HSC Public Health Agency

agenda

108th Meeting of the Public Health Agency Board

Thursday 20 December 2018 at 1:30pm

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

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 15 November 2018		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/01/12/18**	Mr Cummings

items for noting

8 2.00	Personal and Public Involvement Update	**PHA/02/12/18**	Mrs Hinds
9 2.20	Sexually Transmitted Infection Surveillance in Northern Ireland 2018	**PHA/03/12/18**	Dr Mairs
10 2.40	HSC R&D Division Annual Report 2017-18	**PHA/04/12/18**	Dr Mairs

items for approval

11 3.00	Public Consultation on the Northern Ireland Diabetic Eye Screening Programme	**PHA/05/12/18**	Dr Mairs
12 3.20	Information Governance Strategy incorporating the Information Governance Framework 2018 - 2022	**PHA/06/12/18**	Mr McClean

committee updates

13 3.35	Update from Governance and Audit Committee (to include minutes of previous meeting)	**PHA/07/12/18**	Mr Drew
14 3.50	Update from Remuneration Committee		Chair

closing items

15 4.00	Any Other Business	Chair
16 4.05	Details of next meeting: *Thursday 21 February 2019 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

107th Meeting of the Public Health Agency Board

Thursday 15 November 2018 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Leslie Drew (Chair)	-	Non-Executive Director
Mrs Valerie Watts	-	Interim Chief Executive
Dr Adrian Mairs	-	Acting Director of Public Health
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Councillor William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director
Miss Rosemary Taylor	-	Assistant Director Planning and Operational Services (*on behalf of Mr McClean*)

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Ms Nicola Woods	-	Boardroom Apprentice
Mr Robert Graham	-	Secretariat

Apologies

Mr Andrew Dougal	-	Chair
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Ms Marie Roulston	-	Director of Social Care and Children, HSCB

111/18	**Item 1 – Welcome and Apologies**
111/18.1	Mr Drew welcomed everyone to the meeting. Apologies were noted from Mr Andrew Dougal, Mr Edmond McClean and Ms Marie Roulston.
112/18	**Item 2 - Declaration of Interests**
112/18.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
113/18	**Item 3 – Minutes of previous meeting held on 18 October 2018**
113/18.1	The minutes of the previous meeting, held on 18 October 2018, were

approved as an accurate record of that meeting.

114/18 **Item 4 – Matters Arising**

101/18.2 Waiting Lists

114/18.1 Councillor Ashe asked about a further update on waiting lists. The Interim Chief Executive advised that she would cover this as part of her Chief Executive's Report.

105/18.10 Procurement Plan

114/18.2 Miss Taylor advised that the group taking forward the work on procurement had held its first meeting yesterday.

108/18.6 Community Planning

114/18.3 In response to a query about the review of community plans, Miss Taylor advised that this is due to take place in November 2019.

115/18 **Item 5 – Chair's Business**

115/18.1 Mr Drew noted that the Chair's Business had been circulated via e-mail to members in advance of the meeting.

115/18.2 There was a reference in the report to homelessness and Ms Mann-Kler expressed her concern about the basic sanitary needs of homeless people being met. She suggested that the Board should receive an update on homelessness at a future meeting.

115/18.3 Alderman Porter noted that some homeless people choose to live on the street. The Interim Chief Executive advised that the number of people who are homeless is very small as there are hostel beds, but many homeless people do not avail of them. Mr Clayton said that it would be useful for the PHA Board to get a briefing on any work PHA is doing in this area. Councillor Ashe added that it would be useful to get data on the actual numbers as well as an update on what PHA is doing.

115/18.4 Mrs McKissick advised that 3 years ago the Patient Client Council undertook a literature review about the prevalence of homelessness and "sofa surfing". She said that they organised a workshop which involved the Department of Communities, Department of Health and service users. She added that there is a new Homelessness Strategy.

115/18.5 The Interim Chief Executive said that she had recently met with political representatives to discuss issues such as homelessness, street triage and de-escalation services.

115/18.6 Mr Clayton noted that there is a legal obligation on Trusts if a child is homeless and he said that he would welcome a briefing as going forward

PHA may have additional responsibilities in this area when it inherits the social care and children's functions following the closure of HSCB.

116/18 **Item 6 – Chief Executive's Business**

116/18.1 The Interim Chief Executive began with an update on the neurology call back exercise. She said that following the review of 2,500 neurology patients earlier this year, a decision was taken to recall a further 1,044 people. She explained that this further group consists of patients who had been seen by Dr Watt and discharged to the care of their GP, and that this process is being concentrated on specific groups of patients taking specific, specialised medicines.

116/18.2 The Interim Chief Executive said that the HSC would want to apologise for any distress and uncertainty that this process brings and it is clearly our responsibility to act on clinical advice and the emerging outcomes from the first phase of the recall. She advised that the review appointments started last weekend and are scheduled to be completed within a four month period.

116/18.3 The Interim Chief Executive assured members that the primary focus of this exercise is to reassure everyone who has received a letter that they are on the correct treatment; and request that they should not stop, or make adjustments to, their medication until they have been reviewed by a consultant neurologist at their appointment. She explained that anyone who does not receive a letter does not have to take any action and that there is a dedicated advice line in place for any concerns anyone may have.

116/18.4 The Interim Chief Executive informed members that new prototype elective care centres will undertake routine day surgery for cataracts and treatment of varicose veins from December 2018. She hoped that this development will have an impact on the number of patients treated and crucially, these centres will operate on separate sites from urgent and emergency hospital care meaning they will not be competing for operating rooms and other resources, leading to fewer cancellations of operations. She noted that while some patients may be asked to travel further for their treatment, they will be seen faster and have a better experience and it is the expectation of the Department of Health that patients who have been assessed as requiring treatment for cataracts and varicose veins will, by December 2021, be treated within 13 weeks as per Ministerial targets.

116/18.5 The Interim Chief Executive noted that 25th October saw the second anniversary of the launch of Delivering Together. As part of the transformation programme, she advised members that a new healthcare hub was announced on 19 October which will help transform healthcare for the homeless. She advised members that the Northern Ireland Ambulance Service recently launched a consultation regarding proposals for changing their service delivery.

116/18.6 The Interim Chief Executive updated members on the HSC restructuring saying that work is well under way with regard to the design groups which are co-chaired by HSCB and Department staff. She added that a second meeting of the staff side forum has also taken place, and that the Oversight Board, chaired by the Permanent Secretary, has agreed an internal communications framework to support engagement with staff. She acknowledged that in order to meet the overall timelines, there needs to be an Assembly or other legislative vehicle in place by January, but it is equally important that work must continue to ensure preparations are in place to move towards closer working, and most importantly, to give staff the certainty they want and time to prepare for the new arrangements.

116/18.7 The Interim Chief Executive informed members that a neonatal initiative delivered by Allied Health Professionals (AHPs) across NI neonatal units secured the overall award at the Advancing Healthcare Awards at the Le Mon hotel on 7 November. She advised that this model has been developed and led by Geraldine Teague, Lead AHP Consultant & Heather Reid, Public Health Consultant from the PHA and has been operating regionally since 2016. She added that at the awards ceremony this regional model won the DoH 'Transforming the Workforce' Award for 'Aiding Holistic Partnerships', which was awarded by the Permanent Secretary Richard Pengelly, as well as being awarded the overall winner on the night.

116/18.8 The Interim Chief Executive said there was more success for PHA as on Friday 9 November, the CIM Ireland Marketing Awards took place to celebrate the very best marketing innovations, interventions and campaigns crafted by organisations, businesses and agencies from across Ireland, and that PHA's #NotsorryMums breastfeeding campaign won the award for 'Best Cause related marketing'. She said that she would wish to convey her congratulations on behalf of the Board to both sets of winners.

116/18.9 Professor Rooney asked whether the neurology call back exercise is having an impact on current waiting lists. Dr Mairs said that this is being monitored on a weekly basis, but he assured members that there is no impact on core neurology services. He added that extra clinics are being provided by the independent sector. However, he suggested that there may be an impact in the future; hence there is an ongoing review of neurology services.

116/18.10 Professor Rooney asked whether PHA is involved in the design groups. The Interim Chief Executive said that PHA is involved in some of them, but she had made the point to the Department that the PHA has an important role in this work.

116/18.11 Professor Rooney asked about the transfer of paediatric pathology services to Alder Hey. Dr Mairs explained that HSCB is responsible for commissioning this service, but that PHA provides advice and support. The Interim Chief Executive said that the information provided by PHA is

passed onto the Director of Commissioning. Professor Rooney asked whether the opinion of a psychologist was sought as part of the decision making process. She felt the decision was lacking psychological advice.

116/18.12 Mr Clayton noted that the timeline for the second neurology call back was longer than the first exercise. Dr Mairs said that this is deliberate as a risk-based approach is being adopted. He explained that it became clear that there needed to be follow up with those patients who had been discharged by Dr Watt, but were still on medication and had not been reviewed by another neurologist. He said that these patients may have been mis-diagnosed, or that they may be on medication that they do not require. He added that this cohort has been split into four groups, with each group being looked at using a risk-based approach. Furthermore, he explained that the impact on HSC staff had been taken into consideration as this work has been ongoing constantly for six months.

116/18.13 Councillor Ashe expressed his concern that the statement made regarding the paediatric pathology decision was a joint statement and that the PHA Board had not been informed before the decision was made public. Dr Mairs explained that although the consultant who spoke on the issue is employed by PHA, she was speaking on behalf of HSCB and PHA. The Interim Chief Executive apologised to members that they had not briefed beforehand. Mr Cummings said that Northern Ireland has been proactive in securing this service from Alder Hey because there is a UK-wide shortage of this service.

116/18.14 Ms Mann-Kler noted that there had been a news story regarding cervical screening in England, and asked if there were any implications for Northern Ireland. Dr Mairs assured members that there were no implications for Northern Ireland.

117/18 Item 7 – Finance Report (PHA/01/11/18)

117/18.1 Mr Cummings advised that the Finance Report for the period up to 30 September 2018 showed a year to date surplus of £1.6m. He explained that a re-alignment of Trust budgets had taken place, but that there is a deficit in the Belfast Trust due to funds relating to the Lifeline budget not having been transferred. Within the management and administration budget, he advised that there is a surplus of £400k which continues to be a concern due to recruitment issues. He said that there is some good news for PHA as there should shortly be confirmation of PHA being authorised to run two public information campaigns this year.

117/18.2 Mr Stewart said that he was delighted that there is progress within regard to campaigns, but he asked whether there was any chance of the surplus within the management and administration being increased given this relates to vacant posts and there is only four months of the financial year remaining. The Interim Chief Executive informed members that the PHA is due to have its mid-year ground clearing meeting with its sponsor branch in the Department of Health next week, and that as part of that

meeting the Department wishes to carry out its own analysis of PHA's vacant posts and to understand the risks. She assured members that there are ongoing efforts to fill vacant posts.

117/18.3 Mr Clayton asked for an update on transformation funding, and if there will be an underspend. Mr Cummings advised that PHA is responsible for 36 transformation projects, which are all proceeding. He explained that, in an attempt to speed up the process of getting initiatives underway, the HSCB and PHA no longer has to approve the Trust expenditure. He added that there is likely to be an underspend due to the difficulties in recruiting posts. The Interim Chief Executive expressed her concern about the change in process regarding approvals of IPTs (Investment Planning Templates) and said she has written to the Permanent Secretary in this regard.

117/18.4 Alderman Porter asked for reassurance that the HSC will still receive its funding from the confidence and supply arrangement in this financial year. Mr Cummings said that there is £100m earmarked for health, which is only guaranteed for this financial year, and that there are no assumptions relating to funding for 2019/20. Alderman Porter asked if he could see written confirmation regarding the funding for 2018/19.

117/18.5 Ms Mann-Kler asked if PHA was confident of achieving a break even position. Mr Cummings said that he was confident as PHA has achieved this every year. The Interim Chief Executive said that her only concern was that additional non-recurrent funding is offered to the Agency in January or February by the Department.

117/18.6 The Board noted the Finance Report.

118/18 Item 8 – Update on Our Future Foyle Initiative (PHA/02/11/18)

118/18.1 Mr Drew welcomed Mr Brendan Bonner to the meeting. He noted that the Board had received information about the Our Future Foyle initiative at a previous meeting and welcomed the opportunity to learn more.

118/18.2 Mr Bonner said that his presentation would start by dealing with the issue of suicide but would lead to a discussion about issues such as technology, use of the arts, job creation and regeneration etc. He said that there is no other project in the world dealing with suicide prevention in this holistic and innovative approach. He informed members that since February 2017 there have been 14 deaths by suicide at the river, one search currently ongoing (which will bring the total to 15) and over 1,700 attempts from 3 years of data collected via CCTV monitoring. He said that the evidence based human and emotional costs of suicide equate to £1.7m per instance of suicide.

118/18.3 Mr Bonner pointed out this was not an issue about one bridge (Foyle Bridge) but about a 6 miles radius of the river and all its infrastructure, where vulnerable individuals had access to mean in terms of access to

	the river. He outlined on a map the high risk areas, which included the 3 bridges and the river banks.
118/18.4	Mr Bonner explained that a consultation, involving over 5,000 participants, was undertaken to ask what people would like to see happen to improve the perception of the river, and based on the responses a model, the "Foyle Triangle" suicide prevention tool was developed. He said that this model would look at core issues as awareness, identification of people at risk and providing support and then linking between creating physical barriers, soft barriers and increasing footfall in the area.
118/18.5	Mr Bonner gave members an overview of the three key social and cultural interventions being proposed: Foyle Bubbles, Foyle Experience and Foyle Reeds.
118/18.6	Mr Bonner said that Foyle Bubbles is an initiative whereby people can visit the river and avail of services, whether it be a local business or an advice drop-in point which are in the form of "bubble". He added that the bubbles can be interactive, and can light up when people are nearby, thereby allowing CCTV to pick up any individuals who may be in distress and get assistance to them. He advised that 44 such spaces are being planned, and there are already up to 80 expressions of interest. He added that the bubbles would be located at the points highlighted in the map earlier, where there was ease of access to the river.
118/18.7	Mr Bonner explained that the Foyle Experience allows artists to make use of the space by the river to create an experience for residents and visitors. He said that during the May Day weekend many such artworks, developed by QUB, were installed at various points of high risk and over 15,000 people "engagements" with these works were recorded, and also no recorded suicide attempts that weekend. He added that the final artworks would be integrated with new technology to ensure they were inactive and easily accessible.
118/18.8	The third aspect is Foyle Reeds which Mr Bonner explained is the construction of 12,000 light up reeds along the Foyle Bridge which act as a physical barrier and are also impossible to climb over. He added that these reeds can change colour to mark significant events and people will be able to use an app to book their own time slot to light the reeds for their own event. He said that initial feedback on the reeds has been positive. He explained that this was an innovative barrier compared to the traditional solution of railings and it helped transform the cognitive association of the bridge for citizens and vulnerable people.
118/18.9	In terms of cost, Mr Bonner advised that the initiative will cost £27m over 5 years, but that there is support from the Department of Communities and the Department of Infrastructure, and that Transformation funding slippages has been earmarked as a potential source. He said that he had met with the Permanent Secretaries Group who were interested in this

work. He explained that the business case is currently being compiled by the Strategic Investment Board and the planning aspects are being dealt with the by Derry City and Strabane Council. He also hoped that local fund raising (Crowd Funding) would provide up to £500k of recurrent funding. Finally, he said that there is buy in from all political parties.

118/18.10 Alderman Porter thanked Mr Bonner for the presentation, but questioned whether the amounts of money being discussed would make a difference. He also suggested that people may choose to light up the bridge to mark the occasion of when they lost a loved one to suicide. He said that a similar initiative in Dublin had cost €15m, but only 1 out of 9 projects was deemed to have been successful. He asked how much evaluation has been done. Mr Bonner said that every aspect of this initiative is evidence based. He added that the lights are only to be used for celebratory events, and in terms of the cost he noted that suicide has already cost £25m over the last 16 months.

118/18.11 Ms Mann-Kler said that the presentation was very powerful and she felt that the innovations being described in the joining up of arts, creativity, health and wellbeing is the way public health should be going. She asked if suicide rates had decreased during periods such as the Derry City of Culture celebrations, and what indicators, apart from suicide, would be used to know whether the health and wellbeing of people is increasing. Mr Bonner advised that when there are other activities in the city, the suicide rate does decrease. He advised that the Strategic Investment Board business case has identified a broad range of indicators. He also said that the community planning group is looking at ways to measure "happiness" as a key outcome, and that this project will change people's perceptions.

118/18.12 Mr Clayton noted that the presentation mentioned a lot of partners and he asked what the breakdown of the expenditure would look like. Mr Bonner advised that there is no capital cost to PHA, as funding will come from the likes of Transformation funding and statutory partners such as the Department of Infrastructure. He added that TourismNI are also interested as the bridges link the "Wild Atlantic Way" with the "Causeway Coastal Route". In response to Mr Clayton's follow up question, he reiterated that the only costs to PHA are management and evaluation costs.

118/18.13 Councillor Ashe commended the initiative saying that thought needs to be given to those individuals who are involved in retrieving the bodies of the individuals who have taken their lives, and the sickness absences that may ensue.

118/18.14 Professor Rooney congratulated Mr Bonner on this project and commended the work in areas such as helplessness, alienation and entrapment. She hoped that the momentum on this work can be maintained.

118/18.15 The Interim Chief Executive said that this is a fantastic piece of work, not only as a public health initiative, but as a tourism initiative. She noted that in her previous role she had contributed to the regeneration plan and the application for the City of Culture bid, and that the main aim was to create a place where people would want to go and would enjoy being in. She said that after 30 years of the Troubles, people wanted to see something different and they were excited when the funding for the Peace Bridge was confirmed. She added that the Police and Fire Games and the Clipper Round the World Yacht Race were two other event building on earlier initiatives.

118/18.16 The Interim Chief Executive said she was speaking from personal experience and is aware of the effect that suicide has on those family members that are left behind, and she commended Mr Bonner on his enthusiasm in taking this work forward. She wished to put on record her thanks to Mr Bonner for getting the project to this stage. Mrs McKissick praised the work of the project and the use of art.

118/18.17 Mr Drew thanked Mr Bonner for attending the meeting to deliver the presentation. He commended the joined up approach and the energy behind the initiative and he looked forward to the Board receiving more updates as this important work progresses.

118/18.18 The Board noted the update on the Our Future Foyle initiative.

119/18 Item 9 – NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2016/17 (PHA/03/11/18)

119/18.1 Mr Drew welcomed Dr Stephen Bergin to the meeting and asked him to present the report on the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme.

119/18.2 Dr Bergin said that before presenting the AAA Report, he wished to brief members on PHA's work to reduce inequalities across all its screening programmes. He advised that PHA commissions and quality assures 8 programmes which equate to almost 400,000 screening episodes per year. He said that PHA works with Trusts and primary care and has a direct responsibility for the delivery of these programmes. He added that this is a priority element of the PHA's work and that PHA is working hard to maintain its high performance in delivering these programmes.

119/18.3 Dr Bergin explained that all programmes are determined at a national level, and that there are inequalities across all 8 programmes. He said that the biggest issue is non-uptake, and that by not participating individuals increase the risk of harm. The main reasons for non-uptake, he said, include not having time, a lack of understanding, anxiety, young adults leading busy lives, rurality, ethnicity and homelessness. He said that to tackle this PHA needs to, for example, target its efforts in areas such as social media, but also to be out engaging with the population through initiatives such as Men's Sheds. Dr Bergin said that evidence

119/18.4	showed that people who are less well-off are less likely to avail of screening, as are foreign nationals and people with physical or learning disabilities.
119/18.5	Dr Bergin gave members an overview of the work of the Women's Resource and Development Agency (WRDA), an organisation which trains peer facilitators who target the bottom 20% of the population in terms of socio-economic deprivation. He added that a recent evaluation of its work has shown the programme to be worthwhile.
119/18.6	Mr Clayton thanked Dr Bergin for his presentation and said that he was pleased to see how much work PHA is doing to address inequalities, and added that he would be interested to learn more about the work of WRDA.
119/18.7	Dr Bergin moved on to present the AAA Screening Programme report. He explained that this programme is run by the Belfast Trust who have a cadre of staff who go out and deliver it across the whole of Northern Ireland. He advised that when men are screened and present with a small or medium sized aneurysm they are put under surveillance, but if they have a large aneurysm they are referred to a surgeon to explore potential need for surgery.
119/18.8	Dr Bergin advised that men aged 65 are invited to take up the programme and that the uptake for 2016/17 was 84%. He added that 107 aneurysms were detected that year.
119/18.9	Dr Bergin said that inequalities within this programme are not as wide in England than in Northern Ireland. He said that PHA recently held a service user event for those who had participated in the programme and that some of these service users are on the regional coordinating group. He added that there is ongoing work to further engage with service users.
119/18.10	Dr Bergin informed members that later this year the programme will be subject to an external quality assurance visit conducted in collaboration with Public Health England.
119/18.11	Mr Drew said that this was an excellent and easy to read report and thanked Dr Bergin for his presentation.
119/18.12	Professor Rooney noted that the report stated that the number of deaths from aneurysms could be halved, and asked if figures were available. Dr Bergin said that there are data but he did not have the information to hand. Dr Mairs said that a reduction in deaths from AAA due the screening programme should now begin to become apparent, as the programme prevented deaths 5 – 10 years into the future. He added that when the programme was being planned the prevalence rate was expected to be around 4%, but this has now reduced to 1.2% due to changes in lifestyle factors, such as smoking.

119/18.13 Ms Mann-Kler said that there is clearly a qualitative benefit from doing this work, but asked if there is a quantitative benefit for the NHS. Dr Mairs said that there are data available to show that the programme is cost-effective down to a prevalence rate of 0.9%. Dr Bergin added that no screening programme would be run, unless it met cost effectiveness criteria.

119/18.14 Mr Clayton said that the report was excellent, but asked about the inequality gap and if this was related to access issues, or lifestyle, or a combination of many factors. Dr Bergin said that there are many factors, but he said that knowledge also changes people's attitude.

119/18.15 Mrs McKissick commended the co-production element with the involvement of service users.

119/18.16 The Board noted the Northern Ireland Abdominal Aortic Aneurysm Annual Report for 2016/17.

120/18 Item 10 – Annual Immunisation Report for Northern Ireland (PHA/04/11/18)

120/18.1 Mr Drew welcomed Dr Lucy Jessop to the meeting and invited her to present the Annual Immunisation Report.

120/18.2 Dr Jessop explained that this is the third annual immunisation report and includes vaccine coverage for all targeted childhood and adult programmes in Northern Ireland. She gave an overview of the key findings for the report. She highlighted that the uptake of HPV among girls was slightly lower than in the previous year. She noted that this was the first year that accurate data was available for uptake of the pertussis vaccine among pregnant women, and she advised that the uptake of the shingles vaccine among 70 and 78 year olds was slightly higher than the previous year.

120/18.3 Dr Jessop advised that the uptake of the HPV vaccine programme for men who have sex with men (MSM) was 73.3% for the first dose, but decreased for the second and third doses.

120/18.4 In terms of the priorities going forward, Dr Jessop will continue to work with school health and communication colleagues to improve the uptake of the HPV vaccine. Dr Jessop informed members that two studies had been undertaken using data regarding, firstly, variation in pertussis containing vaccine and seasonal influenza coverage among pregnant women and, secondly, the HPV vaccine among MSM. She said that the findings of these two studies will help to improve uptake of these programmes.

120/18.5 Dr Jessop informed members that the evaluation from a PPI initiative with the Roma community had highlighted that people within that community are not against immunisation, but there are practical reasons

for not getting vaccinated, including not be able to read or having no fixed address.

120/18.6 Dr Jessop explained that this report does not contain information regarding uptake of the flu vaccine as this would not be available until June so is covered in a separate report.

120/18.7 Mr Stewart asked about the drop in rates for the second and third doses of the HPV vaccine among MSM. Dr Jessop said that this is a timing issue depending on when the men attend GUM clinics, and is not a cause for concern.

120/18.8 Ms Mann-Kler said that she was pleased that Northern Ireland is doing well compared to other parts of the UK. She asked whether there were any global threats that PHA should be aware of, and whether there were any issues with regard to storage of vaccines post Brexit. Dr Jessop advised that many vaccines are manufactured in the UK so there should be no impact on supply. She added that all vaccines are still very effective and that the UK is a world leader in this field and will continue to monitor trends

120/18.9 Mr Drew asked what more could be done to encourage people to come forward to be vaccinated, citing the use of social media as a method. Dr Jessop said that there is a lot of work being done to encourage uptake, and that PHA is constantly using social media to update people with regard to vaccines.

120/18.10 The Board noted the Annual Immunisation Report for 2017/18.

121/18 Item 11 – Annual Business Plan Mid-Year Monitoring Report (PHA/05/11/18)

121/18.1 Miss Taylor said that this report was for the first six months of 2018/19, and that of the 75 actions in the Business Plan, 68 were rated as “green”, with 6 rated as “amber” and 1 rated as “red” in terms of implementation. She added that the report contained further detail regarding the mitigating actions for those targets rated “amber” or “red”.

121/18.2 Mr Stewart said that he was concerned that some of the targets had not been rated correctly. He felt that the target relating to campaigns should have been rated “red”, and that the target relating to procurement should have been rated “amber”. Miss Taylor noted the points, but said that within campaigns that there has been a lot of campaign work undertaken on social media and other forums. Ms Mann-Kler asked if any slippage could be utilised to help with campaigns. Miss Taylor hoped that this would be the case, and this may then allow for the target relating to campaigns to move from “amber” to “green”.

121/18.3 Mrs McKissick drew members’ attention to the MyNI initiative and said that this had been a major success and was an excellent example of

service user-led, evidence-based work which has effected a new way of talking and communicating with people. She added that the programme has been extended for a further 6 months. Mr Stewart said that he would like to hear more about this initiative. Dr Mairs said that it is linked to work being done on NI Direct, where there is a resource for people can find out where they can get help depending on their symptoms.

121/18.4 The Board noted the annual business plan mid-year monitoring report.

122/18 Item 12 – Any Other Business

122/18.1 The Interim Chief Executive asked that any members of the Board available to sit on an interview panel for the new Director of Quality Improvement should advise the Chair who would then contact her.

123/18 Item 13 – Details of Next Meeting

Thursday 20 December 2018 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Signed by Chair:

Date: 20 December 2018

HSC Public Health Agency

minutes

107th Meeting of the Public Health Agency Board

Thursday 15 November 2018 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

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Mrs Valerie Watts	-	Interim Chief Executive
Dr Adrian Mairs	-	Acting Director of Public Health
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Councillor William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director
Miss Rosemary Taylor	-	Assistant Director Planning and Operational Services (*on behalf of Mr McClean*)

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Ms Nicola Woods	-	Boardroom Apprentice
Mr Robert Graham	-	Secretariat

Apologies

Mr Andrew Dougal	-	Chair
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Ms Marie Roulston	-	Director of Social Care and Children, HSCB

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112/18.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
113/18	**Item 3 – Minutes of previous meeting held on 18 October 2018**
113/18.1	The minutes of the previous meeting, held on 18 October 2018, were

approved as an accurate record of that meeting.

114/18 **Item 4 – Matters Arising**

101/18.2 Waiting Lists

114/18.1 Councillor Ashe asked about a further update on waiting lists. The Interim Chief Executive advised that she would cover this as part of her Chief Executive's Report.

105/18.10 Procurement Plan

114/18.2 Miss Taylor advised that the group taking forward the work on procurement had held its first meeting yesterday.

108/18.6 Community Planning

114/18.3 In response to a query about the review of community plans, Miss Taylor advised that this is due to take place in November 2019.

115/18 **Item 5 – Chair's Business**

115/18.1 Mr Drew noted that the Chair's Business had been circulated via e-mail to members in advance of the meeting.

115/18.2 There was a reference in the report to homelessness and Ms Mann-Kler expressed her concern about the basic sanitary needs of homeless people being met. She suggested that the Board should receive an update on homelessness at a future meeting.

115/18.3 Alderman Porter noted that some homeless people choose to live on the street. The Interim Chief Executive advised that the number of people who are homeless is very small as there are hostel beds, but many homeless people do not avail of them. Mr Clayton said that it would be useful for the PHA Board to get a briefing on any work PHA is doing in this area. Councillor Ashe added that it would be useful to get data on the actual numbers as well as an update on what PHA is doing.

115/18.4 Mrs McKissick advised that 3 years ago the Patient Client Council undertook a literature review about the prevalence of homelessness and "sofa surfing". She said that they organised a workshop which involved the Department of Communities, Department of Health and service users. She added that there is a new Homelessness Strategy.

115/18.5 The Interim Chief Executive said that she had recently met with political representatives to discuss issues such as homelessness, street triage and de-escalation services.

115/18.6 Mr Clayton noted that there is a legal obligation on Trusts if a child is homeless and he said that he would welcome a briefing as going forward

PHA may have additional responsibilities in this area when it inherits the social care and children's functions following the closure of HSCB.

116/18 Item 6 – Chief Executive's Business

116/18.1 The Interim Chief Executive began with an update on the neurology call back exercise. She said that following the review of 2,500 neurology patients earlier this year, a decision was taken to recall a further 1,044 people. She explained that this further group consists of patients who had been seen by Dr Watt and discharged to the care of their GP, and that this process is being concentrated on specific groups of patients taking specific, specialised medicines.

116/18.2 The Interim Chief Executive said that the HSC would want to apologise for any distress and uncertainty that this process brings and it is clearly our responsibility to act on clinical advice and the emerging outcomes from the first phase of the recall. She advised that the review appointments started last weekend and are scheduled to be completed within a four month period.

116/18.3 The Interim Chief Executive assured members that the primary focus of this exercise is to reassure everyone who has received a letter that they are on the correct treatment; and request that they should not stop, or make adjustments to, their medication until they have been reviewed by a consultant neurologist at their appointment. She explained that anyone who does not receive a letter does not have to take any action and that there is a dedicated advice line in place for any concerns anyone may have.

116/18.4 The Interim Chief Executive informed members that new prototype elective care centres will undertake routine day surgery for cataracts and treatment of varicose veins from December 2018. She hoped that this development will have an impact on the number of patients treated and crucially, these centres will operate on separate sites from urgent and emergency hospital care meaning they will not be competing for operating rooms and other resources, leading to fewer cancellations of operations. She noted that while some patients may be asked to travel further for their treatment, they will be seen faster and have a better experience and it is the expectation of the Department of Health that patients who have been assessed as requiring treatment for cataracts and varicose veins will, by December 2021, be treated within 13 weeks as per Ministerial targets.

116/18.5 The Interim Chief Executive noted that 25th October saw the second anniversary of the launch of Delivering Together. As part of the transformation programme, she advised members that a new healthcare hub was announced on 19 October which will help transform healthcare for the homeless. She advised members that the Northern Ireland Ambulance Service recently launched a consultation regarding proposals for changing their service delivery.

116/18.6 The Interim Chief Executive updated members on the HSC restructuring saying that work is well under way with regard to the design groups which are co-chaired by HSCB and Department staff. She added that a second meeting of the staff side forum has also taken place, and that the Oversight Board, chaired by the Permanent Secretary, has agreed an internal communications framework to support engagement with staff. She acknowledged that in order to meet the overall timelines, there needs to be an Assembly or other legislative vehicle in place by January, but it is equally important that work must continue to ensure preparations are in place to move towards closer working, and most importantly, to give staff the certainty they want and time to prepare for the new arrangements.

116/18.7 The Interim Chief Executive informed members that a neonatal initiative delivered by Allied Health Professionals (AHPs) across NI neonatal units secured the overall award at the Advancing Healthcare Awards at the Le Mon hotel on 7 November. She advised that this model has been developed and led by Geraldine Teague, Lead AHP Consultant & Heather Reid, Public Health Consultant from the PHA and has been operating regionally since 2016. She added that at the awards ceremony this regional model won the DoH 'Transforming the Workforce' Award for 'Aiding Holistic Partnerships', which was awarded by the Permanent Secretary Richard Pengelly, as well as being awarded the overall winner on the night.

116/18.8 The Interim Chief Executive said there was more success for PHA as on Friday 9 November, the CIM Ireland Marketing Awards took place to celebrate the very best marketing innovations, interventions and campaigns crafted by organisations, businesses and agencies from across Ireland, and that PHA's #NotsorryMums breastfeeding campaign won the award for 'Best Cause related marketing'. She said that she would wish to convey her congratulations on behalf of the Board to both sets of winners.

116/18.9 Professor Rooney asked whether the neurology call back exercise is having an impact on current waiting lists. Dr Mairs said that this is being monitored on a weekly basis, but he assured members that there is no impact on core neurology services. He added that extra clinics are being provided by the independent sector. However, he suggested that there may be an impact in the future; hence there is an ongoing review of neurology services.

116/18.10 Professor Rooney asked whether PHA is involved in the design groups. The Interim Chief Executive said that PHA is involved in some of them, but she had made the point to the Department that the PHA has an important role in this work.

