HSC Public Health Agency

agenda

Title of Meeting	129th Meeting of the Public Health Agency Board
Date	21 January 2021 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 17 December 2020		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 1.55	Finance Report	**PHA/01/01/21**	Director of Finance
8 2.05	Update on COVID-19		Chief Executive

items for noting

9 2.35	Update on PPI	**PHA/02/01/21**	Mr Morton
10 2.55	HIV Surveillance Report for Northern Ireland 2020	**PHA/03/01/21**	Dr Bergin
11 3.15	Level of Funding for Health Research in Northern Ireland		Chair
12 3.25	Allocation of funds by the PHA • External organisations • Health and Social Care Trusts		Chair

closing items

13 Any Other Business
3.40

14 Details of next meeting:

Thursday 18 February 2021 at 1.30pm

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

minutes

Title of Meeting	128th Meeting of the Public Health Agency Board
Date	17 December 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

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

In Attendance

Mr Lindsay Stead	-	Interim Director of Finance, HSCB *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Dr Aideen Keaney	-	Director of Quality Improvement
Ms Marie Roulston	-	Director of Social Care and Children, HSCB

124/20	**Item 1 – Welcome and Apologies**
124/20.1	The Chair welcomed everyone to the meeting. Apologies were noted from Dr Aideen Keaney and Ms Marie Roulston.
124/20.2	The Chair welcomed Dr Stephen Bergin to his first meeting as Interim Director of Public Health and Mr Stephen Wilson to his first meeting as Interim Director of Operations. He also welcomed Mr Lindsay Stead to his first meeting as Interim Director of Finance in HSCB.
125/20	**Item 2 – Declaration of Interests**
125/20.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. Ms Mann-Kler declared an interest with regard to Item

10 as she is a Commissioner with the Equality Commission.

125/20.2 The Chair passed on his congratulations to three of the Non-Executive Directors who have been appointed to additional new roles. He advised that Ms Mann-Kler is now a lay member of the General Medical Council (GMC); that Mr Stewart is now the Chair of the Audit Committee of the Livestock Marketing Commission and that Mr Clayton is now an Executive Member of the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO).

126/20 Item 3 – Minutes of previous meeting held on 19 November 2020

126/20.1 The minutes of the Board meeting held on 19 November 2020 were **APPROVED** as an accurate record of that meeting

127/20 Item 4 – Matters Arising

120/20.2 Self-Isolation Support Pathways

127/20.1 The Chair said that he was pleased to see that the leaflets giving advice to people who have to self-isolate have now been translated into 15 different languages.

128/20 Item 5 – Chair's Business

128/20.1 The Chair said that following a meeting with Non-Executive Directors, it was agreed that further discussion was required with the Interim Chief Executive regarding PHA's approach to appointing a Director of Operations and how the finance function will be handled. The Interim Chief Executive explained that Ms Sharon Gallagher will be attending the Board meeting in January in her capacity as Deputy Secretary in the Department of Health and Chief Executive of the Health and Social Care Board. She added that the issue of the finance function has been flagged up with Ms Gallagher. The Chair suggested that a paper could be prepared in advance for members. The Interim Chief Executive advised that Ms Gallagher will be accompanied by Ms Martina Moore who is the Director of Transformation. She added that she had raised this matter at an Oversight Board meeting yesterday.

128/20.2 Mr Stewart said that it is the view of the Board that the appropriate support needs to be in place for the Accounting Officer, and that Ms Gallagher should have an overview of the issues in advance of any discussion. Professor Rooney suggested that the Interim Chief Executive may have her own views on the matter. The Interim Chief Executive said that it will ultimately be up to the Department of Health to determine if PHA should have its own Director of Finance, but she assured members that there will be a function in place until March 2022 and that it may be prudent to hear what Ms Gallagher has to say when she attends the January meeting and then form a view on any next steps. She said that this is a delicate matter and that there is a view that

	all ALBs (including the PHA) should have a central finance function provided by BSO. Mr Stewart recalled that at a recent PHA staff briefing, the Permanent Secretary had indicated that in his view, the PHA should have its own finance function.
128/20.3	The Chair advised that he had shared with members an e-mail exchange he had had with Mr Wilson where he outlined his views on a PHA Communications Strategy and said that it was not to be viewed as a criticism of the Agency's current approach. He noted that the PHA's campaigns budget this year is considerably underspent and he was conscious that PHA had previously lost this funding, but had successfully secured its reinstatement after much negotiation. He acknowledged that while there is pressure to deliver certain campaigns, there is a public perception that other areas are being neglected and he asked whether it would be possible to reuse campaigns that have already been filmed as this would give a message that PHA is not solely focused on COVID-19. He cited the first campaign on stroke and the antimicrobial resistance campaign.
128/20.4	Mr Wilson said that he did not perceive any criticism from the communication, but he pointed out that the inescapable fact that there is a small campaigns team in PHA which is focused on COVID-19 related work. He advised that a business case has been submitted to the Department for Health to up-staff the communications function in PHA, but a determination on that has not yet been made. However, he informed members that he has received an assurance that PHA's campaigns budget will not be affected as there is recognition of the important role that PHA plays and there is support for the business cases that have been submitted. He said that PHA needs to grow its marketing and digital work as this is essential to an integrated communications team.
128/20.5	Mr Wilson advised that PHA is looking at launching additional campaigns in-year in the areas of obesity and stroke, but he explained that the stroke campaign may not be available in its present form as it has run its course and contracts for it need to be renegotiated.
128/20.6	Professor Rooney asked about funding to upgrade the PHA website. Mr Wilson said that a separate business case has been submitted regarding the website, but this is capital funding. Professor Rooney noted that PHA should be putting out positive messages on areas such as screening, where those programmes are now up and running again. Mr Wilson agreed, but said that PHA does not currently have marketing expertise in-house. Professor Rooney queried if there was anything that the Board could do to expedite the approval of the business cases. The Chair noted that the funding for campaigns is available and asked if PHA could run a campaign of its choice, but Mr Wilson pointed out that PHA's campaigns programme has to be approved by the Department.
128/20.7	Ms Mann-Kler asked if there are any behavioural psychologists

	employed within the communications team. She also asked about the extent to which PHA's communications strategy looks at all segments of society, given COVID-19 has impacted on some more than others. She noted that a point had been raised with Dr Ruth Hussey as part of her review of PHA about the need for the PHA communications unit to be beefed up. Mr Wilson responded saying that although there are no behavioural psychologists in the team, PHA does have access to support from a range of sources and that some of the staff in the Health Intelligence team have a psychology background. He added that this has been included in the business case submitted to the Department.
128/20.8	The Chair asked why PHA does not advertise on the BBC as it has previously undertaken public service announcements. Mr Wilson explained that the placement of such announcements is managed by the BBC centrally in London.
128/20.9	The Chair asked members to reflect on the e-mail he had shared with them regarding contact tracing. He said that understanding behaviours is key to getting people to comply with the 10-day self-isolation period. He added that PHA's role should not end once it has achieved the contact. He acknowledged that there is now a link with AdviceNI, but the number of people availing of this service is quite small. He said that when it comes to self-isolating, people are not only concerned about money, but also about being able to cope and getting their children to school as well as trying to understand the messaging coming out from politicians. He felt that how the messaging is delivered is important and that there may be more of an impact if it was delivered by those working on the front line. Mr Wilson pointed out that this has been done previously and while there was a novelty factor, he was not sure if it would have the same impact. The Chair noted that in this week's coverage about acute care issues, clinicians have been used to raise public awareness.
128/20.10	The Chair noted the proposed rollout of the COVID-19 vaccination programme and asked if the vaccines are currently flowing. The Interim Chief Executive said that she is due to attend a meeting of the Vaccination Programme Board later this afternoon and that there will be no statements made regarding the flow of the vaccine in Northern Ireland until it is being rolled out in all 5 Trust areas. She said that GPs have not yet received any doses. The Chair advised members that there is a programme on BBC Radio 4 discussing how the vaccine can be rolled out across the world and it also deals with the messaging being promulgated by anti-vaxxers (available on BBC Sounds on Radio 4, Monday 14 December at 11.30am). He reported that the Health Minister as well as the First Minister and the Deputy First Minister visited the contact tracing centre on 11 December.
129/20	**Item 6 – Chief Executive's Business**
129/20.1	The Interim Chief Executive presented her Report which she said

covered a range of areas and was important in terms of keeping members up to date. She noted that as members had received the Report in advance, she would deal with any queries they had.

129/20.2 Mr Clayton asked about the messaging around the vaccination programme and dispelling concerns being raised by anti-vaxxers. He noted in particular that women who are either pregnant or planning to become pregnant have concerns about whether the vaccine causes fertility issues. He suggested that any misinformation in the public domain should be corrected and a reassurance given. Mr Wilson said that this particular issue has been discussed and will be included in any "questions and answers" documents, and that messaging will be put out through social media channels with female staff presenting the message.

129/20.3 Mr Clayton noted that PHA has begun to do enhanced contact tracing, but given the concerns about the rising number of cases he asked whether this can be maintained and if the digital self-trace will offer some mitigation. The Interim Chief Executive advised that there is a meeting held three times a week to look at contact tracing. She said that it is anticipated that the number of positive cases will start to increase from 26 December so there may be a move away from enhanced contact tracing as these calls can take up to 45 minutes. She advised that more staff have been recruited, but this will mean that other work will be paused. She explained that each morning a risk assessment will be carried out based on the numbers that have come in overnight and a determination will be made if the enhanced contact tracing can be done. Furthermore, she said that the number of attempted calls made within 48 hours to contacts will be reduced from 5 to 3.

129/20.4 Ms Mann-Kler thanked the Interim Chief Executive for the Report and asked about the modelling for the third wave. The Interim Chief Executive said that the number of positive cases could rise to 3,000 per day. When asked by Ms Mann-Kler if this was from 27th December, the Interim Chief Executive explained that the people who will test positive around 27th December are already likely to be infected so the numbers will increase from the end of December into early January. She went on to say that the modelling will determine how many staff are needed. She explained that anyone who receives a positive test result will get an e-mail and can use the Digital Self Trace on which Ms Jennifer Lamont will give a presentation later in the meeting.

129/20.5 Ms Mann-Kler asked if there is a tipping point where contact tracing becomes obsolete. The Interim Chief Executive said that the view is that contact tracing should continue. She added that people will know that they have tested positive and that the people they live with will know that they have tested positive so they should know to do the right thing, but PHA cannot make people stay at home.

129/20.6 Alderman Porter said that if PHA finds that its system is under pressure it should move quickly and proactively to get messages out and consider doing briefings with politicians to keep them updated. The Interim Chief Executive said that she and Mr Wilson will be on duty over the next 3 weeks and will monitor the situation. Ms Mann-Kler expressed concern about the wellbeing of the Interim Chief Executive and staff given there has been no let up over the last number of months. The Interim Chief Executive said she is mindful that staff need to take a break. Ms Mann-Kler suggested that there should be a communication to all staff from the Chair expressing the Board's appreciation and support for their efforts. The Chair agreed that it is important that staff get that message and also that people work together and help each other to ensure that those who need a break can get one over the holiday period **(Action – Chair)**.

130/20 Item 7 – Finance Report (PHA/01/12/20)

130/20.1 Mr Stead thanked the Chair for his welcome and said that he would be covering the role of Director of Finance in HSCB for the months of December and January before Mr Colin Bradley takes on the role in February and March. He advised that Ms Tracey McCaig will be the new permanent Director of Finance and that she has previously worked in HSCB.

130/20.2 Moving to the Finance Report, Mr Stead said that PHA's financial position is similar to that of the previous month with a year to date underspend of approximately £500k, largely due to an inability to spend against core business activities, a position that many other HSC organisations are facing, as well as an underspend in relation to the management and administration budget. In relation to the full year position, he projected that PHA will achieve a break even position as its underspend should be retracted by the Department of Health as part of the January monitoring round. He said that the position will continue to be monitored.

130/20.3 Mr Stead said that PHA has a £4m budget in relation to Transformation funding and he was not expecting any material slippage in that area. He said that PHA will work closely with Trusts to ensure that there are no risks associated with this spend. In terms of the COVID-19 budget, he advised that PHA has submitted a revised bid to the Department for up to £10.3m of funding and there is a separate paper outlining how this was arrived at. He pointed out that if any staff working on COVID-19 are redeployed to the vaccination programme, there is a separate funding stream so those costs will have to be amended but the finance staff will work with PHA to identify these costs. For Transformation and COVID-19 expenditure, he also pointed out that there is a recurrent element going into 2021/22 so work is progressing to assess the scale of that, but he advised that he is not yet aware of what the health budget will be for next year.

130/20.4 Mr Stewart sought clarity on whether the £10.3m bid for funding will be

approved by the Department. Mr Stead confirmed his expectation that it will be approved and added that PHA is in contact with the Department on an almost daily basis refining the assumptions. The Chair sought clarity regarding the set up costs vis-à-vis the ongoing costs of contact tracing. Mr Stead said that these figures are based on an original bid which has subsequently been revised and he drew members' attention to the supporting paper. The Chair asked what the monthly costs are of the contact tracing service and Mr Stead advised that these work out at approximately £400k per month. The Chair said that based on his calculations Northern Ireland should be receiving £343m of the UK budget for testing and contact tracing, of which £86m might be awarded for the contact tracing element. Professor Rooney thanked Mr Stead for the separate information on COVID-19 funding and asked if there a way of capturing the total financial resource being dedicated to COVID-19. The Interim Chief Executive said that this can be looked at.

130/20.5 Mr Stewart noted that there is an expectation that some of the COVID-19 funding will be recurrent and he asked if there is a timeline for getting an understanding of what this recurrent element will look like. Mr Stead advised that work is ongoing with PHA colleagues to project what next year's costs will be. He explained that the £10m bid is a recent revision so the full year effect is still being worked through. He advised that PHA has to work with the Department in terms of its planning for 2021/22 and then submit a bid for what resource it feels is required.

130/20.6 Members noted the Finance Report.

131/20 Item 8 – Update on COVID-19

Ms Jennifer Lamont joined the meeting for this item.

131/20.1 The Interim Chief Executive said that there had already been discussion in the meeting relating to contact tracing and testing, but she noted that the Board had expressed an interest at the last meeting about hearing more on the Digital Self-Trace initiative. She advised that Ms Jennifer Lamont has been working with the PHA since April/May on the contact tracing work and has been linking with Kainos. She invited Ms Lamont to give members more detail about the Digital Self-Trace initiative.

131/20.2 Ms Lamont advised that she had been brought into the PHA to assist with the logistics of the contact tracing programme and that at the start of the pandemic there was a sense that the contact tracing would be carried out manually, and although this remains PHA's core approach, there is now a digital element, namely the Digital Self-Trace. She explained that when an individual receives a positive test result they will also receive two text messages, the first contains a code for the proximity app and the second is a code for the HSC COVID-19 website where they can then go and input their own contacts manually which then automatically sends out messages to those contacts. She added that the website will also ask for details of where the individual has been

and this information is fed into the central Dynamics system. She said the self-trace initiative launched on 9 October and there has consistently been an uptake of around 20%, but last week a public information campaign was launched and this has seen the uptake increase to around 30%. She said that leaflets have also been produced to market the self-tracing service in order to increase uptake.

131/20.3 The Chair asked that when an individual receives a message, does PHA receive any notification that the message has been delivered and that the individual will act on the advice to self-isolate. Ms Lamont said that while PHA will know how many messages have successfully been delivered, it does not know how many people are self-isolating. She noted that during the last period when the numbers of daily positive cases began to decrease, the performance of the contact tracing centre improved as there had been a period when the numbers increased dramatically that the centre had not been able to reach individuals. The Chair asked if there is information in the text message about self-isolation. Ms Lamont explained that as there is a limit to the number of characters in the text, it contains a link to a website that people can go to for advice.

