken a systematic approach, filtering a long list of actions to create a draft list of realistic, achievable actions that require a partnership approach. Other councils such as Newry, Mourne and Down have taken a more prescriptive approach.

Work is ongoing across councils to engage more with community and voluntary agencies. Armagh, Banbridge and Craigavon for example are facilitating the community and voluntary sector to co-design their involvement and their participation in the community planning governance structure has been acknowledged.

How developed are the plans and how do they build on good practice or evidence?

The processes vary in speed and approach between councils, however all action plans are currently expected to be agreed in early 2018. A number of councils are already in the final stages of agreeing their action plans (Ards and North Down, Newry, Mourne and Down, Fermanagh and Omagh for example) where others are just beginning such as Lisburn and Castlereagh and Mid and East Antrim.

The need for actions to build on good practice and evidence has been championed by HSC statutory partners and has been a point of discussion at the HSC Community Planning Forum.

Where actions have been proposed, they are based on existing good practice and evidence or aim to develop good practice and evidence. Antrim and Newtownabbey for example are proposing to progress programmes such as Greenways (based on Connswater Community Greenway) and ‘Take 5’ steps to wellbeing. On the other hand, Newry, Mourne and Down are proposing actions that help gather further information that when considered with other available information will inform future work e.g. mapping alcohol and fast food outlets.

Evidence has also been used to help agree targets. Belfast City Council for example has used evidence to draft and agree a number of targets including a target to reduce the level of health inequalities between the worst and least deprived areas in the Belfast City Council area.

How do the actions relate to the 4 key areas of focus (early years, age-friendly, physical activity and mental health)?

The four themes agreed by HSC provide a strong framework for building action plans, particularly for health and wellbeing and have been reflected across all eleven community plans. The actions emerging all relate to these four areas and while actions will be rooted in local need, the four themes have facilitated regional and strategic alignment with Making Life Better and the draft programme for Government. It is important to note that a number of actions will align with more than one of these areas of focus and equally will contribute to a number of outcomes within the community plans, not just those relating to health and wellbeing.

Action plans have not yet been finalised or confirmed but a number of potential actions have been proposed. The following tables highlight some of the early actions proposed to date.

Early Years
Promotion of Breastfeeding Welcome Here Scheme with businesses Parenting programmes Improving access to and provision of play and recreational facilities (this also links with physical activity)

Age Friendly
Implementation of Age Friendly Implementation of Age Well Dementia Friendly Communities

Physical Activity (and healthy behaviours)
Nutrition programmes Physical activity programmes Greenways (also links across to other 3 areas) Increasing uptake of sports/recreation programmes Mapping alcohol and fast food outlets

Mental Health
Take 5 approach to wellbeing Develop or promote programmes to improve emotional wellbeing and resilience Mental health emotional wellbeing questionnaire

What is the expected contribution from other partners?

As action plans are developing, the expected contribution is not clear and is inconsistent across councils at this stage in the process. PHA and HSC colleagues have raised the potential disparity between what could be requested in terms of the contribution to community planning versus what HSC has the capacity and resources to commit. This is an ongoing conversation and has also been raised with Department of Health (DoH).

General requests have been and are being made for commitment, data and information and resources and PHA is supporting these requests where appropriate within each council. Requests are reviewed as they are made in line with PHA procedures and policies. In terms of commitment, requests have been made for action leads and owners and for membership of various sub groups. Data and information has also been requested in various formats.
Commitment to collaborative working is a key contribution from all partners. Meaningful collaboration takes time and true partnership working and requires a real commitment from members. PHA has worked within the spirit of community planning and collaboration from the inception of community planning and continues to take this approach.

There have been a small number of requests for non-recurrent resources including funds to support Mid and East Antrim's local older people's network and the Ageing Well initiative in Mid Ulster. Requests for resources continue to be monitored and reviewed as they are received and in line with normal business guidelines and procedures.

There is some concern around the potential levels of contribution of resources from HSC. Each community planning process includes at least 3 HSC organisations and so there is the potential for HSC to be cumulatively contributing a large proportion of resources through its individual partner organisations. Discussions are ongoing around the resources requested from HSC as a whole and the possible need for regional guidance.

The HSC Community Planning Forum has provided the opportunity to work through these discussions and to agree common messages for HSC Statutory Partners working within community planning. As action planning progresses and the final plans are agreed, expectations should become clearer. HSC partners will continue to liaise and ensure alignment.

Are there opportunities for upscaling across council areas?

Action plans are still developing and evolving however, there appear to be opportunities emerging and some appetite for upscaling across council areas, although this may not be seen in the immediate future. Recent discussion at the joint

HSC and Local Government Chief Executive meeting for example considered the potential for a regional initiative in the future.

Similar needs and targets have been identified across council areas and alignment around the four themes also provides a basis for this.

The opportunities for upscaling will become clearer as action plans are finalised, however one particular emerging opportunity is around older people and active ageing. Identified as a key priority for most councils, a number of councils have also included their intentions to implement the age friendly programme and/or dementia friendly initiatives.

Are there any budget/investment implications?

There are no clear or identified budget or investment implications in most councils at this stage in action planning. Many proposed actions in some councils are building on or adding value to current PHA investments however, there may be some implications related to these in the future.

The following areas have identified potential budget/investment implications:

- PHA is funding an Age Friendly Coordinator shared between Ards and North Down and Lisburn and Castlereagh councils
- PHA anticipates a possible investment in an Age Friendly Coordinator post in Armagh, Banbridge and Craigavon and the hosting and facilitation of the 'Have Your Say' survey.
- PHA have committed resources to joint working with Belfast Council through the Belfast Strategic Partnership
- PHA has committed some funding this year to support Mid and East Antrim's local older people's network
- PHA anticipates a potential resource or in kind contribution towards the mental health and emotional wellbeing questionnaire in Newry, Mourne and Down.

Conclusion

While specific actions and overall action plans are still developing and emerging, PHA continues to play a key role in community planning strategy and delivery. PHA has also been the driver behind closer working alignment with HSC and Local Government through the facilitation of the joint Chief Executives meetings and the HSC Community Planning Forum.The experiences to date have been mostly positive across councils and opportunities are emerging to improve health and wellbeing through community planning processes.

PHA board are asked to note PHAs committed involvement and contributions to community planning to date and the continued work to ensure alignment across HSC.