116/18.11 Professor Rooney asked about the transfer of paediatric pathology services to Alder Hey. Dr Mairs explained that HSCB is responsible for commissioning this service, but that PHA provides advice and support. The Interim Chief Executive said that the information provided by PHA is

passed onto the Director of Commissioning. Professor Rooney asked whether the opinion of a psychologist was sought as part of the decision making process. She felt the decision was lacking psychological advice.

116/18.12 Mr Clayton noted that the timeline for the second neurology call back was longer than the first exercise. Dr Mairs said that this is deliberate as a risk-based approach is being adopted. He explained that it became clear that there needed to be follow up with those patients who had been discharged by Dr Watt, but were still on medication and had not been reviewed by another neurologist. He said that these patients may have been mis-diagnosed, or that they may be on medication that they do not require. He added that this cohort has been split into four groups, with each group being looked at using a risk-based approach. Furthermore, he explained that the impact on HSC staff had been taken into consideration as this work has been ongoing constantly for six months.

116/18.13 Councillor Ashe expressed his concern that the statement made regarding the paediatric pathology decision was a joint statement and that the PHA Board had not been informed before the decision was made public. Dr Mairs explained that although the consultant who spoke on the issue is employed by PHA, she was speaking on behalf of HSCB and PHA. The Interim Chief Executive apologised to members that they had not briefed beforehand. Mr Cummings said that Northern Ireland has been proactive in securing this service from Alder Hey because there is a UK-wide shortage of this service.

116/18.14 Ms Mann-Kler noted that there had been a news story regarding cervical screening in England, and asked if there were any implications for Northern Ireland. Dr Mairs assured members that there were no implications for Northern Ireland.

117/18 Item 7 – Finance Report (PHA/01/11/18)

117/18.1 Mr Cummings advised that the Finance Report for the period up to 30 September 2018 showed a year to date surplus of £1.6m. He explained that a re-aligned of Trust budgets had taken place, but that there is a deficit in the Belfast Trust due to funds relating to the Lifeline budget not having been transferred. Within the management and administration budget, he advised that there is a surplus of £400k which continues to be a concern due to recruitment issues. He said that there is some good news for PHA as there should shortly be confirmation of PHA being authorised to run two public information campaigns this year.

117/18.2 Mr Stewart said that he was delighted that there is progress within regard to campaigns, but he asked whether there was any chance of the surplus within the management and administration being reduced given this relates to vacant posts and there is only four months of the financial year remaining. The Interim Chief Executive informed members that the PHA is due to have its mid-year ground clearing meeting with its sponsor branch in the Department of Health next week, and that as part of that

meeting the Department wishes to carry out its own analysis of PHA's vacant posts and to understand the risks. She assured members that there are ongoing efforts to fill vacant posts.

117/18.3 Mr Clayton asked for an update on transformation funding, and if there will be an underspend. Mr Cummings advised that PHA is responsible for 36 transformation projects, which are all proceeding. He explained that, in an attempt to speed up the process of getting initiatives underway, the HSCB and PHA no longer has to approve the Trust expenditure. He added that there is likely to be an underspend due to the difficulties in recruiting posts. The Interim Chief Executive expressed her concern about the change in process regarding approvals of IPTs (Investment Planning Templates) and said she has written to the Permanent Secretary in this regard.

117/18.4 Alderman Porter asked for reassurance that the HSC will still receive its funding from the confidence and supply arrangement in this financial year. Mr Cummings said that there is £100m earmarked for health, which is only guaranteed for this financial year, and that there are no assumptions relating to funding for 2019/20. Alderman Porter asked if he could see written confirmation regarding the funding for 2018/19.

117/18.5 Ms Mann-Kler asked if PHA was confident of achieving a break even position. Mr Cummings said that he was confident as PHA has achieved this every year. The Interim Chief Executive said that her only concern was that additional non-recurrent funding is offered to the Agency in January or February by the Department.

117/18.6 The Board noted the Finance Report.

118/18 Item 8 – Update on Our Future Foyle Initiative (PHA/02/11/18)

118/18.1 Mr Drew welcomed Mr Brendan Bonner to the meeting. He noted that the Board had received information about the Our Future Foyle initiative at a previous meeting and welcomed the opportunity to learn more.

118/18.2 Mr Bonner said that his presentation would start by dealing with the issue of suicide but would lead to a discussion about issues such as technology, use of the arts, job creation and regeneration etc. He said that there is no other project in the world dealing with suicide prevention in this holistic and innovative approach. He informed members that since February 2017 there have been 14 deaths by suicide at the river, one search currently ongoing (which will bring the total to 15) and over 1,700 attempts from 3 years of data collected via CCTV monitoring. He said that the evidence based human and emotional costs of suicide equate to £1.7m per instance of suicide.

118/18.3 Mr Bonner pointed out this was not an issue about one bridge (Foyle Bridge) but about a 6 miles radius of the river and all its infrastructure, where vulnerable individuals had access to mean in terms of access to

	the river. He outlined on a map the high risk areas, which included the 3 bridges and the river banks.
118/18.4	Mr Bonner explained that a consultation, involving over 5,000 participants, was undertaken to ask what people would like to see happen to improve the perception of the river, and based on the responses a model, the "Foyle Triangle" suicide prevention tool was developed. He said that this model would look at core issues as awareness, identification of people at risk and providing support and then linking between creating physical barriers, soft barriers and increasing footfall in the area.
118/18.5	Mr Bonner gave members an overview of the three key social and cultural interventions being proposed: Foyle Bubbles, Foyle Experience and Foyle Reeds.
118/18.6	Mr Bonner said that Foyle Bubbles is an initiative whereby people can visit the river and avail of services, whether it be a local business or an advice drop-in point which are in the form of "bubble". He added that the bubbles can be interactive, and can light up when people are nearby, thereby allowing CCTV to pick up any individuals who may be in distress and get assistance to them. He advised that 44 such spaces are being planned, and there are already up to 80 expressions of interest. He added that the bubbles would be located at the points highlighted in the map earlier, where there was ease of access to the river.
118/18.7	Mr Bonner explained that the Foyle Experience allows artists to make use of the space by the river to create an experience for residents and visitors. He said that during the May Day weekend many such artworks, developed by QUB, were installed at various points of high risk and over 15,000 people "engagements" with these works were recorded, and also no recorded suicide attempts that weekend. He added that the final artworks would be integrated with new technology to ensure they were inactive and easily accessible.
118/18.8	The third aspect is Foyle Reeds which Mr Bonner explained is the construction of 12,000 light up reeds along the Foyle Bridge which act as a physical barrier and are also impossible to climb over. He added that these reeds can change colour to mark significant events and people will be able to use an app to book their own time slot to light the reeds for their own event. He said that initial feedback on the reeds has been positive. He explained that this was an innovative barrier compared to the traditional solution of railings and it helped transform the cognitive association of the bridge for citizens and vulnerable people.
118/18.9	In terms of cost, Mr Bonner advised that the initiative will cost £27m over 5 years, but that there is support from the Department of Communities and the Department of Infrastructure, and that Transformation funding slippages has been earmarked as a potential source. He said that he had met with the Permanent Secretaries Group who were interested in this

work. He explained that the business case is currently being compiled by the Strategic Investment Board and the planning aspects are being dealt with the by Derry City and Strabane Council. He also hoped that local fund raising (Crowd Funding) would provide up to £500k of recurrent funding. Finally, he said that there is buy in from all political parties.

118/18.10 Alderman Porter thanked Mr Bonner for the presentation, but questioned whether the amounts of money being discussed would make a difference. He also suggested that people may choose to light up the bridge to mark the occasion of when they lost a loved one to suicide. He said that a similar initiative in Dublin had cost €15m, but only 1 out of 9 projects was deemed to have been successful. He asked how much evaluation has been done. Mr Bonner said that every aspect of this initiative is evidence based. He added that the lights are only to be used for celebratory events, and in terms of the cost he noted that suicide has already cost £25m over the last 16 months.

118/18.11 Ms Mann-Kler said that the presentation was very powerful and she felt that the innovations being described in the joining up of arts, creativity, health and wellbeing is the way public health should be going. She asked if suicide rates had decreased during periods such as the Derry City of Centre celebrations, and what indicators, apart from suicide, would be used to know whether the health and wellbeing of people is increasing. Mr Bonner advised that when there are other activities in the city, the suicide rate does decrease. He advised that the Strategic Investment Board business case has identified a broad range of indicators. He also said that the community planning group is looking at ways to measure “happiness” as a key outcome, and that this project will change people’s perceptions.

118/18.12 Mr Clayton noted that the presentation mentioned a lot of partners and he asked what the breakdown of the expenditure would look like. Mr Bonner advised that there is no capital cost to PHA, as funding will come from the likes of Transformation funding and statutory partners such as the Department of Infrastructure. He added that TourismNI are also interested as the bridges link the “Wild Atlantic Way” with the “Causeway Coastal Route”. In response to Mr Clayton’s follow up question, he reiterated that the only costs to PHA are management and evaluation costs.

118/18.13 Councillor Ashe commended the initiative saying that thought needs to be given to those individuals who are involved in retrieving the bodies of the individuals who have taken their lives, and the sickness absences that may ensue.

118/18.14 Professor Rooney congratulated Mr Bonner on this project and commended the work in areas such as helplessness, alienation and entrapment. She hoped that the momentum on this work can be maintained.

118/18.15 The Interim Chief Executive said that this is a fantastic piece of work, not only as a public health initiative, but as a tourism initiative. She noted that in her previous role she had contributed to the regeneration plan and the application for the City of Culture bid, and that the main aim was to create a place where people would want to go and would enjoy being in. She said that after 30 years of the Troubles, people wanted to see something different and they were excited when the funding for the Peace Bridge was confirmed. She added that the Police and Fire Games and the Clipper Round the World Yacht Race were two other event building on earlier initiatives.

118/18.16 The Interim Chief Executive said she was speaking from personal experience and is aware of the effect that suicide has on those family members that are left behind, and she commended Mr Bonner on his enthusiasm in taking this work forward. She wished to put on record her thanks to Mr Bonner for getting the project to this stage. Mrs McKissick praised the work of the project and the use of art.

118/18.17 Mr Drew thanked Mr Bonner for attending the meeting to deliver the presentation. He commended the joined up approach and the energy behind the initiative and he looked forward to the Board receiving more updates as this important work progresses.

118/18.18 The Board noted the update on the Our Future Foyle initiative.

119/18 Item 9 – NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2016/17 (PHA/03/11/18)

119/18.1 Mr Drew welcomed Dr Stephen Bergin to the meeting and asked him to present the report on the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme.

119/18.2 Dr Bergin said that before presenting the AAA Report, he wished to brief members on PHA's work to reduce inequalities across all its screening programmes. He advised that PHA commissions and quality assures 8 programmes which equate to almost 400,000 screening episodes per year. He said that PHA works with Trusts and primary care and has a direct responsibility for the delivery of these programmes. He added that this is a priority element of the PHA's work and that PHA is working hard to maintain its high performance in delivering these programmes.

119/18.3 Dr Bergin explained that all programmes are determined at a national level, and that there are inequalities across all 8 programmes. He said that the biggest issue is non-uptake, and that by not participating individuals increase the risk of harm. The main reasons for non-uptake, he said, include not having time, a lack of understanding, anxiety, young adults leading busy lives, rurality, ethnicity and homelessness. He said that to tackle this PHA needs to, for example, target its efforts in areas such as social media, but also to be out engaging with the population through initiatives such as Men's Sheds. Dr Bergin said that evidence

119/18.4	showed that people who are less well-off are less likely to avail of screening, as are foreign nationals and people with physical or learning disabilities.
119/18.5	Dr Bergin gave members an overview of the work of the Women's Resource and Development Agency (WRDA), an organisation which trains peer facilitators who target the bottom 20% of the population in terms of socio-economic deprivation. He added that a recent evaluation of its work has shown the programme to be worthwhile.
119/18.6	Mr Clayton thanked Dr Bergin for his presentation and said that he was pleased to see how much work PHA is doing to address inequalities, and added that he would be interested to learn more about the work of WRDA.
119/18.7	Dr Bergin moved on to present the AAA Screening Programme report. He explained that this programme is run by the Belfast Trust who have a cadre of staff who go out and deliver it across the whole of Northern Ireland. He advised that when men are screened and present with a small or medium sized aneurysm they are put under surveillance, but if they have a large aneurysm they are referred to a surgeon to explore potential need for surgery.
119/18.8	Dr Bergin advised that men aged 65 are invited to take up the programme and that the uptake for 2016/17 was 84%. He added that 107 aneurysms were detected that year.
119/18.9	Dr Bergin said that inequalities within this programme are not as wide in England than in Northern Ireland. He said that PHA recently held a service user event for those who had participated in the programme and that some of these service users are on the regional coordinating group. He added that there is ongoing work to further engage with service users.
119/18.10	Dr Bergin informed members that later this year the programme will be subject to an external quality assurance visit conducted in collaboration with Public Health England.
119/18.11	Mr Drew said that this was an excellent and easy to read report and thanked Dr Bergin for his presentation.
119/18.12	Professor Rooney noted that the report stated that the number of deaths from aneurysms could be halved, and asked if figures were available. Dr Bergin said that there are data but he did not have the information to hand. Dr Mairs said that a reduction in deaths from AAA due the screening programme should now begin to become apparent, as the programme prevented deaths 5 – 10 years into the future. He added that when the programme was being planned the prevalence rate was expected to be around 4%, but this has now reduced to 1.2% due to changes in lifestyle factors, such as smoking.

119/18.13 Ms Mann-Kler said that there is clearly a qualitative benefit from doing this work, but asked if there is a quantitative benefit for the NHS. Dr Mairs said that there are data available to show that the programme is cost-effective down to a prevalence rate of 0.9%. Dr Bergin added that no screening programme would be run, unless it met cost effectiveness criteria.

119/18.14 Mr Clayton said that the report was excellent, but asked about the inequality gap and if this was related to access issues, or lifestyle, or a combination of many factors. Dr Bergin said that there are many factors, but he said that knowledge also changes people's attitude.

119/18.15 Mrs McKissick commended the co-production element with the involvement of service users.

119/18.16 The Board noted the Northern Ireland Abdominal Aortic Aneurysm Annual Report for 2016/17.

120/18 Item 10 – Annual Immunisation Report for Northern Ireland (PHA/04/11/18)

120/18.1 Mr Drew welcomed Dr Lucy Jessop to the meeting and invited her to present the Annual Immunisation Report.

120/18.2 Dr Jessop explained that this is the third annual immunisation report and includes vaccine coverage for all targeted childhood and adult programmes in Northern Ireland. She gave an overview of the key findings for the report. She highlighted that the uptake of HPV among girls was slightly lower than in the previous year. She noted that this was the first year that accurate data was available for uptake of the pertussis vaccine among pregnant women, and she advised that the uptake of the shingles vaccine among 70 and 78 year olds was slightly higher than the previous year.

120/18.3 Dr Jessop advised that the uptake of the HPV vaccine programme for men who have sex with men (MSM) was 73.3% for the first dose, but decreased for the second and third doses.

120/18.4 In terms of the priorities going forward, Dr Jessop will continue to work with school health and communication colleagues to improve the uptake of the HPV vaccine. Dr Jessop informed members that two studies had been undertaken using data regarding, firstly, variation in pertussis containing vaccine and seasonal influenza coverage among pregnant women and, secondly, the HPV vaccine among MSM. She said that the findings of these two studies will help to improve uptake of these programmes.

120/18.5 Dr Jessop informed members that the evaluation from a PPI initiative with the Roma community had highlighted that people within that community are not against immunisation, but there are practical reasons

for not getting vaccinated, including not be able to read or having no fixed address.

120/18.6 Dr Jessop explained that this report does not contain information regarding uptake of the flu vaccine as this would not be available until June so is covered in a separate report.

120/18.7 Mr Stewart asked about the drop in rates for the second and third doses of the HPV vaccine among MSM. Dr Jessop said that this is a timing issue depending on when the men attend GUM clinics, and is not a cause for concern.

120/18.8 Ms Mann-Kler said that she was pleased that Northern Ireland is doing well compared to other parts of the UK. She asked whether there were any global threats that PHA should be aware of, and whether there were any issues with regard to storage of vaccines post Brexit. Dr Jessop advised that many vaccines are manufactured in the UK so there should be no impact on supply. She added that all vaccines are still very effective and that the UK is a world leader in this field and will continue to monitor trends

120/18.9 Mr Drew asked what more could be done to encourage people to come forward to be vaccinated, citing the use of social media as a method. Dr Jessop said that there is a lot of work being done to encourage uptake, and that PHA is constantly using social media to update people with regard to vaccines.

120/18.10 The Board noted the Annual Immunisation Report for 2017/18.

121/18 Item 11 – Annual Business Plan Mid-Year Monitoring Report (PHA/05/11/18)

121/18.1 Miss Taylor said that this report was for the first six months of 2018/19, and that of the 75 actions in the Business Plan, 68 were rated as “green”, with 6 rated as “amber” and 1 rated as “red” in terms of implementation. She added that the report contained further detail regarding the mitigating actions for those targets rated “amber” or “red”.

121/18.2 Mr Stewart said that he was concerned that some of the targets had not been rated correctly. He felt that the target relating to campaigns should have been rated “red”, and that the target relating to procurement should have been rated “amber”. Miss Taylor noted the points, but said that within campaigns that there has been a lot of campaign work undertaken on social media and other forums. Ms Mann-Kler asked if any slippage could be utilised to help with campaigns. Miss Taylor hoped that this would be the case, and this may then allow for the target relating to campaigns to move from “amber” to “green”.

121/18.3 Mrs McKissick drew members’ attention to the MyNI initiative and said that this had been a major success and was an excellent example of

	service user-led, evidence-based work which has effected a new way of talking and communicating with people. She added that the programme has been extended for a further 6 months. Mr Stewart said that he would like to hear more about this initiative. Dr Mairs said that it is linked to work being done on NI Direct, where there is a resource for people can find out where they can get help depending on their symptoms.
121/18.4	The Board noted the annual business plan mid-year monitoring report.
122/18	**Item 12 – Any Other Business**
122/18.1	The Interim Chief Executive asked that any members of the Board available to sit on an interview panel for the new Director of Quality Improvement should advise the Chair who would then contact her.
123/18	**Item 13 – Details of Next Meeting**
	Thursday 20 December 2018 at 1.30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast
	Signed by Chair:
	Date:

Public Health Agency

Finance Report

2018-19

Month 7 - October 2018

PHA Financial Report - Executive Summary

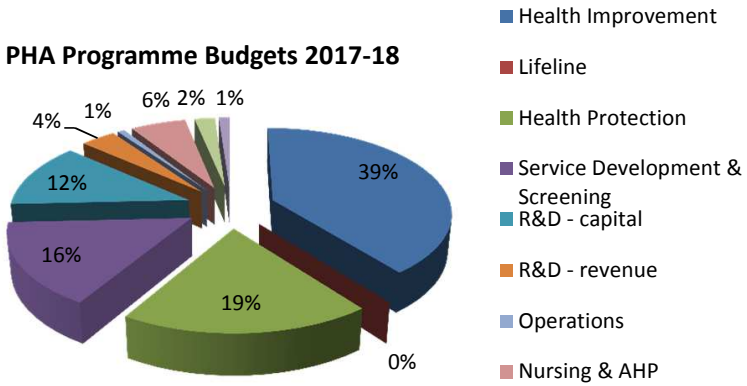
Year to Date Financial Position (page 2)

At the end of month 7 PHA is underspent against its profiled budget by approximately £1.6m. This underspend is primarily within Health Protection Programme budgets (page 4), and also includes some underspends on Administration budgets, as shown in more detail on page 5.

Whilst this position is not unusual for this stage of the year due to the difficulty of accurately profiling expenditure, budget managers are being encouraged to closely review their positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

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

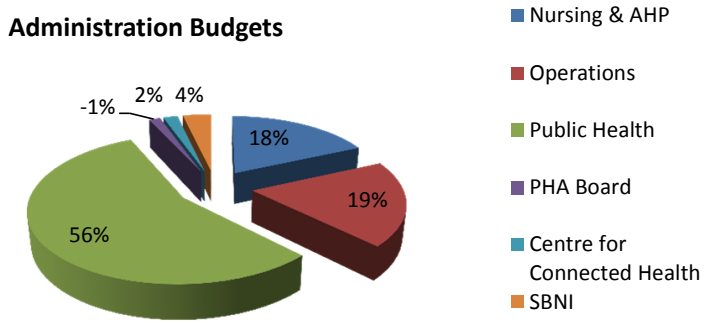


Administration Budgets (page 5)

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

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

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



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year. Slippage is expected to arise from Administration budgets in particular, however management expect this to be used to fund a range of in-year pressures and initiatives. A retraction of £1.4m unspent ringfenced funds, including Confidence and Supply Transformation Funds, has been assumed at month 7.

Public Health Agency
2018-19 Summary Position - October 2018

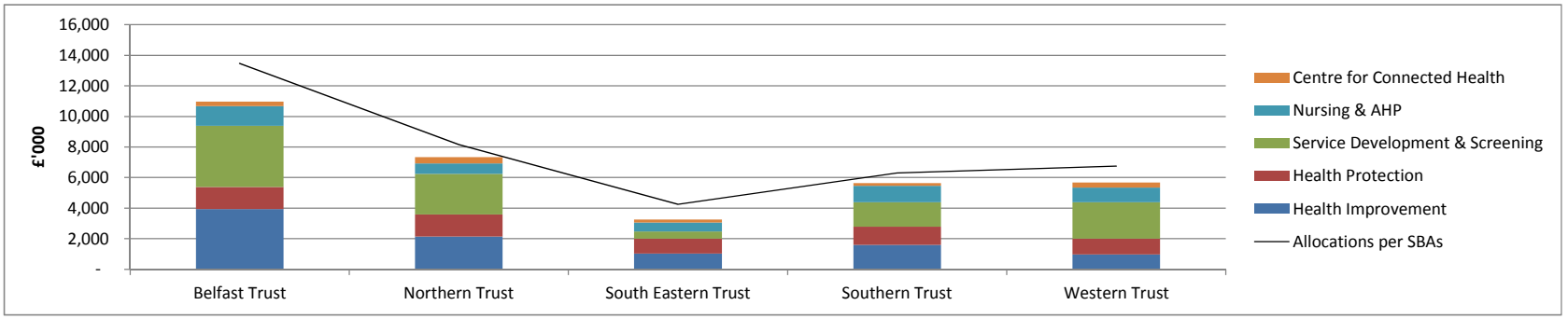
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust £'000	PHA Direct £'000	Trust & Direct £'000	Admin £'000	£'000	Trust £'000	PHA Direct £'000	Trust & Direct £'000	Admin £'000	£'000
Available Resources										
Departmental Revenue Allocation	32,930	42,217	8,873	18,989	**103,009**	17,539	20,121	2,519	10,881	**51,058**
Revenue Income from Other Sources	28	197		648	**873**	16	197	-	379	**593**
Departmental Allocation Retraction			(1,436)		**(1,436)**					
Total Available Resources	32,958	42,414	7,437	19,637	**102,446**	17,555	20,317	2,519	11,260	**51,652**
Expenditure										
Trusts	32,958	-	2,569	-	**35,528**	19,226	-	1,499	-	**20,725**
PHA Direct Programme *	-	43,094	4,868	-	**47,961**	-	17,615	895	-	**18,509**
PHA Administration	-	-		18,957	**18,957**	-	-		10,814	**10,814**
Total Proposed Budgets	32,958	43,094	7,437	18,957	**102,446**	19,226	17,615	2,394	10,814	**50,047**
Surplus/(Deficit) - Revenue	-	(680)	-	680	-	(1,671)	2,703	125	446	**1,603**
Cumulative variance (%)						***-9.52%***	***13.30%***	***4.96%***	***3.96%***	***3.10%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £1.6m, mainly due to spend behind profile on Health Protection Programme budgets (see page 4), and also a year to date underspend on Administration budgets (see page 5). It is currently anticipated that the PHA will achieve breakeven for the full year.

An allocation retraction by the DoH for £1.4m (mainly Confidence and Supply Transformation Funds) has been assumed against ringfenced budgets at this point.

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

Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	3,934	2,137	1,033	1,587	961	-	**9,651**	4,123	5,630	(1,507)
Health Protection	1,451	1,450	966	1,190	1,043	-	**6,100**	3,475	3,558	(83)
Service Development & Screening	4,004	2,650	477	1,613	2,392	-	**11,135**	6,431	6,496	(65)
Nursing & AHP	1,290	688	579	1,078	956	-	**4,591**	2,662	2,678	(17)
Centre for Connected Health	297	420	204	163	325	-	**1,409**	822	822	0
Other	24	13	11	12	11	-	**72**	42	42	0
Total current RRLs	**11,000**	**7,358**	**3,270**	**5,643**	**5,687**	**-**	**32,958**	**17,555**	**19,226**	**(1,671)**
Cumulative variance (%)										***-9.52%***

	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
Ringfenced	**492**	**463**	**589**	**350**	**641**	**35**	**2,569**	**1,499**	**1,499**	**0**
										0.00%

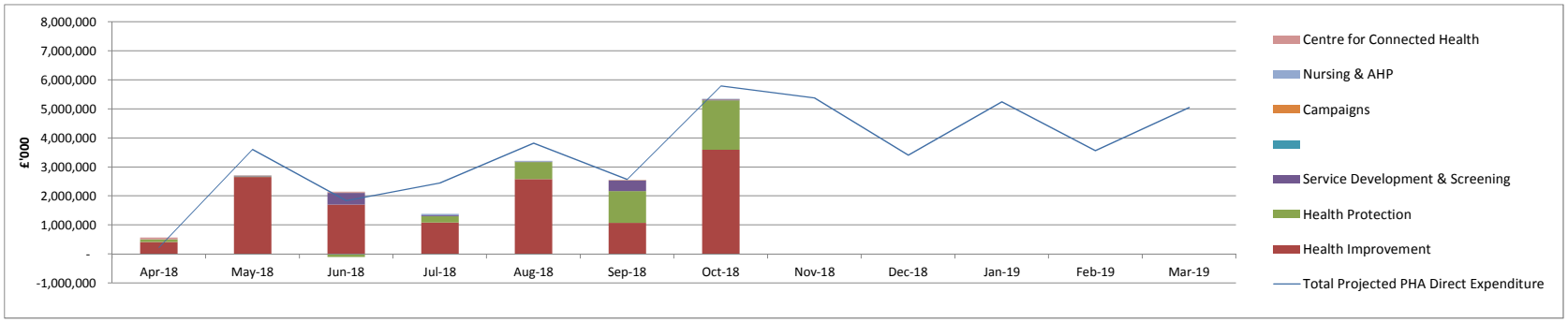
The above table shows the current Trust allocations split by budget area.

The year to date overspend on Trust budgets is primarily due to an outstanding budget transfer to BHSCT for Lifeline Contract (£1.3m year to date effect). The budget is currently held in the PHA Direct budget on page 4, and will be re-aligned for month 8.

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

Ringfenced funds allocated to Trusts have been assumed at breakeven.

PHA Direct Programme Expenditure



	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Projected Expenditure																	
Health Improvement	88	3,053	1,155	2,225	3,121	1,291	2,625	2,322	1,021	3,056	2,759	1,974	**24,689**	13,556	13,102	454	*3.3%*
Health Protection	56	347	93	78	446	888	2,960	1,817	1,023	1,001	709	1,149	**10,567**	4,868	3,637	1,231	*25.3%*
Service Development & Screening	18	140	524	74	74	328	130	68	199	74	51	792	**2,472**	1,288	1,098	190	*14.8%*
Research & Development - revenue	-	-	-	-	-	-	-	1,100	1,100	1,011	-	-	**3,211**	-	3	(3)	*0.0%*
Campaigns	9	9	9	9	9	9	9	9	9	9	9	93	**195**	65	13	52	*-100.0%*
Nursing & AHP	17	17	20	24	130	16	34	43	20	50	15	106	**492**	258	109	149	*57.8%*
Centre for Connected Health	40	40	40	40	40	40	40	24	40	40	24	40	**451**	282	92	190	*67.4%*
Other	-	-	-	-	-	-	-	-	-	-	-	900	**900**	0	(440)	440	*100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,450**	**3,820**	**2,573**	**5,797**	**5,382**	**3,413**	**5,242**	**3,567**	**5,055**	**42,976**	**20,317**	**17,615**	2,703	
Cumulative variance (%)																***13.30%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**1,380**	**3,097**	**2,563**	**5,214**	**-**	**-**	**-**	**-**	**-**	**17,615**				
Variance	**(343)**	**824**	**(165)**	**1,071**	**723**	**10**	**583**						**2,703**				

	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Total Projected Ringfenced PHA Direct Expenditure	**-**	**3**	**19**	**501**	**146**	**28**	**323**	**131**	**103**	**604**	**1,112**	**3,333**	**6,305**	**1,020**	**895**	**125**
																12.25%
Actual Expenditure	**-**	**170**	**55**	**299**	**24**	**68**	**279**						**895**			
Variance	**-**	**(167)**	**(35)**	**202**	**122**	**(41)**	**44**						**125**			

The budgets and profiles are shown after adjusting for retractions and new allocations from DoH. The projected expenditure figures also include a planned overspend to absorb underspends on Administration budgets.

The year-to-date position shows a £2.7m surplus, which is mainly due to (i) delays in payments within Health Protection (£1.2m), and (ii) Lifeline funding (£1.3m) remaining in the Health Improvement budget but which is due to transfer to BHSCT, hence the spend is shown on page 3. The £0.9m budget in the Other line reflects funds which are being held centrally pending approval of IPTs and business cases, prior to being issued to the respective budget areas.

Ringfenced funds are showing a surplus of £0.1m at the end of month 7. A breakeven position is anticipated at year end based on an assumed allocation retraction of £0.534m from Confidence and Supply Transformation Funds.

PHA Administration

2018-19 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	3,519	2,605	10,888	173	319	484	**17,988**
Goods & Services	177	1,269	368	35	54	246	**2,150**
Savings target				(500)			**(500)**
Total Budget	**3,696**	**3,874**	**11,256**	**(292)**	**373**	**730**	**19,638**
Budget profiled to date							
Salaries	1,938	1,519	6,345	101	186	282	**10,371**
Goods & Services	94	684	218	(271)	37	127	**890**
Total	**2,032**	**2,203**	**6,563**	**(170)**	**223**	**410**	**11,260**
Actual expenditure to date							
Salaries	1,881	1,406	6,059	66	201	169	**9,782**
Goods & Services	125	581	205	5	10	105	**1,031**
Total	**2,006**	**1,987**	**6,264**	**71**	**211**	**274**	**10,814**
Surplus/(Deficit) to date							
Salaries	57	113	285	35	(15)	113	**588**
Goods & Services	(31)	103	13	(276)	27	22	**(142)**
Surplus/(Deficit)	**26**	**216**	**299**	**(242)**	**12**	**135**	**446**
Cumulative variance (%)	*1.29%*	*9.79%*	*4.55%*	*141.93%*	*5.31%*	*33.06%*	***3.96%***

A savings target of £0.5m was applied to the PHA's Administration budget in 2018-19. 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 has been generated by a number of vacancies during the year. Senior management continue to monitor this closely in the context of PHA's obligation to achieve a breakeven position for the financial year. SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

October 2018

Public Health Agency
2017-18 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	PHA Direct	Mgt & Admin	Total	Trust	PHA Direct	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Capital Grant Allocation & Income	7,070	3,581	-	**10,651**	4,124	1,926	-	**6,050**
Expenditure								
Capital Expenditure - Trusts	7,070			**7,070**	4,124			**4,124**
Capital Expenditure - PHA Direct		3,581		**3,581**		1,133		**1,133**
	7,070	3,581	-	**10,651**	4,124	1,133	-	**5,257**
Surplus/(Deficit) - Capital	-	-	-	-	-	793	-	**793**
Cumulative variance (%)					*0.00%*	*41.18%*	*0.00%*	***13.11%***

PHA has received a Capital budget of £10.6m in 2018-19, most of which relates to Research & Development projects in Trusts and other organisations. A surplus of £0.8m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	October 2018 Value	October 2018 Volume	Cumulative position as at 31 October 2018 Value	Cumulative position as at 31 October 2018 Volume
Total bills paid (relating to Prompt Payment target)	£5,145,733	537	£24,060,848	3,046
Total bills paid on time (within 30 days or under other agreed terms)	£5,122,490	521	£23,803,662	2,899
Percentage of bills paid on time	**99.5%**	**97.0%**	**98.9%**	**95.2%**

Prompt Payment performance for the year to date shows that on both value and volume the PHA is achieving its 30 day target of 95.0%. 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 93.7% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

HSC Public Health Agency

board paper

Personal and Public Involvement Update

date	20 December 2018	**item**	8	**reference**	PHA/02/12/18

presented by Mrs Mary Hinds, Director of Nursing, Midwifery and AHPs

action required For noting

Summary

To meet the PPI objectives within Outcome 4 & 5 of the PHA Corporate Business Plan the PHA provide twice yearly updates to the Board on the progress of the PHA PPI Action Plan. This report highlights the achievements that have been made in the last six month period. It focuses on the PPI Standards of Leadership, Governance, Opportunities and support for involvement, knowledge and skills and measuring outcomes.