131/20.4 Ms Mann-Kler asked if PHA is setting targets in terms of the Digital Self-Trace and how success will be measured. She asked if there is an insight or understanding in terms of the groups that are using the platform which may inform future campaigns, and she also asked how Northern Ireland is doing in this area compared to other parts of the UK. Ms Lamont advised that there are metadata which shows who is accessing the digital platform and PHA can also get information in terms of people who commence the self-trace process but do not complete it. She added that the platform was developed in conjunction with the Behavioural Science Group and is very intuitive. She said that PHA has not set any targets, but given the uptake was 20% prior to a campaign being launched, then a higher uptake would be a success. In terms of other jurisdictions, she said that it would be difficult to undertake a comparison as each country has adopted a slightly different approach and there would have to be caveats around culture and behaviours. She explained that in order to be effective PHA should be reaching 80% of index cases within 24 hours and 80% of their contacts within 48 hours, but is achieving a success rate of 95%. However, she added that it is very difficult to measure whether people are then complying with the instructions given. The Chair commended the achievement of reaching 95% of cases within 24 hours.

131/20.5 Mr Clayton asked how disaggregated the metadata are because he noted that there are some population groups that are more vulnerable to COVID-19. He queried whether PHA would know if these groups are using the platform, and he also asked about the usefulness of the platform in terms of identifying clusters. Ms Lamont said that PHA does not request data across each of the Section 75 categories. She said that there is information relating to age and postcode but it is only

	voluntary for individuals to disclose their ethnicity. She pointed out that postcodes may help identify trends in areas of deprivation. She explained that an EQIA is being completed but that PHA is able to monitor spread across a range of indicators. She said that the contact tracing centre is the first line of defence in terms of dealing with clusters.
131/20.6	Ms Lamont explained that within the Digital Self-Trace, the average number of contacts per index case is around 2 so if an individual indicates that they have 0 contacts or a high number of contacts, this is immediately flagged up. Mr Clayton asked why PHA is not looking at data across all of the Section 75 groups. Ms Lamont explained that PHA is holding data solely for the purpose of stopping the transmission of an infection, so there are issues in terms of what information can be asked for, but that there will be a meeting shortly with the Equality Commission to look at this. She said that PHA is conscious of the impact on different groups.
131/20.7	Dr Bergin suggested that Dr Peter Sheridan could attend a future PHA Board workshop to deliver a presentation similar to one he delivered last Friday for the First Minister, Deputy First Minister and Health Minister which showed how the business intelligence gathered from contact tracing had prevented up to 700 new cases in one area. He said that the definition of a cluster takes into consideration factors such as time, place and person. He pointed out that PHA does not solely rely on the contact tracing service and that there is also the Duty Room as well as an education cell and a care homes cell. He added that that there are epidemiologists looking at modelling and clusters, and there is now a Department-led nosocomial cell. The Chair agreed that it would be useful to invite Dr Sheridan to a future workshop.
131/20.8	Alderman Porter asked whether there are cases where an individual receive a negative test result, but then test positive shortly after, and if it is due to the test not being performed correctly. Dr Bergin advised that the test is a reliable test and that staff are trained to administer it and there are standard operating procedures in place. He suggested that there are individuals who continue to show positivity beyond their symptomatic period due to contagions in their system, and that although no test is 100% reliable, the test currently used is very reliable. Alderman Porter asked if an individual could have received an incorrect test result due to not being tested properly, but Dr Bergin said that he would not have this information to hand.
131/20.9	The Chair said that he wished to take this opportunity to thank Ms Lamont for attending the meeting and to the staff working in the contact tracing centre for their continuing dedication and enthusiasm to this work which is vital in combating the virus

132/20	**Item 9 – Update from Chair of Governance and Audit Committee (PHA/02/12/20)**
132/20.1	Mr Stewart said that the minutes of the meeting held on 1 October were available and that he had given an overview of those issues at a previous meeting. He added that these minutes show the efforts of Ms Mann-Kler and Mr Clayton in supporting the Committee.
132/20.2	Mr Stewart advised that the Committee met on 13 December and discussed a range of matters. He said that instead of a separate sub-Committee of the Board being established to deal with procurement, it was proposed that a Board member join the current Procurement Board. He reported that the Committee had discussed the need for correspondence to be sent to the Permanent Secretary around outlining concerns about the number of vacancies at senior level in the PHA.
132/20.3	Mr Stewart reported that there had been some criticism from Internal Audit following a risk management audit about the timeliness of the Corporate Risk Register being updated and brought to the Committee, but he felt that this was unwarranted given that the Interim Chief Executive had asked for a comprehensive overview of the Corporate Risk Register to be carried out.
132/20.4	Mr Stewart advised members that Mr Clayton will be taking over from him as the NED representative on the Information Governance Steering Group. He said that the Committee also discussed the issue of finance support to the PHA following the closure of HSCB, but this has been picked up earlier in the meeting.
132/20.5	Mr Stewart said that the Committee had felt it appropriate that there should be an Internal Audit carried out of the contact tracing service given the expenditure to date and the potential reputational risks.
132/20.6	The Chair thanked Mr Stewart and the other members for their work in supporting the Committee.
132/20.7	Members noted the update from the Chair of the Governance and Audit Committee.
133/20	**Item 10 - Draft Annual Progress Report 2019-20 to the Equality Commission on implementation of Section 75 and the duties under the Disability Discrimination Order (PHA/03/12/20)** *Ms Karen Beattie joined the meeting for this item. Miss Rosemary Taylor joined the meeting for this item and the next item.*
133/20.1	The Chair welcomed Ms Karen Beattie to the meeting and began by thanking the Equality Unit for their patience in allowing this Report to be submitted to this meeting instead of the previous one. Miss Taylor introduced the item saying that PHA is required to submit an Annual

Report to the Equality Commission and that normally this would be submitted in August but due to COVID-19, there was an extension until 31 December. She thanked Ms Beattie and Ms Anne Basten for their work in compiling this Report and invited Ms Beattie to take members through it.

133/20.2 Ms Beattie began her presentation by giving an overview of the statutory duties placed on organisations such as the PHA. She explained that the Report then looks at key achievements and any gaps as well as priorities going forward. In terms of statutory duties, she advised that PHA has a responsibility has a duty to equality screen policies and programmes. With regard to duties under the Disability Discrimination Order, she said that PHA has a role to promote positive attitudes towards people with a disability and to encourage their active participation in public life.

133/20.3 Ms Beattie said that the Report referenced a range of initiatives across different themes that show where PHA has delivered outcomes for each of the different Section 75 groups. In terms of co-production she highlighted the establishment of the Frailty Network. In terms of access to information, she highlighted the translation of materials into other languages or easy to read formats. However, she noted that the number of equality screenings completed was low and this could leave PHA vulnerable to challenge.

133/20.4 Moving on to duties under the Disability Discrimination Act, Ms Beattie advised that PHA had participated in the Disability Placement Scheme.

133/20.5 Ms Beattie said that going forward PHA needs to increase the number of equality screenings, to improve its data collection and monitoring so it has better intelligence in terms of who is accessing its programmes or services. She said that PHA also needs to engage with Section 75 groups and to increase the number of staff who participate in equality training.

133/20.6 Mr Clayton picked up on Ms Beattie's concern about the lack of Equality Screenings as this had been flagged up previously. He said it was strange that this area is an issue given that the Report contains evidence of the good work PHA is doing. He pointed out that not only would PHA be vulnerable to challenge but it asked questions about where the oversight is given that screening is not being seen as a tool for decision making. In terms of the data, he noted that there were no specific references to how PHA creates improved opportunities for individuals regardless of their sexual orientation, but there are areas of work in this area highlighted in the Report. He also noted that there were no new actions for 2021/22, but simply the same actions being rolled forward. Ms Beattie said that with regard to the Equality Action Plan, BSO had approached the Equality Commission with the suggestion that some activities would be included that did not require public consultation, but that there will be other actions across all HSC

bodies which will be consulted on jointly.

133/20.7 Mr Clayton asked about the equality screenings and why the number of completed screenings is low. Miss Taylor agreed that the number is low given that there is so much good work being done which is not being recognised. She said that there is a check box on papers going to Agency Management Team meetings to indicate whether an equality screening has been carried out and Directors may need to work with their teams to reinforce the importance of this. The Chair suggested that there should be an update on this brought back to the Board in 3/4 months' time, but given other work, he suggested by June 2021 **(Action – Miss Taylor)**.

133/20.8 Ms Mann-Kler asked if the Equality Unit provides its services across a range of HSC bodies. She queried if the Board could be doing more to provide leadership in this area. She said that the development of the Corporate Plan gives PHA a unique opportunity to look at equality. She commented that the training figures are disappointing and asked whether NEDs had taken up the training. She felt that the training should be mandatory and expressed concern that the same messages are coming out of the Report as from previous years and suggested that an action plan should be developed. She reflected that everything PHA does has equality at its heart. She also felt that there is an issue in terms of data collection and said that if the Equality Unit plays a regional role there should be an opportunity to collect data more efficiently. On the whole she said that the Report was comprehensive but it is difficult to crystallise the main achievements and she asked if there was a report which celebrates the achievements but also highlights the areas that need to be focused on going forward.

133/20.9 Ms Beattie said that the Equality Unit provides support and advice to all HSC regional organisations. She agreed that it would be helpful if there was a drive to reinforce the need to undertake equality screenings. She acknowledged that it does take time to complete screenings and they can be perceived to be an additional burden, but by completing them it allows the staff member an opportunity to explore any issues and identify any potential problems early on. She pointed out that while the training figures appear to be low, 35 staff from PHA attended face to face training which is aimed at policy makers. She agreed that there is a lack of equality data across all HSC bodies and this has been picked up on by the Equality Commission, but there is an acknowledgement that there are difficulties in getting service users to provide equality data and that efforts are being made to obtain this data so it can be analysed and monitored.

133/20.10 The Chair declared an interest in that he is currently chair of the Disability Champions Network for regional health organisations. He noted the work that has been ongoing with recruitment agencies in terms of ensuring improved representation of people with disabilities and he asked if there was any data available on this. Ms Beattie advised

	that there are limited data as recruitment agencies do not collect data against the different Section 75 groups, disability being one of these. She added that this is the first time that recruitment agencies have had to work with these equality objectives so if these non-statutory bodies can provide this data it will result in a bigger evidence base to effect change. The Chair advised that the Disability Network has invited Mrs Paula Smyth to its next meeting. He noted that individuals may be reluctant to disclose that they have a disability and he asked if there were any reasons why this may be the case. Ms Beattie said that there could be a number of factors, perhaps depending on how the question is asked or people may feel that a long-standing illness is not necessarily a disability. She added that the Tapestry Network is doing work in this area with some of its members showcasing themselves and sharing information about their disabilities.
133/20.11	Alderman Porter asked whether this Report looks at issues such as discrepancies in funding and whether PHA's funding is skewed towards particular areas. He also asked what is being done to look at the geographical spread of funding. Ms Beattie advised that under Section 75 PHA has a duty to promote equality of opportunity and part of that would be an assessment of need. She cited an example within the Report of developing materials relating to breast screening in an easy to read format as there was an awareness that there were particular sectors where there were health issues so a resource was put in to address a particular need. She also referenced work in the area of LGBT.
133/20.12	Alderman Porter asked if there is evidence that PHA funding is skewed towards certain sections of the community and whether different groups receive different levels of funding. The Chair said that this would not be the role of the Equality Unit. Alderman Ashe asked how PHA's equality of opportunity can be demonstrated if there is no awareness of when funding streams are being released, or when grant funding is available and he asked if he could be included on the distribution list to receive such information. Mr Wilson responded saying that Board members receive all press releases where this information would have been publicised. The Chair said that the issue is that some organisations appear to be receiving funding regularly and sought an assurance that all organisations receive the same opportunities.
133/20.13	Ms Mann-Kler said that in terms of next steps, the Executive Directors should prepare an action plan and bring this back to the Board in a few months' time so as to ensure that when next year's Report is being presented, the same issues are not being highlighted. She offered any assistance she could provide in this matter. The Chair suggested that this should come to the Board in June given pressures relating to COVID-19 **(Action – Interim Chief Executive)**.
133/20.14	The Chair thanked Ms Beattie for the Report. Ms Beattie advised that PHA is due to carry out a 5-year review of its Equality Scheme before

June 2021 and that this presents an opportunity for PHA to review the last 5 years in terms of what has worked well, what has not worked well and what the priorities are going forward. She said the work will involve liaising with PHA stakeholders and she asked whether any PHA Board members would wish to be involved. The Chair said that he would be happy for the Board to be involved **(Action – Chair)**.

133/20.15 Members **APPROVED** the draft Annual Progress Report 2019-20 to the Equality Commission on implementation of Section 75 and the duties under the Disability Discrimination Order.

134/20 Item 11 – PHA Assurance Framework (PHA/04/12/20)

134/20.1 Miss Taylor said that members will be familiar with the Assurance Framework as it is reviewed biannually and is brought to the Board annually. She said that this update has been approved by the Agency Management Team and the Governance and Audit Committee.

134/20.2 Miss Taylor said that the Assurance Framework is an important governance document as it sets out the various reports which are brought to the various committees of PHA. She explained that this year's Framework has undergone an extensive revision following recommendations made in a recent Internal Audit review and she thanked Mr Graham for this work in compiling this. She said that the Framework contained additional information, including a Lead Director for each item, and where applicable, a link to the Corporate Risk Register. She added that there are also some additional items which have been included.

134/20.3 Members **APPROVED** the PHA Assurance Framework.

135/20 Item 12 - R&D Annual Reports 2018/19 and 2019/20 (PHA/05/12/20)

Dr Janice Bailie joined the meeting for this item.

135/20.1 Dr Bailie advised that she was presenting two Reports to the Board; one for 2018/19 and 2019/20. She noted that she had last presented a report on the impact of R&D programmes in September 2019.

135/20.2 Dr Bailie advised that the information presented is reported under various strands and that the team is continuing to implement its R&D Strategy. She added that this year the team has taken on a lot of additional work due to the COVID-19 pandemic. She explained that a Scientific and Technical Advisory Cell was established to deal with queries and that the team worked with Trusts to ensure that Northern Ireland was well-placed to participate in UK-wide studies. She said that the team was involved in vaccine trials in the Belfast and Western Trust areas and in the establishment of a Behavioural Science Group. She added that she expected many of the COVID-19 strands to continue and she expressed her thanks to the team for taking on all of this additional

work.

135/20.3 Dr Bergin said that the work of the R&D team is integral to the COVID-19 response and he pointed out that Northern Ireland receives approximately one-third of the level of R&D funding that is available in other parts of the UK. The Chair felt that people do not understand the importance of medical research to society and recalled that in 2011, at the time of the financial crisis, the Government did not cut the research budget as it appreciated the economic benefit of medical research. He said that Northern Ireland should continue to fight for R&D funding and he asked whether other countries in the UK face the same issue with regard to funding. Dr Bailie explained that each of the 4 countries has a separate R&D budget, but Northern Ireland's budget is by far the lowest of the four countries of the UK. She said that England has contributed directly to Northern Ireland to support some of our work. She added that for the longer term, it is planned to continue with the centralised allocation of priority studies so additional funding will be coming to Northern Ireland. The Chair asked about the decision making process for funding. Dr Bailie said that funding comes from central Government but she was not sure whether it was the Executive or the Department of Health who determine the allocation for R&D funding and she acknowledged that R&D is competing with other priorities.

135/20.4 Professor Rooney commented that COVID-19 has changed the role of R&D in relation to public health research and she asked if there will be an opportunity to enhance this further. Dr Bailie said that PHA does provide funding for public health research and there is a Northern Ireland Public Health Network. She added that a lot of public health research is carried out by universities and PHA encourages them to liaise with PHA. She suggested that PHA could appoint a Director of R&D in order to develop a research culture in the organisation. She said that PHA does not tend to ring fence funding in particular areas, but she would be content to fund specific research in public health if this was required. The Chair noted that organisations like PHA should also commission their own research.

135/20.5 The Interim Chief Executive advised that she had to leave the meeting and she informed members that she had received a draft report from Dr Ruth Hussey following her review of PHA. She explained that there were a couple of queries that required followed up and that she would share it with members once she had received the final version. She said that the report will be a helpful report for PHA going forward and that Dr Hussey had been able to speak to approximately 50 people while she was compiling it.

At this point the Interim Chief Executive left the meeting.