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the Personal and Public Involvement update.

HSC Public Health Agency

Personal and Public Involvement (PPI)

PHA Board Update December 2018

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.

Standard 1. Leadership

Progressing PPI

The PPI Team continue to drive the integration of PPI into HSC culture and practice using the PPI standards as the basis for our work. We undertake this work through the:

- Regional HSC PPI Forum which the PHA co-chair with a service user/carer;
- PHA internal PPI Leads Group.

In the last six month period, work has been focused on a range of areas.

The Regional HSC PPI Forum

The Forum continues to work to provide leadership and guidance to HSC in relation to Involvement. During this period, two Forum meetings were held. In October, Rodney Morton, Deputy Chief Nursing Officer, presented the Co-production Guide which was developed for the HSC to help support the understanding and adoption of this approach as we strive to become a more person centred service. In November, the Forum held a workshop to consider priorities for 2019 and also discuss in further detail, the implementation of work arising from the Co-production Guide. It sets out how people that use HSC services, their carers and the staff that provide them can meaningfully work together, to effect real and positive change on the basis of real partnership. It requires all HSC organisations to review the extent of Partnership working across their services and to develop an integrated plan in order to strengthen Co-production between people who use services, staff, their representatives, local communities and multi-agency partners.

Transformation Funding

The DoH allocated some £587,000 through the PHA into the HSC system to take forward a number of areas which would support progress in the fields of Involvement, Co-production and Partnership Working. The investments were allocated across a number of areas including support to each Trust to

engage an additional staff member to drive forward these related areas and to seek to engage / employ service users and carers with lived experience to contribute towards this. In addition there was support for the HSC to test out Involvement, Co-production and Partnership Working initiatives and to look at the concept and practice of establishing Citizens Hubs.

The PHA has on behalf of the DoH, taken the lead in this process, liaising with the DoH and all HSC partners, working with service users and carers, developing the commissioning spec for the IPTs (Buisness cases), allocating the funding, providing advice and guidance and undertaking the strategic monitoring of the roll out against the indicative performance indicators**.**

We continue to work to develop better linkages between PPI, Patient Client Experience and 10,000 more voices. Investment was also made in the related field of Patient and Client Experience to recruit two part time staff and project costs. The funding will be used to facilitate the use of 10,000 more voices methodology to support the transformation of MDT services.

Churchill Fellowship

After successfully being awarded a prestigious Churchill Fellowship, Michelle Tennyson, PHA's Assistant Director of AHPs, PPI and 10,000 voices, has now travelled to her first location Alaska.

Michelle is studying culture change as a means of ensuring more effective partnership working with service users as carers.

Michelle is about to embark on phase 2 of her trip where she will be examining relationship based case in Arizona and Philadelphia.

Professional Advice and guidance

Strategic/Transformative

The PHA PPI team continues to provide this critical service to the wider HSC. A few examples of this are referenced below:

Involvement in Inquiry into Hyponatraemia Related Deaths (IHRD). The Inquiry into Hyponatraemia Related Deaths, has been one of the most difficult and challenging episodes to face the HSC in recent times. Lord Chief Justice O'Hara's Report made some 96 Recommendations with 120 Actions. The DoH through the Permanent Secretary, Mr Richard Pengelly, committed to addressing these through an Involvement and partnership based approach, that would include all stakeholders and which would ensure that service users, carers and the public were actively and meaningfully involved as genuine partners in developing a plan to take forward the implementation of the recommendations. In order to support them to do so, the DoH came to the PHA to seek our assistance and to avail of the expertise and experience in Involvement and Partnership Working that sat within the PPI team. As a result, the DoH sought additional support from the Regional Involvement Lead and one of the Senior PPI Officers from the PHA, on a part time basis to take the lead in this area (resources and backfill were provided). Good progress is being made with service users and carers having been recruited onto the 9 workstreams, with a draft Strategic Involvement Plan developed and with key involvement mechanisms, structures and support / guiding documentation having been developed under the teams' leadership.

Adult Social Care team in DoH came to the PHA for advice and guidance on how to effectively involve service users and carers in the transformation of these services in N. Ireland. We have worked alongside them and carers. We then collectively developed an Involvement Plan which included the establishment of an Independent Expert Carers Panel. Over 100 applications were received at the initial stage. This has now been narrowed down to 40 people using a selection process involving DoH, PHA

and carer representatives. The DoH will now work to establish the Panel to ensure carers voices are at the centre of the Reform programme of work.

Encompass is a HSC wide initiative with many concepts. Key to this transformative programme is the development and delivery of an Electronic Health and Care record (EHCR) for our population. We have been working with this programme on a number of fronts. One of the most exciting has been the recruitment of 20 service users and carers to work with the team to input into a specification for the procurement of a key service provider for ECHR and the subsequent management and assessment of feedback to inform and shape the final decision.

Operational

Recurrent Pregnancy Loss Pathway. The PHA PPI team has worked to support colleagues to engage with people who have lived experience of recurrent pregnancy loss, including the establishment of a reference group. We have put in place guidance and support for their involvement enabling their input to be factored into the development of their care pathway with a focus on improving quality, experience and outcomes for them and others in future.

Standard 2. Governance

Implementing PPI Monitoring and Audit Recommendations

Following receipt of the internal PHA PPI Monitoring and Internal Audit reports on PPI, a paper was presented to AMT outlining the recommendations from both reports in late June 2018. Following approval from AMT, the recommendations from both reports have been mapped against the existing PPI Action Plan. Where required, new actions have been added. The PHA through the internal PPI Leads Group and the Regional HSC PPI Forum, continue to make good progress against these actions. (The above Monitoring Reports are attached in Appendices 2 and 3 for Members' information).

Publication of Consultation Scheme – Guidance

The PHA has led on the development of a Consultation Scheme Template for HSC Trusts and other HSC Organisations. This has been developed in partnership with the Regional Forum and seeks to put in place a template for how organisations will consult and engage, which is in line with the Statutory Duty for Consultation and Involvement.

Standard 3. Opportunities and Support for Involvement

Involvement Guides

The PHA PPI team is developing a number of guides to support HSC staff to undertake effective Involvement. The guides will support staff through the Involvement journey, giving practical guidance at each stage. The areas are based on the 3 stages of Planning, Doing and Reviewing. The guides have been developed using PPI and Co-production approaches and are based on the expertise and experience of the PHA PPI team, input from HSC PPI colleagues, from wider HSC clinical and operational staff and service users and carers. A PPI Guides workshop was held in June 2018 to further develop the guides. Participants included representatives from all HSC Trusts, the DoH, PCC, HSCB, HSC Leadership Centre, RQIA, NICSS. There was a mix of service users, carers, HSC clinicians and managers, other HSC staff and the Community and Voluntary sector.

The guides are currently in final draft format and are undergoing user testing, this will be supplemented by a final electronic engagement exercise with stakeholders. A suite of 10 guides will launch in 2019.

Reimbursement and Remuneration Workshop

In line with the recently launched Co-production Guide, a Reimbursement and Remuneration for Service User and Carer Involvement Workshop was held in June 2018. This workshop set out to raise awareness of the importance of the roles and responsibilities of HSC organisations and service users and carers in relation to the reimbursement for involvement and to consider the core elements of a Recognition Framework for service users and carers involved in HSC. The development of a Recognition Framework will seek to promote a consistency in approach and practice to the payment of service users and carers getting involved in HSC. This includes both out of pocket expenses and the potential for payment for time, input and expertise. The workshop

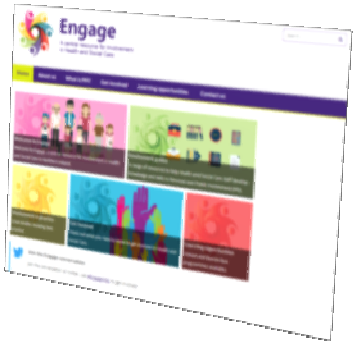
brought together a range of HSC staff, service users, carers and members of the 3rd sector to start the conversation. A report will be presented to the DoH consisting of workshop feedback and next steps. PHA will work to up-date the current interim Out of Pocket Expenses Guidance for service users and carers alongside seeking to establish clearer guidance for people who receive benefits and are also involved in HSC.

Bursary Scheme for Service Users and Carers

The PHA has launched a bursary scheme for service users and carers to support their involvement in HSC. The scheme will support individual personal development and provide access to funding to allow service users and carers to access training or conference/events. All information is available on the Engage website.

PPI On-line Resources

The Engage website continues to support HSC staff, service users and carers to build their knowledge and skills on involvement. Over 2,000 new users have visited the website in the last six months and over 30% of users access via a mobile device. It is a repository of information, good practice, tools, guides and evidence of the benefits of involvement. This is being updated to ensure information and resources are up to date.



Standard 4. Knowledge and Skills

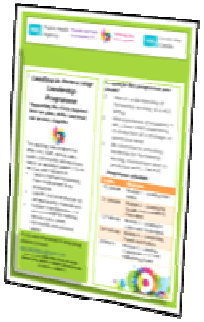
Progressing knowledge and skills for clinical staff

In line with our responsibilities as set out in the Departmental Circular of 2012, the PHA working through the auspices of the Regional HSC PPI Forum has been at the forefront of commissioning and indeed developing training programmes for Involvement. The Engage and Involve resource, both the hard copy taught programme, materials and the e-learning components for staff and service users & carers have been endorsed by the DoH and are recognised as the core training and development tools for Involvement.

As reported previously, the PHA has also and continues to commission specialised training for specific related areas and last year, for the first time, introduced a Leadership programme in this field, which is being run again in this financial year.

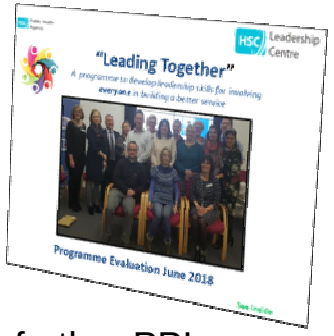
One of the greatest challenges however has been reach into the clinical professions and front line staff and much of this is down to the time and work pressure that such staff are facing and also the connections that are needed to be able to open up access into these areas. In order to progress this area the Forum is working closely with the Clinical Education Centre (CEC), who will undertake a review of Involvement training material and approaches. This work will build on the PPI training materials already developed, including Engage & Involve, e-learning and the Leadership Programme. This work is just commencing and we hope to give a full update at our next scheduled report in June 2019.

Leading in Partnership – Leadership Programme for Involvement and Co-production



Following the success of the 2017/18 programme the DoH have funded the programme until 2020. This was in part due to the excellent feedback for a pilot programme which indicated that it is substantially different from existing HSC leadership programmes for professional groups and management. In 2018/19 the programme has attracted a lot of interest and is substantially oversubscribed with 45 applications being received to date. The pilot programme evaluation showed success in the following key areas:

- Enhanced leadership capability - the programme has developed 23 Involvement leaders, who are already utilising the knowledge and skills they acquired during the programme to take forward innovative Involvement projects, challenging the system where Involvement is not being included and working in different ways with service users and carers in their service.



- An Alumni Network has been established for programme participants and an email circulation list has been set up to allow Leadership graduates to continue to engage with one another.

- Support the development of individuals to their fullest leadership potential – this has been progressed through the access to professional coaching sessions, invitations to further PPI training events and workshops.

Standard 5. Monitoring

PHA Monitoring

Following the PHA monitoring and audit reports in early 2018, further work has been undertaken at corporate and directorate levels to support the embedding of PPI into the culture and practice of PHA staff. A review of the internal PPI leads group, TOR and membership has taken place and steps have been made to endure that full divisional attendance is achieved (in line with the audit recommendation). AMT has also indicated that the Assistant Directors will take an active role in the oversight of the implementation of the monitoring and audit recommendations. In addition, divisional PPI leads have been working to ensure that PPI is included in divisional business plans and that staff avail of the training opportunities offered.

External Monitoring

In line with PHA responsibilities to provide assurances to the DoH in regards to the implementation of the Statutory Duty of Involvement in HSC Trusts, the PHA is continuing to review this process. The programme of monitoring has been undertaken for a period of three years which has involved an extensive programme of work to review how each HSC Trust is complying with the PPI Standards. In line with discussion with the DoH, the 2017/18 monitoring programme has been undertaken in a different format. It has been more akin to an up-date report this year to determine how each Trust has been working to implement the recommendations arising from the previous year's reports. The submissions will be reviewed and a report will be submitted to the Department of Health in early 2019 to outline performance in this area. We are also extending this to the Northern Ireland Ambulance Service (NIAS), and will be engaged in discussions with the DoH about if and how the monitoring of Co-production could be effectively integrated into the existing programme of Involvement monitoring..

Review of External Monitoring process

The Regional HSC PPI Forum has also started to review the current monitoring process, with a view to aligning it to an outcomes based framework to help determine the impact of Involvement. This will include research models in other areas and the involvement of a wide range of partners to consider what we need to measure and how this should be undertaken.

Personal and Public Involvement (PPI)

PHA Board Update December 2018, summary.

Standard 1. Leadership

Progressing PPI
The PPI Team continue to drive the integration of PPI into HSC culture and practice using the PPI standards as the basis for our work. We undertake this work through the:

- Regional HSC PPI Forum which the PHA co-chair with a service user/carer;
- PHA internal PPI Leads Group.

In the last six month period, work has been focused on a range of areas.

- **The Regional HSC PPI Forum** During this period, two Forum meetings were held. In October, Rodney Morton, Deputy Chief Nursing Officer, presented the Co-production Guide. In November, the Forum held a workshop to consider priorities for 2019 and also discuss in further detail, the implementation of work arising from the Co-production Guide.
- **Transformation Funding** The DoH allocated some £587,000 through the PHA into the HSC system to take forward a number of areas which would support progress in the fields of Involvement, Co-production and Partnership Working.
- **Churchill Fellowship** After successfully being awarded a prestigious Churchill Fellowship, Michelle Tennyson, PHA's Assistant Director of AHPs, PPI and 10,000 voices, has now travelled to her first location, Alaska.
- **Strategic/Transformative** The PPI team continues to provide this critical service to the wider HSC through provision of specialist Involvement and Co-production expertise, advice and guidance. Including:
    - Involvement in Inquiry into Hyponatraemia Related Deaths (IHRD).
    - Adult Social Care.
    - Encompass.
    - Recurrent Pregnancy Loss Pathway.

Standard 2. Governance

- **Implementing PPI Monitoring and Audit Recommendations** Following approval from AMT, the recommendations from both reports have been mapped against the existing PPI Action Plan. Work is ongoing.
- **Publication of Consultation Scheme – Guidance** The PHA has led on the development of a Consultation Scheme Template for HSC Trusts and other HSC Organisations.

Standard 3. Opportunities and Support for Involvement

- **Involvement Guides** A PPI Guides workshop was held in June 2018 to further develop the guides. A suite of 10 guides will launch in 2019.
- **Reimbursement and Remuneration Workshop** In line with the recently launched Co-production Guide, a Reimbursement and Remuneration for Service User and Carer Involvement Workshop was held in June 2018. A report will be presented to the DoH consisting of workshop feedback and next steps.
- **Bursary Scheme for Service Users and Carers** The PHA has launched a bursary scheme for service users and carers to support their involvement in HSC.
- **PPI On-line Resources** The Engage website continues to support HSC staff, service users and carers to build their knowledge and skills on involvement. Over 2,000 new users have visited the.

Standard 4. Knowledge and Skills

- **Progressing knowledge and skills for clinical staff** The Forum is working closely with the Clinical Education Centre (CEC), who will undertake a review of Involvement training material and approaches.
- **Leading in Partnership – Leadership Programme for Involvement and Co-production** Following the success of the 2017/18 programme the DoH have funded the programme until 2020. The programme will commence in January 2019 and is oversubscribed.

Standard 5. Monitoring

- **PHA Monitoring** A review of the internal PPI leads group, TOR and membership has taken place and steps have been made to endure that full divisional attendance is achieved (in line with the audit recommendation).
- **External Monitoring** The 2017/18 monitoring programme has been undertaken as an up-date report this year to determine how each Trust has been working to implement the recommendations arising from the previous year's reports. The submissions will be reviewed and a report will be submitted to the Department of Health in early 2019 to outline performance in this area.

HSC Public Health Agency

board paper

Sexually Transmitted Infection Surveillance in Northern Ireland 2018

date	20 December 2018	**item**	9	**reference**	PHA/03/12/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

This report provides an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2017.

Key points are that new episodes of gonorrhoea seen in Northern Ireland genito-urinary medicine clinics increased by 15% from 2016 (592 episodes) to 2017 (679). As elsewhere in the UK there is evidence of emerging resistance to one of the first line antibiotics used for treatment. There is also a general upward trend in episodes of herpes infections.

The majority of STIs are diagnosed in people in the16-34 year old age group. Men who have sex with men (MSM) have a disproportionate burden of disease.

The report reinforces previous recommendations that all cases of gonorrhoea should be managed within the GUM service, and that safer sex messages should continue to be promoted to the general population, young people and MSM.

Equality Impact Assessment

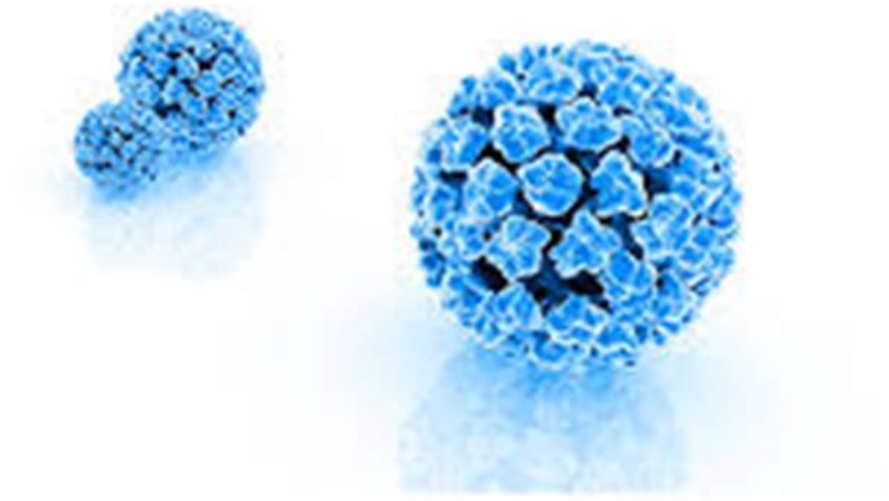
Not applicable.

Recommendation

The Board is asked to **NOTE** the Surveillance Report on Sexually Transmitted Infections.

Sexually Transmitted Infection surveillance in Northern Ireland 2018

An analysis of data for the calendar year 2017



HSC Public Health Agency

Contents Page

This report aims to provide an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2017.

In order to prevent possible disclosure, where the number of any category of episodes in any one year is between one and four, this is reported either within a cumulative figure, or as an asterix. In addition, where the anonymised figure can be deduced from the totals, the next smallest figure will also be anonymised.

Summary points

In Northern Ireland Genito-Urinary Medicine (GUM) clinics in 2017

- New diagnoses of chlamydia increased by 2%; 1,684 diagnoses in 2017 compared with 1,648 in 2016.
- New diagnoses of gonorrhoea increased by 15%; 679 in 2017 compared with 592 in 2016.
- New diagnoses of genital herpes simplex (first episode) increased by 3%; 463 in 2017 compared with 448 in 2016.
- New diagnoses of genital warts (first episode) decreased by 10%; 1,600 in 2017 compared with 1,786 in 2016.
- New diagnoses of infectious syphilis decreased by 11%; 50 in 2017 compared with 56 in 2016.

Surveillance arrangements and sources of data

GUMCAD

GUM clinics in Northern Ireland have upgraded their reporting software used for recording attendances to GUMCAD v2. GUMCAD collects anonymised patient-level data on all STI tests and diagnoses in Northern Ireland.

GUMCAD data reflect only those diagnoses made in GUM clinics. It follows that accessibility of those services to the public, as measured by service capacity and geographic location of services, may influence the diagnostic rate of STIs. Thus, direct comparison of different regions, or indeed different time periods within the same region if service access should change, must be interpreted with caution.

Given that the majority of new diagnoses originate from the GUM clinic at the Royal Victoria Hospital (the clinic that provides greatest access), the clinic location is not a useful proxy for patient residence.

As a result of the changes gonorrhoea and chlamydia are no longer categorised as complicated and uncomplicated. Therefore the way gonorrhoea and chlamydia are presented within the report has been amended and some figures are not directly comparable to data from previous years as annotated in the relevant figures.

Laboratory reporting

Laboratory data represent an important complementary source to clinician-initiated surveillance arrangements. Laboratory reporting of *Chlamydia trachomatis* in Northern Ireland is provided for 2006–2017. Antibiotic susceptibility information for *Neisseria gonorrhoeae* isolates is provided for 2017.

Enhanced syphilis surveillance

Enhanced surveillance arrangements for infectious syphilis in Northern Ireland have been in place since syphilis first re-emerged in September 2001. Based on anonymised, confidential reporting by GUM clinicians to the Public Health Agency (PHA), a range of demographic, clinical and risk factor data are collected on cases of primary, secondary and early latent stage syphilis.

1: Diagnoses provided in Northern Ireland GUM clinics in 2017

During 2017:

• 5,726 new STI diagnoses were made, an increase of less than 1% compared with 2016 (5,719);

• 64% (3,659/5,726) of new STI diagnoses were in males;

• three types of infection accounted for 72% of **new STI diagnoses** – chlamydia (29%), genital warts (first infections) (28%) and non-specific genital infection (15%);

• 1,663 **other STI diagnoses** were made;

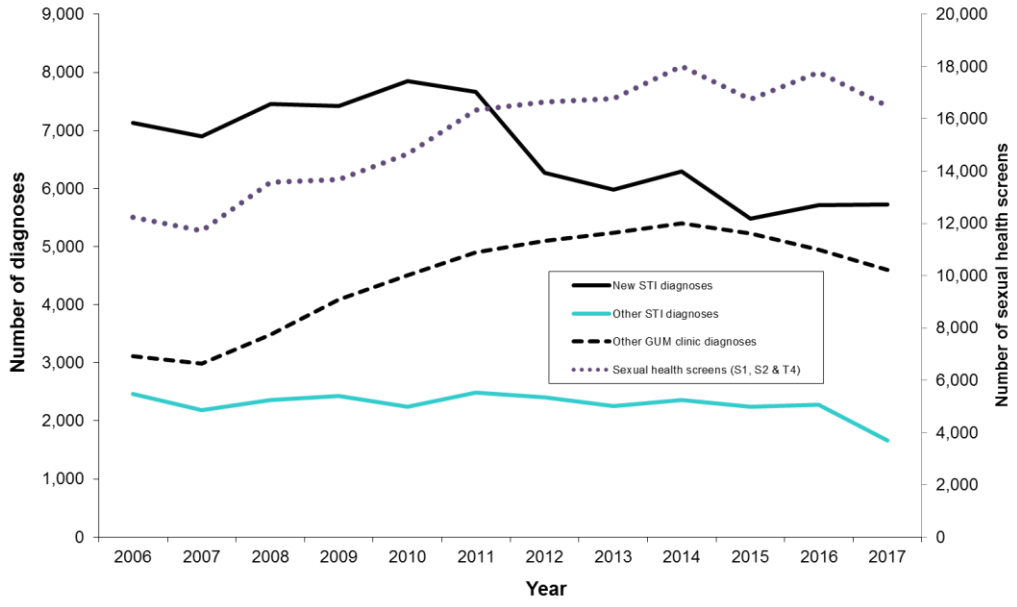
• 4,600 **other diagnoses made at GUM clinics**.

Trends: 2006–2017

Between 2006 and 2011 the number of **new STI diagnoses** remained relatively stable. However, between 2011 and 2017, the numbers have decreased by 25% (Figure 1.1). The decrease in new STI diagnoses from 2011 must be interpreted with caution. This largely reflects a steep decline in new diagnoses of complicated and uncomplicated non-specific genital infection (NSGI) (Figure 1.2). This decrease is likely to be due to the change in test technology within GUM clinics, whereby the more sensitive dual platform PCR test for gonorrhoea and chlamydia has largely replaced the invasive urethral culture in asymptomatic patients[1]. This has resulted in more detections of organisms with proven pathogenicity, particularly gonorrhoea and thus NSGI diagnoses have fallen (Figure 1.2).

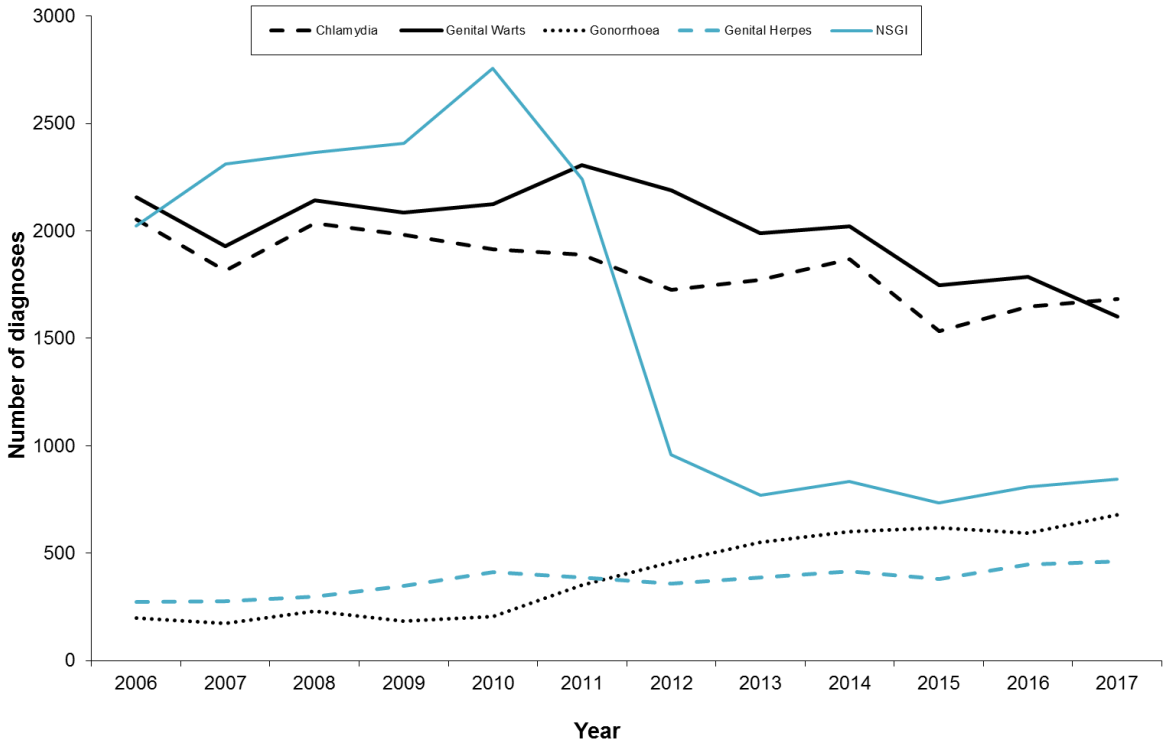
There has been an increased trend in annual **other GUM clinic diagnoses** between 2007 and 2014 with a decrease year on year from 2015. The number of **other STI diagnoses** has remained largely stable since 2006. An explanation of STI categories is provided in Appendix 1. The number of sexual health screens performed annually has shown an increased trend from 2007 with stabilisation since 2014, likely reflecting a capacity ceiling within GUM clinics.

Figure 1.1: Trends in diagnoses and sexual health screens made in Northern Ireland GUM clinics, 2006–2017



During 2006–2017, chlamydia infection, non-specific genital infection (NSGI) and genital warts (first infections) accounted for the highest proportion of new STI diagnoses (72%) made in Northern Ireland GUM clinics (Figure 1.2). Specific disease trends will be examined in chapters 2 to 6.

Figure 1.2: Trends in new diagnoses of STIs in Northern Ireland GUM clinics, 2006–2017



2: Chlamydia

Genital chlamydia is a bacterial infection caused by *Chlamydia trachomatis*. The infection is asymptomatic in at least 50% of men and 70% of women. In women, untreated infection can cause chronic pelvic pain and lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility. An infected pregnant woman may also pass the infection to her baby during delivery. Complications in men include urethritis, epididymitis and Reiter's Syndrome.

Consistent with elsewhere in the UK, chlamydia is the most common bacterial STI diagnosed in Northern Ireland GUM clinics.

Although there is no organised regional chlamydia testing programme in Northern Ireland, symptomatic and asymptomatic testing of those at risk is undertaken within primary care and sexual health services.

Diagnoses made in GUM clinics during 2017

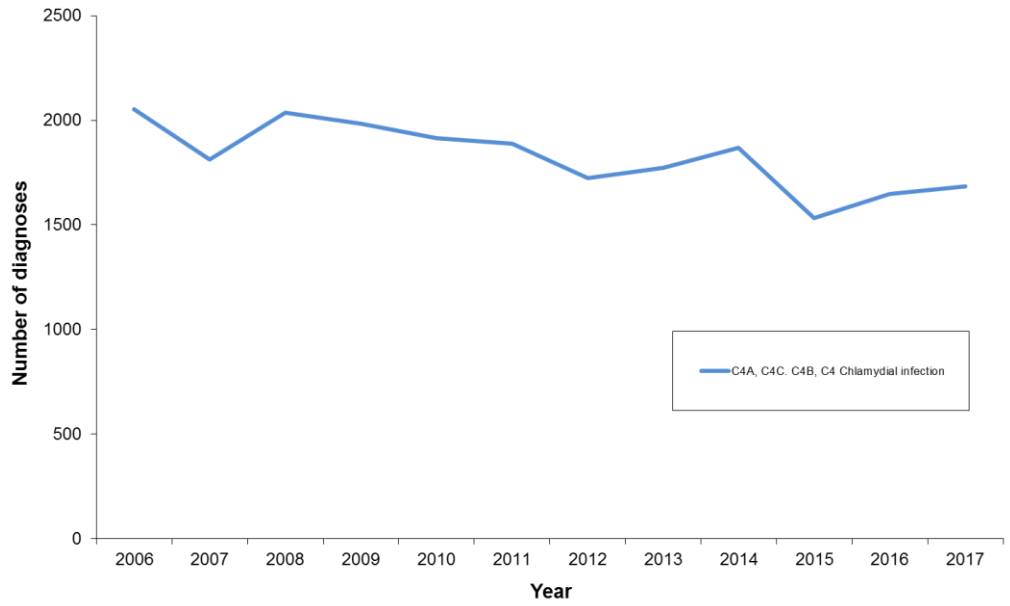
Chlamydial infection accounted for 29% (1,684/5,726) of all new STI diagnoses made in Northern Ireland GUM clinics during 2017.

- There were 1,684 new episodes of chlamydial infection diagnosed in Northern Ireland GUM clinics in 2017, compared with 1,648 in 2016.
- 1,025 (61%) of these were diagnosed in males.
- The highest rates of infection in both males and females were in the 20–24 years age group, accounting for 34% of male and 46% of female diagnoses.
- The rate of diagnoses in the 16–19 years age group is more than one and half times higher in females as in males.
- 24% (246/1,025) of the total male diagnoses occurred in men who have sex with men (MSM).

Trends: 2006–2017

Between 2006 and 2017, diagnoses of chlamydial infection decreased by 18%, from 2,053 diagnoses in 2006 to 1,684 in 2017 (Figure 2.1).

Figure 2.1: Diagnoses of chlamydia in Northern Ireland, 2006–2017



Age and gender trends: chlamydia

From 2012–2017, diagnostic rates in females were consistently highest in the 16–24 years age group, peaking between 20 and 24 years (Figure 2.2). In males, the highest rates were in the 20–34 years age group, again peaking between 20 and 24 years.

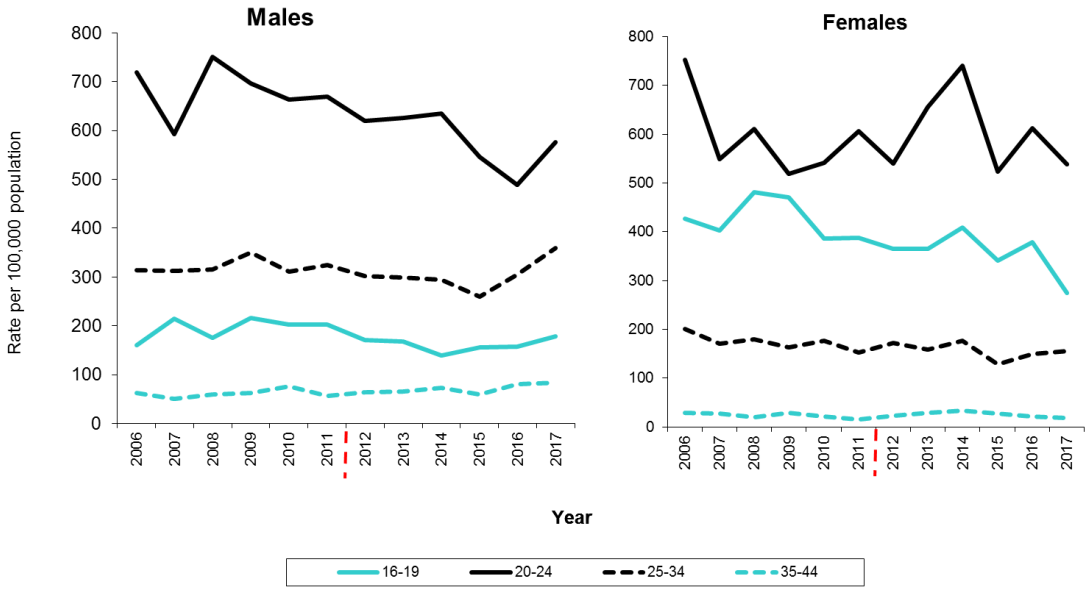
Diagnostic rates in those under 25 years of age were consistently higher in females, with rates in those aged 25 years and over consistently higher in males. Diagnostic rates in females aged over 24 years decrease due to changes in sexual behaviour, as well as decreased susceptibility.

Diagnoses in those under 16 years of age accounted less than 1% (30/10,226) of all diagnoses made during the period 2012–2017.

Diagnoses in the 45+ years' age group accounted for 3% (327/10,226) of all diagnoses made during the period 2012–2017.

The proportion of male chlamydia diagnoses attributed to MSM has ranged from 6% in 2006 to 24% in 2017.

Figure 2.2: Rates of chlamydial infection in Northern Ireland, by gender and age group, 2006–2017



Footnote: Rates have been re-calculated from 2012 to include KC60 code C4B – Complicated chlamydia

Genital chlamydia trachomatis laboratory reporting, 2006–2017

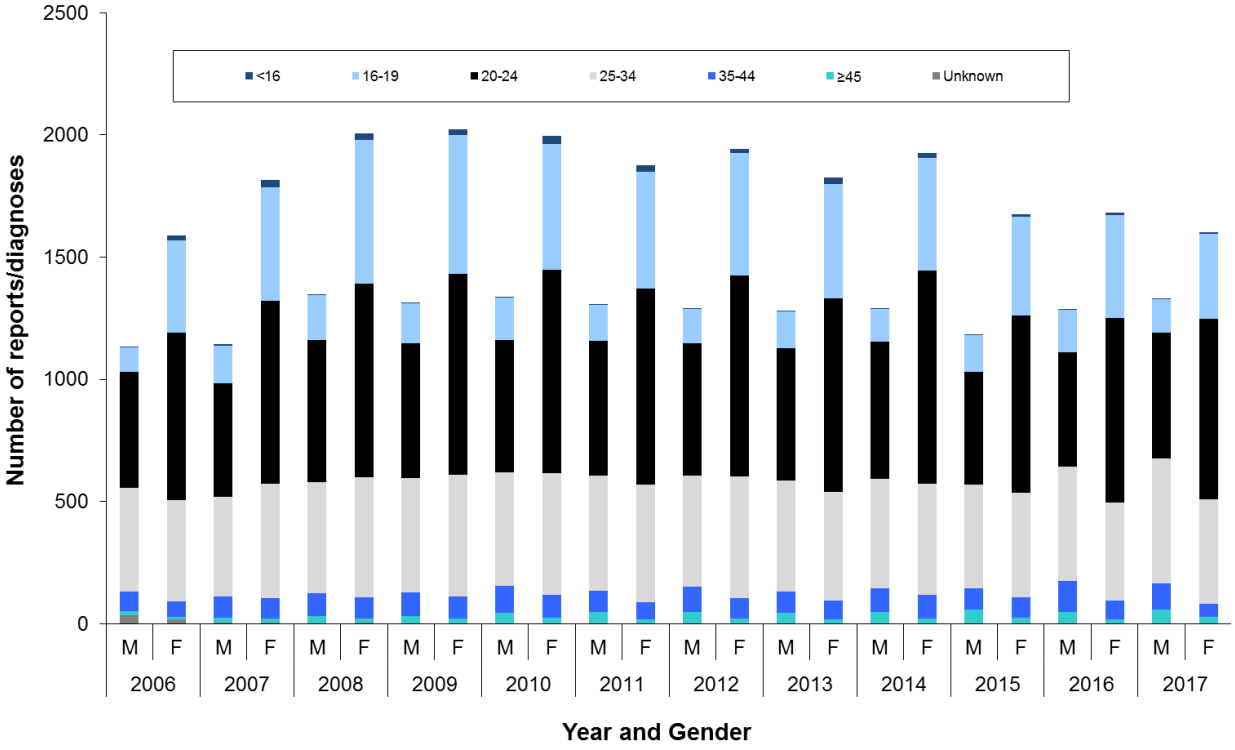
During 2017, 2,936 laboratory confirmed cases of genital chlamydia trachomatis were reported, a decrease of 1% compared with 2016. GP specimens accounted for 33% (982/2,936) of cases reported during 2017 (Table 2.1). Between 2006 and 2017, confirmations from GP specimens increased by 36%.

Table 2.1: Referral source of genital *Chlamydia trachomatis* specimens, 2006–2017

Referral Source	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	TOTAL
GP Number (%)	720 (26.1)	894 (29.7)	979 (29.0)	1025 (30.3)	1124 (33.5)	1096 (34.3)	1207 (37.1)	1102 (35.2)	1093 (33.9)	1028 (35.8)	977 (32.8)	982 (33.4)	12,227
Other	2,036	2,121	2,396	2,353	2,231	2,104	2,044	2,023	2,130	1,836	1,998	1,954	25,226
Total	**2,756**	**3,015**	**3,375**	**3,378**	**3,355**	**3,200**	**3,251**	**3,125**	**3,223**	**2,864**	**2,975**	**2,936**	**37,453**

Higher numbers of diagnoses are consistently reported in females, accounting for 55% (1,602/2,936) of all cases reported by laboratories during 2017. The majority (68%; 14,986/21,955) of female cases reported in the period 2006–2017 were aged between 16 and 24 years. Between 2006 and 2017 females accounted for 79% of the diagnoses made by a GP. Males accounted for between 38% and 45% of cases reported annually since 2006. The majority of male cases reported since 2006 were in the 20–34 years age group (Figure 2.3). Information on gender was missing for 1% of cases reported during the period 2006–2017.

Figure 2.3: Laboratory reports of genital *Chlamydia trachomatis*, by age and gender, 2006–2017



3: Gonorrhoea

Gonorrhoea is a bacterial STI caused by *Neisseria gonorrhoeae*. Untreated, gonorrhoea can enter the bloodstream or spread to the joints, and in women it can cause pelvic inflammatory disease, ectopic pregnancy and infertility. An infected pregnant woman may pass the infection to her baby during delivery.

Diagnoses made in GUM clinics during 2017

Gonorrhoea accounted for 12% (679/5,726) of all new STI diagnoses made in Northern Ireland GUM clinics during 2017.

- There were 679 new episodes of gonorrhoea diagnosed in Northern Ireland GUM clinics in 2016, compared with 592 in 2016, an increase of 15%.

- 529 (78%) of these were diagnosed in males.

- The highest diagnostic rates in both men and women were in the 20–24 years age group.

- 72% of female diagnoses were in the 16–24 years age group and 23% were in the 25–34 years age group.

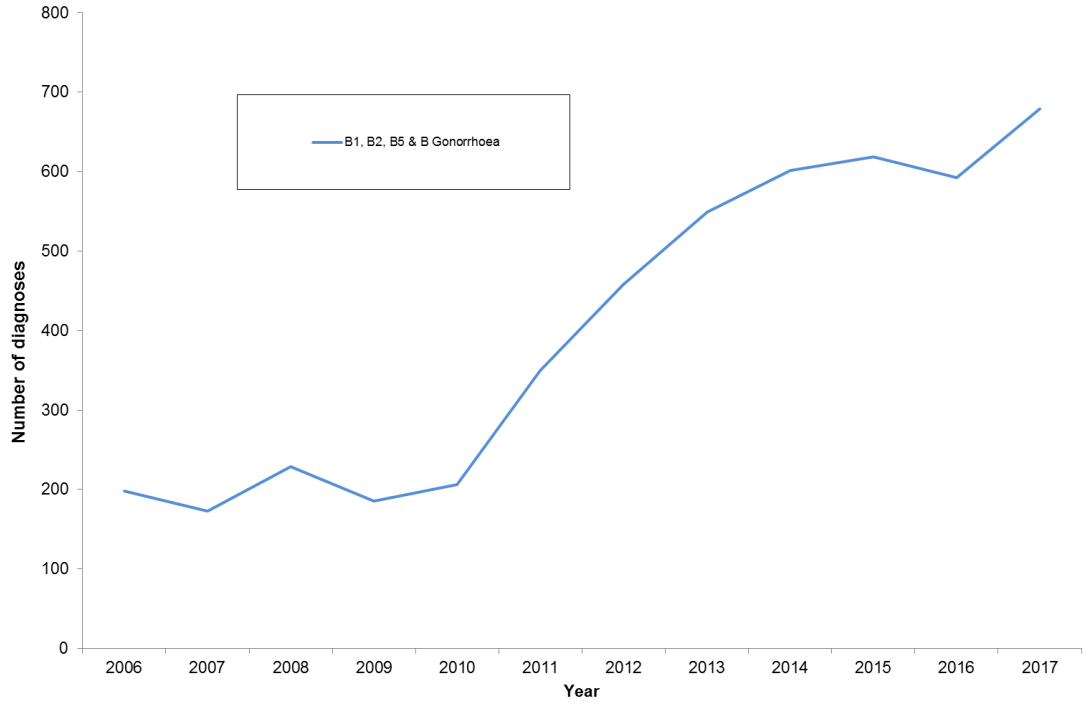
- 39% of male diagnoses were in the 16–24 years age group and 35% were in the 25–34 years age group.

- 64% (340/529) of male diagnoses were attributed to MSM.

Trends: 2006–2017

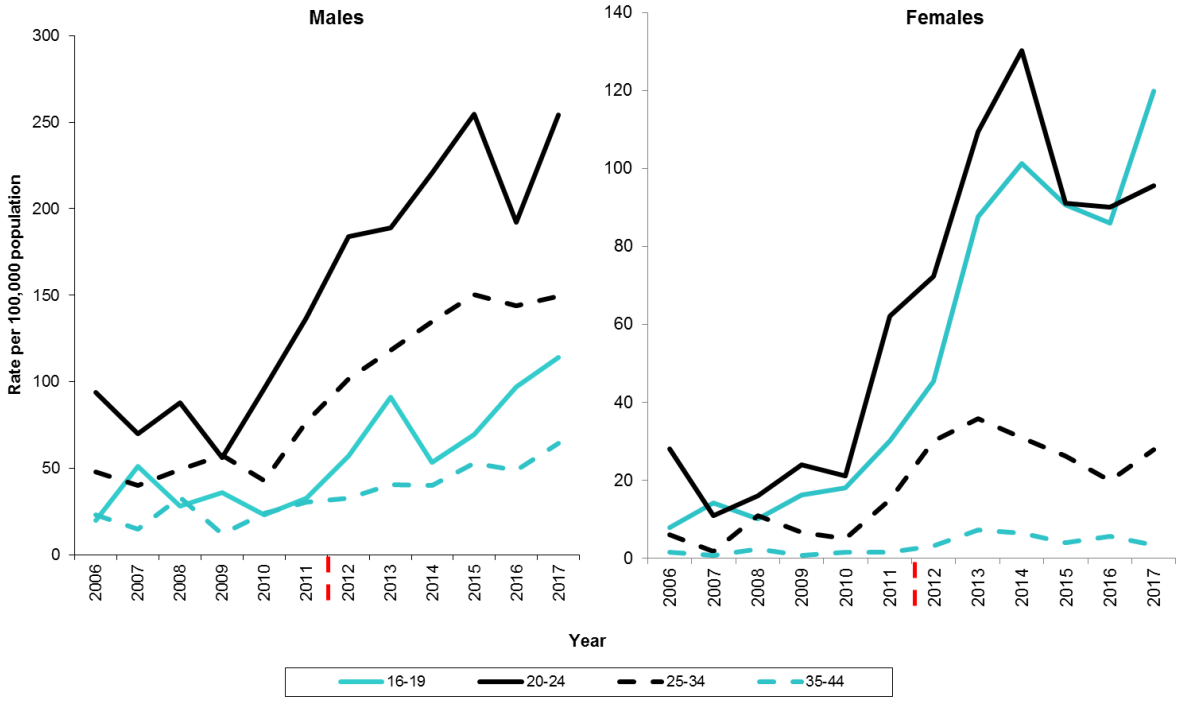
The annual number of diagnoses of gonorrhoea has shown very little change between 2006 - 2010. However diagnoses rose dramatically between 2010 and 2015 with a 200% increase; 619 diagnoses in 2015 compared with 206 in 2010 (Figure 3.1). The number of diagnoses in 2017 (679) is the highest ever recorded in Northern Ireland. The proportion of male diagnoses attributed to MSM ranged from 24% in 2006 to 65% in 2016, with 64% in 2017.

Figure 3.1: Diagnoses of gonorrhoea in Northern Ireland, 2006–2017



Age, gender and sexual orientation trends: gonorrhoea

Figure 3.2: Rates of gonorrhoea in Northern Ireland, by age group, 2006–2017

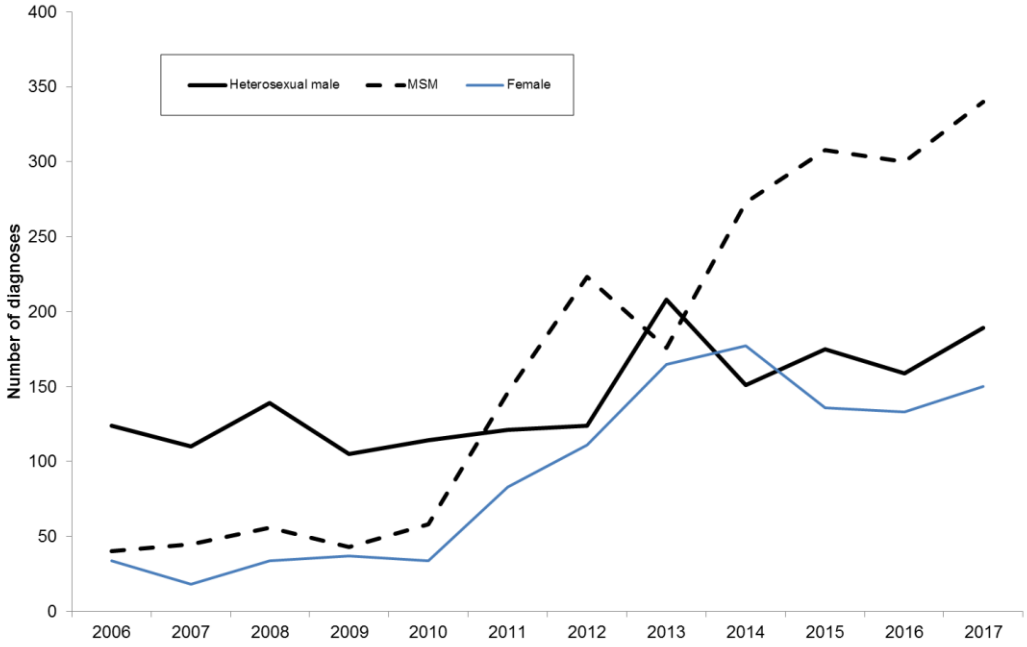


Footnote: Rates have been re-calculated from 2012 to include KC60 code B5 Complicated gonorrhoea

In males, all age groups have seen an increase in diagnostic rates since 2011. The largest increases and highest diagnostic rates have consistently been in the 20–24 years age groups, followed by the 25-34 years age group (Figure 3.2). From 2012–2017, fewer than 10 diagnoses were made annually in males aged under 16 years. Males aged 45 years and over accounted for 11% (282/2,626) of all male diagnoses during the period 2012–2017.

In females, the increases since 2011 have clearly mostly affected the 16-19, and 20-24 age groups (Figure 3.2). In 2017, episodes in females aged 16-19 years have increased by 40% when compared to 2016.

Figure 3.3: Number of diagnoses of gonorrhoea by sexual orientation in Northern Ireland, 2006-2017



The increase in diagnoses since 2010 has largely affected MSM and females. The number of MSM diagnoses continue to increase with 340 diagnosis made in 2017, the highest number recorded in Northern Ireland to date. There has been a much smaller though still generally upward trend in heterosexual males.

Interpretation of the increase in diagnoses is made difficult by the introduction across Northern Ireland of combined chlamydia and gonorrhoea PCR testing in both GUM and community settings since 2010. The increase in numbers of people tested, and the increased sensitivity of the test compared with traditional culture methods, particularly at extra genital sites, may at least partly explain the increase seen in both the heterosexual and MSM populations. This is unlikely, however, to account for the continued increases being seen.

Neisseria gonorrhoeae antimicrobial susceptibility reporting 2017

Gonorrhoea is also of particular concern due to its ability to develop resistance to successive antimicrobial agents. Current treatment guidelines recommend the use of a combination of oral azithromycin and intra-muscular ceftriaxone, and that treatment should be followed by a test of cure. By combining antibiotics in this way it is hoped to slow the development of resistance to each component.

However, there is now evidence of emerging resistance to both these antibiotics. Resistance to azithromycin at minimum inhibitory concentration (MIC) levels >0.5 mg/l is reported throughout Europe. High-level azithromycin resistant (HL-AZiR) *Neisseria gonorrhoeae* (minimum inhibitory concentration (MIC) >256 mg/l) is now also detected more widely. There have also been a small number of reports of ceftriaxone resistance, mostly related to acquisition in Asia. The first global report of HLAziR *Neisseria gonorrhoeae* which is also resistant to ceftriaxone was reported in England in 2018. The isolate was confirmed with a ceftriaxone MIC of 0.5 mg/L and an azithromycin MIC of >256 mg/L (high-level azithromycin resistant, HLAziR). On wider antimicrobial susceptibility testing, the strain was susceptible only to spectinomycin.

Neisseria gonorrhoeae antimicrobial susceptibility in Northern Ireland is monitored through a combination of routine diagnostic laboratory surveillance and, since 2015, participation in the European Gonococcal Surveillance Project (Euro-GASP). This sentinel programme tests a small number of isolates using PHE reference lab methodology, and allows comparison (as part of an overall UK sample) with countries elsewhere in Europe.

During 2017, laboratories reported antibiotic susceptibility data for 273 isolates as part of routine surveillance. Ninety seven percent of isolates were tested against azithromycin and 99.6% tested against ceftriaxone. 7% (19) were identified as resistant to azithromycin and all were susceptible to ceftriaxone (Table 3.1).

From 2016 to the end of 2017, the reference lab confirmed less than 10 HL-AZiR cases in Northern Ireland, affecting mostly young heterosexuals. While to date there is no evidence of widespread transmission, enhanced surveillance will continue.

During 2017, 20 isolates were tested within the EUROGASP programme and showed similar resistance pattern to UK overall with 5% resistant to azithromycin and 0% to ceftriaxone[2].

Table 3.1: *Neisseria gonorrhoeae* antibiotic susceptibility reported activity for antibiotics - 2017

Antibiotics	Susceptible		Resistant		Intermediate		Total specimens Reported	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Azithromycin	216	81.2	19	7.1	31	11.7	266	100
Cefotaxime	2	100	0	0	0	0	2	100
Ceftriaxone	272	100	0	0	0	0	272	100
Ciprofloxacin	194	78.5	51	20.6	2	0.8	247	100
Doxycycline	122	68.9	44	24.9	11	6.2	177	100
Penicillin	32	15.7	78	38.2	94	46.1	204	100

Key recommendations to reduce the spread of antimicrobial-resistant Neisseria *gonorrhoeae* are:

- all primary diagnostic laboratories should test gonococcal isolates for susceptibility to first line antimicrobials and refer azithromycin and/or ceftriaxone resistant isolates to the PHE reference laboratory for confirmation;
- all cases of gonorrhoea should be treated and managed within GUM services;
- GUM services should ensure all patients with gonorrhoea are treated and managed according to national guidelines and be alert to changes in antimicrobials recommended for front line use;
- anyone having sex with new or casual sexual partners should be advised to use condoms consistently and correctly and test regularly for sexually transmitted infections.

4: Genital herpes

Genital herpes is caused by the herpes simplex virus (HSV), of which there are two distinct subtypes. HSV2 is almost exclusively associated with genital infection. Historically, HSV1 has mainly been associated with oral infection, but the proportion of genital herpes attributed to HSV1 in the UK is increasing. Genital herpes infection may facilitate HIV transmission, can cause severe systemic disease in those with impaired immunity, and can be potentially fatal to neonates.

Diagnoses made in GUM clinics during 2017

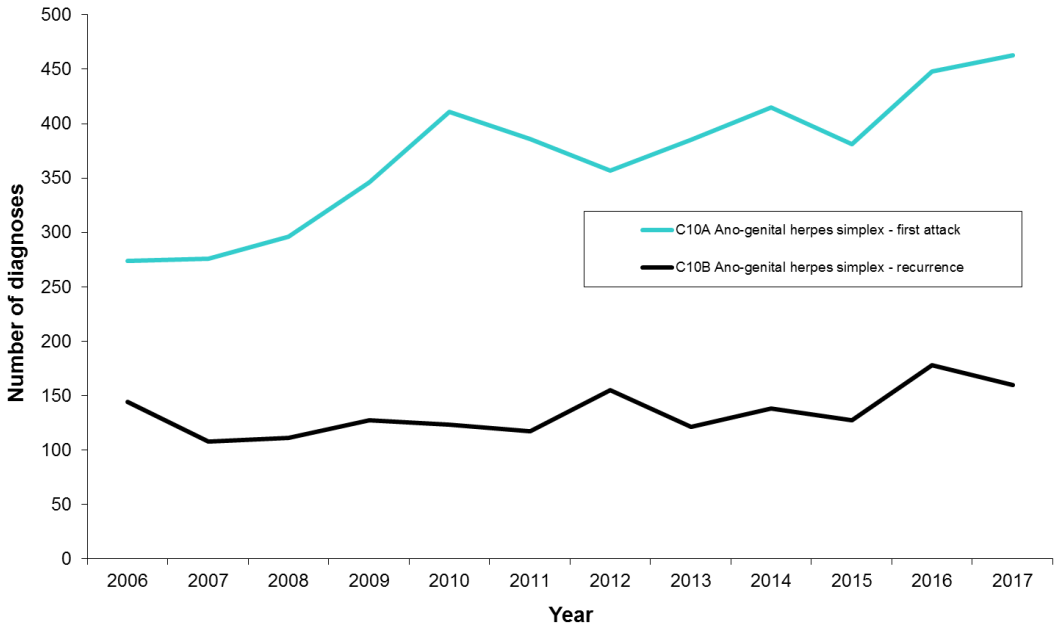
Genital herpes (first episodes) accounted for 8% (463/5,726) of all new STI diagnoses made in Northern Ireland GUM clinics during 2017.

- There were 623 episodes (first infections and recurrent infections) of genital herpes diagnosed in Northern Ireland GUM clinics in 2017.
- 400 (64%) of these were diagnosed in females.
- 463 (74%) of the total attendances for herpes in 2017 were for treatment of first infection and 160 (26%) were for treatment of recurrent infection.
- 26% of male diagnoses (58/223) and 26% (102/400) of female diagnoses were recurrent infections.
- The highest diagnostic rates of first infection in men were in the 20-34 years age group and in women were in the 16-24 years age group.
- Diagnostic rates of first infection in most age groups were higher in females, but most particularly in the 16-19 age group.
- 16% (27/165) of male first diagnoses occurred in MSM.

Trends: 2006–2017

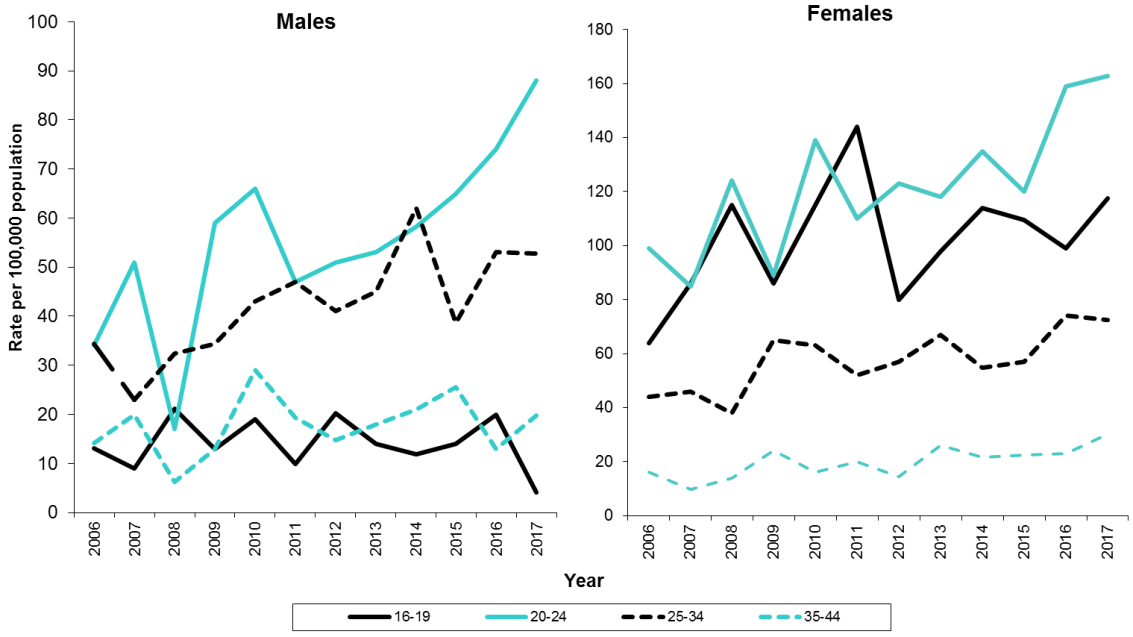
Annual numbers of first diagnoses of genital herpes increased each year from 2008-2010 with numbers remaining similar from 2011 to 2015. However, figures have increased by 22% in 2017 (463) when compare with 2015 (381). (Figure 4.1)

Figure 4.1: Diagnoses of genital herpes in Northern Ireland, 2006–2017



Age and gender trends: genital herpes (first episode)

Figure 4.2: Rates of diagnosis of genital herpes (first episode) in Northern Ireland, by age and gender, 2006–2017



Diagnostic rates in females were consistently highest in the 16–24 years age group. In males, the highest diagnostic rates were in the 20–34 years age group (Figure 4.2). The figures in the 20-24 age band in males have almost doubled since 2011.

Males under 20 years of age accounted for 6% (87/1,552) of all male diagnoses of genital herpes (first episode) made during the period 2006–2017, with diagnoses in the 45+ years age group accounting for 12% (181/1,552).

Females under 16 years of age accounted for 1% (36/2,886) of all female diagnoses made during the period 2006–2017, with diagnoses in the 45+ years age group accounting for 7% (208/2,886).

5: Genital warts

Genital warts are caused by human papillomavirus (HPV). There are approximately 100 types of HPV, of which about 40 infect the genital tract. HPV types 6 and 11 cause the majority of genital warts. Persistent HPV infections can also lead to cancers – anal, throat and penile cancers in men, and vaginal, vulval and cervical cancers in women. The majority of HPV related cancers are associated with types 16 and 18.

HPV vaccine for girls was introduced as a school based programme in Northern Ireland in 2008/09. Until September 2012 the vaccine used protected against the oncogenic types 16 and 18, but not those types causing genital warts.[3] From September 2012 onwards, the vaccine used also contains additional protection against types 6 and 11 which account for 90% of genital warts. In September 2014 the HPV immunisation programme changed from a three dose to a two dose schedule for those starting the course under the age of 15, in line with national recommendations.

From October 2016, the same quadrivalent HPV vaccine was introduced for MSM aged up to 45 years attending GUM clinics. Evidence suggests MSM attending GUM, sexual health and HIV treatment services bear a significantly increased burden of HPV related disease and adverse outcomes compared to heterosexual men. HPV type16-associated anal cancers in particular are more common in MSM compared to heterosexual men. This is even more marked in those with HIV infection.

Diagnoses made in GUM clinics during 2017

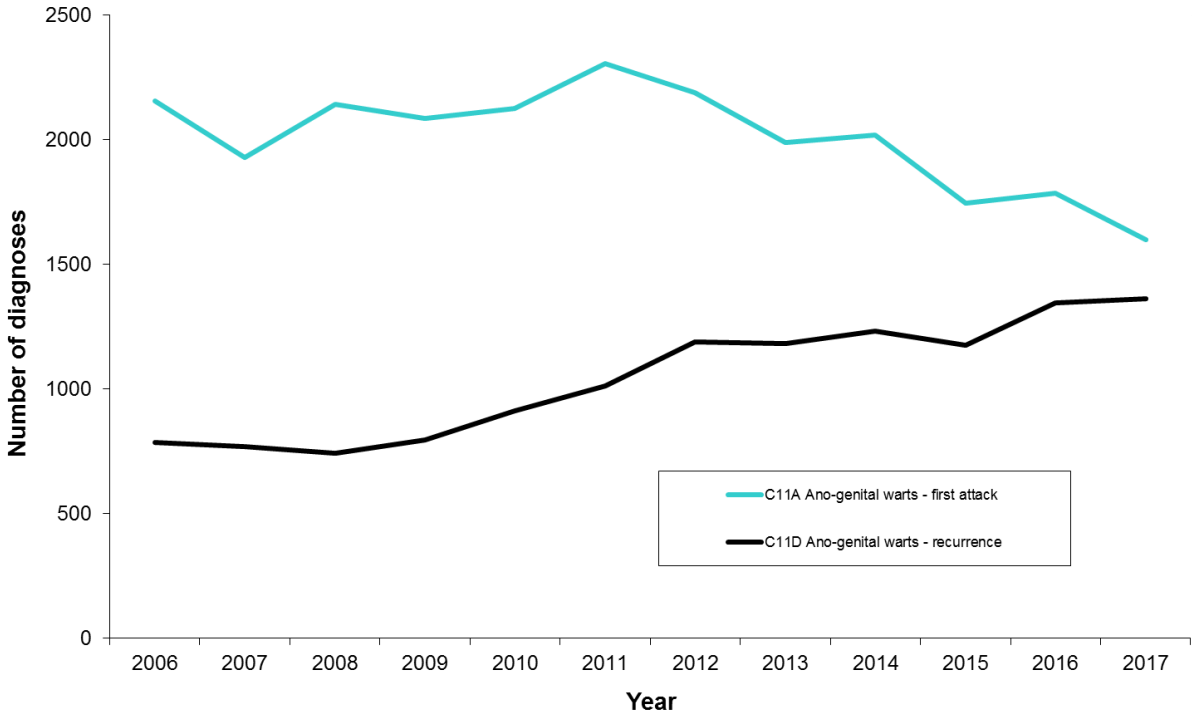
Genital warts (first episodes) accounted for 28% (1,600/5,726) of all new STI diagnoses made in Northern Ireland GUM clinics during 2017.

- There were 2,961 episodes (first infections and recurrent infections) of genital warts diagnosed in Northern Ireland GUM clinics in 2017.
- 1,861 (63%) of these were diagnosed in males.
- 1,600 (54%) of the total attendances for genital warts in 2017 were for treatment of first infection and 1,361 (46%) were for treatment of recurrent infection.
- 50% of male diagnoses (926/1,861) were recurrent infections, compared with 40% (435/1,100) of female diagnoses.
- The highest diagnostic rates of first infection in both men and women were in the 20–24 years age group.
- 31% of male diagnoses and 39% of female diagnoses of first infection were in the 20–24 years age group.
- The diagnostic rate in females aged 16–19 years (186/100,000) is higher than that of males the same age (112/100,000). However, diagnostic rates in those aged over 19 years were higher in males.
- 9% (82/935) of male first diagnoses occurred in MSM.