135/20.6 Returning to the R&D reports, Dr Bailie said that she felt that during the pandemic people have looked to research for answers and that research has delivered and she hoped that this has changed people's perceptions

	of research. The Chair said that he would formally write to those who make decisions regarding research funding to strengthen the case for more funding **(Action – Chair)**. Professor Rooney said that the suggestion to have a Director of Research in PHA is a useful one.
135/20.7	The Chair asked Dr Bailie to thank her colleagues for the work that they have done and to pass on that this work is valued by the Board.
135/20.8	Members noted the R&D Annual Reports.
136/20	**Item 13 - Director of Public Health Annual Report (PHA/06/12/20)**
	Professor Hugo van Woerden joined the meeting for this item.
136/20.1	Professor van Woerden began by apologising for the late submission of his Report. He said that at previous Board meetings there have not been many written updates on COVID-19 so this Report tells the story of the first wave of COVID-19. He added that the Report not only focuses on the health protection aspect, but also on the contribution of other parts of the Agency including Nursing and HSCQI.
136/20.2	Professor van Woerden said that the report shows that Northern Ireland has performed comparatively well compared to the other parts of the UK and had a lower death rate from COVID-19. He thanked all of those involved in preparing the Report. The Chair noted that it was clear that it was a team effort. Dr Bergin said that he was happy to support the hard work that had gone into preparing the Report.
136/20.3	The Chair asked if there was any particular reason why Northern Ireland had a lower mortality rate compared to the rest of the UK. Professor van Woerden suggested that this may be due to Northern Ireland being on a different island, and also that its airport does not receive many international flights. He added that Northern Ireland had taken on board early advice in the epidemic and put out advice which helped.
136/20.4	The Chair said that members will take time to read the report in full and he thanked Professor van Woerden for taking the time to compile it. He thanked him again for his achievements during his time as Director of Public Health and for his ability to deliver presentations which outlined in lay terms the latest data regarding the pandemic. He thanked him for his work leading the public health directorate during the first wave and he wished him well for his retirement. Professor van Woerden thanked members for their support in the epidemic and propagated advice which helped.
136/20.5	The Board noted the Director of Public Health Annual Report.
137/20	**Item 14 – Any Other Business**
137/20.1	Alderman Porter returned to the issue he raised as part of the discussion

	on the Equality Report and he requested that a piece of work be undertaken outlining what areas PHA funds, particularly with regard to Healthy Living Centre, to ensure that this funding is not skewed. He sought an assurance that PHA is not funding the same groups all of the time. Mr Clayton noted Alderman Porter's point, and said that while it is important to see where PHA is spending its funding, it should be looked at through the lens of Section 75 as this explain why there may be particular areas that receive more funding than others. Alderman Porter said that he needed to see the data to be assured that there is no skewing of resources.
137/20.2	Alderman Ashe asked about the application process for organisations to apply for PHA funding and if this is made public. He noted that on the previous occasion the Board was provided with detail on programmes funding by PHA, it appeared to be mainly Belfast-centric.
137/20.3	The Chair said that he would ask for this information. He advised members that there are currently some re-tendering exercises taking place and he will be sitting on the PHA Procurement Board.
137/20.4	The Chair thanked members for their commitment over the previous 12 months. He said that it has been a demanding year which has taken its toll on staff and he wished all members a healthy and safe Christmas period.
138/20	**Item 15 – Details of Next Meeting** *Thursday 21 January 2021 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7ES* Signed by Chair: Date:

Public Health Agency

Finance Report

2020-21

Month 8 - November 2020

PHA Financial Report - Executive Summary

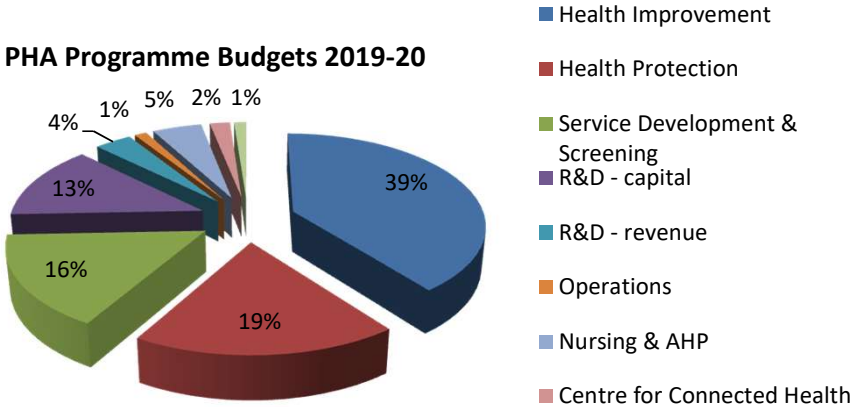
Year to Date Financial Position (page 2)

At the end of month 8 PHA is reporting an underspend of £1.6m against its profiled budget. This underspend is the result of delays in expenditure on the Health Improvement and Service Development & Screening budgets (page 4), combined with an underspend on Administration budgets (page 6).

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

Programme Budgets (pages 3&4)

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

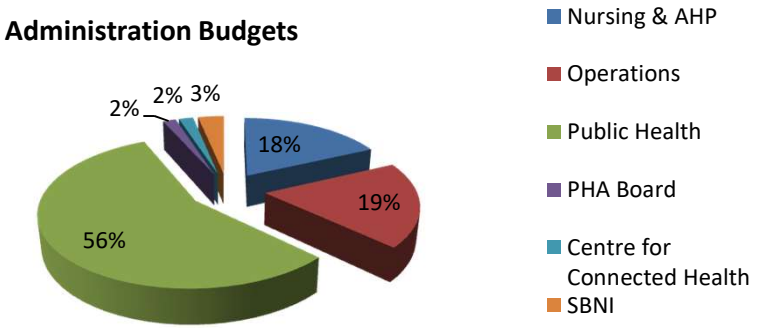


Administration Budgets (page 5)

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. In previous years this has been used to fund a range of in-year pressures and initiatives, however the impact of COVID-19 has reduced the potential to absorb this slippage in 2020-21. Discussions are on-going with the Department in the respect of the overall HSC financial position, and the forecast position reported above reflects these discussions.

Public Health Agency
2020 -21 Summary Position - November 2020

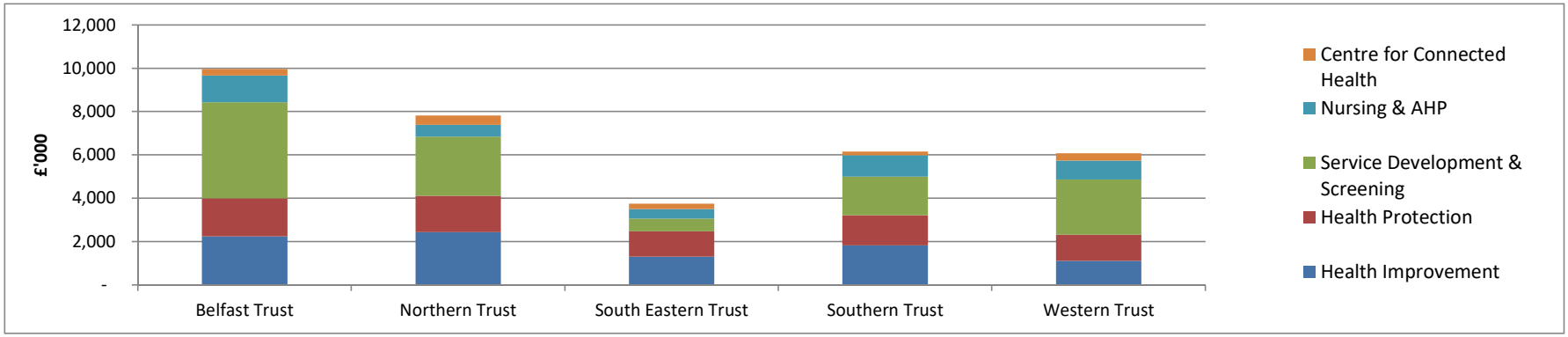
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	34,293	49,512	14,487	22,096	**120,386**	22,862	29,396	3,271	14,556	**70,085**
Revenue Income from Other Sources	-	23	-	878	**901**	-	23	-	528	**551**
Total Available Resources	34,293	49,534	14,487	22,974	**121,288**	22,862	29,419	3,271	15,085	**70,635**
Expenditure										
Trusts	34,293	-	1,786	-	**36,079**	22,862	-	1,144	-	**24,006**
PHA Direct Programme *	-	50,195	12,701	-	**62,897**	-	28,258	2,126	-	**30,385**
PHA Administration	-	-	-	22,313	**22,313**	-	-		14,634	**14,634**
Total Proposed Budgets	34,293	50,195	14,487	22,313	**121,289**	22,862	28,258	3,271	14,634	**69,025**
Surplus/(Deficit) - Revenue	-	(661)	-	661	-	-	1,161	-	451	**1,612**
Cumulative variance (%)						***0.00%***	***3.95%***	***0.00%***	***2.99%***	***2.28%***

The year to date financial position for the PHA shows an underspend of £1.6m, with the surplus mainly coming from the Health Improvement and Service Development & Screening budgets, combined with an underspend on Administration budgets.

A year-end breakeven position is currently forecast. A forecast surplus is anticipated on the Administration budget, with the impact of COVID-19 restricting the potential to utilise this funding on Programme priorities as in previous years. Discussions are on-going with the Department in the respect of the overall HSC financial position, and the forecast position reported above reflects these discussions.

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

Programme Expenditure with Trusts

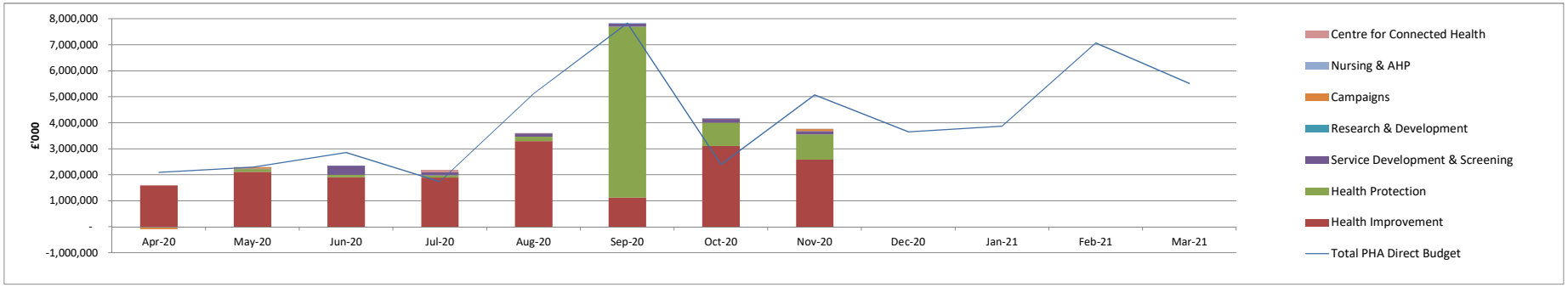


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	2,249	2,437	1,312	1,833	1,110	**8,941**	5,961	5,961	-
Health Protection	1,752	1,686	1,174	1,393	1,208	**7,214**	4,810	4,810	-
Service Development & Screening	4,426	2,720	573	1,769	2,556	**12,044**	8,029	8,029	-
Nursing & AHP	1,241	544	446	990	868	**4,089**	2,726	2,726	-
Centre for Connected Health	301	431	247	172	338	**1,489**	993	993	-
Other	152	122	56	91	95	**516**	344	344	-
Total current RRLs	**10,122**	**7,941**	**3,808**	**6,248**	**6,174**	**34,293**	**22,862**	**22,862**	-
Cumulative variance (%)									***0.00%***

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

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

PHA Direct Programme Expenditure



	Apr-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	2,096	2,096	2,096	1,239	4,555	972	1,209	4,056	1,043	1,210	4,707	3,852	**29,132**	18,320	17,630	689	*3.8%*
Health Protection	-	100	160	192	186	6,577	917	916	888	487	270	173	**10,866**	9,047	8,897	150	*1.7%*
Service Development & Screening	-	95	562	215	364	215	215	31	340	335	556	475	**3,403**	1,696	1,329	367	*21.6%*
Research & Development	-	-	-	-	-	-	-	-	1,000	1,000	1,211	250	**3,461**	-	-	-	*0.0%*
Campaigns	-	-	-	10	20	45	35	10	250	489	232	30	**1,121**	120	42	78	*65.0%*
Nursing & AHP	-	-	39	14	4	27	19	61	98	64	94	96	**518**	166	87	78	*47.3%*
Centre for Connected Health	-	-	-	70	-	-	-	-	36	291	-	-	**397**	70	70	0	*0.2%*
Other	-	-	-	-	-	-	-	-	-	-	-	611	**611**	-	202	(202)	*100.0%*
Total PHA Direct Budget	**2,096**	**2,291**	**2,857**	**1,740**	**5,130**	**7,836**	**2,395**	**5,074**	**3,654**	**3,876**	**7,072**	**5,488**	**49,508**	**29,419**	**28,258**	**1,161**	
Cumulative variance (%)																***3.95%***	
Actual Expenditure	**1,504**	**2,380**	**2,394**	**2,219**	**3,594**	**7,874**	**4,577**	**3,715**	**-**	**-**	**-**	**-**	**28,258**				
Variance	**592**	**(89)**	**463**	**(479)**	**1,535**	**(38)**	**(2,182)**	**1,358**					**1,161**				

The year-to-date position shows an underspend of approximately £1.2m. This surplus is mainly coming from the Health Improvement and Service Development & Screening budgets, with the impact of the COVID-19 pandemic causing underspends in some areas.

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

An approximate breakeven position is expected on PHA Direct budgets for the full year. As in previous years, the organisation expects a surplus to arise on Administration budgets which would normally have been absorbed through PHA Direct budgets to address programme priorities, but this is unlikely to be an option in 2020-21 and therefore represents a risk which will be kept under close review.

Public Health Agency
2020-21 Ringfenced Position

	Annual Budget				Year to Date			
	Covid £'000	Transformation £'000	DAERA & EITP £'000	£'000	Covid £'000	Transformation £'000	DAERA & EITP £'000	£'000
Available Resources								
DoH Allocation	2,363	3,837	311	**6,512**	467	1,292	153	**1,913**
Assumed Allocation	7,975	-	-	**7,975**	1,358	-	-	**1,358**
Total	10,338	3,837	311	**14,487**	1,825	1,292	153	**3,271**
Expenditure								
Trusts	751	967	68	**1,786**	500	644	-	**1,144**
PHA Direct	9,587	2,871	243	**12,701**	1,325	647	154	**2,126**
Total	10,338	3,837	311	**14,487**	1,825	1,292	154	**3,271**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

PHA has received a COVID allocation of £2.4m to date, which is primarily for Child Flu Vaccine. As at November £0.5m has been incurred against these allocations, with the expenditure expected during quarters 3 & 4. A further £8.0m is expected to be received from DoH on the basis of COVID bids submitted to date, and this funding is included in the full year position shown above. The costs incurred at present are in relation to Track & Trace, COVID Communication Campaigns and Child Flu Vaccinations costs.

A number of Transformation projects are also on-going, and separate ringfenced funding has been received for these totalling £4.0m, however it is assumed slippage of £0.2m will be retracted by DoH, leaving an allocation of £3.8m. These projects are being monitored and reported on separately to DoH, and a breakeven position is expected for the year.

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

PHA Administration

2020-21 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	3,940	326	2,957	12,345	314	348	467	**20,697**
Goods & Services	149	18	1,322	408	54	58	269	**2,277**
Total Budget	**4,089**	**344**	**4,279**	**12,753**	**369**	**406**	**735**	**22,975**
Budget profiled to date								
Salaries	2,546	217	1,970	8,226	205	232	311	**13,707**
Goods & Services	99	12	881	230	36	39	79	**1,377**
Total	**2,645**	**229**	**2,852**	**8,456**	**241**	**271**	**390**	**15,084**
Actual expenditure to date								
Salaries	2,556	236	1,831	8,362	164	248	272	**13,669**
Goods & Services	77	2	765	56	10	2	53	**965**
Total	**2,633**	**238**	**2,596**	**8,418**	**174**	**250**	**326**	**14,634**
Surplus/(Deficit) to date								
Salaries	(10)	(19)	139	(136)	41	(16)	39	**38**
Goods & Services	22	10	117	174	26	36	26	**412**
Surplus/(Deficit)	**12**	**(9)**	**256**	**38**	**67**	**20**	**65**	**450**
Cumulative variance (%)	*0.47%*	*-3.81%*	*8.98%*	*0.45%*	*27.90%*	*7.47%*	*16.53%*	***2.98%***

PHA's administration budget is showing a year-to-date surplus of £0.45m, which is being generated by a number of long standing vacancies. Although efforts continue to fill vacant posts as far as possible, this has proved to be challenging, and the surplus on the salaries budget continues to be high. In addition in 2020-21 many staff are largely working from home, and this has driven a downturn in Goods & Services expenditure in areas such as travel and courses, which is expected to lead to increased slippage at year-end. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £0.7m.