Trends: 2006–2017

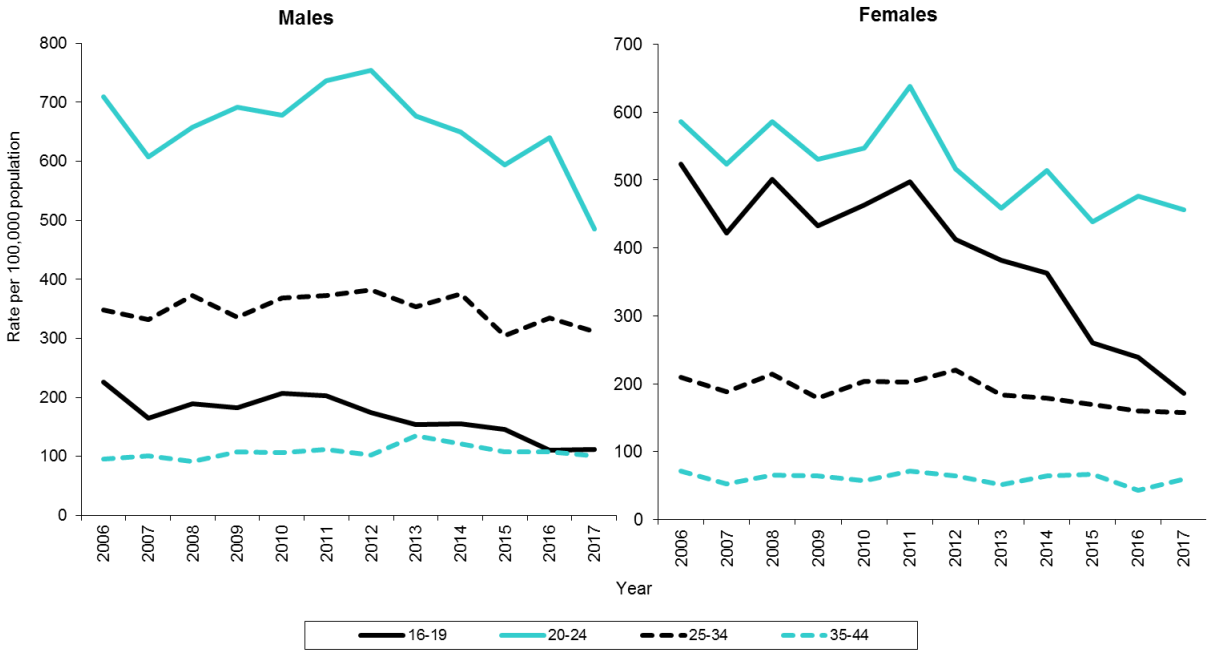
The number of annual diagnoses of first infections of genital warts has shown little variation between 2006 and 2011. There has been a 31% decrease in first episodes of infection since 2011 (Figure 5.1).

Figure 5.1: Diagnoses of genital warts in Northern Ireland, 2006–2017



Age and gender trends: genital warts (first episode)

Figure 5.2: Rates of diagnosis of genital warts (first episode) in Northern Ireland, by age and gender, 2006–2017



Between 2006 and 2017, diagnostic rates have been consistently highest in 20-24 year old males and females, followed by 16-19 year old females and 25-34 year old males. Individuals under 16 year old accounted for 0.4% (90/24,076) of diagnoses (first episode) made during 2006-2017, while the 45+ year age group accounted for 6% (1,540/24,076).

During 2006-2017, the proportion of male diagnoses attributed to MSM ranged from 2% in 2006 to 10% in 2012, with 9% in 2017.

The decline in diagnostic rates from 2011 has been greatest in females aged 16-19 years (63%) and in males in the same age group (45%). It is like that this pattern in females is explained by an unexpected direct protective effect from the bivalent vaccine introduced in 2009, and the expected effect from the switch to the quadrivalent vaccine in 2012 with smaller indirect effects being seen in males.

6: Syphilis

Syphilis is a bacterial infection caused by the spirochete *Treponema pallidum*. Its importance lies in its ability to promote both the acquisition and transmission of HIV, and in the potential for serious or even fatal consequences if left untreated. Late syphilis can cause complications of the cardiovascular, central nervous and mucocutaneous systems. Infectious syphilis in pregnant women can cause miscarriage, stillbirth or congenital infection.

Northern Ireland has, in common with elsewhere in the UK and Europe, experienced a marked increase in infectious syphilis since 2000. In the decade prior to 2000, on average only one case of infectious syphilis per year was reported.

Diagnoses made in GUM clinics 2017

During 2017:

• 35 new episodes of primary and secondary syphilis were reported;

• 15 additional episodes of early latent syphilis were also reported;

• 64% (32/50) were diagnosed in MSM;

Enhanced surveillance 2017

Information from enhanced surveillance arrangements is available for 43 cases:

• 43 episodes occurred in Northern Ireland residents and, in 28 episodes, syphilis was likely to have been acquired through exposure within Northern Ireland;

• 21% (9/43) also reported as being HIV positive;

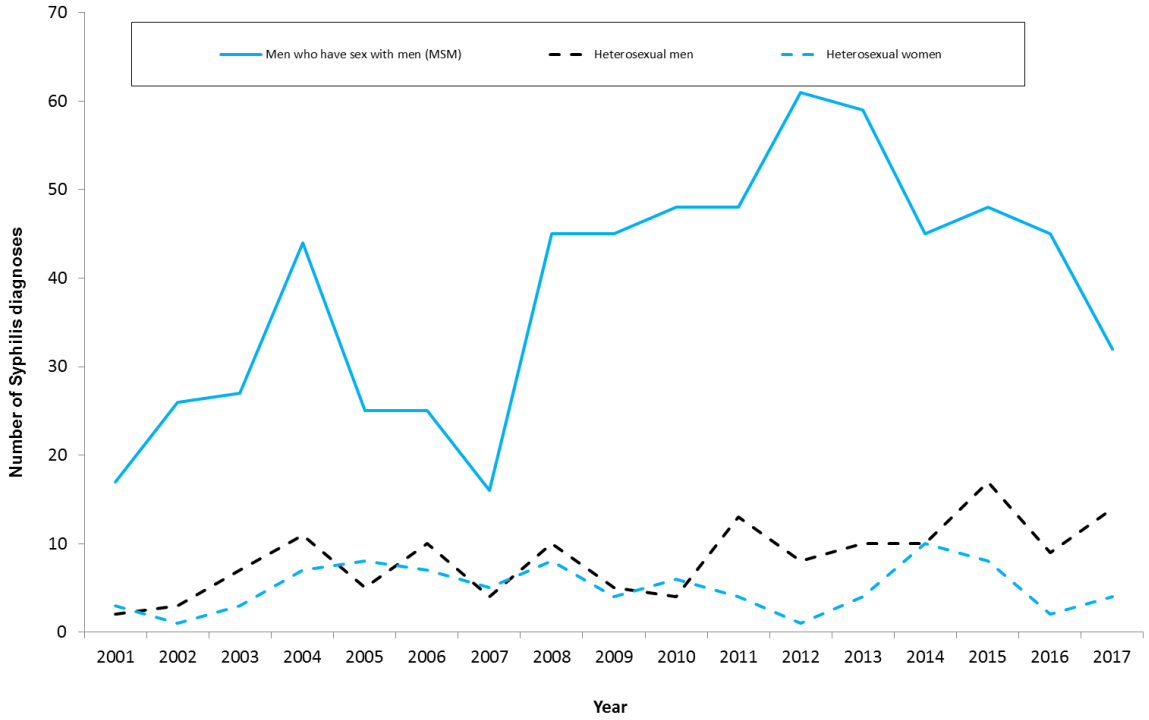
• diagnosed co-infections also included chlamydia and gonorrhoea;

• 21% (9/43) reported having had two sexual partners in the three months preceding diagnosis.

Trend information

Infectious syphilis is now endemic within Northern Ireland. Annual numbers of new diagnostic episodes have been consistently highest in MSM (Figure 6.1). Following an annual decrease from 2004 to 2007, numbers had increased from 2008 to 2015. However, 2016 saw a 24% decrease when compared to 2015; 56 in 2016 and 74 in 2015 there has been a further 11% decrease in 2017 (50). Numbers in females have remained relatively constant, while there is an upward trend in heterosexual males.

Figure 6.1: Number of infectious syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001-2017

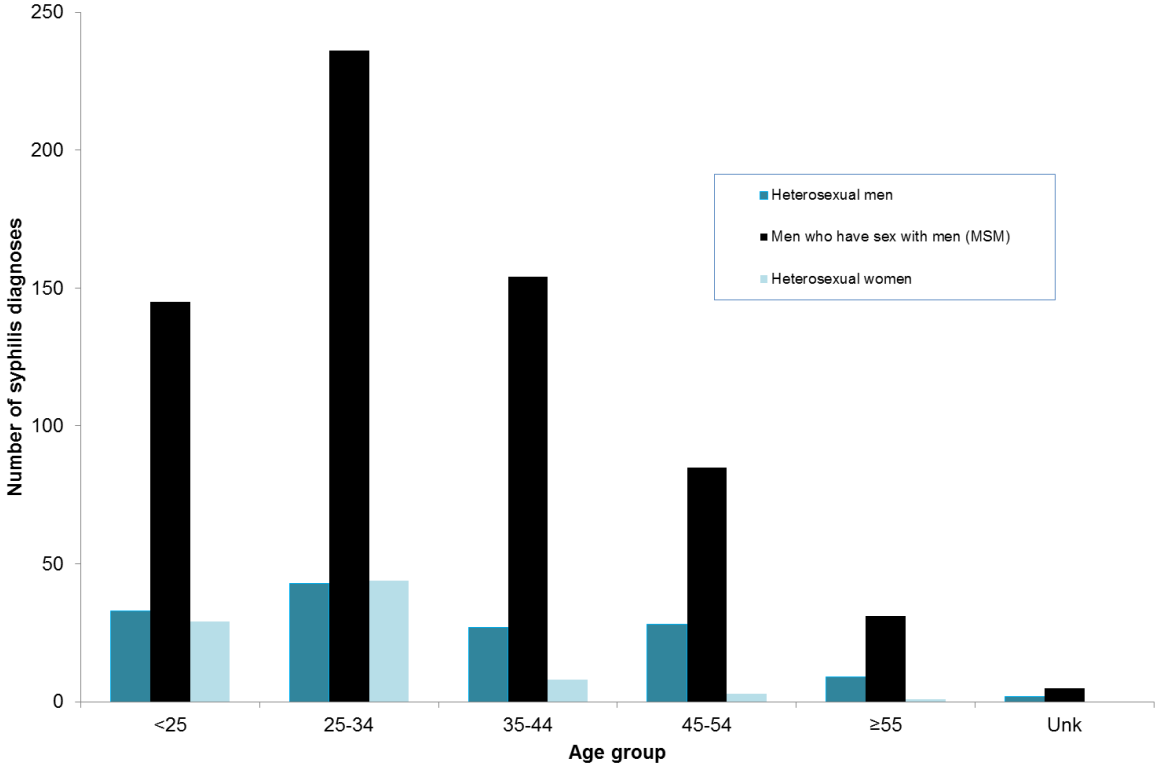


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011- 2017

Age and sexual orientation

Analysis of cumulative data by age and sexual orientation shows the highest number of episodes in heterosexual females was in the 25–34 years age group (52%; 44/85). In MSM, the highest number of episodes was in the 25–44 years age group (59%; 390/656). In heterosexual males, diagnoses were more evenly spread across the age bands, with those aged 25+ years accounting for 75% (107/142) of diagnoses. Information on age was missing for seven episodes (Figure 6.2).

Figure 6.2: Age distribution of syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001–2017

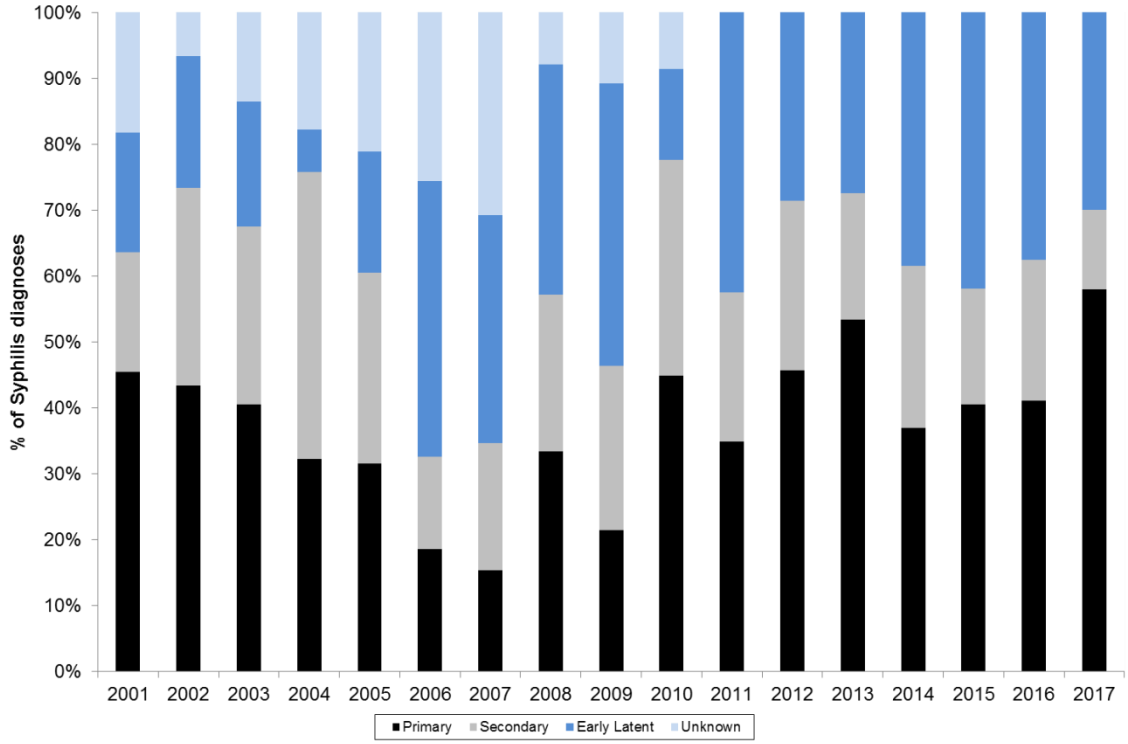


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011 -2017

Stage of disease

Since 2001 the majority of diagnoses have been made at the primary or secondary stage of disease, although there has been some significant year to year variation. Interpretation of data prior to 2011 is difficult due to variation in the extent to which stage is unknown. Over the past 5 years the percentage of diagnoses made during the (symptomatic) primary stage of syphilis has ranged from 37% to 58%. This suggests there is still a significant lack of awareness of the signs and symptoms of infectious syphilis in the affected population.

Figure 6.3: Stage of disease, by year of diagnosis



Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011-2017

7: Summary and conclusions

Compared with 2016, 2017 saw a small increase of 1% in annual numbers of new STI diagnoses made in Northern Ireland GUM clinics. Gonorrhoea increased by 15%, Genital Herpes by 3% and Chlamydia increased by 2%.

The highest diagnostic rates of the common STIs occur in 16-24 year old females and 20-34 year old males. People aged 16-34 year old account for 82% of new STIs.

MSM are at disproportionate risk of contracting some STIs accounting for 61% of male infectious syphilis, 64% of male gonorrhoea, 16% of male herpes and 24% of male chlamydia infections.

2017 has seen a 15% increase in the number of diagnoses of gonorrhoea made in GUM clinics. There were 679 diagnoses made, which is the highest number reported in Northern Ireland to date. Analysis of antimicrobial sensitivity patterns has shown a significant level of resistance to azithromycin, including the emergence of high-level azithromycin resistance disease. This highlights the importance of culturing specimens for antibiotic susceptibility, adhering to current treatment guidelines, and performing a test of cure for all cases of gonorrhoea. All cases of gonorrhoea should be managed within the GUM service.

Analysis suggests that a sustained decline in first episodes of genital warts is now occurring in young females, due to the impact of the human papilloma vaccine, first introduced (as a bivalent vaccine) in 2009, and (as a quadrivalent vaccine) in 2012. A smaller effect due to herd immunity is seen in similar aged males.

Recommendations

Safer sex messages should continue to be promoted to the general population, young people and MSM. The risks to health of unprotected casual sex, both within and outside Northern Ireland, need to be reinforced.

Individuals can reduce their risk of acquiring or transmitting an STI by:

- Always using a condom when having sex with casual and new partners;
- Getting tested if at risk, as these infections are frequently asymptomatic;
- MSM having unprotected sex with casual or new partners should have an HIV/STI screen at least annually, and every three months if changing partners regularly;
- Reducing the number of sexual partners and avoiding overlapping sexual relationships.

References

1. British Association for Sexual Health and HIV. UK National guideline for the management of gonorrhoea in adults 2011. Available at: www.bashh.org/guidelines

2. Public Health England. The Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP). Available at: https://www.gov.uk/government/publications/gonococcal-resistance-to-antimicrobials-surveillance-programme-grasp-report.

3. Howell Jones R et al (2013). Declining genital warts in young women in England associated with HPV 16/18 vaccination: an ecological study. J Infect Dis. 1;208(9): 1397-403

Appendix 1: STI groupings

New STI diagnoses
Chlamydial infection (uncomplicated and complicated)
Gonorrhoea (uncomplicated and complicated)
Infectious and early latent syphilis
Genital herpes simplex (first episode)
Genital warts (first episode)
New HIV diagnosis
Non-specific genital infection (uncomplicated and complicated)
Chancroid/lymphogranuloma venereum (LGV)/donovanosis
Molluscum contagiosum
Trichomoniasis
Scabies
Pediculus pubis
Other STI diagnoses
Congenital and other acquired syphilis
Recurrent genital herpes simplex
Recurrent and re-registered genital warts
Subsequent HIV presentations (including AIDS)
Ophthalmia neonatorum (chlamydial or gonococcal)
Epidemiological treatment of suspected STIs (syphilis, chlamydia, gonorrhoea, non-specific genital infection)
Other diagnoses made at GUM clinics
Viral hepatitis B and C
Vaginosis and balanitis (including epidemiological treatment)
Anogenital candidiasis (including epidemiological treatment)
Urinary tract infection
Cervical abnormalities
Other conditions requiring treatment at a GUM clinic

Appendix 2: Number of new episodes of selected diagnoses by gender and age group, Northern Ireland, 2006-2017

		2006			2007			2008			2009			2010			2011			2012			2013			2014			2015			2016			2017		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Chlamydia	<16	*	*	22	*	*	11	*	*	13	0	8	8	*	*	11	0	9	9	0	*	*	*	7	*	0	6	6	*	4	*	*	*	*	*	*	*
	16-19	87	220	307	115	206	321	93	243	336	113	236	349	105	192	297	104	191	295	87	177	264	85	175	260	70	194	264	78	162	240	78	176	254	86	124	210
	20-24	445	458	903	375	342	717	477	385	862	447	327	774	423	338	761	424	374	798	390	329	719	387	396	783	391	443	834	336	309	645	298	354	652	346	304	650
	25-34	362	239	601	365	205	570	371	220	591	416	201	617	373	220	593	390	191	581	366	217	583	362	200	562	359	223	582	318	162	480	374	187	561	441	195	636
	35-44	80	39	119	65	36	101	76	27	103	81	39	120	96	28	124	71	20	91	77	29	106	78	35	113	85	42	127	70	34	104	94	27	121	97	22	119
	45+	*	*	27	*	*	23	*	*	41	33	5	38	*	*	46	47	9	56	39	*	*	*	11	*	45	9	54	*	7	*	*	*	*	*	*	*
	Total	**993**	**986**	**1,979**	**938**	**805**	**1,743**	**1,050**	**896**	**1,946**	**1,090**	**816**	**1,906**	**1,036**	**796**	**1,832**	**1,036**	**794**	**1,830**	**959**	**764**	**1,723**	**946**	**824**	**1,770**	**950**	**917**	**1,867**	**856**	**678**	**1534**	**891**	**757**	**1648**	**1,025**	**659**	**1,684**
	% in MSM	*6%*			*4%*			*4%*			*11%*			*14%*			*15%*			*10%*			*12%*			*17%*			*14%*			*21%*			*24%*		
Gonorrhoea^	<16	0	0	0	0	0	0	0	0	0	0	0	0	0	*	*	*	*	*	0	*	*	*	*	*	*	*	*	*	0	*	0	*	*	*	0	0	0
	16-19	*	*	15	27	7	34	15	5	20	19	8	27	12	9	21	17	15	32	*	22	*	46	42	88	*	48	*	35	43	78	48	40	88	55	54	109
	20-24	58	17	75	44	7	51	56	10	66	36	15	51	61	13	74	87	38	125	116	44	160	117	66	183	136	78	214	157	54	211	117	52	169	153	54	207
	25-34	55	7	62	*	*	49	58	13	71	69	8	77	51	6	57	93	19	112	123	38	161	143	45	188	164	39	203	183	33	216	176	25	201	184	35	219
	35-44	*	*	32	*	*	21	*	*	45	*	*	16	30	*	*	*	*	40	*	*	44	48	9	57	47	8	55	62	5	67	57	*	*	*	*	79
	45+	*	*	11	17	0	17	*	*	24	*	*	9	18	*	*	*	*	*	39	*	*	*	*	*	47	*	*	*	*	*	61	7	68	*	*	65
	Total	**163**	**32**	**195**	**155**	**17**	**172**	**194**	**32**	**226**	**148**	**32**	**180**	**172**	**32**	**204**	**259**	**77**	**336**	**347**	**111**	**458**	**384**	**165**	**549**	**424**	**177**	**601**	**483**	**136**	**619**	**459**	**133**	**592**	**529**	**150**	**679**
	% in MSM	*24%*			*29%*			*29%*			*29%*			*34%*			*56%*			*65%*			*46%*			*64%*			*64%*			*65%*			*64%*		
Syphilis	<16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	16-19	0	*	*	*	0	*	*	0	*	0	0	0	0	0	0	*	*	*	*	0	*	*	0	*	*	*	*	*	*	*	*	0	*	0	0	0
	20-24	*	*	13	5	0	5	*	*	10	*	*	*	*	*	12	5	0	5	15	0	15	11	*	*	11	*	*	8	0	8	*	*	9	6	0	6
	25-34	10	0	10	*	*	9	*	*	10	*	*	11	18	0	18	11	0	11	18	0	18	17	*	*	12	*	*	14	*	16	*	*	14	*	*	16
	35-44	*	0	*	*	0	*	*	0	*	9	0	9	6	0	6	*	*	*	8	0	8	8	0	8	*	*	*	*	*	*	*	0	*	7	0	7
	45+	*	0	*	*	0	*	8	0	8	6	0	6	*	*	10	10	0	10	*	0	*	10	0	10	5	0	5	9	0	9	7	0	7	*	*	6
	Total	*****	*****	**30**	*****	*****	**22**	*****	*****	**33**	*****	*****	**29**	*****	*****	**46**	*****	*****	**38**	**50**	**0**	**50**	**48**	*****	*****	**34**	**7**	**41**	**40**	**5**	**45**	**33**	**2**	**35**	*****	*****	**35**
	% in MSM	*52%*			*52%*			*45%*			*78%*			*75%*			*78%*			*90%*			*83%*			*76%*			*75%*			*88%*			*61%*		
Herpes	<16	0	*	*	0	*	*	0	*	*	0	*	*	0	*	*	0	6	6	0	5	5	0	0	0	0	*	*	0	*	*	0	7	7	*	*	*
	16-19	7	33	40	5	44	49	11	58	69	7	43	50	10	57	67	5	71	76	10	39	49	7	47	54	6	54	60	7	52	59	10	46	56	*	*	55
	20-24	21	60	81	32	53	85	11	78	89	38	56	94	42	87	129	30	68	98	32	75	107	33	71	104	36	81	117	40	71	111	45	92	137	53	92	145
	25-34	39	52	91	27	55	82	38	47	85	41	80	121	52	79	131	56	65	121	50	72	122	55	85	140	76	69	145	47	71	118	65	93	158	65	91	156
	35-44	18	21	39	26	13	39	8	19	27	17	32	49	36	21	57	24	26	50	18	18	36	21	32	53	24	27	51	30	28	58	15	28	43	23	37	60
	45+	6	*	*	13	*	*	10	*	*	18	*	*	13	*	*	14	21	35	17	21	38	14	20	34	14	*	*	17	*	*	23	24	47	22	23	*
	Total	**91**	**183**	**274**	**103**	**173**	**276**	**78**	**218**	**296**	**121**	**225**	**346**	**153**	**258**	**411**	**129**	**257**	**386**	**127**	**230**	**357**	**130**	**255**	**385**	**156**	**259**	**415**	**141**	**240**	**381**	**158**	**290**	**448**	**165**	**298**	**463**
	% in MSM	*2%*			*4%*			*6%*			*7%*			*12%*			*11%*			*10%*			*23%*			*16%*			*14%*			*14%*			*16%*		
Warts	<16	*	*	11	*	*	5	*	*	10	*	*	18	*	*	11	*	*	*	0	10	10	0	6	6	0	*	*	*	*	*	*	0	*	*	*	*
	16-19	122	270	392	88	216	304	100	253	353	95	217	312	107	230	337	104	245	349	88	200	288	78	183	261	78	172	250	*	123	196	*	*	166	*	*	*
	20-24	440	356	796	384	326	710	419	369	788	444	334	778	432	342	774	467	394	861	475	314	788	419	276	695	401	308	709	365	259	624	390	275	665	292	258	550
	25-34	401	249	650	387	227	614	439	262	701	400	221	621	442	255	697	448	254	702	462	278	739	427	232	659	456	226	682	371	214	585	409	200	609	384	198	582
	35-44	123	95	218	131	70	201	119	88	207	138	86	224	135	74	209	138	91	229	124	82	206	160	64	224	142	81	223	126	83	209	126	53	179	117	73	190
	45+	*	*	89	*	*	95	*	*	84	*	*	133	*	*	98	*	*	154	99	58	157	89	55	144	100	*	*	80	*	*	104	*	*	87	52	139
	Total	**1,142**	**1,014**	**2,156**	**1,050**	**879**	**1,929**	**1,132**	**1,011**	**2,143**	**1,160**	**926**	**2,086**	**1,179**	**947**	**2,126**	**1,237**	**1,068**	**2,305**	**1,248**	**942**	**2,188**	**1,173**	**816**	**1,989**	**1,177**	**843**	**2,020**	**1,016**	**730**	**1,746**	**1,085**	**701**	**1,786**	**935**	**666**	**1,600**
	% in MSM	*2%*			*3%*			*2%*			*6%*			*8%*			*8%*			*10%*			*9%*			*9%*			*9%*			*8%*			*9%*		
Total diagnoses		6,292	5,718	12,010	6,211	5,110	11,321	6,546	5,787	12,333	6,966	5,356	12,322	7,304	5,222	12,526	7,046	5,729	12,775	6,117	5,000	11,117	5,728	4,752	10,480	5,953	4,937	10,890	5,481	4,186	9,667	5,692	4,375	10,067	5,341	3,888	9,229
Total workload		8,871	7,104	15,975	8,480	6,488	14,968	9,897	8,321	18,218	11,903	9,698	21,601	13,242	10,542	23,784	14,035	11,704	25,739	16,140	11,887	28,027	15,720	11,381	27,101	16,955	12,129	29,084	15,446	10,842	26,288	16,811	11,403	28,214	21,148	11,835	32,983

Notes on using these tables:

% in MSM represents the propotion of the total male diagnoses attributed to men w ho have sex w ith men (MSM)

^ It is likely that the use of more sensitive Nucleic Acid Amplification Tests (NAATs) has contributed to the increase in gonorrhoea.

* Data is confidential
Following recent ONS guidance on data disclosure, the rules on publication of STI data w ith small cell sizes have changed. Cells w ith a value betw een 1 and 4 w ill now be anonymised w ith an astrix. In addition, w here the anonymised cell can be deduced from the totals, the next smallest cells w ill also be anonymised.

Due to a GUM clinic migrating to new GUMCAD softw are using SHHAPT codes figures from 2012 have been recalculated to include B5 (complicated gonorrhoea) and C4B (complicated chlamydia)
Rates have neen calculated using the mid year estimates

Definitions of selected conditions:

Chlamydia	Chlamydial infection, KC60 code C4a, C4c, C4b & SHHAPT code C4
Gonorrhoea	gonorrhoea, KC60 code B1, B2, B5 & SHHAPT B
Syphilis	primary and secondary infectious syphilis, KC60 code A1, A2
Herpes	anogenital herpes simplex (first attack), KC60 code C10a
Warts	anogenital w arts (first attack), KC60 code C11a
Total diagnoses	all diagnoses made, includes all A, B, C and E KC60 codes
Total w orkload	all w orkload not requiring a diagnoses, includes all D, P and S KC60 codes

Appendix 3: Rates of new episodes of selected diagnoses by gender and age group, Northern Ireland, 2006-2017

		2006			2007			2008			2009			2010			2011			2012			2013			2014			2015			2016			2017		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Chlamydia	<16	*	*	28.8	*	*	14.6	*	*	17.4	0.0	22.1	10.8	*	*	14.9	0.0	25.0	12.2	0.0	*	*	*	20.1	*	0.0	17.7	8.6	*	11.8	*	*	*	*	*	*	*
	16-19	161.1	427.1	291.0	215.4	402.6	307.0	176.1	481.1	325.3	216.4	471.1	341.1	203.0	386.2	292.8	203.1	387.7	293.6	167.6	356.1	259.9	166	354.5	257.7	135.0	383.7	255.6	154.9	341.5	245.4	155.8	371.8	260.8	178.1	275.2	225
	20-24	718.5	753.3	735.7	593.0	548.5	570.9	749.5	610.9	680.6	697.1	519.2	609.0	663.5	540.7	602.7	669.5	606.0	638.2	614.3	517.5	566.7	622.1	605.2	613.8	624.5	688	655.8	545	516.0	530.7	484.7	599.4	540.9	575.3	537.9	557.2
	25-34	314.2	201.1	256.8	313.3	169.8	240.3	314.5	179.6	245.8	349.5	162.5	254.2	311.0	176.3	242.3	324.6	152.1	236.4	297.4	166.5	230.6	293.3	151.3	220.8	290	163.4	225.6	261.3	128.5	193.7	306.0	148.7	226.3	358.4	155.6	256.1
	35-44	62.1	29.3	45.4	50.2	27.0	38.4	58.8	20.2	39.2	63.4	29.4	46.1	76.2	21.4	48.3	57.3	15.5	36.0	60.0	22.1	40.7	61.4	22.4	41.5	71.6	30.7	50.6	59.7	27.5	43.1	80.4	21.9	50.3	83.5	17.9	49.8
	45+	*	*	4.2	*	*	3.5	*	*	6.1	10.3	1.4	5.6	*	*	6.6	14.0	2.4	7.9	10.2	*	*	*	2.1	*	12.1	1.8	6.7	*	1.8	*	*	*	*	*	*	*
	Total	**116.4**	**110.8**	**113.5**	**108.8**	**89.5**	**98.9**	**120.6**	**98.7**	**109.4**	**124.1**	**89.2**	**106.3**	**117.1**	**86.5**	**101.5**	**116.5**	**85.8**	**100.9**	**105.1**	**79.2**	**91.9**	**103.7**	**82.5**	**92.9**	**103.4**	**90.7**	**96.9**	**94.8**	**72.3**	**83.3**	**98.0**	**80.3**	**89.0**	**111.4**	**69.3**	**90.0**
Gonorrhoea	<16	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	*	*	*	*	*	0.0	*	*	*	*	*	*	*	*	*	0	*	0.0	*	*	0.0	0	0
	16-19	*	*	14.2	50.6	13.7	32.5	28.4	9.9	19.4	36.4	16.0	26.4	23.2	18.1	20.7	33.2	30.4	31.9	*	45.3	*	90.9	87.6	89.3	*	101.2	*	69.5	90.6	79.8	95.8	84.5	90.3	113.9	119.9	116.8
	20-24	93.6	28.0	61.1	69.6	11.2	40.6	88.0	15.9	52.1	56.1	23.8	40.1	95.7	20.8	58.6	137.4	61.6	100.0	184.1	70.6	128.4	187.4	104.5	146.5	219	121.9	171.1	254.6	90.2	173.6	190.3	88.1	140.2	254.4	95.5	177.4
	25-34	47.7	5.9	26.5	*	*	20.7	49.2	10.6	29.5	58.0	6.5	31.7	42.5	4.8	23.3	77.4	15.1	45.6	100.8	27.7	63.5	116.5	34.1	74.4	133.9	23.8	77.9	150.4	26.2	87.2	144	19.9	81.1	149.5	27.9	88.2
	35-44	*	*	12.2	*	*	8.0	*	*	17.1	*	*	6.1	23.8	*	12.5	*	*	15.8	*	*	17.7	40.4	5.6	22.6	39.2	4.8	21.6	52.9	4.0	27.8	48.7	*	*	*	*	33
	45+	*	*	1.7	5.6	0.0	2.6	*	*	3.6	*	*	1.3	5.5	*	2.7	*	*	*	11.1	*	*	*	*	*	13.2	*	*	*	*	*	16.9	1.8	8.9	*	*	8.3
	Total	**19.1**	**3.6**	**11.2**	**18.0**	**1.9**	**9.8**	**22.3**	**3.5**	**12.7**	**16.8**	**3.5**	**10.0**	**19.4**	**3.5**	**11.3**	**29.1**	**8.3**	**18.5**	**38.5**	**11.5**	**24.7**	**42.4**	**16.8**	**29.3**	**46.6**	**17.2**	**31.6**	**53.5**	**14.5**	**33.6**	**50.5**	**14.1**	**32.0**	**57.5**	**15.8**	**36.3**
Syphilis	<16	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	16-19	0.0	*	*	*	0.0	*	*	0.0	*	0.0	0.0	0.0	0.0	0.0	0.0	*	*	*	*	0.0	*	*	0.0	*	*	*	*	*	*	*	*	0.0	*	0	0.0	0.0
	20-24	*	*	10.6	7.9	0.0	4.0	*	1.6	7.9	*	*	*	*	*	9.5	7.9	0.0	4.0	23.8	0.0	12.1	17.8	*	*	17.8	*	*	13.0	0.0	6.6	*	*	14.6	10	0.0	5.1
	25-34	8.7	0.0	4.3	*	*	3.8	*	2.4	4.2	*	*	4.5	15.0	0.0	7.4	9.2	0.0	4.5	14.9	0.0	7.3	14.0	*	*	9.9	*	*	11.5	*	6.5	*	*	11.5	*	*	6.4
	35-44	*	0.0	*	*	0.0	*	*	0.0	*	7.0	0.0	3.5	4.8	0.0	2.3	*	*	*	6.6	0.0	3.2	6.7	0.0	3.3	4.3	*	*	*	*	*	*	0.0	*	6.0	0.0	2.9
	45+	*	0.0	*	*	0.0	*	2.6	0.0	1.2	1.9	0.0	0.9	*	*	1.4	3.0	0.0	1.4	*	0.0	*	2.9	0.0	1.4	1.4	0.0	0.7	2.5	0.0	1.2	1.9	0.0	1.9	*	*	0.8
	Total	*****	*****	**1.7**	*****	*****	**1.2**	*****	*****	**1.9**	*****	*****	**1.6**	*****	*****	**2.5**	*****	*****	**2.1**	**5.6**	**0.0**	**2.7**	**5.4**	*****	**2.8**	**3.8**	**0.7**	**2.2**	**4.4**	**0.5**	**2.4**	**3.6**	**0.2**	**3.8**	**3.6**	**0.2**	**1.9**
Herpes	<16	0.0	*	*	0.0	*	*	0.0	*	*	0.0	*	*	0.0	*	*	0.0	16.7	8.1	0.0	13.9	6.8	0.0	0.0	0.0	0.0	*	*	0.0	*	*	0.0	21.3	10.3	*	*	3.0
	16-19	13.0	64.1	37.9	9.4	86.0	46.9	20.8	114.8	66.8	13.4	85.8	48.9	19.3	114.7	66.1	9.8	144.1	75.6	19.7	80.3	49.4	13.8	98.0	54.8	11.9	113.8	61.3	13.9	109.6	60.3	20.0	97.2	57.5	*	*	58.9
	20-24	33.9	98.7	66.0	50.6	85.0	67.7	17.3	123.8	70.3	59.3	88.9	74.0	65.9	139.2	102.2	47.4	110.2	78.4	50.8	123.2	86.4	53.3	117.7	85.1	58.4	135.3	96.3	64.9	118.6	91.3	73.2	155.8	113.7	88.1	162.8	124.3
	25-34	33.8	43.8	38.9	23.2	45.5	34.6	32.2	38.4	35.3	34.4	64.7	49.8	43.4	63.3	53.5	46.6	51.8	49.2	41.3	57.1	49.4	45.4	67.3	56.6	62.4	54.7	58.5	38.6	56.3	47.6	53.2	74.0	63.7	52.8	72.6	62.8
	35-44	14.0	15.8	14.9	20.1	9.7	14.8	6.2	14.2	10.3	13.3	24.1	18.8	28.6	16.1	22.2	19.4	20.2	19.8	14.8	14.2	14.5	17.7	25.6	21.8	20.5	21.8	21.2	25.6	22.6	24.1	12.8	22.7	17.9	19.8	30.1	25.1
	45+	2.0	*	*	4.2	*	*	3.2	*	*	5.6	*	*	4.0	*	*	4.2	5.6	4.9	5.0	5.5	5.3	4.0	5.2	4.6	3.9	*	*	4.8	*	*	6.4	6.0	6.2	5.9	5.6	5.7
	Total	**10.7**	**20.6**	**15.7**	**11.9**	**19.2**	**15.7**	**9.0**	**24.0**	**16.6**	**13.8**	**24.6**	**19.3**	**17.3**	**28.0**	**22.8**	**14.5**	**27.8**	**21.3**	**14.2**	**24.8**	**19.6**	**14.5**	**27.3**	**21.0**	**17.3**	**27.6**	**22.5**	**15.6**	**25.6**	**20.7**	**17.4**	**30.8**	**24.2**	**17.9**	**31.3**	**24.7**
Warts	<16	*	*	14.4	*	*	6.6	*	*	13.4	*	*	24.2	*	*	14.9	*	*	*	0.0	27.9	13.6	0.0	17.2	8.4	0.0	*	*	*	*	*	*	0.0	*	*	*	*
	16-19	226.0	524.2	371.6	164.8	422.1	290.7	189.4	500.9	341.7	182.0	433.2	305.0	206.9	462.7	332.3	203.1	497.3	347.4	173.6	411.7	290.1	154.1	381.7	264.8	154.9	362.6	255.6	*	259.3	259.3	*	*	170.4	*	*	147.8
	20-24	710.4	585.5	648.6	607.2	522.8	565.3	658.4	585.5	622.1	692.4	530.4	612.1	677.6	547.1	613.0	737.4	638.4	688.5	754.0	515.8	637	677.0	457.6	568.8	650.4	514.3	583.4	592.0	432.5	432.5	634.3	465.7	551.7	485.5	456.5	471.5
	25-34	348.0	209.6	277.7	332.2	188.0	258.8	372.1	213.9	291.5	336.0	178.6	255.8	368.6	204.3	284.8	372.8	202.3	285.7	381.7	220.4	299.4	352.8	183.8	266.5	374.7	179.2	275.2	304.8	169.7	169.7	334.7	159.0	245.6	312.1	158.0	234.3
	35-44	95.4	71.4	83.2	101.2	52.5	76.5	92.1	65.9	78.8	108.0	64.9	86.0	107.1	56.6	81.4	111.4	70.6	90.6	102.0	64.7	83	134.6	51.3	91.9	121.1	65.4	92.5	107.5	67.0	67	107.7	42.9	74.5	100.8	59.4	79.5
	45+	*	*	13.9	*	*	14.5	*	*	12.6	*	*	19.5	*	*	14.1	*	*	21.7	28.9	15.2	21.7	25.5	14.2	19.6	28.2	*	*	22.5	*	*	28.8	*	*	23.4	12.7	17.8
	Total	**133.9**	**113.9**	**123.7**	**121.8**	**97.7**	**109.5**	**130.0**	**111.3**	**120.5**	**132.0**	**101.2**	**116.3**	**133.3**	**102.9**	**117.8**	**139.1**	**115.5**	**127.0**	**139.5**	**101.4**	**120.1**	**130.7**	**87.5**	**108.7**	**130.4**	**89.9**	**109.8**	**112.5**	**77.8**	**77.8**	**119.3**	**74.4**	**96.5**	**101.6**	**70.0**	**85.5**

Notes on using these tables:

Diagnoses are calculated on GUM clinics in the region, rates are calculated for the region's resident population

Diagnostic rates for specific age groups were estimated by dividing the annual number of diagnoses in each age bracket by the estimated mid-year resident population of Northern Ireland for each age group. The denominators used to calculate rates in people under 16 and over 44 years of age were the population aged 13 to 15, and the population aged over 44 years respectively. The total population was used for the calculation of overall rates.

2001-2011 rates have been revised using revised mid year estimates to take into account the 2011 Census

* Data is confidential
Following recent ONS guidance on data disclosure, the rules on publication of STI data with small cell sizes have changed. Cells with a value between 1 and 4 will now be anonymised with an astrix. In addition, where the anonymised cell can be deduced from the totals, the next smallest cells will also be anonymised.

Definitions of selected conditions:

Chlamydia	Chlamydial infection, KC60 code C4a, C4c, C4b & SHHAPT code C4
Gonorrhoea	gonorrhoea, KC60 code B1, B2, B5 & SHHAPT B
Syphilis	primary and secondary infectious syphilis, KC60 code A1, A2
Herpes	anogenital herpes simplex (first attack), KC60 code C10a
Warts	anogenital warts (first attack), KC60 code C11a
Total diagnoses	all diagnoses made, includes all A, B, C and E KC60 codes
Total workload	all workload not requiring a diagnoses, includes all D, P and S KC60 codes

Public Health Agency
12-22 Linenhall Street
Belfast
BT2 8BS
Tel: 028 90321313

www.publichealth.hscni.net

HSC Public Health Agency

board paper

HSC R&D Division Annual Report 2017-18

date	20 December 2018	**item**	10	**reference**	PHA/04/12/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

The attached paper outlines the work and achievements of HSC R&D Division for the financial year 2017-18, with an update on highlights of 2018-19 to date.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the HSC R&D Division Annual Report for 2017-18.

HSC R&D Division Annual Report

2017-18 Financial Year

An update to the R&D Strategy Implementation Plan at April 2017-18 is attached at Annex 1 – (updates for the period from April 2018-date are included in green). The Strategy has five key objectives, and actions to deliver on these are set out in the plan, which is updated at regular quarterly business planning meetings and shared on a six-monthly basis with the HSC R&D Strategic Advisory Group, and annually with the PHA Board. Two meetings of the Strategic Advisory Group took place during 2017-18, on 7 July 2017 & 14 March 2018.

Budget

The HSC R&D Fund was allocated in 2017-18 from capital funds, and remains unchanged in value, standing at a baseline value of £10.3m. Additional slippage of £1.529m was received at year end and distributed across a number of ongoing awards to alleviate pressures in future financial years and add value to existing studies. Total funding of £15.84m was available including external income and the NIHR contribution of £3.53m (from revenue budget).

As stated in previous reports, the HSC R&D Fund remains lower per capita than other parts of the UK by a factor of approximately three-fold, therefore HSC R&D Division continues to seek to augment the fund through partnership initiatives and actively encourages and facilitates researchers to make applications to major funders (see actions under Objective 2 in the Implementation Plan).

The 2017-18 year-end budget outturn, including income, is summarised in Annex 2, and shows break even at £569 under the total spend of £15.84m.

Research Portfolio

The sections below summarise status of each work 'strand' at year end 2017-18 (key to strands also provided in Annex 2):

Career Development (CDV)

HSC R&D Division recognises the need to invest in training for future health and social care researchers, both in general and also where there are specific skills gaps. A number of Doctoral, Post-Doctoral, Senior Researcher and Clinician Scientist Fellowship programmes are managed by the National Institute of Health Research in England, which are highly competitive and awarded only to high calibre candidates. Researchers from Northern Ireland can apply to these schemes, and if successful, their award is funded from the HSC R&D Fund. There were no successful applicants in the last round of NIHR Fellowship awards, but a number of applications have gone forward at the various levels for the next round, for which interviews will be held in summer 2018. This work contributes to Actions 1.1 & 1.3.2 in the Implementation Plan.

Commissioned Research (COM)

Two main commissioned research programmes are underway, in Mental Health and Dementia Care. Both programmes were funded following priority-setting initiatives involving service users and HSC professionals.

Five studies were funded under the Mental Health programme, two further studies were launched during 2017-18, details on the R&D website at http://www.research.hscni.net/bamford-implementation-commissioned-call-portfolio

The Dementia Care commissioned call http://www.research.hscni.net/dementia-care-commissioned-call-2013-2014 was a £2m fund created through a partnership between HSC R&D Division and The Atlantic Philanthropies. Three of the seven funded studies were launched during the Dementia Together NI event in November 2017.

Further opportunities to commission relevant research are being explored.

The Opportunity-Led Commissioned funding scheme is a further opportunity for HSC R&D Division to leverage funding into Northern Ireland. This scheme allows researchers to request additional funding from HSC R&D Division, to match funding obtained from another source (up to 50% of the total value of a study may be requested). This work contributes to Action 4.2 in the Implementation Plan.

Dissemination (DIS)

Dissemination of the results of research remains a key priority for HSC R&D Division. Within this strand the HSC R&D Division and the Health Research Board have historically offered a series of short training courses and 2-year part-time Fellowships under the Cochrane Programme. The Cochrane Library is also free to access for all citizens on the Island of Ireland, thanks to contributions from HSC R&D Division and the Health Research Board. In consultation with the HRB, their Board and our Strategic Advisory Group, a call was launched in 2017-18 to re-structure systematic review support in Ireland, including the Cochrane Programmes but on a broader scale. The level of investment from HSC R&D Fund would be maintained at the current level, but this new entity will take on the administrative burden that was formerly borne by the HSC R&D Division and HRB.

Support continues for the other work streams previously detailed under this strand, including the Workshops & Conferences support scheme, the HSC Innovations service, and the annual ResearchFish data collection process is also included under this work strand.

Education and Training (EAT)

The annual Doctoral Fellowships scheme ran again during 2017-18, with four Fellowship awards being offered, of which three will be taken up. These will commence during 2018-19, along with the fourth award that was deferred from the previous scheme. As usual, two trainees have been offered the GP Research Training awards, which will get under way during 2018-19. This work contributes to action 1.3 in the Implementation Plan.

A long-running Memorandum of Understanding between Northern Ireland, Ireland and the United States is the Ireland- Northern Ireland- National Cancer Institute (NCI) Cancer Consortium. Under this MoU, Northern Ireland researchers are able to access three places per year on each of two NCI summer courses, the Cancer Prevention and Molecular Cancer Prevention Courses, which run in the National Cancer Institute in Baltimore. Three attendees will attend the courses during 2017-18. Also see action 2.5.3 in the Implementation Plan.

The two new education and training schemes, detailed in the previous report, were the Centre for Cancer Research & Cell Biology Fellowship and the Wellcome Irish Clinical Academic Training Awards, will begin to get underway and incur spend during 2018-19. These will contribute to Action 1.3.2 in the Implementation Plan.

Responsive mode funding (RES)

Knowledge exchange is an important mechanism to allow the diffusion of research findings into practice, policy and, where appropriate, enterprise. HSC R&D Division, as part of their implementation of the R&D strategy, continues to review the support provided for Knowledge Exchange, with a view to increasing competence and capability in this important area, however, budgetary limitations have currently resulted in no further awards being funded during 2017-18. (See action 5.1.3 in the Implementation Plan).

Special Initiatives and Strategic Links (SPI and STL)

These two work strands currently consume the most significant proportion of the HSC R&D Fund, and the key initiatives will be detailed below:

Infrastructure Support in HSC Trusts and Universities

An overall review of the research infrastructure funded from the HSC R&D Fund commenced in 2017-18, as outlined in the Implementation Plan under action 1.3.4. This is still ongoing and due to complete during 2018-19. Following this a period of re-structuring may be necessary. PHA and HSC R&D Division would welcome discussion and advice from colleagues in DoH on how best to proceed with continuing this support given the large number of posts supported over a number of years.

Other infrastructure investments continue as previously detailed, with new investments for 2018-19 being

- The Centre of Excellence for Precision Medicine, based at QUB. This will receive support of £500k over the next five years, with half-year funding anticipated in 2018-19.
- Health Data Research UK – Northern Ireland will contribute £50k per annum over the next five years in partnership with other UK Health Departments and Research Councils

Support for UK Schemes (SUS)

This work strand covers a small number of contributions to UK-wide consortia, as well as payment for services from the Health Research Authority in the UK-wide work on research governance. This work is led for Northern Ireland by the Assistant Director of R&D on behalf of DoH and the HSC. The AD attends meetings and leads policy decision-making in partnership with the other three UK nation leads. A number of the Trust R&D Managers are involved in the operational work to translate the policy decisions into practice, and local meetings are regularly convened with all five Trusts and the Universities to discuss, (see actions 3.1 and 3.2).

Two further work strands, Recognised Research Groups (RRG) and Core Funded Units (CFU), are no longer active, with only one award remaining in the final stages of completion under the RRG strand.

General

A number of cross-cutting or underpinning activities are ongoing that do not appear in the sections above. R&D Division maintains a dedicated website and issues regular bulletins to the research community (action 1.1.3). Work is ongoing to develop a template for Trusts to report on research activity (action 1.2.2). Links have been established to support the development of research within the social work and social care professions (actions 1.4.1. and 1.4.2). HSC R&D Division continues to develop relationships with key commercial sector partners such as InvestNI. Personal and Public Involvement in research has been an important part of the work of HSC R&D Division for almost 10 years, and a vibrant group, 'Public Involvement Enhancing Research' (PIER), is co-chaired by a PPI

representative and Dr Gail Johnston, Programme Manager in HSC R&D Division. This contributes to actions under 4.1 of the Implementation Plan. A number of collaborative initiatives with the Health Research Board are underway and this trend is set to continue during future years. This contributes to action 3.5. Work is also ongoing to scope and develop a research training programme for novice and experienced researchers (see action 1.1.1). HSC R&D Division also works alongside the Honest Broker Governance Board and the Administrative Data Research Centre to facilitate research using routinely collected health data (action 4.3).

2017-18 Position and 2018-19 investment

HSC is pleased to advise that the HSC R&D Fund achieved break even in 2017-18 as presented in Annex 2. Annex 3 details new funding awards made and started in 2017-18.

2018-19 Year to date

Budget

Initial budgetary allocation for 2018-19 was £9.8m, however, a further allocation and end-of year slippage is anticipated as in previous years. The annual subscription to participate in the NIHR programmes of £3.211m was also confirmed. Additional income from R&D Division activities (not including CHITIN award), is estimated at £391k. Activities from April 2018 have proceeded as outlined in the attached Implementation Strategy update in green, and the HSC R&D Fund remains on target for break even in 2018-19.

Highlights of the 2018-19 year to date have included:

- Completion of the consultative review of R&D infrastructure, which has proceeded to the next phase of effecting changes recommended by the review. This phase will also necessitate consultation throughout the process as a move to some more centralised management and structure has been proposed for research governance and a move to a more generic model for the Northern Ireland Clinical Research Networks is also in the pipeline.
- A new reporting system for research activity will replace the previous research governance controls assurance standard and is due to be issued by Professor Ian Young in his role as Chief Scientific Advisor for the first reporting period of 2018-19. Refer to sections 1.2 and 1.3.4 of Implementation update (Annex 1).
- A new model to support creation of systematic reviews and associated training has been put in place for Ireland, in partnership with the Health Research Board. Previously, this support was wholly channelled through the Cochrane programme, but the new model sees an expansion of the scope to include a broader programme of reviews, including the Campbell Collaboration and other reviews. The Centre will also encompass the former Cochrane short courses, the Cochrane Fellowship awards and Cochrane Ireland. (Annex 1, section 5.1.2).
- HSC R&D Division has also confirmed a further three years' support for the NI Cohort of Lifestyle and Ageing (NICOLA) project, following approval of the business case by DoH. This longitudinal study is providing important information on the long-term health and social outcomes of a cohort of over 8000 people in Northern Ireland to inform future health services for our ageing population. Strategic links with other similar cohorts in Ireland, UK and beyond are also possible through the continuation of this project (Annex 1, section 1.4.3).
- HSC R&D Division has become a partner (investing £250k over five years), in the UK-wide consortium funding the Health Data Research UK (HDR-UK) initiative, which aims, through the appropriate and safe use of routinely collected health data for research, to inform better health and social care services for the future. Through this consortium, a joint bid from Swansea University and Queen's University has received £3m to set up one of six national Centres of Excellence supported by HDR-UK (Annex 1, section 1.3.2 & 2.5.2).
- HSC R&D Division, in partnership with InvestNI, has provided £0.5m to support a new Centre for Precision Medicine at Queen's University Centre for Cancer and Cell Biology. The Centre will provide a UK-wide service for the development of precision medicine diagnostics and treatments, and the R&D funds will be used to support a team of experts working towards adoption of these new tests into clinical practice (see Annex 1, section 2.6.5).

Ongoing work has brought some additional funding successes from the EU to supplement the HSC R&D Fund. Progress with these is detailed below:

- Launch of the Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN) Project took place on 21 September 2018. This €8.8m EU-funded initiative will support the delivery of 11 trials of novel healthcare interventions throughout Northern Ireland and in the border counties of the Republic of Ireland and represents a major partnership with the Health Research Board, Ireland. Several studies are already underway. The CHITIN launch has created some new opportunities for dissemination of the work of HSC R&D Division, led by the Communication Manager supported by the CHITIN award, and has attracted some media interest (Annex 1; Section 2.4.1 and 5.2.3 & 5.2.4).
- HSC R&D Division has become a partner in a new Horizon 2020-funded award – Securing the adoption of personalised medicine in regions (SAPHIRE), which will bring €380k to PHA. R&D Division will lead two work packages which aim to foster collaborative research projects between EU member states and beyond in the area of personalised medicine (see Annex 1, Section 2.4.1).
- HSC R&D Division is also part of the Transfer of Organisational innovations for Resilient, Effective, equitable, Accessible, sustainable and Comprehensive Health Services and Systems (To-REACH) Consortium. Alongside other Consortium partners, a Northern Ireland workshop was hosted by HSC R&D Division in April 2018. These regional workshops gathered inputs contributing towards a Strategic Research Agenda in Health Services and Public Health Research. Based on an initial draft of the Strategic Workshop Agenda, the EU Commission has agreed that the Consortium can work towards a Joint Programme, with estimated co-funding from the EU Commission to create a pot of up to €50m for one or more funding calls in the next EU Framework Programme – Horizon Europe. The nature of participation for UK regions will depend on the outcome of negotiations for the UK leaving the EU (annex 1, section 2.4.1).

HSC R&D Implementation Strategy - Quarterly Update (October 2018)

Objectives should be coloured red (significant delay) amber (slightly behind schedule) or green (on track) to signify progress lll

OBJECTIVE 1.

To support research, researchers and the use of evidence from research to improve the quality of both health and social care and for better policy making

Actions	Timescale	Responsible Officer/Institution	Update Colour	Progress Update
1.1 Engage with HSC organisations to raise awareness of the value of research skills for productive professional employees, and encourage capacity building through education and training to foster a research-active workforce for the HSC				
1.1.1 Develop a research training programme to enhance staff capability and skills, and commission annual training schedule to enable staff to develop the required competencies	By April 2017	Sorcha Finnegan		Project has been picked up by new Programme Manager following retirement of previous post-holder. Options for training requirements for various needs are being explored, including online training provided by Health Research Authority (England) and shared training with the Universities for alternatives to Good Clinical Practice training. Training programme in progress for R&D governance staff, examples include Attribution of costs of R&D (AcoRD) online training, study-wide review, leadership days.
1.1.2 Establish a structured framework to support HSC professionals towards the development of post-doctoral and senior research careers	By December 2018	Sorcha Finnegan		Exploring the possibility of contacting alumni from Doctoral Fellowships and others, and arranging events or workshops to establish a community of past awardees. Also looking at how NI National Institue of Health Research (NIHR) Fellowship award holders could be integrated into NIHR lists and events.
1.1.3 Raise awareness through regular R&D updates in various formats for the HSC community to highlight research successes	Weekly e-mail. Quarterly web features, other media	All		Regular updates to website and email newsletter are main vehicles, but other avenues also used eg PHA internal mailing list; infographics/leaflets now available and stands booked for events NHS R&D Forum in May 2019 and PHA Conference in November 2018.
1.2 Encourage HSC organisations to support staff to undertake research relevant to their clinical responsibilities				
1.2.1 Establish a bi-annual meeting with each Trust with R&D Director and responsible Executive Director to review research activity & capacity development	By September 2016	Ian Young		Regular meetings with Trust R&D Directors. Further meetings to be sought following implementation of new reporting process.
1.2.2 Agree and establish a formal process for HSC Trusts at executive level to report on research activity through appropriate metrics	By September 2016	Ian Young		Discussed at R&D Director's meetings. A report template, incorporating the UK-wide agreed metrics, will be issued to Trusts from Chief Scientific Advisor for first reporting year 2018-19.

1.3 Provide funding support at all levels for HSC relevant research, with appropriate involvement of HSC professionals				
1.3.1 Continue to provide funding to support early-stage research projects within HSC	Annual	Janice Bailie		R&D Director's (Discretionary) Fund - £50,000 per Trust each year, allows start-up funding to be provided for small scale projects or may be used for support posts at discretion of R&D Directors - reports are provided on annual basis to provide detail of awards made.
1.3.2 Invest in appropriate education and training & career development awards programmes	Annual	Sorcha Finnegan/Gail Johnston		Investment has continued in HSC R&D Doctoral Fellowship awards as well as some specialist clinical Fellowship schemes (Wellcome-Irish Clinical Academic Training scheme and Centre for Cancer Research & Cell Biology Clinical Fellowship scheme, also supporting NIHR awards (doctoral, post-doctoral, career development, senior fellowship and clinical scientist awards and specialist GP Academic Research Training scheme for early-stage research training in primary care). New awards in pipeline include a Fellowship associated with Health Data Research UK (HDR-UK). Also considering future investment in Health Economics Fellowships following recent completion of the second fellow.
1.3.3 Continue with existing researcher-led award schemes and establish new schemes where appropriate	Ongoing cycle	All		Owing to budget limitations, most of the investment in researcher-led awards is currently through the Opportunity-led scheme. Researchers who have secured or are making funding applications to other funders can approach HSC R&D Division to partner fund up to 50% of the overall value of the award. Recent examples funded include funding for staffing in a Person-centred Connected Health Living Lab at Ulster University, co-funded with Department for Economy, co-funding with Invest NI of the Centre for Precision Medicine at QUB, and some smaller scale co-funded projects, for example to explore understanding of palliative care through the NI Life & Times survey.

1.3.4 Continue to provide funding for necessary underpinning R&D infrastructure	Ongoing	All		Investment in infrastructure (ie skilled research professionals), has consumed the largest proportion of HSC R&D Fund over the last 10 years. The individual elements of the infrastructure can be fully- or partially-funded by HSC R&D Division, and information on each can be viewed at the following link: http://www.research.hscni.net/infrastructure Currently the funded infrastructure is under review, and new initiatives have been delayed in 2017-18 due to issues with budget allocation. Review is now complete and work is ongoing to consult on proposed new structures and workplan to effect change.
1.3.5 Identify sources of funding for protected time for HSC professionals to prepare research funding applications and participate in studies	By April 2018	All		Funding built into some programmes, but limited on account of budgetary constraints - additional funding has been built into the new funding bid for 2018/19 - 2020/21. Funding awarded for 17/18 to Northern Ireland Biobank in support of Consultant Pathologist PAs and technical support time.
1.4 Engage specifically with social work, social care and public health to develop mechanisms to support and foster research in these areas				
1.4.1 Ensure appropriate representation for social care and public health on HSC R&D Division strategic and operational groups	By December 2015	Janice Bailie/All		Social Care and Public Health representatives added to membership of R&D Strategic Advisory Group. Appropriate representation on operational groups eg Child Development Research Workstream; NI Public Health Research Network groups
1.4.2 Identify support needs for social work & social care researchers and work with relevant colleagues to address these through specific funding schemes or other measures	By Sept 2016	All		Child Care Research Forum funded, encouraged to join NI Public Health Research Network; able to access advice from R&D team, Assistant Director to attend strategic meetings. Input was provided to the development and dissemination of an ESRC Innovation in Social Care funding call on mental health launched July 2018. Further discussion with ESRC on new investment in knowledge transfer hubs for social care.

1.4.3 Ensure strategic alignment of the activities of the NI Centre of Excellence for Public Health with HSC R&D Division priorities, through active partnership	Ongoing	All		Professor Frank Kee, Centre of Excellence Director now member of R&D Strategic Advisory Group; R&D Division team part of Centre of Excellence Executive Management Committee and Board; members of R&D Division team attend and input to events and away days. Input has been provided to the final report to the UKCRC funding partnership and scientific conference to mark the successful delivery and closure of the second quinquennium. Investment now confirmed from HSC R&D Fund for ongoing support to NI Cohort for Lifestyle and Ageing (NICOLA) study.
1.4.4 Support the development of public health research in Northern Ireland through the Northern Ireland Public Health Research Network (NIPHRN) action plan, specific funding schemes or other measures	From October 2015	Nicola Armstrong		Ongoing activity in support of NI Public Health Research Network to produce applications to funders such as National Institute of Health Research and others; workshop programme in place for funding opportunities and creation of collaborations in breastfeeding research. Support of the transfer of the Director of the network from QUB to UU and the consequent respective research office communications.

OBJECTIVE 2.

To compete successfully for R&D funding, and optimise local funding, to deliver returns on investment for health and wellbeing, academia and commerce

Actions	Timescale	Responsible Officer/Institution	Update Colour	Progress Update
2.1 Aim to increase the HSC R&D Fund to align with the average per capita level of other UK health research funds				
2.1.1 Work with key stakeholders to increase the value of the HSC R&D Fund budget	By April 2018	All		Budget bid 2018-2021 submitted for increased funding (£14-£16m); ongoing efforts to agree partnership funding.
2.2 Bid for funds to continue investment in the NIHR Evaluation, Trials and Studies UK funding streams, providing access to additional research funds for Northern Ireland				
2.2.1 Provide support for researchers to prepare bids through Enabling Research Awards Scheme and other mechanisms	Ongoing	Julie McCarroll		Scheme initially not been re-opened due to lack of certainty around NIHR Evaluation, Trials and Studies investment; now aim to revise the scheme and re-open Q4 2018/2019 (pending business case approval).
2.2.2 Submit business case to DoH for continuation of investment in NETSCC programmes	By Sept 2016	Janice Bailie/Julie McCarroll		Confirmation of continued investment confirmed in writing by Seamus Camplisson.
2.3 Seek co-funding from other Government Departments eg Department for the Econony (DfE), to support health-relevant research initiatives				
2.3.1 Explore potential funding streams eg NIHR i4i and work with relevant stakeholders towards co-investment	By April 2018	Janice Bailie		Ongoing; discussed with Wales and in context of Life Sciences Northern Ireland
2.4 Increase the focus on relevant EU funding streams and facilitate HSC researchers to access EU opportunities				

2.4.1 Work within relevant networks to review the communication of relevant EU funding opportunities across the HSC, universities and other potential partners	Ongoing	Janice Bailie/Julie McCarroll		Liaising with Horizon 2020 (H2020) Northern Ireland Contact Points and contributing to networking and dissemination activities. Workshop in mid-November to promote 2018 calls. Content of update emails from H2020 Contact Points being revised for upload to HSC R&D Division website and link included in e-newsletter. Attendance at H2020 NICP Network meetings ongoing. HSC R&D Division, PHA also beneficiary of three EU funding awards, Transfer of Organisational innovations for Resilient, Effective, equitable, Accessible, sustainable and Comprehensive Health Services and Systems.(To-REACH; H2020; €40k); Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN; INTERREG VA programme; €8.8m; launch September 2018) and most recently Securing Adoption of Personalised Health in Regions (SAPHIRE; H2020; €380k).
2.4.2 Support and participate in at least 2 events annually to promote EU funding opportunities	Ongoing	Janice Bailie/Julie McCarroll		(1) Health Information Day held on 14 November 2017; (2) Meaningful Integration of Data, Analytics & Services (MIDAS) workshop (H2020; SE Trust partner) being supported and information disseminated; (3) TO-REACH national stakeholder event held on 17 April 2018 (4) Facilitation at H2020 Personalised Medicine and Digital Health Innovation event 11 September 2018.
2.4.3 Monitor and report on EU funding awards bringing funds into HSC to OFMDFM via DoH	Ongoing	Janice Bailie/Julie McCarroll		Reports provided to DoH NI upon request.
2.5 Adopt a partnership approach, identifying and investing in research funding initiatives and consortia that can bring health, social and financial benefits to Northern Ireland				
2.5.1 Review existing partnership investment eg US-Ireland Partnership awards; Ireland-Northern Ireland NCI partnership programme	Ongoing	All		Review ongoing, investment continued. Interest in US-Ireland partnership scheme has been strong. Negotiation with Medical Research Council, who have increased their co-investment in the Northern Ireland costs of US-Ireland to £175k per award.