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

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

Public Health Agency
2020-21 Capital Position

	Annual Budget				Year to Date			
	Programme		Mgt & Admin		Programme		Mgt & Admin	
	Trust £'000	PHA Direct £'000	£'000	Total £'000	Trust £'000	PHA Direct £'000	£'000	Total £'000
Available Resources								
Capital Grant Allocation & Income	8,346	4,113	-	**12,459**	5,331	2,891	-	**8,221**
Expenditure								
Capital Expenditure - Trusts	8,346			**8,346**	5,331			**5,331**
Capital Expenditure - PHA Direct		4,113		**4,113**		516		**516**
	8,346	4,113	-	**12,459**	5,331	516	-	**5,847**
Surplus/(Deficit) - Capital	-	-	-	-	-	**2,375**	-	**2,375**
Cumulative variance (%)								

PHA has received a Capital budget of £12.5m including income in 2020-21, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £5.8m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	November 2020 Value	November 2020 Volume	Cumulative position as at 30 November 2020 Value	Cumulative position as at 30 November 2020 Volume
Total bills paid (relating to Prompt Payment target)	£4,939,681	524	£37,736,940	2,603
Total bills paid on time (within 30 days or under other agreed terms)	£4,875,093	506	£37,098,651	2,378
Percentage of bills paid on time	**98.7%**	**96.6%**	**98.3%**	**91.4%**

Prompt Payment performance for November and the year to date shows that on value the PHA is achieving its 30 day target of 95.0%. Cumulatively to date PHA are not achieving the 95% target on volume and further efforts will require to be made in order to achieve the 95% target for year end.

The 10 day prompt payment performance remained strong at 81.3% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2020-21 of 70%.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	21 January 2021
Title of paper	Personal and Public Involvement Update
Reference	PHA/02/01/21
Prepared by	Martin Quinn
Lead Director	Rodney Morton
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the biannual update on PHA's Personal and Public Involvement work.

2 Background Information

To meet the PPI objectives within Outcomes 4 & 5 of the PHA Corporate Business Plan the PHA provides twice yearly updates to the Board on the progress of the PHA PPI Action Plan.

3 Key Issues

The PHA in line with our leadership responsibilities in the field of Involvement & Co-Production and our Governance arrangements are required to bring about a twice yearly update report for consideration by the PHA Board.

The Board update report sits very much within the context of the COVID-19 pandemic and reflects how the team have responded to this under the themes of Leadership, Transformation and Capacity Building.

4 Next Steps

The next biannual Report will be brought to the Board in June 2021.

HSC Public Health Agency

Personal and Public Involvement (PPI)

PHA Board Update January 2021

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

PPI and the PHA's role

Personal and Public Involvement (PPI) is the active and effective involvement of services users, carers and the public in health and social care services. People have a right to be involved in and consulted on decisions that affect their health and social care. Under the Health and Social Care (HSC) Reform Act (NI) 2009, PPI is a legislative requirement.

The Public Health Agency (PHA) was assigned primary responsibility for leading the implementation of PPI across the HSC system by the then DHSSPS in the 2012 PPI Policy Circular. It requires the PHA to provide the Department of Health (DoH) 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.

Report context and Covid-19 response

This Update Report on PPI is in line with our Governance requirements, whereby the Board are presented with twice yearly updates on our work in respect of the Statutory Duty of Involvement and our leadership responsibilities for the oversight of the implementation of PPI policy in the HSC. The report covers the period from June to December 2020. It gives an overview of the progress made against the PHA PPI Action Plan, including how we have discharged our leadership responsibilities in Involvement, Co-Production and related areas across the HSC system.

Of particular note in this period is the impact of the Covid-19 pandemic and significant changes to the team that have arisen. Preparing for Covid-19 has had a huge impact on what we have been able to do, previously anticipated timelines, how we work and what we have focused our energies on. Much of the originally planned work was slowed down, put on hold, or not possible to complete because of ongoing societal restrictions, but the PPI staff team redirected much of our time, expertise, skills and experience to support the collective effort to combat the Covid-19 virus. Members of the team have in the first wave of the Pandemic:

- served on the Communications and Knowledge Management Cells;
- covered EOC rotas;
- been trained in Contact Tracing;
- covered Contact Tracing rotas;
- served on the PHA/HSCB & BSO Staff Health & Well-Being Group.

In this second Wave, members of the team have:

- become members of the Communications cell and Vaccinations sub group;
- worked full time in Contact Tracing;
- supported the Second Wave Planning Group by developing an indicative Involvement Framework;
- contributed to and provided professional involvement advice and guidance to projects and discreet pieces of work connected to the HSC response to Covid-19, or which have been trying to operate in an environment hugely changed by it, including how to manage in the “new norm,” where public gatherings and indoor meetings are in effect prohibited, where social distancing is a key requisite, where human face to face interaction has in the main, to be facilitated virtually with technology being much more widely utilised to enable communication and interaction.

Beyond this, the team have faced challenges with key and experienced members of staff leaving to take up new posts and others being released to support system wide priorities from a professional involvement perspective. This has obviously depleted capacity and brought management challenges in how to keep core work going, in how to respond to increasing demands for leadership, advice and guidance and in working to ensure that the remaining staff members are not overwhelmed!

Leadership

Ministerial support

The team were delighted that Minister for Health Robin Swann MLA took time out from his hectic schedule in October to join a cohort of the Leading in Partnership Programme, to discuss their learning experiences on Leadership in Involvement, Co-Production and Partnership Working. The Minister was welcomed to the virtual session by Director Rodney Morton. He was given an outline of the programme from our Assistant Director Michelle Tennyson, before hearing directly from the course participants themselves, who included HSC staff, service users and carers.

The Minister was unambiguous in his endorsement of this overall approach and saluted the PHA, and our partners in the HSC Leadership Centre, for our determination and creativity in rising to the challenge to deliver this programme in the circumstances. As Minister, he restated his commitment to the statutory duty of Involvement and re-iterated his and the Department's belief that we need to harness this collaborative approach to effectively tackle the challenges that we face in terms of health and social well-being.

Regional HSC PPI Forum

As we moved towards the end of the first wave of the pandemic, there was a major question as to how we might, or indeed whether we should, proceed with the planned summer meeting of the Regional HSC PPI Forum (the vehicle through which the PHA exercises much of its leadership in the field of Involvement and Co-Production).

Engagement with many of our service user and carer members revealed that quite a few were shielding and there was understandable nervousness about meetings of any kind. As such, the decision was taken in agreement with the Co-Chairs to cancel the summer meeting of the Forum. A virtual meeting with available service users and carers was held at the end of July to keep connectivity with service user and carer forum members. It explored the challenges that the ongoing Covid-19 restrictions had brought to people's experiences of both the health service in general and also the impact on interaction and involvement.

The strategic meeting of the Regional Forum was held online on the 14th September via the Zoom platform as a result of ongoing Covid-19 restrictions. It was co-chaired by Don Harley and Michelle Tennyson and attended by senior management and Directors from across the HSC, in association with service user and carer members. This meeting focused on involvement and related matters in the context of Covid-19 and looked at exploring the challenges and opportunities for Involvement, Co-Production and Partnership Working in the circumstances. The meeting also discussed the role, function, form and operation of the Forum in the field of Involvement and Co-Production as we move forward.

The focus of the Forum meeting planned for the 23rd November is to secure input from the HSC system and service users and carers into the PHA's Integrated Plan for PPI, Co-Production, Partnership Working and PCE from 2021 onwards.

Professional advice and guidance

The PHA PPI team provides a wide range of professional advice and guidance on Involvement, across all sectors of the HSC. This is a critical service which has seen further growth in the last six months during a time of constrained capacity. The support provided varies in nature from project to project, but in the main it entails:

- the provision of professional involvement advice and guidance;
- helping to facilitate the development of an involvement plan;
- practical support in helping the project promoter to secure service user/carer participation;
- professional involvement advice and guidance during the implementation of the work.

The PPI team has provided Involvement leadership, advice and guidance across dozens of pieces of work in the HSC in the last 6 months, with a number of significant of these being strategic high profile initiatives. A few of these are outlined briefly in the following section:

Hyponatraemia Implementation Programme

The PHA continues to proactively support the DoH in taking forward the Involvement elements of planning around the implementation of the recommendations from the Inquiry into Hyponatraemia Related Deaths. Two members of the PPI Team Claire Fordyce and James McLaughlin work directly (100% of their capacity) with the Department to progress this work which is overseen/guided by the Regional Involvement Lead.

The Hyponatraemia Implementation Programme is a model of co-production at the regional policy level and this work has recently been showcased as part of the following:

- The annual NICON Conference in October 2020. The Department were invited to present the Hyponatraemia Implementation Programme model for involvement as part of the 'Patients as Partners' breakout session.

- The PHA, Consultation and Co-production Tuesday Topic sessions. As part of the Stakeholder Mapping session in October 2020, the Duty of Candour Workstream presented a case study example. This work demonstrated a co-produced approach to identifying and engaging stakeholders led to a better informed policy-making process.

Work has continued during this period to progress identified priority areas, particularly in relation to the Duty of Candour. The team has taken forward work to:

- complete and finalise the Duty of Candour Workstream and Being Open sub-group pre-consultation work - this involved an extensive stakeholder mapping process to identify and engage a range of stakeholders to consider the potential barriers and opportunities to the introduction of this statutory duty. All this work has been collated into a comprehensive report and is available here;

- nearly 1,000 stakeholders were involved in this process from a range of sectors - this was an extensive programme of work which the PHA Officers have advised on, co-ordinated and managed. In recent months, this has included adapting to on-line formats and undertaking involvement via the Zoom platform to enable the work to continue;

- develop draft guidance for individuals in relation to Openness in Health and Social Care - this work has been undertaken entirely on a virtual platform with service users and carers and builds on the work of the Being Open sub-group. Working with the Patient and Client Council (PCC) through the Make Change Together programme, 13 service users and carers were recruited on a Task and Finish basis. Through an on-line platform, an induction was provided and four meetings have furthered this work, which will be presented to the DoH as part of the development of Openness Guidance. An evaluation of this work will be undertaken to help continue to adapt our approaches to effectively involve whilst social distancing.

Review of Urgent and Emergency Care

The PHA continued to work closely with the DoH to support their endeavours to ensure the inclusion of best practice. Involvement, Co-Production and Consultation methodologies are applied to the upcoming pre and full consultation stages of the review. With support from our PPI officer assigned to the work (Roisin Kelly), the Review team have now established a Co-Production Working Group, undertaken an Involvement Stakeholder Analysis, developed and implemented an Involvement Plan.

A strategic report based on learning during the involvement for the Review was subsequently developed. It included an overview of a range of involvement initiatives including an 'attitudes and behaviours' survey completed by over 500 people at 19 urgent and emergency care sites across the region; a research review and two regional workshops in Belfast and Omagh. These workshops were delivered with 140 service user, carer, community and voluntary sector representatives in attendance. This report will also be used as a chapter in the Urgent and Emergency Review report and will form the basis for further engagement.

No More Silos

To provide ongoing professional involvement, co-production, consultation and engagement support to the No More Silos network, as well as other Hospital Service Reform projects, our Senior PPI Officer, Roisin Kelly, has now been assigned to work exclusively on this work with the DoH. With support from the PHA, the Network has included the voice of service users and carers from the outset with the allocation of spaces and active

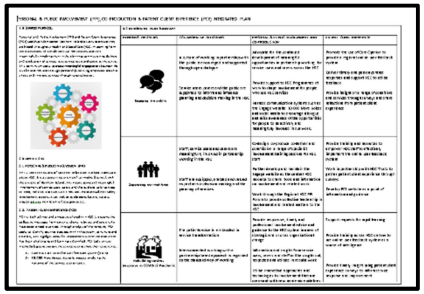
participation on the No More Silos Regional Network and Local Implementation Group's. Through our Officer, we are leading further work to embed involvement at the regional and local level in these key programmes.

RQIA Involvement advice and support requests

As part of a review of RQIA's Clinical and Social Care Governance Review process the RQIA approached the PHA PPI team to develop a bespoke training and workshop session for RQIA staff. This took place in September 2020. The session will form the basis of new process for the inclusion of service user and carer voices across the Review programme and within specific Reviews.

Further advice and guidance has been sought from the PHA PPI team in respect of how to embed Involvement into the work that the RQIA are undertaking in respect of their work on the Neurology Deceased Patients Review.

Development of Integrated Partnership Working Plan for PHA



In line with the Commissioning Plan Direction for 2019/20 the PHA are required to develop a plan that integrates a number of related areas such as Involvement, Co-Production, PCE, 10,000 more voices etc. into one organisational 'Partnership Working' plan. The DoH provided guidance on this in late 2019 and the PHA had

initiated a process to take forward the development of this prior to the outbreak of the Covid-19 pandemic.

Work restarted on the development of this plan a few months ago and the Regional PPI Forum members were invited to contribute to it at their workshop in November. It is hoped that a final draft of the plan will be available for PHA management consideration by early 2021.

UK Standards for Public Involvement – Better public involvement for better health and social care research

Commentary | Open Access | Published: 16 September 2020

'All hands-on deck', working together to develop UK standards for public involvement in research

Sally Crowe, Ade Adebajo, Hothan Esmael, Simon Denegri, Angela Martin, Bob McAlister, Barbara Moore, Martin Quinn, Una Rennard, Julie Simpson, Paula Wray & Philippa Yeeles

Research Involvement and Engagement **6**, Article number: 53 (2020) | Cite this article

471 Accesses | **19** Altmetric | Metrics

Abstract

Background

Public involvement in research is an established part of the research process in the UK, however there remain questions about what good public involvement in research looks and feels like. Until now public involvement practitioners, researchers and members of the public have looked for answers in examples shared across networks, published case studies, guidance and research articles. Pulling these strands together, the UK Standards for Public Involvement provides six statements (standards) about public involvement in research. They were produced by a partnership of organisations from Scotland, Northern Ireland, Wales and England with contributions from involvement practitioners, public partners, researchers and research funders.

https://researchinvolvement.biomedcentral.com/articles/10.1186/s40900-020-00229-y#ethics

The PHA was a key partner in this initiative, with our own involvement standards being an inspiration and acting as a pathfinder for this 4 Nation collaborative. This work has now been written up and published:

"***All hands-on deck, working together to develop UK Standards for Public Involvement in Research"***

The PHA's Regional PPI lead has been cited as one of the co-authors. It is now being used across the UK as a resource to support effective involvement in research under the auspices of NIHR (National Institute for Healthcare Research)

This work is being built upon and has now morphed into a 5 Nation initiative to cover all of the island of Ireland as well, with R&D colleagues in the PHA and PPI staff participating.

This work has been critical to enabling the concept and practice of Involvement to move to the centre stage in the research world. It has helped forge and strengthen the ethos of partnership working and raised awareness of and appreciation of the benefits of this approach in a number of research fields, in turn encouraging more people to participate in and contribute to research and more researchers to think about how and proactively engage with service users, carers, advocates and the public in the design, development, implementation and evaluation of their research.

Transformation Funding

The PHA continues to work with HSC partners in respect of the Transformation extension funding allocated by the DoH. Partnership Working Officers advancing PPI and Co-Production have been funded via the PHA and remain in place in each of the 5 geographical based Trusts.

The PHA have also been leading on the roll out of an exciting programme of training and development, funded via the Transformation programme (detailed later in the report), which has helped build a critical mass of people who are aware of the value and importance of this approach both within the HSC workforce and externally amongst service users and carers.

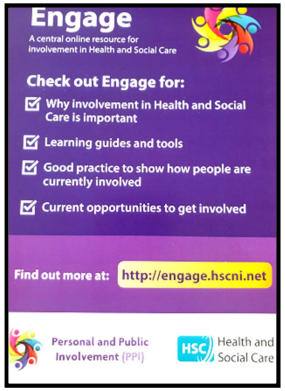
In addition, funding has been made available to enable work with Trust Mental Health colleagues, including service user consultants, to advance the concept and practice of engagement, support and remuneration of people with lived and living experience as partners in the HSC, in line with the direction of travel set out in the Co-Production Guide. The PCC have also been funded for work in a similar vein, whereby they wish to test out their "Paid Associates" model. The PHA PPI team continue to work closely with DoH in our endeavours to secure ongoing / recurrent funding based on the outcome of these projects where appropriate.

Monitoring

The research that had been commissioned by the PHA from Community Evaluation N.I. and the follow up report, which was funded using Transformation monies, has been very useful in moving the thinking of the system towards a position whereby Involvement monitoring would be more effectively aligned to Outcomes, Programme for Government and PHA strategic Public Health goals.

Whilst the impact of Covid-19 may have slowed down the progress of these deliberations, it is still very much the direction of travel that is envisaged and when time is right, it is something that we intend to take forward in partnership with HSC colleagues, service users and carers. We know that whilst good data on things that are readily quantifiable needs to be collected where feasible, the ultimate goal in this field is to be able to identify and assess the tangible difference/impact that involvement and co-production makes to outcomes for service users, carers, staff and the services.

Capacity Building and Support

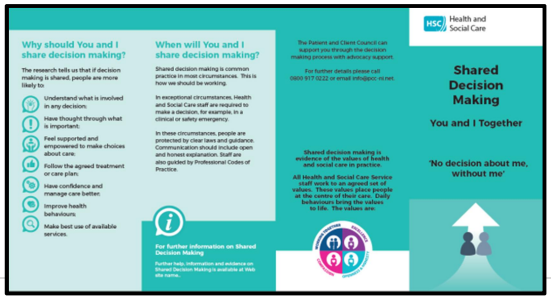


Engage website and Shared Decision Making

The Engage website continues to support HSC staff, service users, carers and the general public, to build their knowledge and skills on involvement.

Engage is a central source of information, good practice and resources on involvement, PPI and Co-Production. This includes a range of Involvement guides to support good practice. It is also somewhere that key opportunities for Involvement across the HSC can be promoted.

Like all such mediums, there is a need for constant management and updating which is a significant challenge for the depleted staff resource at present. Despite this, the PPI team are currently reviewing and updating the Engage website in partnership with service users and carers alongside looking to avail of technical input on the website structure refurb.

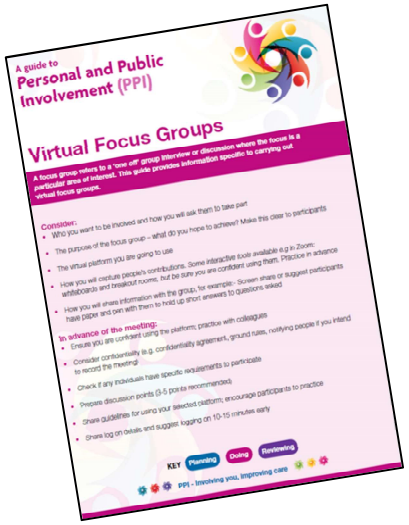


Having a centralised, effective and vibrant online resource for all things Involvement is vital in the current climate. Colleagues in the Clinical Education Centre (CEC) are now also working with the PHA to place the resources around Shared Decision Making on this website, making use of the synergies around this and Involvement in general. The hope is that this will

further strengthen the website and encourage its use across the system and by the wider public, leading in turn to further interaction and cross fertilization of ideas, information and best practice.

Involvement Guides in the Covid-19 environment / era

In response to the quickly changing situation brought about by Covid-19, the PHA PPI team looked to undertake the rapid development of updates/revisions and or new guides to support involvement. This included guides on Hard to Reach Groups/Easy to Ignore Groups, FAQ's, Involvement during Covid 19, Making Virtual Meetings Engaging, Virtual Focus Groups and Online Questionnaires.


A guide to
Personal and Public Involvement (PPI)

Virtual Focus Groups

A focus group refers to a 'one off' group interview or discussion where the focus is a particular area of interest. This guide provides information specific to carrying out virtual focus groups.

Consider:
- Who you want to be involved and how you will ask them to take part
- The purpose of the focus group – what do you hope to achieve? Make this clear to participants
- The virtual platform you are going to use
- How you will capture people's contributions. Some interactive tools available e.g in Zoom: whiteboards and breakout rooms, but be sure you are confident using them. Practice in advance
- How you will share information with the group, for example:- Screen share or suggest participants have paper and pen with them to hold up short answers to questions asked

In advance of the meeting:
- Ensure you are confident using the platform; practice with colleagues
- Consider confidentiality (e.g. confidentiality agreement, ground rules, notifying people if you intend to record the meeting)
- Check if any individuals have specific requirements to participate
- Prepare discussion points (3-5 points recommended)
- Share guidelines for using your selected platform; encourage participants to practice
- Share log on details and suggest logging on 10-15 minutes early

KEY Planning Doing Reviewing

PPI - Involving you, improving care

As well as a full coloured guide, a version that will be more economical for people to print at home has also been produced.

Involvement and Co-Production Training

During Covid-19 the PHA has adapted to successfully provide a range of relevant training opportunities for HSC Staff, Service Users, Carers, Community and Voluntary Sector colleagues.

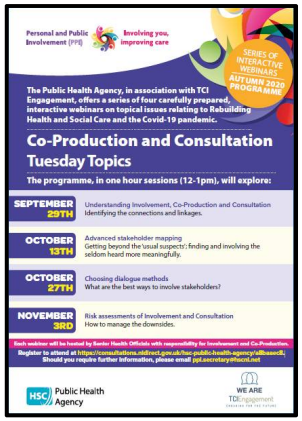
The Engage & Involve resource, both the hard copy taught programme, materials and the e-learning components for staff, service users and carers have been endorsed by the DoH and are recognised as the core training and development tools for Involvement. We are currently adapting these modules for delivery online.

This year, PHA has focused on the commissioning specialised training for specific Involvement related areas. In the last six months, approximately 600 people have attended training initiatives with additional training delivered and commissioned by the PHA PPI team. This included:

- Co-Production and Consultation Webinar series
- Leading in Partnership – Leadership Programme for Involvement and Co-Production x 2
- Bespoke training - Creating and delivering virtual training
- Bespoke training for HSC staff including RQIA, PHA and HSCB
- Bespoke training for IHRD and Diabetes Network Co-Production Groups
- Undergraduate and Postgraduate training at QUB, UU and HSC Leadership Centre
- Delivery of bespoke information sessions for a range of areas as requested

Co-Production and Consultation Webinar Series

The PHA successfully ran a series of bespoke Webinars was to support Involvement leadership across the HSC. The Co-Production and Consultation – Tuesday Topics were developed as part of the PHA's ongoing schedule of training for best practice in partnership working. The programme ran between September and November 2020 and was attended by 470 participants, reaching an additional 460 people through recordings of the session. The series was designed to support HSC staff continue to meet their statutory obligations to Involve and Consult as they navigate Involvement, Co-Production and Consultation, as part of HSC Rebuild and resumption of business.



The Webinar series looked at some of the fundamental Involvement and Co-Production issues facing HSC staff, including:

- Understanding Involvement, Co-Production and Consultation
- Advanced stakeholder mapping
- Choosing dialogue methods
- Risk assessment of Involvement and Consultation

The webinars were designed and commissioned by the PHA PPI team and were delivered by the PHA in partnership with The Consultation Institute, who are a membership body for public dialogue, engagement,

participation and consultation professionals. There was input from a range of PHA, DoH, HSC and service user and carer colleagues across each of the webinars.

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

In 2019/20 the PHA commissioned two further cohorts of the successful 'Leading in Partnership' leadership programme. Over 100 participants have now undertaken the programme, including HSC staff, service users, carers and members of the community and voluntary sector. The programme continues to be in demand, with Cohort 5 which started in November having three times as many applicants compared to the number of available places, with more than 60 applicants for 18 spaces. Cohort 6 is due to start in January 2021 and already has received over 40 applications. With the continued success of the programme, we are now looking at developing one off sessions, that will give applicants a 'taster' of the programme, as well as being able to reach a wider audience than the current programme can facilitate.

Through these developments, we are aiming to build a cohort of people in the region with knowledge, expertise and experience in involvement and co-production. This "critical mass" of people both within HSC and external to it, with these attributes, will be key in our collective endeavours to deliver systemic cultural change the HSC, in our drive to become a truly person centred service. One where partnership working is valued, respected and seen as standard practice and where we strive to co-design and co-produce services that are targeted to need, that are of the highest quality, that are efficient and owned and respected by the community.


Personal and Public Involvement (PPI)
Involving you, improving care
Leading in Partnership Leadership Programme
Supporting the HSC to Improve how we plan, deliver and lead our services together.
This exciting new programme offers HSC staff, service users, carers, community and voluntary sector an excellent opportunity to develop your capacity to:
► Lead in Partnership working from involvement to co-production
► Use PPI and co-production to achieve quality improvement
► Support transformation and service change by involving service users, carers, community and voluntary sector
To apply for this programme you should:
1. Have an understanding of Partnership working in a HSC setting
2. Have experience of engaging in PPI, patient client experience, co-production at a strategic or operational level
3. Be committed to providing leadership for Partnership working, involvement and co-production within the HSC
PROGRAMME SCHEDULE
MODULES
Cohort1 Sinead Smyth
Cohort 2 2021 Fiddes & Grufas
Module 1: Leading from Within
OCTOBER 26TH
JANUARY 27TH
Module 2: Partnership Working
NOVEMBER 12TH
FEBRUARY 11TH
Module 3: Leading to Listen and Understand
NOVEMBER 26TH
FEBRUARY 25TH
Module 4: Leading Collectively
DECEMBER 9TH
MARCH 12TH
Module 5: Shared learning event, including presentations and networking
JANUARY 9TH
MARCH 26TH
If you are Interested in attending please contact: ppi.secretary@hscni.net
(Venue; HSC Leadership Centre, Hampton Manor Drive, Belfast.
Modules will commence at 10am – 4.30pm.)
HSC Public Health Agency
HSC Health and Social Care

Conclusion and next steps

In common with colleagues across the HSC, it is evident that the PHA's PPI team have demonstrated their willingness to rise to the challenges brought about by the Covid-19 pandemic. This has manifested itself in people taking on new roles and responsibilities, in being trained to assist in these where needed, in being flexible around working arrangements, in showing leadership and vision in how we progress core work in uncertain times and a rapidly evolving situation. This is a key strength of the team and is something that we need to recognise, foster, encourage and support.

The PHA Board themselves expressed an interest in what they might do to further facilitate the embedding of Involvement, Co-Production and Partnership working in the PHA. To that end, we would like to invite members to consider availing of a bespoke Executive Briefing on Involvement, Co-Production and Partnership Working, which we would be designed to support members in their Involvement Leadership role and which in turn, would send out a very powerful message, in respect of the commitment to these concepts and practices both within the PHA and across the system. If members were amenable to the idea, this could be taken forward by working with the Non-Executive Lead for Involvement, Deepa Mann-Kler, on the design of the Briefing and would propose to identify a date possibly in March to deliver it.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	21 January 2021
Title of paper	HIV Surveillance Report for Northern Ireland 2020
Reference	PHA/03/01/20
Prepared by	Dr Claire Neill
Lead Director	Dr Stephen Bergin
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is for members to note the HIV Surveillance Report for Northern Ireland for 2020.

2 Background Information

This report aims to provide an overview of HIV epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus is on data collected in 2019. New HIV diagnoses are defined by area of residence. Please note this is a change from previous years, where reporting of a new diagnosis was based on the clinic of diagnosis. This change ensures that we are reporting in the same way as the rest of the United Kingdom (UK), but should be noted with due caution when making comparisons.

3 Key Issues

During 2019, there were 52 new first diagnoses of HIV in residents of Northern Ireland. This is lower than the 80 diagnoses identified in Northern Ireland last year, and remains lower than the peak of 102 new diagnoses recorded in 2015.

Gay and bisexual men (GBM) accounted for 40% of new diagnoses, and heterosexuals for 52% of new diagnoses. This is the first time that heterosexual transmission has been higher than GBM transmission in the past ten years. There

has also been a declining trend in new diagnoses in people born in the UK since 2015.

Overall, testing activity increased by 4% this year to include a total of 68,912 tests. Testing increased in hospital settings (by 14%) and in primary care (by 4%). GUM clinics saw a reduction in testing of 6%. There were 1,123 HIV-infected individuals resident in Northern Ireland who received care in 2019, compared with 1,131 in 2018. These figures reflect continuing new diagnoses, transfers of care into and out of Northern Ireland, and the role of antiretroviral therapy (ART) in increasing survival rates.

Although prevalence (numbers receiving care/1000 population) is still relatively lower in Northern Ireland, it has increased at a greater rate than elsewhere in the UK. Belfast is approaching the prevalence level at which expanded testing in primary and secondary care is recommended (rate of 2 per 100,000 of the population).

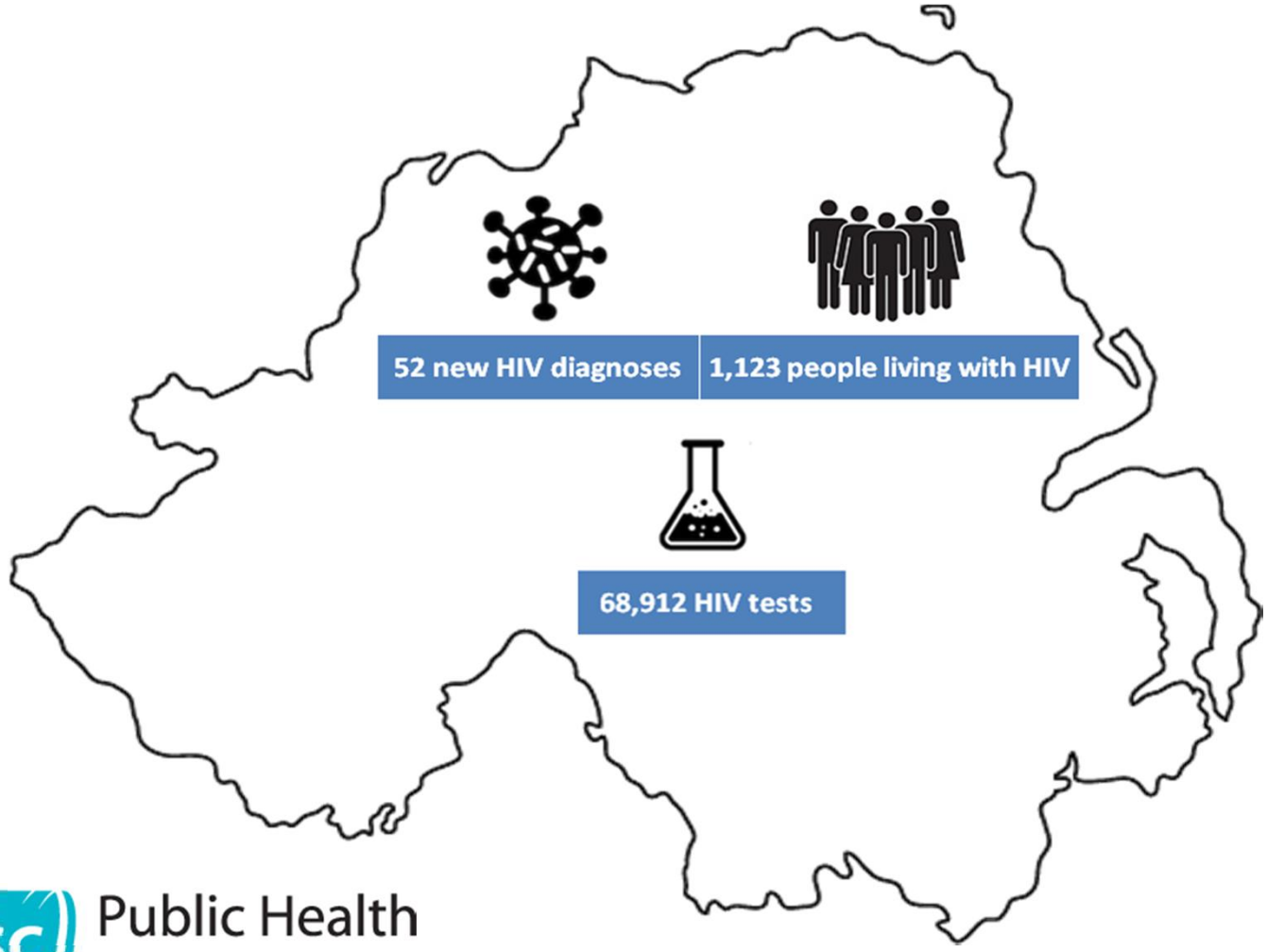
In 2014, UNAIDS set a target that by 2020 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained ART, and 90% of all people receiving ART will have viral suppression. This target has now been updated to 95% for each of the above areas by 2030. Modelling suggests that achieving these targets globally will enable the world to end the AIDS epidemic by 2030. The report notes that in 2019 in Northern Ireland, 100% of those in care received ART, and 97% of those on treatment had viral suppression as defined by <= 200 copies/ml. Although two of the three targets have been achieved earlier than the 2030 target, the remaining target that 95% of those infected are aware of their infection is not yet attained. National estimates of the number of all people living with HIV in the UK, including those undiagnosed, are obtained from a complex statistical model (multi-parameter evidence synthesis (MPES)) fitted to census, surveillance, and survey-type prevalence data. The estimate for 2019 equates to 93% of people living with HIV in Northern Ireland being aware of their infection.