2.5.2 Explore opportunities for new partnership investments	Ongoing	All		Currently planning new investments in funding consortia to create opportunities for NI researchers to compete/participate - Joint Programme in Neurodegenerative Disease - 9 projects funded including one led from NI - a research team from recent Dementia Care Commissioned funding call (joint funding HSC R&D Division and Atlantic Philanthropies); Health Data Research UK (HDR-UK) - investment in new UK-wide initiative to maximise the use of health data in research; UK-Prevention Research Partnership - consortium of funders to follow on from the National Prevention Research Initiative. Anticipate funding opportunities from HSC R&D DIvision participation in two EU Co-ordination and Support Actions.
2.5.3 Review membership of and investments through funders fora eg National Cancer Research Institute, Experimental Medicine Funders Group, Antimicrobial Resistance Funders Forum, National Prevention Research Initiative	Ongoing	All		Discontinued investment in National Awareness and Early Detection Initiative (final stage); continued with National Cancer Research Institute; Experimental Medicine Funders Group - further funding committed; Anti-Microbial Resistance Funders Forum - no funding committed as yet but involvment continued; National Prevention Research Initiative re-launched as UK-Prevention Research Partnership with new investment planned', all decisions in consultation with Strategic Advisory Group.
2.5.4 Develop co-funding arrangements with charitable funders to develop and fund research programmes in key areas	At least one new co-funding programme per year	All		One Opportunity-led proposal likely to lead to a project co-funded with Alzheimer's Society UK. One Opportunity-led project to allow the opening of a Movember study in Northern Ireland funded. Meeting held with new NI Director of Stroke Association, initially to explore potential for Stroke Association lectureship - now hoping to co-fund extension of H2020-funded Colchicine for Prevention of Vascular Inflammation in Non-cardio Embolic Stroke (CONVINCE) Stroke trial along with HRB and Stroke Association. Have re-opened discussions with Muscular Dystrophy UK, re co-funding of Doctoral Fellowship, and exploring potential avenues for co-funding in Rheumatology with British Rheumatology Society and Versus Arthritis.

2.6 Develop effective relationships with industry and representative organisations to ensure productive research partnerships				
2.6.1 Review outputs from HSC Innovations service and ensure activity is fit for purpose	Quarterly meetings and annual reports to Strategic Advisory Group	Janice Bailie/Julie McCarroll		Quarterly update meetings with Assistant Director on-going; presentation to March 2018 Strategic Advisory Group meeting; progress report received October 2018 and currently undergoing review.
2.6.2 Work with key stakeholders to develop industry forum, establish meeting programme and at least one annual event co-supported with industry and representative groups eg ABPI, Biobusiness	Quarterly / Annually	All		Clinical Innovation Collaborative's annual conference incorporated into the European Association of Precision Medicine Conference 2017 with dedicated sessions; continue to work with Invest NI, QUB Business Alliance and UU Innovation and Impact. Attendance of 2 PMs at QUB "Who wants to hire you?" event for post-docs; attendance at INI / Innovate UK Knowledge Transfer Network event on R&D and Life & Health Science business.
2.6.3 Develop metrics and agree annual targets for industry-sponsored or -collaborative clinical trials activity in Northern Ireland HSC	By October 2016	Janice Bailie/Ian Young		Professor Ian Young discussing in context of replacement for Research Governance Controls Assurance Standard; impacted by UK wide metrics discussions initiated September 2017. New Annual reporting template (replacing Controls Assurance Standard), will capture these metrics.
2.6.4 Work with key stakeholders to scope and establish a Northern Ireland Health Innovation & Life Sciences Hub, with appropriate governance arrangements	By October 2016	Janice Bailie/Ian Young		Now termed Life Sciences NI. Discussions reached an advanced stage with Departments of Health and Economy; InvestNI and PHA. Funding awarded through DoH Transformation Fund; Legal advice being sought as to how we can proceed particularly considering the political situation. Progress stalled for prolonged period, but fresh impetus has been generated by new QUB Vice Chancellor and closer working relationships between Univesrities, with Life & Health Sciences Cluster being proposed for NI.
2.6.5 Participate in strategic and operational management groups for Precision Medicine Catapult to help maximise the performance of the Northern Ireland Centre of Excellence	From September 2015	Janice Bailie		National investment replaced by local investment; HSC R&D Division plans shared funding model with QUB/Invest NI; funding letter issued.

OBJECTIVE 3.

To support all those who contribute to health and social care research, development and innovation by enhancing our research infrastructure, benefitting from local, national and international partnerships

Actions	Timescale	Responsible Officer/Institution	Update Colour	Progress Update
3.1 Commission an independent review of HSC infrastructure currently supported through the HSC R&D Fund to ensure it continues to be fit for purpose				
3.1.1 Identify independent review Panel, organise review process and report	By April 2017	Gail Johnston/ All		A Change Manager was appointed in May 2018, who is progressing some of the national changes associated with the approvals process. An options appraisal has been completed and report with recommendations shared with Directors of R&D, before full consultation to proceed.
3.1.2 Undertake relevant re-structuring of HSC R&D infrastructure in response to review recommendations	By April 2018	All		Interim arrangements for delivery of research approvals in process as above, some elements implemented, including e-submission of all Intergrated Research Application System (IRAS) forms, effecting simultaneous submission for ethics and R&D processes.
3.1.3 Monitor delivery of infrastructure on targets and objectives	Ongoing from April 2018	All		A draft implementation plan has been developed informed by results from phase 1 and 2 of infrastructure review.
3.2 Work with the other UK Health Departments to ensure research governance systems that facilitate UK-wide working within an effective governance environment				
3.2.1 Monitor HSC R&D permissions metrics – work towards time for approval to be at least equivalent to that in England	By Sept 2016	Ian Young/Janice Bailie		Local metrics made publicly available on HSC R&D Divison website - timelines acceptable but not yet possible to compare directly with national figures as not yet consistent for any of the 4 nations; UK-wide metrics discussions initiated September 2017; timing outwith R&D Division control.
3.3 Support identified areas of research strength by pursuing the creation of funding streams for new elements of research infrastructure such as Biomedical Research Unit(s) (BRUs)				
3.3.1 Consider opportunities for partnership investment in the development of Biomedical Research Unit(s) and other new elements of research infrastructure which are judged to be internationally competitive through peer review	Ongoing	All		Biomedical Research Unit discussions on hold dependent on political situation. Identifying new opportunities for investment e.g. Strength in Places fund, City Deals.

3.4 Support implementation of key national initiatives, including the 100,000 Genomes Project and the Precision Medicine Catapult (PMC)				
3.4.1 Participate in strategic and operational management groups for 100,000 Genomes Project, working with relevant partners towards the mainstreaming of genomic medicine	From Oct 2015	Ian Young/Julie McCarroll		100K Genomes Project underway; PHA part of project steering group (Chair Ian Young as Chief Scientific Advisor); involved in facilitative role in operational matters as needed. Project Steerign Group currently considering proposals for transition of the project to the care pathway.
3.5 Build on existing partnerships and form new relationships with key partners on the island of Ireland to maximise the benefits of cross-border working				
3.5.1 Develop at least one new collaborative funding initiative in Ireland with the Health Research Board or other key stakeholders in RoI (eg Science Foundation Ireland)	By Sept 2016	All		CHITIN INTERREGVA project partners; two co-funded posts in All-Ireland Institute of Hospice & Palliative Care; new Centre for Evidence Synthesis; Wellcome-Irish Clinical Academic Training (ICAT) Programme and CONVINCE Stroke Trial.

OBJECTIVE 4.

To increase the emphasis on research relevant to the priorities of the local population

Actions	Timescale	Responsible Officer/Institution	Update Colour	Progress Update
4.1 Ensure service users and the public are appropriately and effectively involved throughout all HSC research processes				
4.1.1 Ensure Personal and Public Involvement in all funding schemes and monitor through reporting processes	Ongoing	Gail Johnston		HSC R&D Division Public Involvement Enhancing Research (PIER) group involvement in monitoring PPI in annual and final reports to be implemented with reports shared across group. Initial analysis of data collected via ResearchFish has been analysed to inform future progress. This is also helping to inform a closed question set for future responses.
4.1.2 Provide annual training programme for R&D PPI representatives, researchers and service users	Ongoing	Gail Johnston		Annual PIER training programme continues. Building Research Partnerships workshop held x 2 per year for researchers and service users.
4.1.3 Share learning from PPI activity with UK and others	Ongoing	Gail Johnston		HSC R&D Division represented on 2 inter-governmental working groups and 1 international best practice groups convened by NIHR. A poster based on work with NI Cancer Research Consumer Forum (NICRCF) will be presented at International Impact Conference in November 2018.
4.1.4 Lead and participate in initiatives to encourage participation in research such as the 'It's OK to Ask' campaign, and 'Join Dementia Research'	Ongoing	Gail Johnston		NIHR leaflet for this year's I am research campaign was adapted for local use and disseminated on International Clinical Trials day to align with NHS at 70 campaign. Public awareness raising continues with the on-going photo caption campaign.
4.2 Commission relevant research informed by robust priority-setting exercises				
4.2.1 Review and refine research priority-setting process, identify and carry out up to one process every two years in line with strategic needs	By Sept 2016	All		Discussions on-going with social work colleagues and TinyLife; National Cancer Research Initiative James Lind Alliance Priority setting exercise on Living with and Beyond Cancer; part of National Stakeholders Advisory Group (previously HTA PRAMG).
4.2.2 Allocate or secure partnership funding for up to one commissioned research call every two years	By Sept 2017	Janice Bailie/Ian Young		Group convened to discuss possible needs-led call around prescription drug abuse. Research questions identified, and partner funding being sought.

4.3 Facilitate and maximise the use of health and other data routinely collected by the public sector for the benefit of Northern Ireland service users and the public				
4.3.1 Participate in the Honest Broker Governance Board and Working Groups	Ongoing	Nicola Armstrong		Active participation in both groups.
4.3.2 Ensure appropriate governance and management of the NI Administrative Data Research Centre through appropriate representation at strategic management level	Ongoing	Ian Young/Nicola Armstrong		Part of strategic and working groups.
4.4 Monitor and report the outputs and impacts of research supported by the HSC R&D Fund, ensuring it aligns with relevant policy drivers and draws in additional funding for research led by Northern Ireland researchers				
4.4.1 Conduct data collection, analysis and reports through ResearchFish and participation in quinquennial UK Health Research analyses	Ongoing	Sorcha Finnegan/Nicola Armstrong		Planning for next ResearchFish data collection in 2019; working with UK-wide stakeholders towards next UK Health Research Analysis; infographic based on ResearchFish outputs under development to demonstrate outputs and impact of R&D funding. Contribution to the PPI Question Set analysis and evaluation subgroup.
4.4.2 Report to DoH on the return on NETSCC investment	Bi-annually	Julie McCarroll/Janice Bailie		Report to be prepared.

OBJECTIVE 5.

To disseminate research findings in such a way as to promote understanding and knowledge, support and best practice, stimulate further research and celebrate achievement

Actions	Timescale	Responsible Officer/Institution	Update Colour (RAG)	Progress Update
5.1 Support effective dissemination of research findings and use mechanisms of knowledge exchange to drive the adoption of evidence-informed practice and policy				
5.1.1 Provide funding for workshops and conferences	Annually	All		Open scheme depending on budget availability
5.1.2 Provide funding for Cochrane Fellowships	Annually	Gail Johnston		Award for new CBES model incorporating Cochrane training has been made to an all Ireland consortium and will commence in December 2018. Contract has been agreed with HRB.
5.1.3 Provide funding for Knowledge Exchange awards	Bi-ennially	Clive Wolsley		Reviewing scheme
5.1.4 Require all funded proposals to include a dissemination strategy	Ongoing	All		Letters of offer now include requirement for dissemination strategy in Project Management Plan; also looking at introducing Pathway to Impact Plan
5.2 Develop a communication strategy and media profile for HSC R&D Division to ensure relevant messages about HSC-funded research are effectively disseminated				
5.2.1 Develop and publish communication strategy in partnership with relevant stakeholders	By June 2016	Gail Johnston		Strategy still in draft, awaiting outcome of infrastructure review and input from new comms staff
5.2.2 Introduce consistent branding of HSC R&D activity and recognition of outputs, to promote public awareness of the value of undertaking and participating in HSC research	By Sept 2016	All		Continue to signpost researchers to the acknowledgement guidance on HSC R&D Division website and ensure awardees registered; influenced by outcome of infrastructure review. New leaflets have been developed to increase awareness of HSC R&D and NICRN.
5.2.3 Develop relationships with relevant media partners and schedule media reports on HSC R&D-funded research	By April 2017	All		New CHITIN comms support has taken forward in the context of CHITIN project. Launch of CHITIN project with video on new web pages: http://www.research.hscni.net/chitin and some radio interviews scheduled.
5.2.4 Regular R&D updates in various formats for HSC community to raise awareness and highlight positive stories	Ongoing	All		Some excellent work on case studies has been done but limited capacity; new comms support taking forward via CHITIN programme.

Annex 2 Budget

Key to Workstrands:

RRG	Recognised Research Groups
EAT	Education and Training
CDV	Career Development
COM	Commissioned Research
RES	Responsive Mode Research
DIS	Dissemination and Uptake
CFU	Core Funded Units
SPI	Special Initiatives
STL	Strategic Links
SUS	Support for UK Schemes

HSC R&D Division Year end position 2017-18

CAPITAL POSITION

DoH Allocation	11,892,500
Income (Capital Receipts)	418,138
TOTAL CAPITAL BUDGET	12,310,638
TOTAL HSC R&D CAPITAL SPEND	12,310,069
Difference	-569

Breakdown of HSC R&D Capital Spend

Total CRL	7,017,808
EITP	119,126
Other Bodies (inc universities)	5,173,135
TOTAL Spend on Outturn	**12,310,069**

REVENUE POSITION

DoH Allocation NIHR NETSCC	3,530,000
TOTAL HSC R&D REVENUE SPEND	3,530,000
Difference	-

OVERALL POSITION

Revenue & Capital allocation	15,840,638
Total HSC R&D Spend	15,840,069
Difference	569

HSC Research Development Division Final Accounts 2017-18

Annex A

	CRL	General Ledger Month 1-11	General Ledger Month 12	Creditors	Accruals	Debtors	Outturn 2017-18
	£	£	£	£	£	£	£
Income							418,138
Recurrent Allocation							15,422,500
Total Income							**15,840,638**
Recognised Research Groups	-	-2,223	0	0	0	0	-2,223
Education & Training	148,247	521,725	267,564	313	13,515	-	951,364
Career Development	-	153,905	96,868				250,773
Commissioned Research	108,862	209,361	444,739	-	35,162	-1,821	796,304
Responsive Mode Research	-	279,042	50,218				329,260
Dissemination & Uptake	166,026	147,869	188,769	-	2,500	-	505,165
Special Initiatives	2,024,680	318,301	200,737	-	-	-	2,543,718
Strategic Links	4,569,993	3,927,000	1,916,571	-	493	-1,183	10,412,874
Support for UK Schemes	-	36,005	16,830				52,835
Total Operations	**7,017,808**	**5,590,986**	**3,182,296**	**313**	**51,670**	**- 3,004**	**15,840,069**
K9PH05 - Mgt & Admin Accruals					18,000		
Total Accruals					**69,670**		
Underspend							569

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Income		
NICTN Nurses (CRUK)	117,715	
DH England	50,423	
US Ireland Income (MRC)	175,000	
EITP (AP)	75,000	
Total Income	**418,138**	
Additional allocation		
NETSCC Contribution (DHSSPS)	3,530,000	
Total additional allocation	**3,530,000**	
Allocation	**11,892,500**	
Total allocation	15,422,500	
GL Adjustments	-	
Allocation plus income		**15,840,638**

Annex 3: 2017-18 Projects

File Reference	*Research Title*	*Project Start Date*	*Project End Date*	*Total Value of Project (£)*	*Host Institution*
CDV/5250/16	Clinical Doctoral Training Programme and Travel costs	01.02.18	31.01.22	421,500	Queen's University Belfast
COM/5282/16	Opportunity-Led Research Proposal: STAMPP in Northern Ireland	01.06.17	30.08.18	134,378	Queen's University Belfast
COM/5310/16	Opportunity Led: Movember/GAP4: INTERVAL - MCRPC: Intense Exercise for survival with Metastatic Castrate-Resistant Prostate Cancer: a multi-cebtre, randomised, controlled, phase III study	01.09.17	31.08.22	185,460	Queen's University Belfast
COM/5352/17	Opportunity Led: Cessation of smoking in pregnancy (CPIT)	01.10.17	30.09.20	200,000	Queen's University Belfast
COM/5410/17	Understanding social norms and social network effects in school based smoking prevention	01.02.18	30.01.19	40,000	Queen's University Belfast
COM/5412/17	Developing and evaluating an educational intervention for the management of constipation: a feasibility intervention study (DEMCon)	01.02.18	31.01.19	12,000	Ulster University
DIS/5297/16	Psychological interventions for depression in adults bereaved through life-limiting conditions	14.11.17	13.11.19	50,885	Queen's University Belfast
EAT/5313/16	2017 Doctoral Fellowship: Petechiae in Children (PIC) Study - Defining a clinical decision rule for the management of non-blanching rashes in children including the role of rapid point of care testing for procalcitonin and neisseria meningitides DNA	02.08.17	04.08.20	217,635	Queen's University Belfast
EAT/5319/16	2017 Doctoral Fellowship: The use of early pregnancy HbA1c in predicting excessive foetal growth in women at risk of glucose intolerance	02.08.17	01.08.20	193,651	Queen's University Belfast
EAT/5336/17	2017 GPARTS Award: Use of Dermoscopy and Training in Dermoscopy in Primary Care	02.08.17	06.08.19	78,635	Queen's University Belfast
EAT/5337/17	2017 GPARTS Award: Using Activity Theory to explore Project ECHO	02.08.17	06.08.19	82,079	Queen's University Belfast
SPI/5309/16	Medicines Optimisation Innovation Centre	01.07.17	30.06.22	378,658	Northern Health and Social Care Trust
STL/5175/15	US-Ireland R&D Partnership - Systems Modeling of Tumor Heterogeneity and Therapy Response in Colorectal Cancer	01.12.17	30.11.22	725,501	Queen's University Belfast
STL/5179/15	Enabling Research Award: Establishing a clinical phenotype for cachexia in chronic kidney disease.	22.05.17	21.05.19	39,970	Queen's University Belfast
STL/5266/16	Enabling Research Award: Optimal nutrition for prevention of hypertension in pregnancy using a personalised approach (OptiPREG)	01.04.17	31.03.18	40,000	Ulster University
STL/5268/16	Enabling Research Award: Development and piloting of a prehabilitation behavioural change and physical activity intervention for fibromyalgia syndrome	08.01.18	07.07.19	38,826	Ulster University
STL/5269/16	Enabling Research Award: A feasibility study of a pedometer based intervention for patients with Myeloproliferative neoplasms	01.09.17	28.02.19	36,116	Queen's University Belfast
STL/5270/16	Enabling Research Award: Adaptation of the 'Transition to Retirement' intervention: Improving the health and wellbeing of older people with intellectual disabilities through community participation	16.10.17	31.03.18	27,610	Ulster University
STL/5274/16	Enabling Research Award: A feasibility study of the Attention Control Training (ACT) intervention amongst very preterm (VP) infants	12.03.18	11.03.19	39,928	Queen's University Belfast
STL/5275/16	Enabling Research Award: Promoting engaged communication between health care professionals and patients with obesity	01.09.17	28.02.18	38,067	Ulster University
STL/5333/17	All Ireland Institute of Hospice & Palliative Care (AIIHPC) Research Network	01.04.17	31.03.20	92,089	Health Research Board
STL/5334/17	HSC Statistical & Methodological Research Support Service	01.04.17	31.03.22	125,000	Queen's University Belfast
STL/5481/18	Health Data Research UK (HDR UK)	01.04.18	31.03.23	250,000	Medical Research Council
STL/5482/18	UK Prevention Research Partnership (UKPRP)			250,000	Medical Research Council

HSC Public Health Agency

board paper

Public Consultation on the Northern Ireland Diabetic Eye Screening Programme

date	20 December 2018	**item**	11	**reference**	PHA/05/12/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For approval

Summary

The PHA is responsible for the commissioning and quality assurance of the Diabetic Eye Screening Programme (NIDESP) in Northern Ireland. The Programme aims to detect diabetic eye disease at an early stage and therefore prevent sight loss in those with diabetes (aged 12 years and over). A key national standard is that screening should be undertaken once every 12 months. However, the programme has come under growing pressure and is finding it increasingly difficult to meet this standard, with a substantial proportion of those eligible for screening are tested at an interval in excess of 12 months. This is, in part, due to the increasing prevalence of diabetes but also issues attributable to the current service model.

Without reform of the existing service model, there is a risk that programme performance will deteriorate further. A review of potential future options for delivery of the service has been undertaken by the NIDESP Modernisation Project Team and Project Board.

Current Model

NIDESP is currently delivered via a mixed fixed site and mobile model. In the Western HSCT area the programme is provided by community optometrists at six designated HSC sites (fixed model). Elsewhere in Northern Ireland, the service model is based upon a mobile service provided by screener/graders employed by the Belfast HSCT, who visit individual GP practices to undertake screening. In effect, there are therefore over 300 potential screening locations. The multi-site mobile service model is unlikely to be sustainable in the long term.

Proposed future model

Following an extensive process including a regional stakeholder workshop, longlisting, options appraisal, 12 week pre consultation, and shortlisting exercise, the NIDESP Modernisation Project Board is keen to understand the views of key

stakeholders concerning the proposal to change the service delivery model of the NIDESP. Three potential models have been proposed in a consultation report.

Option 2a Regional fixed location service provided at HSC locations e.g. local hospitals, community hospitals health and wellbeing centres, and suitable GP practices. Provided in at least 22 sites across Northern Ireland (including the current 6 sites in WHSCT)
Option 2b Regional fixed location service with sites, in selected GP practices, identified in collaboration with Local Medical Committees. Provided in at least 22 sites across Northern Ireland (including the current 6 sites in WHSCT)
Option 5 High-street optometry based service with digital photography and visual acuity provided at approximately 60 community optometrists' premises throughout Northern Ireland. The current fixed site model in WHSCT would cease

The preferred option for the programme is Option 2a. This model, which ranked highest in the option appraisal scoring process, would address the drivers for change. A fixed site model implemented across N.Ireland would improve the likelihood of meeting the core objectives of the screening programme, in particular, the need to undertake screening within a 12 month screening interval.

Consultation

It is anticipated that a public consultation including a series of engagement events/public meetings will take place over 12 weeks from January 2019. Key stakeholders include

- Service users, their families/carers and the wider public
- Screening staff
- Community Optometrists
- HSC Trusts and local commissioning groups
- Primary Care
- Community and voluntary charitable organisations (Diabetes UK and Royal National Institute for the Blind)

Documentation to be published will include:

- Consultation document, appendices and accompanying questionnaire
- Indicative costs paper
- Equality Impact Assessment
- Rural Needs Impact Assessment

- Options Appraisal

Equality Impact Assessment

Attached.

Recommendation

The Board is asked to **APPROVE** the consultation document on the Northern Ireland Diabetic Eye Screening Programme.

HSC Public Health Agency

board paper

Information Governance Strategy incorporating the Information Governance Framework 2018-2022

date 20 December 2018 **item** 12 **reference** PHA/06/12/18

presented by Mr Edmond McClean, Interim Deputy Chief Executive

action required For approval

Summary

The PHA Information Governance Strategy has been reviewed and updated in line with the new General Data Protection Regulation (GDPR) and the Data Protection Act (DPA) 2018. The Strategy was approved by the PHA Information Governance Steering Group on 25 September 2018.

The following amendments have been made:-

- Reference to DHSSPS amended to DOH throughout.
- Section 2.0 (page 3) – scope updated; Senior Information Risk Officer (SIRO) referred to.
- Section 5.0 (page 5) – Data Protection Act (DPA) 2018, General Data Protection Regulations (GDPR) and Information Management Assurance Standard referred to; Controls Assurance Standard removed.
- Section 6.2 (page 7) – reference to Data Protection Officer (DPO) added.
- Section 6.2 (page 8) – Senior Operations Manager (Delivery) referred to.
- Section 6.7 (page 9) – Information Management Assurance Checklist referred to.
- Section 9.0 (page 10) – equality statement updated.
- Appendix 1 (pages 12, 13) – GDPR referred to.
- Appendix 1 (page 14) – Information Commissioner's Office (ICO) link updated.
- Appendix 1 (page 15) – Good Management, Good Records (GMGR) link updated.
- Appendix 2 (page 17) – Information Governance Steering Group (IGSG) Membership List amended.
- Appendix 3 (page 19, 20) – DPO, Senior Operations Manager (Delivery) and Connect referred to; policy list updated.

Equality Impact Assessment

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were

no negative impacts on any grouping. This policy will therefore not be subject to an Equality Impact Assessment.

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

Recommendation

The PHA board is asked to **APPROVE** the Information Governance Strategy.

Information Governance Strategy

Incorporating the

Information Governance Framework

2018 - 2022

Version	**2.0**
Version 1 approved by	**IGSG - 13/01/15** **GAC - 19/2/15** **PHA board - 19/03/15**
Review Date	**August 2022**

Table of Contents

1.0 Introduction

The Public Health Agency (PHA) is heavily dependent on the information and records it holds. It recognizes that its records and information must be appropriately managed, handled and protected to serve its business needs and acts openly, while at the same time ensuring that personal and sensitive data is protected. It must demonstrate compliance with all relevant legislation[1] as well as standards set by the Department of Health (DOH).

In recognising its public accountability, the PHA will make every effort to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability and structures provide a robust governance framework for information management. The framework will ensure that information is accessible while also ensuring the confidentiality of personal data (client and staff), and corporately sensitive information, through adopting robust security measures to protect that information from accidental loss, accidental disclosure or deliberate unauthorised disclosure.

2.0 Scope of Information Governance

The Information Governance Strategy sets out the framework to ensure that the PHA meets its obligations in respect of information governance; it will also be the vehicle for improving information governance in the PHA. The Strategy covers the 4 year period from 2018 to August 2022 and will be supported by annual Action Plans setting out how it will be implemented. The action plans will be monitored by the Information Governance Steering Group[2], chaired by the Senior Information Risk Owner (Director of Operations) or deputy. Reports will be submitted to the PHA Governance and Audit Committee on a regular basis.

[1] *Appendix 1 Legislation and Guidance*
[2] *Appendix 2 PHA Information Governance Steering Group (IGSG) Terms of Reference (TOR)*

3.0 Purpose

The general purpose of the Information Governance Strategy is to provide clear direction to the PHA in delivering the requirements of information governance and associated policies. The strategy will assist in establishing and maintaining a robust and effective Information Governance Framework[3] that allows PHA to fully discharge its strategic duties, ensuring that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant codes of practice.

The Information Governance Strategy cannot be seen in isolation as information is central to all areas of work in the PHA. Information Governance is also a key element of corporate and clinical governance. This strategy is, therefore, closely linked with other strategies to ensure integration with all aspects of the Agency's business activities.

4.0 Benefits

Benefits of a robust and fully implemented Information Governance strategy can be summarised as follows:

- Ensures that decisions are based on readily accessible, high quality information;
- Ensures that information is held and handled securely, and that personal and sensitive information is safeguarded;
- Reduces risks associated with poor and unregulated systems and processes;
- Reduces data losses and the negative impact such losses have on corporate image;
- Ensures that legal and other DOH requirements are met;
- Supports corporate governance and underpins the assurance framework and corporate risk register;
- Ensures that information and information assets are managed in a coherent manner reducing duplication of effort and increasing availability.

[3] *Appendix 3 PHA Information Governance Framework*

5.0 Objectives

The key objectives of this strategy are to ensure the effective management of Information Governance by:

- Complying with all legislation - Data Protection Act (DPA) 2018 and EU General Data Protection Regulation (GDPR) 2018;
- Complying with DOH recommendations and best practice;
- Establishing, implementing and maintaining policies for the effective management of information;
- Recognising the need for an appropriate balance between openness and confidentiality in the management and use of information;
- Providing assurance that all information risks are identified, managed and, where possible, mitigated;
- Minimising the risk of breaches and inappropriate use of personal data;
- Ensuring that the public are effectively informed and know how to access their information and exercise their right of choice;
- Ensuring that all PHA staff are sufficiently trained and enabled to follow and promote best practice in regard to the management of information;
- Achieving and improving compliance with the regional Information Management Assurance Standard.

6.0 Information Governance Framework

The Information Governance Framework[4] is intended to pull together the various strands of policy and activity covered by 'Information Governance'. This is important as there are several policies[5] which impinge on Information Governance. It will enable PHA to set out and promote a culture of good practice around the processing of information and use of information systems throughout the organisation. That is, to ensure that information is handled to ethical and quality standards in a secure and confidential manner. The PHA requires all employees and Non-Executive Board Members (Members) to comply with policies, procedures and guidelines which are in place to implement this framework.

[4] *Appendix 3 PHA Information Governance Framework*
[5] *Appendix 4 PHA Information Governance Policies*

6.1 Information Governance Policy Statement

A clear policy framework is critical to ensuring a coherent approach to Information Governance across all PHA functions and locations. This strategy is supported by a suite of information governance policies[6]. All Information Governance related policies will be reviewed and updated as necessary on a regular basis.

6.2 Roles, Responsibilities and Reporting Arrangements

- **Chief Executive –** The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DOH directives.

- **PHA board –** The PHA board is responsible for ensuring appropriate systems are in place to ensure effective Information Governance across all of the services for which PHA is responsible. An Information Governance annual report will be presented to the PHA Board at least annually.

- **PHA Governance and Audit Committee (GAC) –** The GAC has responsibility for providing the PHA Board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress on the implementation of this Strategy on an annual basis.

- **PHA Agency Management Team -** AMT will receive updates on Information Governance matters on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The Personal Data Guardian (PDG) will also report to AMT on matters relating to patient identifiable information where appropriate.

- **Information Governance Steering Group (IGSG)** - Consisting of representatives from all PHA Directorates the primary function of the IGSG will be to lead the development and implementation of the Information Governance Framework across the organisation. The Group will be chaired by the SIRO and will meet on a quarterly basis.

[6] *Appendix 4 PHA Information Governance Policies*

- **Senior Information Risk Owner (SIRO) -** The SIRO (Director of Operations) is the focus for the management of information risk at board level. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process.

- **The Personal Data Guardian (PDG)** - The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the 'conscience' of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners (IAOs) where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.

- **Information Asset Owners (IAO's)** - The IAO's primary role will be to manage and address risks associated with the information assets within their function and to provide assurance to the SIRO on the management of those assets. Each PHA Assistant Director is the IAO for their function and also sits on the Information Governance Steering Group.

- **Deputy IAO's –** The Deputy IAO has responsibility delegated from the IAO to support them in the management of the information assets within their function.

- **Assistant Director Planning and Operational Services (AD P&Ops)** - The A/D P&Ops has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda. The Assistant Director is also the Data Protection Officer.

- **Data Protection Officer (DPO)** - The DPO has responsibility for monitoring and ensuring compliance with this policy, GDPR and other, relevant data protection legislation, acting as the contact point with the Information Commissioners' Office, training staff, advising on data protection impact assessments (DPIAs) and conducting internal audits as necessary across the organisation.

- **Senior Operations Manager (Delivery) -** The Senior Operations Manager (Delivery) is operationally responsible for the day to day implementation of all aspects of Information Governance.

- **Records Management Working Group (RMWG)** – Chaired by the Senior Operations Manager (Delivery), this Group will address the Records Management function within the PHA, developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will, in turn, cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.

- **All Staff** - All staff have a responsibility to comply with this strategy and all information governance policies and procedures.

6.3 Leadership

Effective leadership is essential to create and nurture a corporate culture conducive to effective Information Governance. A culture of corporate and individual ownership and responsibility is essential when looking to effective compliance with all statutes and codes of practice.

6.4 Supporting Staff

Clear accountability arrangements will ensure that staff are accountable for the work that they do and the information assets they process and manage. There should be an open and supportive environment in which errors, mistakes or concerns can be raised immediately, with management and corrective measures implemented swiftly and processes changed accordingly.

This culture will further mitigate risks associated with the handling and processing of sensitive information, both corporate and personal in nature.

6.5 Communication

It is important to ensure that staff are aware of Information Governance issues, with updates provided as required. Effective and timely communication of Information Governance matters to all PHA staff is essential if the PHA is to meet the aims and objectives associated with this strategy.

As well as ensuring compliance with this strategy and associated policies and procedures, the wider Information Governance agenda within the Public Sector is a fast moving and quickly developing one. It will often be necessary to communicate new directives or initiatives to staff. Communication to staff must be handled with care to ensure that the message is not lost amongst a wealth of material.

6.6 Training

It is also essential to ensure that all staff understand and have the knowledge and skills necessary to put the Information Governance Strategy and associated policies and procedures into operational use. The PHA will ensure that appropriate training is developed and available to up-skill existing staff and for new staff entering the service. This will include the use of the e-learning platform. All staff are required to undertake mandatory Information Governance training. The responsibility for ensuring that staff participate in these programmes rests with the relevant IAO and line managers, with support from the Information Governance Steering Group. Members should also avail of relevant information governance awareness and training.

6.7 Implementation and Performance Monitoring

An Information Governance Action Plan will be prepared annually. This will also provide a mechanism by which progress can be monitored. The following reporting arrangements will apply:

- Quarterly progress reports on the Information Governance Action plan will be agreed through the Information Governance Steering Group;
- Quarterly reports on progress against the Information Governance action plan will be brought to the Governance and Audit Committee;
- Reports to the Agency Management Team as required;
- An annual report will be brought to the PHA board.