In July 2018, the introduction of pre-exposure prophylaxis (PrEP) targeting people at high risk of acquiring HIV was an important addition to prevention efforts in Northern Ireland, and will be the subject of a future evaluation report. The number of new diagnoses in 2019 saw a steep decline in gay and bisexual men diagnoses, which may reflect the impact of PrEP, as well as improvements in testing, and entry into treatment.

The report recommends promoting safer sex and the benefits of HIV testing to the general population, young people and GBM, and that there should be a renewed focus on the promotion of HIV testing guidelines in both primary and secondary care. It also recommends that service commissioners continue to ensure access to HIV testing outside of health service settings, and importantly, ensuring access to online services.

HIV surveillance in Northern Ireland 2020

An analysis of data for the calendar year 2019



HSC Public Health Agency

Improving Your Health and Wellbeing

HIV surveillance in Northern Ireland

Aim

To provide an overview of HIV 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 2019.

New HIV diagnoses Definition

New HIV diagnoses are defined by area of residence. Please note, this is a change from previous years, where reporting of a new diagnosis was based on the clinic of diagnosis. This change ensures that we are reporting in the same way as the rest of the UK. For historical comparison a table with new HIV diagnoses by clinic of diagnosis has been presented at the end of the slide set in appendix 1.

Caveat

Trends over time must be interpreted with care, as each data source is subject to reporting delay. This means that numbers, particularly for recent years, may rise as a result of receiving further reports.

Other outputs

PHE National and Country HIV surveillance data tables are available at:
https://www.gov.uk/government/statistics/hiv-annual-data-tables

.

HIV surveillance in Northern Ireland

Summary Points 2019:

- 52 new HIV diagnoses were made in Northern Ireland (37 men and 15 women); a 35% decline from 80 in 2018 and a decline of 49% from a peak of 102 new HIV diagnoses reported in 2015.
- 21 (40%, 21/52) new HIV diagnoses occurred through gay and bisexual men (GBM) transmission; a 42% decrease from 36 in 2018.
- 27 (52%, 27/52) new HIV diagnoses occurred through heterosexual transmission. This is the first time that heterosexual transmission has been higher than gay and bisexual men transmission in the past ten years.
- Less than 5 (8%) new HIV diagnoses occurred through other or unknown transmission routes.
- The majority (62%, 32/52) of persons newly diagnosed in 2019 were aged between 25 and 49 years. The number and proportion of people diagnosed aged 50 years or over increased from 9% in 2010 to 29% in 2019. However, diagnoses in those aged 65+ have remained low with only 16 new diagnoses reported over the past ten years.
- 19 (39%, 19/49) new HIV diagnoses were made at a late stage (cases which had a CD4 count within 91 days of diagnosis, and in whom the CD4 count <350 cells/mm^3).

HSC Public Health Agency

Improving Your Health and Wellbeing

Summary Points 2019:

- 17% (2/12) of new diagnoses in gay and bisexual men tested under RITA were as a result of recently acquired infection, compared with 7% in heterosexuals.

- In 2019 there were nine people who were diagnosed with AIDS at their HIV diagnosis (reported AIDS defining illness within 3 months of HIV diagnosis). There were 9 deaths reported.

- 1,123 HIV-infected residents of Northern Ireland (as defined when last seen for statutory medical HIV-related care in 2019) received care (882 men and 241 women).

- 99% (961/974) of those receiving care, and where route of transmission was known, acquired their infection through sexual contact. Of these, 61% (596/974) acquired their infection through sexual contact involving gay and bisexual men and 37% (365/974) through heterosexual contact. One percent (13/974) acquired their infection through non-sexual contact.

- The greatest number of people who received HIV-related care in 2019 were in the 35-64 year age group (76%: 857/1,123). Of those that received HIV-related care during 2019, 82% were white ethnicity, 10% were black-African and 8% were classified in other ethnic groups or not reported.

- 100% of those in care received antiretroviral therapy, and 97% of those on treatment had viral suppression as defined by <= 200 copies/ml (where a viral load was reported).

- 68,912 HIV tests were carried out in Northern Ireland, of which 22,695 were performed as part of the antenatal screening programme.

HIV service developments

There have been a number of service developments that may have some impact on HIV testing and surveillance results during 2019, and going forward

- HIV PrEP clinic opened in July 2018, with requirements for 3 monthly HIV testing in those prescribed PrEP.

- SH:24 is a free online sexual health testing service that provides confidential home-testing for chlamydia, gonorrhoea, syphilis and HIV. The service became available to residents in Northern Ireland in late 2019. The data from SH:24 is not included in this slide set.

New HIV diagnoses

Table: 1 New HIV diagnoses in Northern Ireland: all persons by demographics and probable route of exposure, all years to 2019

Data to end of December 2019

New diagnoses and deaths		<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
HIV diagnoses	Male	488	68	60	69	87	71	81	60	67	60	37
	Female	166	13	13	16	13	22	21	14	16	20	15
	Subtotal	**654**	**81**	**73**	**85**	**100**	**93**	**102**	**74**	**83**	**80**	**52**
AIDS at HIV diagnoses	Male	82	<5	<5	0	<5	<20	<10	6	<10	<5	<10
	Female	21	<5	0	0	<5	<5	<5	0	<5	<5	<5
	Subtotal	**103**	**6**	**<5**	**0**	**<5**	**11**	**8**	**6**	**7**	**5**	**9**
Deaths	Male	75	<5	9	5	<20	<5	6	<10	5	<5	<10
	Female	12	<5	0	0	<5	<5	0	<5	0	<5	<5
	Subtotal	**87**	**5**	**9**	**5**	**11**	**<5**	**6**	**7**	**5**	**<5**	**9**

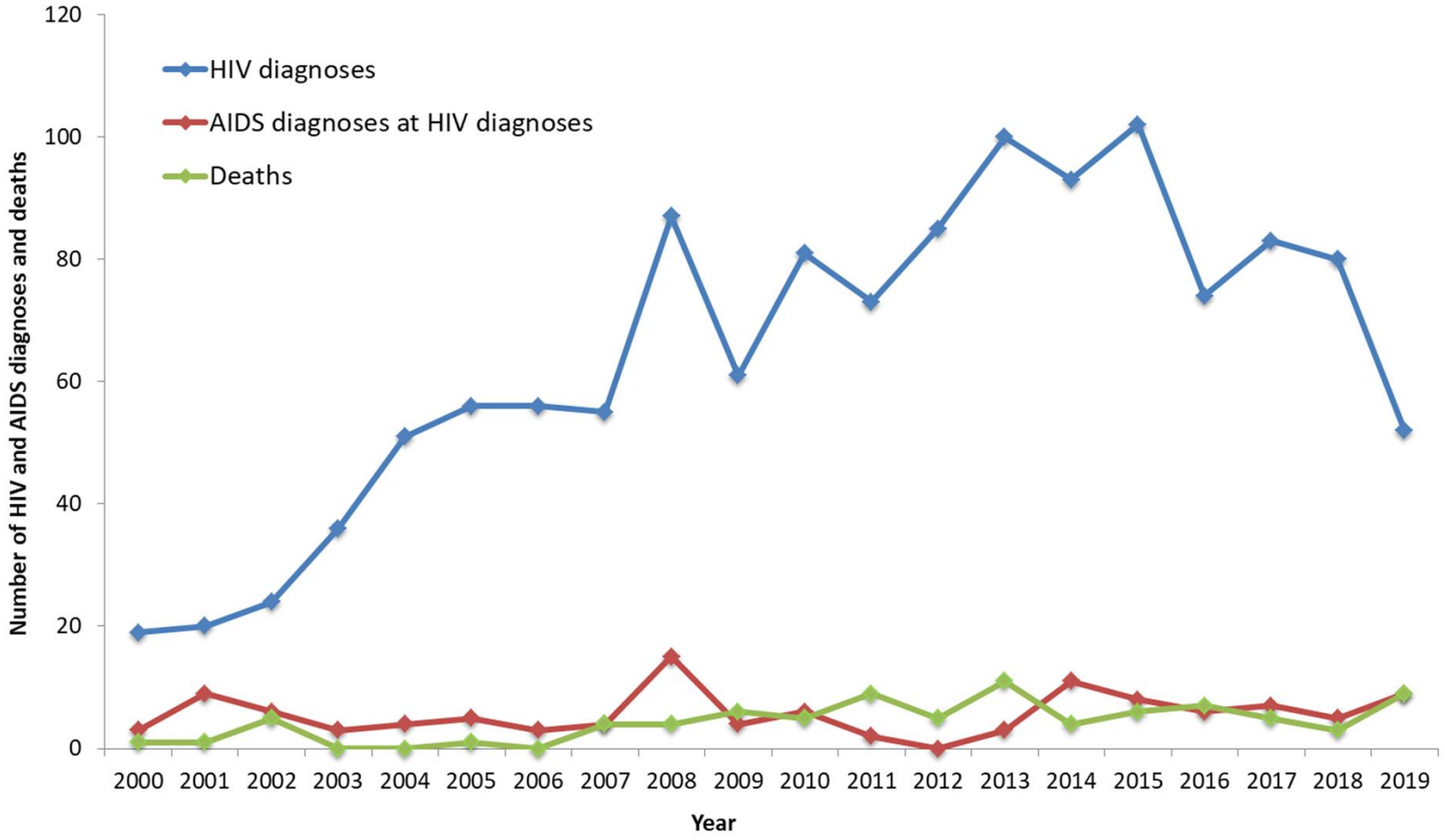
Age at diagnosis	<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<15	7	<5	0	0	0	0	0	0	<5	0	0
15 - 24	94	9	<10	11	<10	<20	9	13	10	<10	<10
25 - 34	244	27	24	34	29	25	37	22	25	23	12
35 - 49	252	37	26	22	38	41	43	25	29	31	20
50 - 64	49	<10	13	18	23	14	13	<10	16	15	14
65 and over	7	0	<5	0	<5	<5	0	<5	<5	<5	<5

Probable exposure category and gender		<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sex between men*		**315**	**53**	**42**	**53**	**52**	**44**	**60**	**42**	**39**	**36**	**21**
Heterosexual contact	Male	137	15	18	13	24	22	16	13	18	12	14
	Female	153	12	12	16	12	19	20	12	11	16	13
	Subtotal	**290**	**27**	**30**	**29**	**36**	**41**	**36**	**25**	**29**	**28**	**27**
Injecting drug use	Male	12	0	0	<5	<5	<5	<5	<5	<5	0	<5
	Female	5	0	0	0	0	0	0	<5	<5	0	<5
	Subtotal	**17**	**0**	**0**	**<5**	**<5**	**<5**	**<5**	**<5**	**<5**	**0**	**<5**
Mother to child	Male	<5	0	0	0	0	0	0	0	<5	0	0
	Female	<10	<5	0	0	0	0	0	0	0	0	<5
	Subtotal	**7**	**<5**	**0**	**0**	**0**	**0**	**0**	**0**	**<5**	**0**	**<5**
Other	Male	<30	0	0	<5	<5	0	0	0	0	0	0
	Female	<5	0	<5	0	0	0	0	0	0	0	0
	Subtotal	**23**	**0**	**<5**	**<5**	**<5**	**0**	**0**	**0**	**0**	**0**	**0**

Notes: New HIV diagnoses are based on residence area.
Total includes individuals with incomplete/not reported demographic data.
*Sex between men includes men who also reported injecting drug use.

Trends in new diagnoses HIV, AIDS and deaths in HIV infected persons

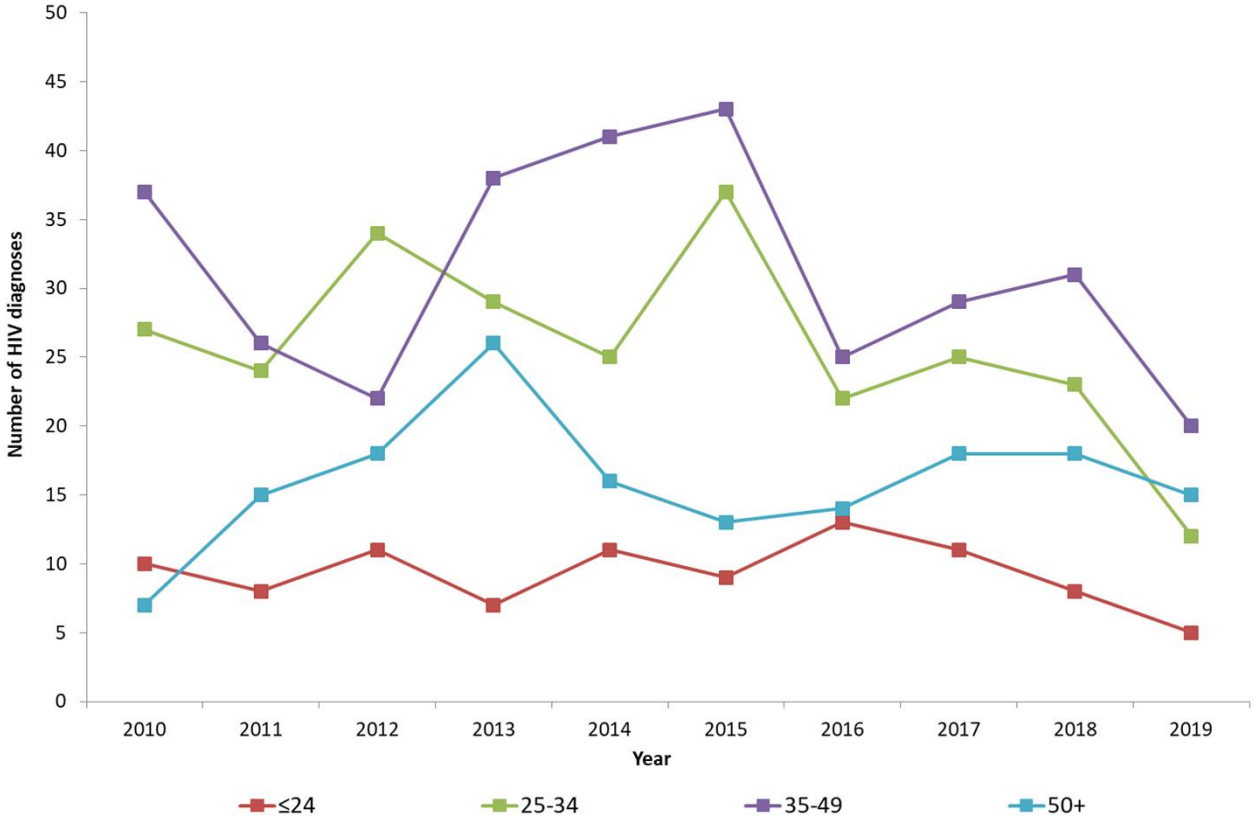
Figure 1: Number of new HIV diagnoses, AIDS* at HIV diagnosis and deaths in people with HIV, Northern Ireland, 2000 to 2019



Note: *AIDS defining illness within 3 months of an HIV diagnosis

Age group

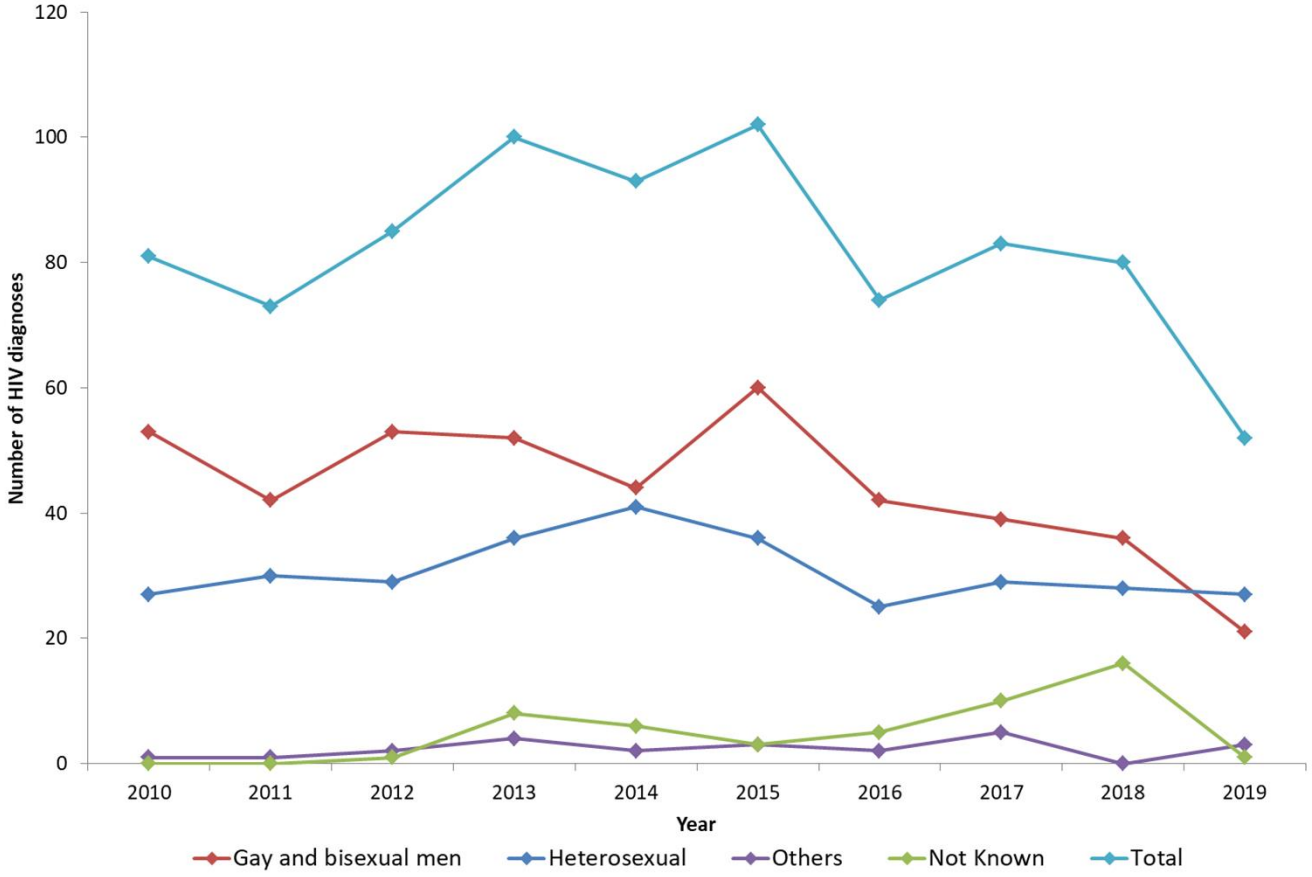
Figure 2: Number of new HIV diagnoses by age group, 2010 – 2019, Northern Ireland



New HIV diagnoses in Northern Ireland have been highest in the 35-49 age group. The largest proportional increase has been seen in the 50+ age group; however, diagnoses in those aged 65+ have remained low with only 16 new diagnoses reported over the past ten years.

Risk groups

Figure 3: Annual new diagnoses of HIV by probable route of exposure, 2010 – 2019, Northern Ireland



New HIV diagnoses in Northern Ireland have been acquired mostly through sexual transmission over the years, with gay and bisexual men accounting for the majority of these from 2010. However, for the first time in the past decade gay and bisexual transmission has been lower in 2019 than heterosexual transmission. The annual number of diagnoses where infection has been acquired through other exposures remains very low.

Risk groups

Gay and bisexual men

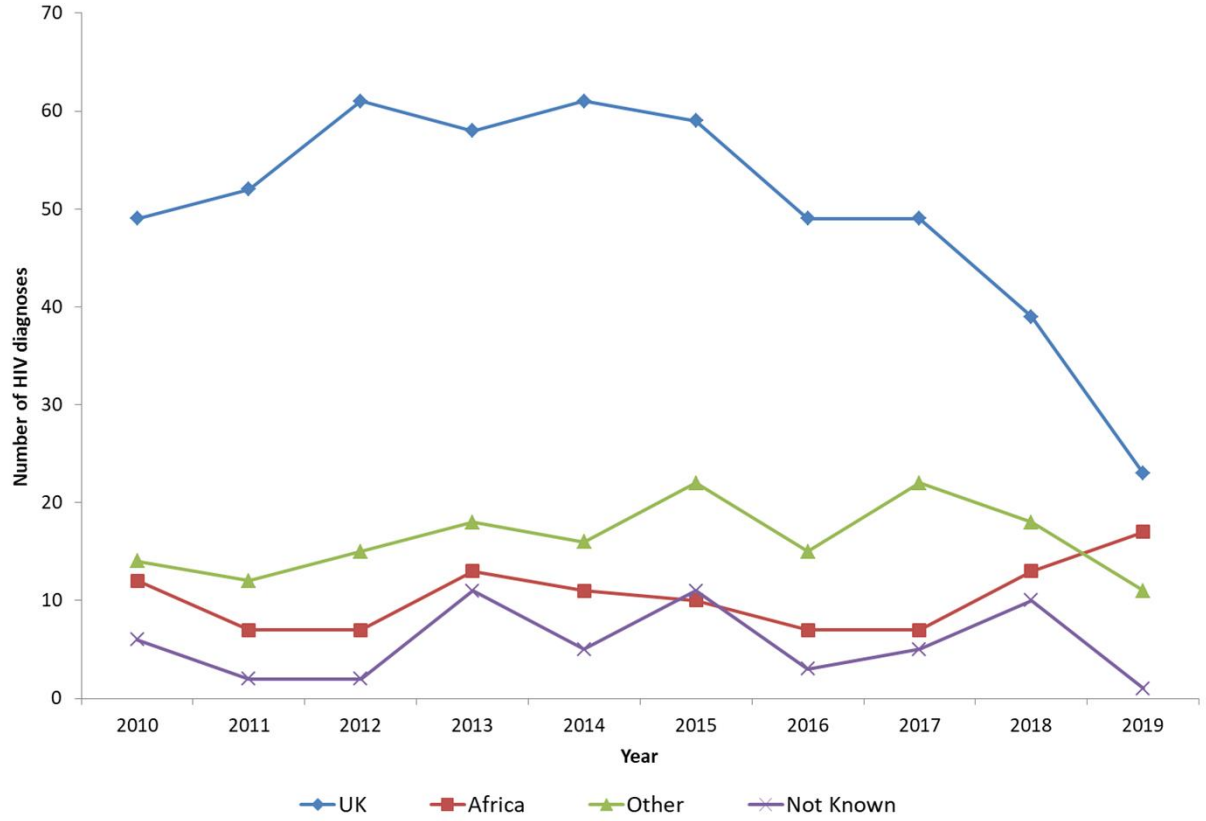
In 2019, 40% (21/52) of all new HIV diagnoses were in gay and bisexual men (compared to 45% (36/80) in 2018 and 65% (53/81) in 2010). Of the gay and bisexual men (GBM) newly diagnosed with HIV in 2019, 90% were white ethnicity (in cases were ethnicity was recorded) and 71% were UK-born. There has been a declining trend in GBM diagnoses since 2016 with a steep decline in 2019.

Heterosexual transmission

Heterosexual contact accounted for 52% (27/52) of all new HIV diagnoses made in 2019 (compared to 35% (28/80) in 2018 and 33% (27/81) in 2010). Black Africans accounted for 46% of new diagnoses in 2019 (in cases were ethnicity was recorded) compared with 25% in 2018 and 50% in 2010. There has been a small declining trend in new heterosexual diagnoses since 2014.

Region of birth

Figure 4: Number of new HIV diagnoses by region of birth, 2010 – 2019, Northern Ireland



The majority (65%; 500/767) of new HIV diagnoses reported since 2010 were born in the UK, in cases were country of birth was recorded. Of the new HIV diagnoses born outside the UK, 39% (104/267) were born in Africa. There has been a general declining trend in diagnoses in people born in the UK since 2015.

Table: 1A New HIV diagnoses in Northern Ireland: all persons by ethnicity, region of birth and CD4 count, all years to 2019

Data to end of December 2019

Ethnicity and gender		<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
White	Male	423	<60	56	65	75	67	76	55	57	43	29
	Female	82	<5	5	9	6	11	12	8	11	11	7
	Subtotal	**505**	**60**	**61**	**74**	**81**	**78**	**88**	**63**	**68**	**54**	**36**
Black African	Male	46	6	<5	<5	6	<5	<5	<5	<5	<5	5
	Female	61	8	<5	<10	7	<10	<10	<10	<5	<10	8
	Subtotal	**107**	**14**	**6**	**9**	**13**	**12**	**6**	**9**	**<5**	**8**	**13**
Black Caribbean		<5	0	0	0	0	0	0	0	0	0	0
Other/mixed		27	<5	<5	<5	5	<5	7	<5	6	6	<5

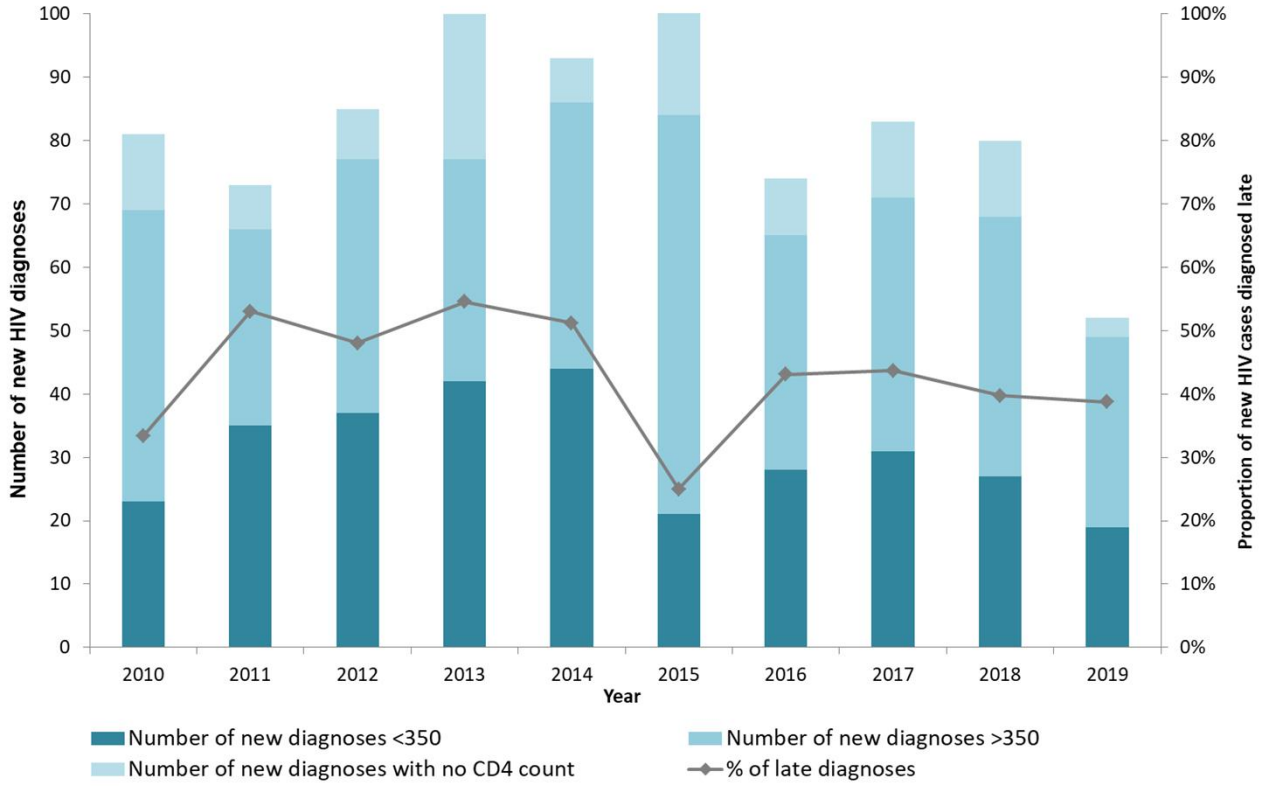
Region of birth	<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
UK	268	49	52	61	58	61	59	49	49	39	23
Europe	67	12	11	13	8	15	16	12	16	11	8
Africa	95	12	7	7	13	11	10	7	7	13	17
Asia	16	<5	0	0	5	<5	5	<5	<5	6	<5
Other	6	<5	<5	<5	5	0	<5	<5	<5	<5	0

CD4 at diagnosis**	<2010	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number with a CD4 count	428	69	66	77	77	86	84	65	71	68	49
Number with CD4 <350	216	23	35	37	42	44	21	28	31	27	19
% of CD4 <350	**50%**	**33%**	**53%**	**48%**	**55%**	**51%**	**25%**	**43%**	**44%**	**40%**	**39%**
Median CD4	**330**	**440**	**330**	**350**	**320**	**340**	**550**	**390**	**410**	**435**	**500**

** CD4 count data are presented for those with a CD4 count available within 91 days of diagnosis.

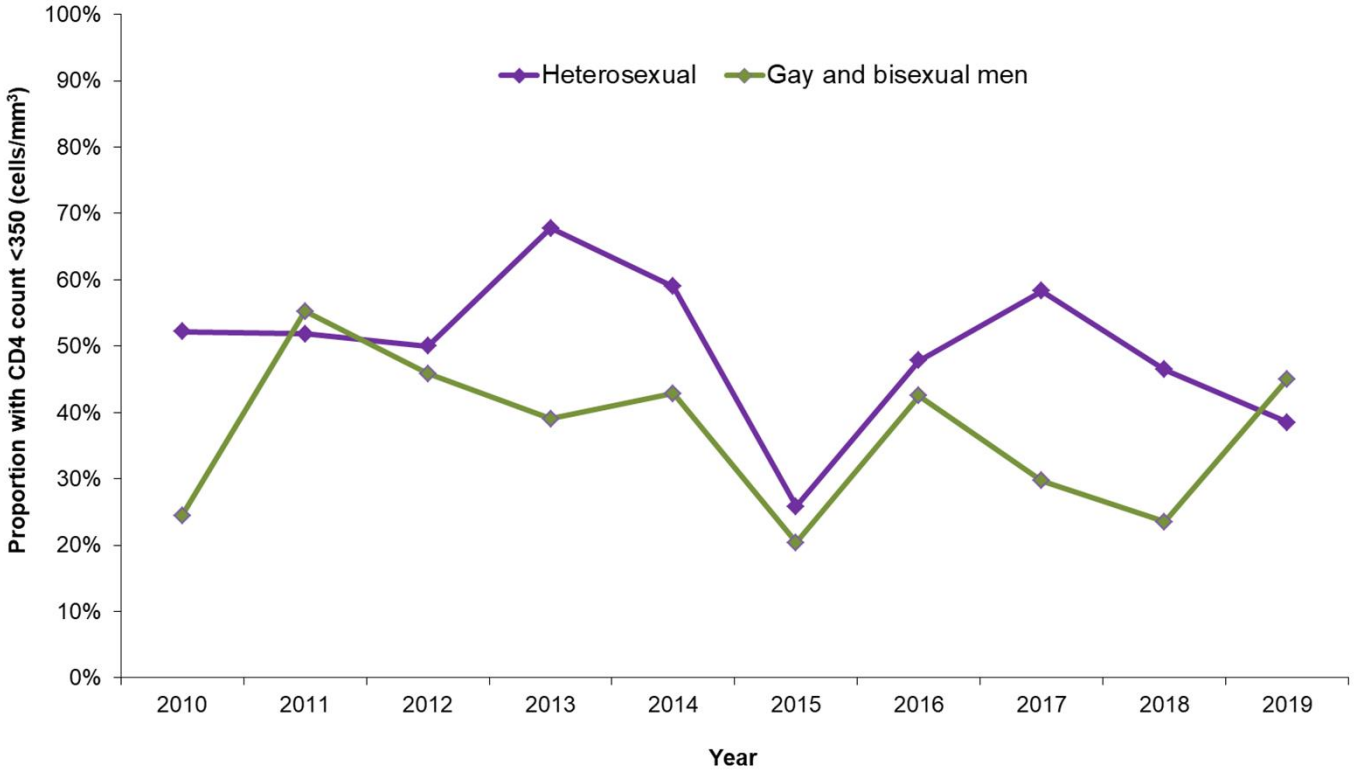
Late diagnoses

Figure 5: Number and proportion of new HIV diagnoses in adults diagnosed with a CD4 count <350 cells/mm^3 within 91 days of diagnosis, 2010 – 2019, Northern Ireland



CD4 counts within 91 days of diagnosis were available for 94% (49/52) of new HIV diagnoses. Thirty-nine percent (19/49) of new HIV diagnoses were diagnosed at a late stage (cases which had a CD4 count within 91 days of diagnosis, and in whom the CD4 count <350 cells/mm^3).