Performance will also be monitored annually through the Information Management Assurance Checklist (IMAC). The IMAC includes an assurance, signed by the Chief Executive, to be returned to the DoH. An assurance on the management of information risk is also provided through the Mid-Year Assurance Statement and the Governance Statement

7.0 Summary and Conclusion

Information Governance is a vital and integral part of the PHA's overall Governance programme. The implementation of the Information Governance Strategy and its subsequent policies, procedures, protocols and guidelines will ensure that the PHA has the appropriate framework in place to meet legislative and organisational requirements and it will drive the development and implementation of improvement plans year on year.

8.0 Equality and Human Rights Considerations

8.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This policy will therefore not be subject to an Equality Impact Assessment.

8.2 This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

8.3 This policy is included in the PHA's Register of Equality Screening Documentation.

9.0 Review of Policy

9.1 The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

9.2 This policy will be reviewed by December 2022, or earlier if relevant guidance is issued.

Appendix 1

Legalisation and Guidance

There are a number of pieces of legislation and guidance which have a significant impact on records management and information governance. A selection of these is listed below.

Public Records Act (Northern Ireland) 1923

All HSC records ·are public records under the terms of the Public Records Act (Northern Ireland) 1923. Chief Executives and senior managers of all Health and Social Care organisations are personally accountable for records management within their organisation. They have a duty to make arrangements for the safekeeping and correct disposal (under the Disposal of Documents Order (Northern Ireland) 1925) of those records under the overall supervision of the Deputy Keeper of Public Records whose responsibility includes permanent preservation.

Data Protection Act 2018 and EU General Data Protection Regulations (GDPR) 2018

The Data Protection Act (DPA) 2018 places a statutory responsibility on the PHA to protect the personal data, which it holds. In relation to records management this means that the PHA must implement measures to:

- Maintain the accuracy of records held;
- Protect the security of personal data;
- Control access to the personal data; and
- Make arrangements for secure disposal once the record is no longer required.

The EU General Data Protection Legislation (GDPR) gives individuals additional rights about how their personal data is used by organisations and applies to all UK and EU organisations that control and or process personal data. It is based on the premise that individuals ('data subjects') should have knowledge of what data is held about them, how it is held, how long for and how it is used.

Confidentiality and Data Protection Act

All HSC bodies and those carrying out functions on behalf of the HSC have a common law duty of confidence to patients/clients and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the HSC who records, handles, stores or otherwise comes across personal information has a personal common law duty of confidence to patients/ clients and to his/her employer. The duty of confidence continues even after the death of the patient/client, or after an employee or contractor has left the HSC.

The Data Protection Act (DPA) 2018, includes electronic and manual records. The Act, which applies to the whole of the United Kingdom, sets out requirements for the "processing" of personal data (i.e. meaning obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data).

A "data subject", namely, a living individual who is the subject of personal data, has a right of access to their personal data and, in certain circumstances, can have their data corrected or even deleted.

The GDPR sets out 7 key principles which lie at the heart of data protection, and must be followed by all data controllers and processors:

Personal data shall be:

"(1) processed lawfully, fairly and in a transparent manner in relation to individuals ('**lawfulness, fairness and transparency'**);

(2) collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be considered to be incompatible with the initial purposes ('**purpose limitation'**);

(3) adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed ('**data minimisation'**);

(4) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ('**accuracy**');

(5) kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the GDPR in order to safeguard the rights and freedoms of individuals ('**storage limitation'**);

(6) processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures ('**integrity and confidentiality'**)."

Additionally,

"(7) The controller shall be responsible for, and be able to demonstrate compliance with, principles (1) – (6) above ('**accountability**')."

The Information Commissioner, who has responsibility for the enforcement of this legislation, provides guidance on the application of data protection legislation.

Further information on the Data Protection Act 2018 and GDPR is available from the Information Commissioner's Website (https://ico.org.uk/).

Freedom of Information Act 2000

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (with some exemptions). The Act makes provision for the Lord Chancellor to issue guidance on how records systems should be maintained in order to facilitate public access to information held. In particular S46 (1) states:

"The Lord Chancellor shall issue, and may from time to time revise, a *code* of *practice providing guidance to relevant authorities* as *to the practice which it would, in his opinion, be desirable for them to follow in connection with the keeping, management and destruction* of *their records".*

The Act was brought fully into force on 1 January 2005. The HSC has two main responsibilities under the Act. The HSC has to maintain its 'Publication Scheme' (effectively a guide to the information which is publicly available) and to deal with individual requests for information.

Anyone can make a request for information, although the request must be made in writing (including email). An Environmental Information Regulation (EIR) request, may, however, be verbal. The request must contain details of name and address of the applicant and the information sought.

The HSC is obliged to produce information recorded both before and after the Act was passed. It is vital that records are held within a structured Records Management system in order to meet the HSC obligations under the Act. It should be noted that the responsibility for responding to information access requests lies with the authority that holds the information. The Act is intended to change the way in which public authorities do business, making them more accountable. The foreword to the Code of Practice on Records Management published by the Lord Chancellor under Section 46 of the Act states:

> *"Any freedom* of *information legislation is only as good* as *the quality of the records to which it provides* access".

This highlights the importance of good Records Management in the PHA.

Further information on the Freedom of Information Act is available from: https://ico.org.uk/.

Good Management, Good Records

These guidelines offer an overview of the key issues, solutions and best practice for HSC teams to follow when preparing a records management strategy. It represents the joint view of DOH and the Public Records Office (PRONI) view of how records should be administered and sets the standard required of the HSC.

The Disposal Schedule has been approved by PRONI. It sets out minimum retention periods for HSC records of all types, except for GP medical records, and indicates which records are most likely to be appropriate for permanent preservation. It also explains the reasoning behind the determination of minimum retention periods, including legal requirements where relevant.

The Schedule does not replace the requirement for PHA to develop and agree their own disposal schedules with PRONI, however, it should form the basis for such schedules.

https://www.health-ni.gov.uk/articles/gmgr-records-management

The PHA has in place a systematic and planned approach to the management of **all** records which ensures that, from the moment a record is created until its ultimate disposal, the PHA can control both the quality and quantity of information it generates; can maintain that information in a manner that effectively services its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

Information Management Assurance Checklist (IMAC)
The PHA will complete the Information Management Assurance Checklist (IMAC) and submit to the Department of Health annually.

Legislation, in particular the Data Protection Act 2018, GDPR, Freedom of Information Act 2000, the Environmental Information Regulations (EIR) 2004 and Access to Health Records (Northern Ireland) Order 1993 impact significantly on the record keeping arrangements in public authorities.

ISO 15489: International Standard on Information and Documentation Records Management

The International Standard on managing recorded information, initially based on an earlier Australian standard, was adopted by ISO in 2001. The Standard acts as an enabler towards accreditation and renewal of IS0 9001 and other quality standards. It also provides a specification against which record management practices may themselves be audited.

Appendix 2

PHA INFORMATION GOVERNANCE STEERING GROUP (IGSG)

(Reviewed March 2017)

Terms of Reference

Purpose

The purpose of the PHA Information Governance Steering Group is to lead the development and implementation of the Information Governance Framework across the organisation. It will report to the PHA Agency Management Team (AMT) and Governance and Audit Committee (GAC) providing assurance for the PHA board on the effectiveness of Information Governance systems and practices within the PHA.

Remit

- Ensure that information governance systems are in place across the PHA, in line with the PHA Information Governance Framework and relevant Standards and legislation.
- Develop Strategic solutions to Common Information Governance problems.
- Provide a forum to raise awareness and share experience and best practice in Information Governance.
- Provide direction to the work of Records Management Working Group.
- Act as Directorate point of contact for Information Governance related issues such as Freedom of Information, Information Security and Data Protection etc.
- Agree and monitor the information governance action plan, ensuring actions are taken forward.

Working Arrangements

- The Group will meet on a quarterly basis.
- The Group may from time to time call upon advisors e.g. ICT Security Manager.
- The group will be chaired by the SIRO, or his nominated deputy.
- The Senior Operations Manager (Delivery) will provide the secretariat for the meeting.
- The agenda and papers will be issued no less than 3 working days in advance of the meeting. Minutes of meeting will be produced and agreed with the chair prior to issue. Draft minutes will be circulated as

soon as possible after the meeting, and brought to the next meeting for approval.
- The Group will review its TOR every three years, or sooner if required.

Reporting Arrangements

The Group will report to:
- AMT
- PHA Governance and Audit Committee

Membership List

SIRO
Director of Operations – Chair (Mr Ed McClean)

PDG
Director of Public Health (Dr Carolyn Harper)

Governance & Audit Committee Representative
Non-Executive Director (Mr Joseph Stewart)

IAO'S
Please note if an IAO cannot attend, their Deputy IAO, or IAA should attend to represent them.

Assistant Director of Health Protection (Dr Gerry Waldron)

Assistant Director HSC R&D (Dr Janice Bailie)

Assistant Director of Allied Health Professional & Public involvement (Ms Michelle Tennyson)

Assistant Director of Health & Social Wellbeing Improvement (Ms Mary Black)

Assistant Director, Service Development (Dr Brid Farrell)

Assistant Director, Screening (Dr Adrian Mairs)

Programme Director, Centre for Connected Health and Social Care (Mr Eddie Ritson)

Assistant Director of Planning & Operational Services
(Ms Rosemary Taylor)

Assistant Director of Communication & Knowledge Management
(Mr Stephen Wilson)

Assistant Director, Children and Young People Public Health Nursing
(Vacant post)

Assistant Director Nursing (Ms Briege Quinn)

Head of Safety, Quality and Patient Experience (Vacant post)

Assistant Director Nursing (Ms Siobhan McIntyre)

Assistant Director Nursing (Ms Eleanor Ross)

Nurse Consultant, E-Health (Ms Claire Buchner)

SBNI Professional Lead (Ms Margaret Burke)

Governance:

Senior Operations Manager (Delivery) (Ms Karen Braithwaite)

Appendix 3 – PHA Information Governance Framework

INFORMATION GOVERNANCE FRAMEWORK		
Heading	**Requirement**	**PHA Structure**
Senior Roles	• IG Lead	• The Chief Executive as Accountable Officer has overall accountability for IG and is required to provide assurance that all risks to the PHA are effectively managed.
	• Senior Information Risk Owner (SIRO)	• SIRO for the PHA is Director of Operations & Chair of the Information Governance Steering Group.
	• Personal Data Guardian (PDG)	• PDG for the PHA is Director of Public Health / Medical Director. • IAOs for the PHA are Assistant Directors within each Directorate.
	• Data Protection Officer (DPO)	• DPO is the Assistant Director of Planning and Operational Services (P&Ops)
Policy	• Over-arching IG Policy • Data Protection Act, GDPR and Data Protection and Confidentiality Policy • Organisation Security Policy • Information Lifecycle Management (Records Management) Policy • Corporate Governance Policy	• Corporate Governance Framework • Information Governance Strategy Incorporating the Information Governance Framework • Information Governance Policy Statement • Data Protection/Confidentiality Policy • ICT Security Policy • Secure Mobile ICT Equipment • Use of the Internet Policy • Use of Electronic Mail Policy • Use of ICT Equipment Policy • Records Management Policy • Freedom of Information Procedures • Access to Information Policy • Data Breach Incident Response Policy
Key Governance Bodies	IG Board/Forum/Steering Group	• PHA Governance & Audit Committee • PHA Information Governance Steering Group • PHA Records Management Working Group
Resources	Details of key staff roles and dedicated budgets	• Assistant Director of Planning & Operational Services • Senior Operations Manager (Delivery) • Governance Administrative Officer (NB none of the above 3 posts are full time Information Governance)

Governance Framework	Details of how responsibility and accountability for IG is cascaded through the organisation.	• All staff contracts include IG clauses • Staff responsibility set out in IG Strategy • Information Asset Register • Notices on Intranet Site (Connect)
Training & Guidance	• Staff Code of Conduct • Training for all staff • Organisation Security Policy • Training for specialist IG roles	• Code of Conduct • IG e-Learning Training mandatory for all staff • PHA ICT Security Policy • SIRO, PDG and IAO's training completed
Incident Management	Documented procedures and staff awareness	• PHA Risk Management Strategy and Policy • Information Sharing Protocol • Guidance for reporting IG related incidents • Data Breach Incident Response Policy (including reporting mechanisms to GAC) • IG Leaflet • Incident and Near Miss Reporting Policy and Procedure

Extract from IM CAS:

The Information Governance Framework may be described in a single one page standalone document or incorporated within an over-arching IG Policy or an IG Strategy and should provide a summary/overview of how an organisation is addressing the IG agenda

Appendix 4 – PHA Information Governance Policies & Guidance

Information Governance: What you need to know leaflet

Information Governance Strategy 2018 - 2022

Records Management Policy

Records Management - Good Management Good Records

Protocol for the handling of requests for information made under the Freedom of Information Act/Data Protection Act

Freedom of Information internal review procedures

Data Breach Incident Response Policy

PHA ICT Security Policy

Procedure for provisioning new starts with access to IT services

Guidance on transferring hard copy personal information

Code of Practice on protecting the confidentiality of service user information

Data Protection/Confidentiality Policy

Access to Information Policy

Data Access Agreement

Data Protection Impact Assessment Policy and Guidance

Guidance on the use of Digital Recorders

Application for mobile phone

Application form for provision of an encrypted USB memory stick

Safestick/SafeXS usage

Application form to enable access to removable media

Application form for secure remote access

HSC Secure Email Service User Guide

Use of Email Policy

Sophos Antivirus Software for Home use

Corporate Social Media Policy and Guidelines

Use of PHA ICT Equipment

Securing Mobile ICT Equipment

HSC Public Health Agency

minutes

Governance and Audit Committee Meeting

Thursday 4 October 2018 at 10.00am

Fifth Floor Meeting Room, 12-22 Linenhall Street, Belfast

Present

Mr Leslie Drew	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Ed McClean	-	Interim Deputy Chief Executive / Director of Operations
Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Paul Cummings	-	Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB
Mr David Charles	-	Internal Audit, BSO
Mr Denver Lynn	-	Northern Ireland Audit Office
Mr Robert Graham	-	Secretariat

Apologies

Ms Deepa Mann-Kler	-	Non-Executive Director
Mrs Catherine McKeown	-	Internal Audit, BSO

		Action
44/18	**Item 1 – Welcome and Apologies**	
44/18.1	Mr Drew welcomed everyone to the meeting.	
44/18.2	Apologies were noted from Ms Deepa Mann-Kler.	
45/18	**Item 2 - Declaration of Interests**	
45/18.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	
46/18	**Item 3 – Minutes of previous meeting held on 6 June 2018**	
46/18.1	The minutes of the previous meeting, held on 6 June 2018 were approved as an accurate record of that meeting, subject to two amendments: firstly, the word “which” changed to “when” in the second line of paragraph 34/18.6. The second amendment was to add the sentence, “He suggested that some of this terminology needed to be more clearly explained	

	to readers within the body of the policy." after paragraph 38/18.7.
47/18	**Item 4 – Matters Arising**
	33/18.3 Internal Audit Review of Shared Services
47/18.1	In response to a question from Mr Drew, Mr Charles advised that the follow up audit of Payroll Shared Services is ongoing, and that the report has not yet been finalised. He added that the level of assurance remained limited, but that he would bring an update to the next meeting.
48/18	**Item 5 – Chair's Business**
48/18.1	The Chair advised that he had no Chair's Business.
49/18	**Item 6 – Quality Improvement Plan Report [GAC/32/10/18]**
49/18.1	Ms Mary McElroy attended the meeting for this item. She explained to members that Trusts are required to submit Quality Improvement Plans, based on locally identified quality improvement initiatives. She said that the findings of this report identify PHA's safety and quality priorities, and that this report covers a 2-year period. Ms McElroy gave an overview of the four key areas covered in the report.
49/18.2	Ms McElroy said that in terms of pressure ulcers, there had been an increase in the Northern Trust, but that PHA has been working with the Trust towards improving their performance. She added that the two wards which showed the highest number of pressure ulcers were both high dependency wards.
49/18.3	Ms McElroy advised that there has been a consistent decrease in the reduction of harm from falls. In terms of compliance with NEWS (National Early Warning Scores), she said that regional compliance has been 90%, and that the focus of this work will move to outcomes and escalation issues.
49/18.4	Ms McElroy said that there has been an increase in the instances of the use of mixed gender accommodation on wards, and that a thematic review will now be carried out which will look to ensure that all Trusts are reporting consistently. She highlighted that there are issues with the estate in some Trusts, particularly the Northern and Southern Trusts.
49/18.5	Mr Cummings explained that there are a number of conflicting

	issues that need to be borne in mind. He said that 12 hours waiting targets in A&E may be breached because it is not possible to place a patient in a single sex ward so there is a knock on effect.
49/18.6	Mr Stewart noted that there are a number of competing priorities, and that these need to be weighted. His main concern was that Trusts are carrying out their own audits (in terms of compliance with the NEWS bundle) and therefore it is difficult to get consistent data. He asked that if Trusts are implementing their own audit process, who is checking that process? Ms McElroy said that the auditing does appear to be consistent, but that the Southern Trust has decided to use external validation. She noted that the results from the Southern Trust have shown a decrease in compliance, but this was partly down to the system the Trust was using, and that PHA has been working with the Trust.
49/18.7	Mr Cummings said that each organisation will have its own Board, so it is not for the PHA to determine what types of management audits should be undertaken. He acknowledged that there are multiple types of audit and therefore it is difficult to get consistency. Mr Charles agreed and added that Internal Audit had carried out an audit of falls management which had identified inconsistencies. He added that an audit of incident management is currently being done.
49/18.8	Mr Clayton asked if there is any monitoring of the independent sector. Ms McElroy said that monitoring has commenced for those services that are commissioned by the HSC, and that there is a commissioning services group.
49/18.9	Mr Clayton asked about the root cause for the number of pressure ulcers in the Northern Trust. Ms McElroy said that leadership may have been an issue and that there has been a change of management within the two wards that were of concern.
49/18.10	Members noted the Quality Improvement Plan report which will be brought to the PHA Board on 18 October.
50/18	**Item 7 – Internal Audit** *Progress Report [GAC/33/10/18]*
50/18.1	Mr Charles advised that to date almost two-thirds of the planned audit work for the year had been carried out. He said that he was presenting four audit reports, and began with the audit of Personal and Public Involvement (PPI),

50/18.2	Mr Charles said that a satisfactory level of assurance was being given to the audit of PPI. In terms of the key findings, he noted that there is not a clear system of measuring the outcomes and impact of PPI. He noted that the Northern Ireland Ambulance Service has not yet completed a self-assessment, and that PHA is largely reliant on the information provided by Trusts, which has not been verified, but acknowledged that there are service user panels. He added that the current PPI Strategy is dated March 2012, and although it was reviewed in 2016, there is no date for its next planned review. He finished by saying that management had accepted all of the recommendations in the report.	
50/18.3	Mr Clayton said that the point about outcomes measurement was well made. He noted that there is a change with the concept of co-production, and that individuals within PPI may not have experience of this. He asked when the self-assessment from NIAS would be received. It was agreed that this would be followed up with Mrs Mary Hinds.	Mrs Hinds
50/18.4	Mr Charles moved onto the Report of the audit of PHA's vaccination programmes. He advised that PHA has 17 different programmes and has a role that includes commissioning, surveillance and quality assurance. He said that a satisfactory level of assurance was being given. In relation to the key findings, he noted that there is no policy in place for the management of vaccination programmes, and no terms of reference for the oversight group of the influenza vaccination programme. He also commented on the timeliness of reporting on the programme. Mr Charles said that all recommendations had been accepted by management.	
50/18.5	Mr Charles noted that the next audit report related to an assignment which was carried out across all HSC organisations about travel and compliance with the Permanent Secretary's letter of September 2016. He explained to members that the HSC has a contract with Selective Travel for the function of booking travel. He advised that a satisfactory level of assurance was being given to PHA, and there were no significant findings.	
50/18.6	Mr Charles went through some of the key areas from the audit. He said that while PHA is using Selective Travel, there is no assurance that it is getting value for money. He added that the current form does not allow staff to indicate that the request is in compliance with the Permanent Secretary's instruction, and he suggested that a regional form should be developed. He also noted that some of the trips are part-funded by other bodies e.g. EU programmes. He suggested	

	that there should be a specific code in the general ledger for travel as it can be difficult to identify any travel which has been paid for by staff and claimed back through HRPTS, rather than being booked through the regional contract.
50/18.7	Mr Charles said that in terms of findings which are specific to PHA, there is a need to ensure clear visibility if more than one individual is attending a specific event. He said that an audit of trips inside the UK and Ireland showed two cases of overnight accommodation in Dublin, and that this should only happen in appropriate cases. He added that management had accepted all the recommendations in the report.
50/18.8	Mr Stewart asked how much audit time was used on this particular assignment, as he felt that time could have been more appropriately used on follow up of other audits. He also sought assurance that any third party funding was not from private sector organisations. Mr Cummings confirmed that that this was the case. Mr Charles advised that up to 13 days had been used for this audit, and as a result, it would be necessary to defer an audit of information governance into the first quarter of next year, but this would require Committee approval.
50/18.9	Mr Cummings expressed his concern that this audit could result in staff not taking the opportunity to attend events which will give them learning that can be fed back into the HSC system, which will make for a poorer health service. Mr Drew agreed saying that staff could be put off requesting travel.
50/18.10	Mr Clayton asked about the implications of deferring the information governance audit. Miss Taylor said that PHA is required to provide an assurance to the Department regarding information governance and this will happen before the year end, therefore members will receive an assurance in this area in advance of the audit being carried out.
50/18.11	Mr Drew noted that PHA has its audit plan, which the Committee has agreed, but that there was no option in that this audit had to be carried out. Mr Cummings suggested that this should be raised as an issue at the next meeting of the Committee Chairs. Mr Charles said that the time spent on the audit in HSC Trusts was significantly greater.
50/18.12	Mr McClean said that one of the challenges for the HSC is to have a simple and effective guidance for staff, and a consistent template. Mr Charles advised that Internal Audit will be preparing an overarching report and that one of the recommendations will be the need for regional consistency.

50/18.13	Mr Charles asked if the Committee was content to defer the audit of information governance. Mr Drew said that he was content, on the basis that another form of assurance will be received. All members agreed with this decision.
50/18.14	Mr Charles moved on to the audit of risk management, and said that a satisfactory level of assurance was being given, with no significant issues. He said that there were two Priority 3 recommendations which had been accepted by management.
50/18.15	The Committee noted the progress report.
	Mid-Year Follow Up [GAC/34/10/18]
50/18.16	Mr Charles presented the mid-year follow up review of outstanding audit recommendations and advised that 70% of these were now fully implemented, with the remainder partially implemented. He highlighted the work ongoing in terms of developing a procurement plan, and four recommendations in the area of research and development.
50/18.17	Mr Drew asked about procurement. Mr McClean noted that a paper had been brought to the last PHA Board meeting which outlined how PHA wants to review its approach to social care procurement and seeking the nomination of a Non-Executive Director to participate in this work. He said that procurement is a big issue for PHA given the potential for legal challenge.
50/18.18	Mr Clayton referred to the recommendations relating to the management of contracts with the community and voluntary sector. Mr McClean said that there are two issues for PHA, verifying and verification. He said that contracts are monitored, KPIs are agreed and performance is measured on a quarterly basis with sign-off by a manager in PHA before any payment is made. However, with regard to verification, he conceded that there is a capacity issue, but that PHA needs to be clear that it is getting the outcomes it requires for both the service user, and the HSC as a whole. He said that the issue of how PHA can do more for the end user had been discussed with Internal Audit. Mr Charles said that this is a regional issue, not unique to PHA, and that although there are processes in place which determine if payments should be made, this is reliant on providers giving accurate information.
50/18.19	Members noted the mid-year follow up report.
	Internal Audit Mid-Year Assurance Statement [GAC/35/10/18]
50/18.20	Mr Charles explained that the Internal Audit Mid-Year

	Assurance Statement summarises all of the previous discussion, and that there are no significant issues.	
50/18.21	In terms of the follow up audits on Shared Services, Mr Charles advised that the fieldwork has just been completed on the audit of Payroll, and that an update on this will be brought to the next meeting.	
50/18.22	Members noted the Internal Audit Mid-year Assurance Statement.	
51/18	**Item 8 – Finance**	
	Fraud Liaison Officer Update Report [GAC/36/10/18]	
51/18.1	Mr Cummings advised that the PHA has provided data for the latest National Fraud Initiative, but that the report from the previous NFI exercise did not contain any benefits for the HSC. Mr Lynn added that that rate evasion and pension fraud were two of the biggest issues emanating from the Report relating to other bodies participating in the NFI exercise.	
51/18.2	Mr Cummings reported that there were no new cases of fraud, but that there remained one ongoing case. He gave members an overview of the alleged fraud, but assured members that the suspected fraud was an issue for DAERA, and no PHA and that the HSC, through the Counter Fraud Unit had done all that was required. He said that the main issue for PHA relates to service continuity.	
51/18.3	Mr Drew said that the PHA Chair was concerned about this particular case and it was agreed that an update would be provided to him.	Mr Cummings
51/18.4	Members noted the Fraud Liaison Officer update.	
	Revenue Business Case Test Drilling 2017/18 [GAC/37/10/18]	
51/18.5	Miss Taylor informed members that a business case test drilling exercise is carried out annually across all HSC organisations and a report prepared, and that this year it was asked that the findings were shared with Governance and Audit Committee Chairs. She said that three PHA business cases were reviewed and two were rated as “green” and one as “amber”, with the key issue being the failure to include an approver signature or a correct project commencement date.	
51/18.6	Mr Cummings advised that 500 business cases are required	

	for the Transformation work and that to date, approximately 75 relate to PHA.
51/18.7	Members noted the update on revenue business case test drilling.
52/18	**Item 9 – Corporate Governance**
	Corporate Risk Register (as at 30 June 2018) [GAC/38/10/18]
52/18.1	Mr McClean advised that the Corporate Risk Register had been updated with four new risks added. He explained that in some instances these new risks were a reconsideration of previous risks. He went through several of the risks in turn giving an update on each.
52/18.2	Mr McClean said that risk 26, relating to market testing of contracts, is an area that presents a challenge to both HSC Trusts, and the PHA, and that PHA will continue to work with the Directorate of Legal Services and PALS in this area.
52/18.3	With regard to risk 38 on re-organisation, Mr McClean explained that this risk had been reduced as it is has been indicated that HSCB will close in March 2020, and that the PHA will remain. He said that there are a number of design teams, and that PHA will contribute to that work, and in particular the design group looking at the social care directorate as that function will transfer to PHA.
52/18.4	In terms of cyber security (risk 39), Miss Taylor advised that regional work is ongoing - an outline business case has been agreed and BSO has appointed a Programme Manager and a gap analysis has been conducted regionally.
52/18.5	For risk 41, Mr McClean advised that a paper regarding campaigns was submitted to the Department of Health in early July. He said that this outlined which campaigns could be developed if funding were to become available. He anticipated that PHA would know shortly if this will be possible.
52/18.6	Mr McClean moved on to risk 43 which relates to the Lifeline service. He said that members will recall that the service has moved to the Belfast Trust. To date, he said that the transition has gone well, but that PHA is still working with BHSCT to confirm the running costs of the service. He added that, despite this, it is possible that this issue would remain on the Corporate Risk Register until at least the end of the 18 months transition period.

52/18.7	Mr Clayton asking if the reduction of the rating of the risk relating to re-organisation from “high” to “medium” was as a result of investment. Mr McClean explained that for a time, there was a possibility that PHA may have also closed, but now there was more certainly regarding the future of PHA. He added that it was important that PHA uses this opportunity to look at its functions and to continue to evolve.
52/18.8	Mr Clayton asked about Transformation monies and if there is a contingency. He said that he attended a meeting recently at which there was an assurance that there was a contingency and that there would be a further meeting in 4/6 weeks to look at this. Mr Cummings said that to date, across HSC only a small proportion of the proposed IPTs have been authorised and only 100 of the 1200 staff regionally required have been appointed. He said that any contingency options being explored should not include options that require the appointment of staff, therefore initiatives such as campaigns, capital, ICT should be considered.
52/18.9	Mr Stewart asking if the risk rating for cyber security is high across all HSC organisations. Miss Taylor said that this was the case.
52/18.10	Members noted the Corporate Risk Register.
	Assurance Framework (as at September 2018) [GAC/39/10/18]
52/18.11	Mr McClean presented the Assurance Framework and said that it had been updated to ensure that it continued to be relevant with current PHA processes and departmental requirements. He added that this document informs what reports are brought to the PHA Board meetings.
52/18.12	Members approved the Assurance Framework.
	Controls Assurance Standards Replacement Assurances from 1 April 2018 [GAC/40/10/18]
52/18.13	Miss Taylor reminded members that there had been discussion at previous meetings about the abolition of Controls Assurance Standards. In terms of replacement assurances, she said that there is a mix of different arrangements, some based on existing practice, but some of which are still under review. She advised that the Department will still receive an overarching assurance through the Governance Statement.
52/18.14	Mr Drew asked about the establishment of a procurement

	board. Miss Taylor advised that there is a procurement board in place in PHA, but that the recent circular has set out wider parameters for its remit, so PHA is amending the terms of reference and membership of its board. Mr McClean added that PHA's procurement board is headed by the Chief Executive as Accounting Officer and that the Director of Operations, Director of Public Health, Director of Nursing and Assistant Director of Health and Wellbeing Improvement are also members. He said that the remit of the Board is to develop and monitor the PHA Procurement Plan.
52/18.15	Members noted the update on the Controls Assurance Standards replacement process.
	Information Governance Update [GAC/41/10/18]
52/18.16	Miss Taylor provided members with an update on the Information Governance Action Plan, which had been prepared following the Information Governance Steering Group last week.
52/18.17	Miss Taylor said that there remained some challenges for PHA in terms of getting all staff to complete their mandatory e-learning training. She added that SIRO and IAO training had not yet taken place, but she was hoping to organise in-house refresher training.
52/18.18	Miss Taylor advised that a workshop will take place to assist staff with the process of reviewing Information Asset Registers. She said that PHA's corporate privacy notice is now on the PHA website, but that function-specific notices may also be required and would be developed as necessary.
52/18.19	Miss Taylor advised that PHA is working with the Directorate of Legal Services regarding contracts as these may require to be updated in line with GDPR. Mr Clayton asked for further information on this. Miss Taylor explained that PHA must ensure that clauses in contracts comply with Data Protection regulations, and that in cases where PHA is the data controller data flows need to be more explicit. She added that on occasions the organisation may be the data controller, hence clarity is needed.
52/18.20	Mr Stewart commented that he had attended the Information Governance Steering Group meeting last week, and that the attendance at the meeting was poor with certain parts of the organisation, particularly Nursing/AHP directorate, not represented. He said that this was an issue for the senior management team to look at. He expressed concern that there was little improvement in the rate of staff compliance

	with the mandatory information governance training, and again highlighted issues with Nursing/AHP directorate. He added that there was an issue in terms of accurate information about staff numbers. Miss Taylor said that the Leadership Centre e-learning system is separate to HRPTS and therefore her staff have to manually match two separate lists.
52/18.21	Members noted the update on the information governance action plan.
53/18	**Item 10 – External Auditor's Report to those Charged with Governance [GAC/42/10/18]**
53/18.1	Mr Lynn advised that members had seen the draft Report to those Charged with Governance at the last meeting, and that this Report had not changed. He reiterated that the accounts had received an unqualified audit opinion and that no reports on the accounts were required. He added that there were no priority one recommendations.
53/18.2	Members noted the Report to those Charged with Governance.
54/18	**Item 11 – PHA Mid-Year Assurance Statement [GAC/43/10/18]**
54/18.1	Mr McClean presented the PHA Mid-Year Assurance Statement and drew members' attention to the internal control divergences, highlighting issues such as the campaigns budget, EU exit and neurology.
54/18.2	Members approved the Mid-Year Assurance Statement which will be brought to the PHA Board meeting on 18 October.
55/18	**Item 12 – SBNI Declaration of Assurance [GAC/44/10/18]**
55/18.1	Mr McClean introduced the Declaration of Assurance, but said that they key issue for PHA is the proposed revision of the Memorandum of Understanding between PHA, SBNI and the Department of Health. He suggested that it would be a useful area for further exploration at a Board workshop.
55/18.2	Mr Clayton expressed a concern of a potential conflict of interest if PHA takes on the social care functions currently carried out by HSCB, and has a corporate host role regarding SBNI. Mr Cummings said that there needs to be clarity about roles and functions.
55/18.3	Members noted the SBNI Declaration of Assurance.

53/18	**Item 13 – Any Other Business** There was no other business.
54/18	**Item 14 – Date and Time of Next Meeting** *Wednesday 12 December 2018 at 10am* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.* Signed by Chair: **Leslie Drew** Date: 12 December 2018