Figure 6: Proportion of new HIV diagnoses in adults with a CD4 count <350 cells/mm^3 within 91 days of diagnosis, by probable route of infection, 2010 – 2019, Northern Ireland

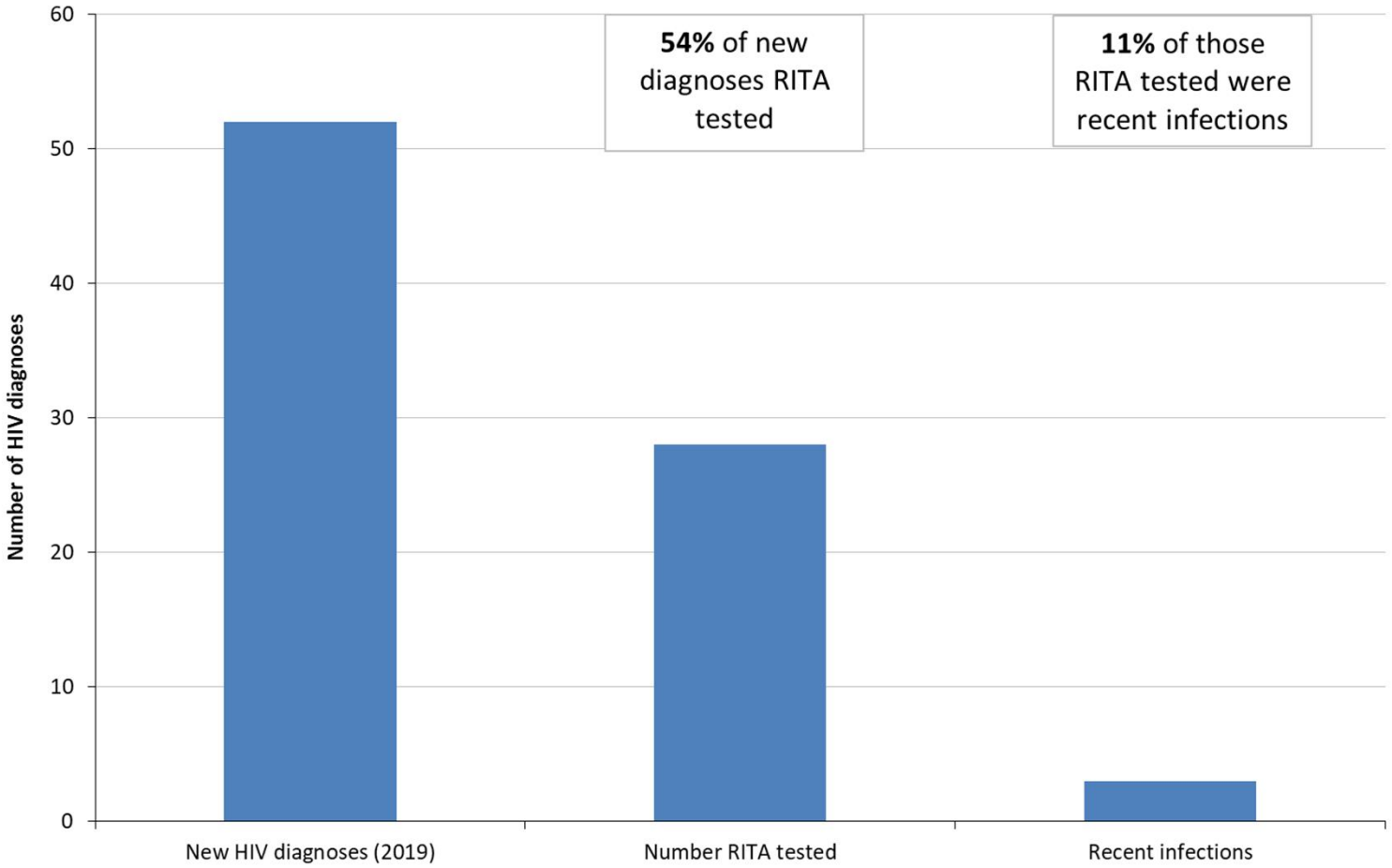


Thirty-eight percent (10/26) of individuals with heterosexually acquired HIV were diagnosed at a late stage in 2019 compared with 45% (9/20) of diagnoses in gay and bisexual men being made at a late stage.

Interpretation of this data for Northern Ireland is complicated by year to year small number variation.

Recent diagnoses

Figure 7: Number of new HIV diagnoses, RITA* tested and recent infections, 2019 Northern Ireland



*The Recent Infection Treatment Algorithm (RITA) allows classification of HIV diagnoses as recent or incident infections (acquired within the last six months). The data used in the algorithm includes CD4 count, anti-retroviral treatment and the diagnosis of an AIDS defining illness.

Prevalent infection

Table: 2 People seen for HIV care in the UK resident in Northern Ireland by demographics and probable exposure route: 2010 to 2019

Data to end of December 2019

Gender	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Male	363	442	508	589	634	734	788	859	893	882
Female	134	136	161	179	183	211	220	223	238	241
Total	**497**	**578**	**669**	**768**	**817**	**945**	**1,008**	**1,082**	**1,131**	**1,123**

Age and gender		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<15	Male	<5	0	0	0	0	0	0	<5	<5	<5
	Female	0	0	0	0	<5	0	0	0	0	0
	Subtotal	**<5**	**0**	**0**	**0**	**<5**	**0**	**0**	**<5**	**<5**	**<5**
15 - 24	Male	14	19	21	16	<20	18	24	<40	<30	<30
	Female	11	6	8	7	<5	5	6	<10	<10	<10
	Subtotal	**25**	**25**	**29**	**23**	**<30**	**23**	**30**	**<40**	**<30**	**<30**
25 - 34	Male	90	107	118	124	125	152	158	162	157	138
	Female	49	53	53	53	53	56	46	45	43	33
	Subtotal	**139**	**160**	**171**	**177**	**178**	**208**	**204**	**207**	**200**	**171**
35 - 49	Male	185	220	246	280	286	324	336	366	374	360
	Female	63	61	73	81	85	98	114	112	119	123
	Subtotal	**248**	**281**	**319**	**361**	**371**	**422**	**450**	**478**	**493**	**483**
50 - 64	Male	64	83	109	149	179	210	239	264	292	310
	Female	11	16	27	38	39	47	50	53	61	64
	Subtotal	**75**	**99**	**136**	**187**	**218**	**257**	**289**	**317**	**353**	**374**
65 and over	Male	<10	13	14	20	<30	30	<40	36	45	53
	Female	0	0	0	0	<5	5	<5	7	10	15
	Subtotal	**<10**	**13**	**14**	**20**	**26**	**35**	**35**	**43**	**55**	**68**

Probable exposure category	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sex between men*	249	306	364	418	454	535	585	633	622	596
Heterosexual contact	231	256	284	321	331	373	381	398	379	365
Injecting drug use	<5	<10	<10	<10	<10	<10	<10	<20	12	<10
Mother to child	<5	<5	<5	<5	<5	<5	<5	<5	5	<5
Other/undetermined	9	10	14	21	22	28	31	36	113	149

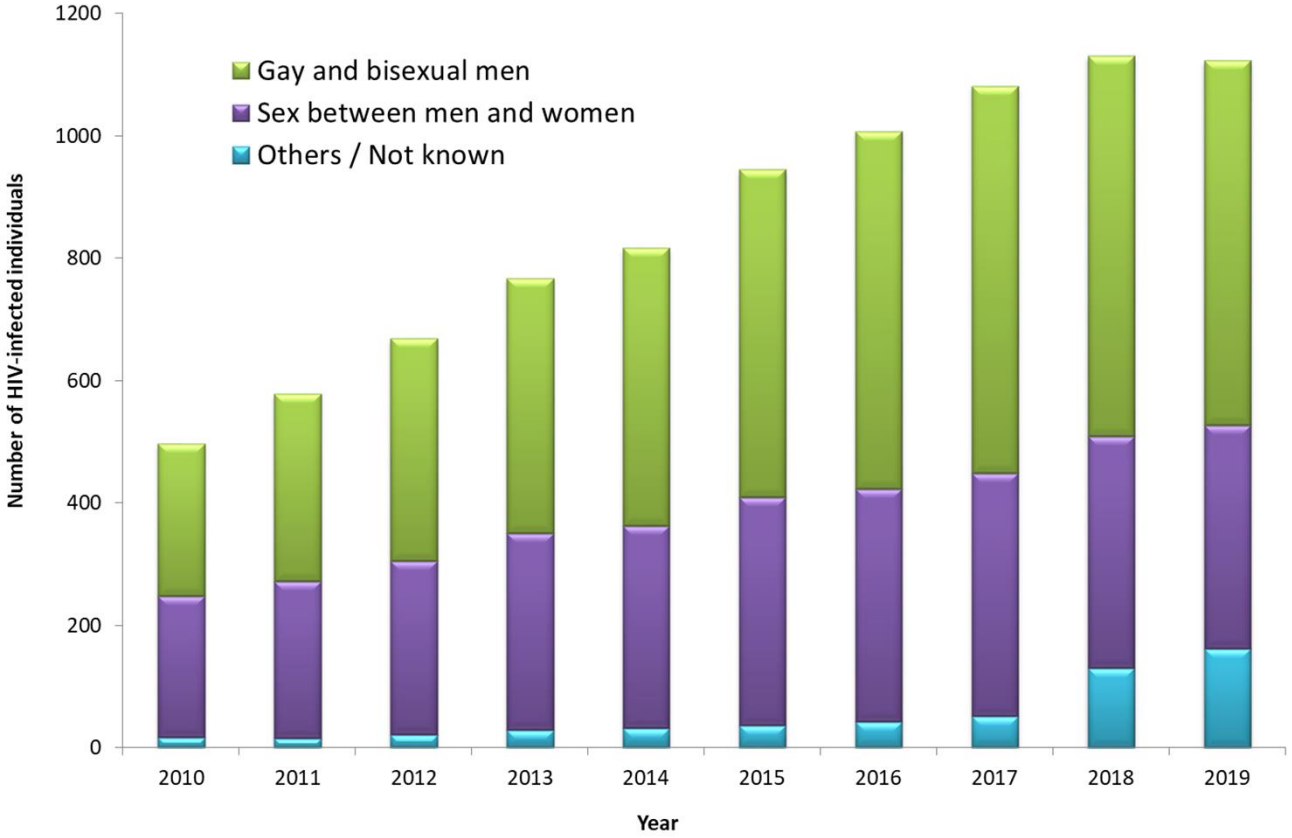
Ethnic group	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
White	389	467	562	636	692	807	863	937	966	924
Black African	86	90	90	107	102	108	114	113	116	108
Black Caribbean	<5	<5	<5	<5	<5	<5	<5	<5	<5	<5
Black other	<5	<5	<5	<5	<5	<5	<5	<5	<5	<5
Asian	10	9	10	14	14	18	18	18	22	21
Other/mixed	7	8	<5	7	5	8	9	9	9	9

Notes: Total includes individuals with incomplete/not reported demographic data.

*Sex between men includes men who also reported injecting drug use.

Prevalent infection

Figure 8: Annual number of HIV infected individuals resident in Northern Ireland accessing HIV-related care, by probable route of infection, 2010 – 2019



1,123 residents in Northern Ireland with diagnosed HIV infection (882 men and 241 women) accessed care in 2019 compared with 1,131 in 2018. These figures reflect continuing new diagnoses, transfers of care into and out of Northern Ireland and the role of HAART in increasing survival rates.

Prevalence by Local Government District of residence

Table 3: Diagnosed HIV prevalence per 1,000 population aged 15-59 years, by Local Government District, 2019, Northern Ireland*

Rate per 1,000 population	Local Government District
0.00 – 0.49	Causeway Coast and Glens Derry City and Strabane Fermanagh and Omagh
0.50 – 0.99	Antrim and Newtownabbey Ards and North Down Armagh City, Banbridge and Craigavon Lisburn and Castlereagh Mid and East Antrim Mid Ulster Newry, Mourne and Down
1.00 – 1.49	
1.50 – 1.99	Belfast

Note: *Numbers may rise as further reports are received and more information is obtained on area of residence. This is more likely to affect recent years, particularly 2019. This may impact on interpretation of trends in more recent years.

Estimates of prevalence derived from the Survey of Prevalent Infection Diagnosed (SOPHID) show that Belfast Local Government District (LGD) area has the highest rate in Northern Ireland at 1.80/1000 population aged 15-59 years (compared with 1.95/1000 population aged 15-59 years in 2018).

All areas remain below the 2/1000 threshold at which expanded testing is recommended. The overall prevalence for the Northern Ireland population is 0.89/1000 population aged 15-59 years.

Progress towards UNAIDS target

In 2014, UNAIDS set a target that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression. This target has been updated to 95% for each of the above areas by 2030. Modelling suggests that achieving these targets globally will enable the world to end the AIDS epidemic by 2030.

Undiagnosed infection

National estimates of the number of all people living with HIV in the UK, including those undiagnosed, are obtained from a complex statistical model (multi-parameter evidence synthesis (MPES)) fitted to census, surveillance and survey-type prevalence data. The estimate for 2019 equates to 93% of people living with HIV in Northern Ireland being aware of their infection.

Antiretroviral therapy and viral load

In 2019, 100% of those in care received ART, and 97% of those on treatment had viral suppression as defined by <= 200 copies/ml (where a viral load was reported).

HIV testing

Table 4: Number of HIV tests performed by healthcare setting, 2010 – 2019, Northern Ireland
(excludes antenatal screening programme)

Service setting	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Change from 2018-2019	
GUM	14,583	15,639	16,725	15,912	17,887	17,022	16,277	18,100	18,847	17,795	- 1,052	-6%
Hospital	8,542	8,628	10,882	11,114	13,253	14,942	15,374	18,517	20,658	23,558	2,900	14%
Primary Care	1,832	2,272	2,786	2,783	3,433	4,093	4,244	4,803	4,095	4,239	144	4%
Other	701	927	783	741	611	738	643	614	642	625	- 17	-3%
Total	**25,658**	**27,466**	**31,176**	**30,550**	**35,184**	**36,795**	**36,538**	**42,034**	**44,242**	**46,217**	**1,975**	**4%**

Source: Regional Virology Laboratory

- During 2019, 46,217 HIV tests were performed outside the antenatal screening programme in a health service setting in Northern Ireland. This represents an increase of 4% (1,975) compared with 2018 (44,242).

- Testing in all settings has increased from 3,138 tests carried out in 2000 to 46,217 in 2019 (Figure 9). The majority of testing is carried out in the GUM or hospital setting, accounting for 89% of all tests during 2019.

Figure 9: Annual number of HIV tests performed, by healthcare setting, 2000-2019, Northern Ireland (excludes antenatal screening programme)

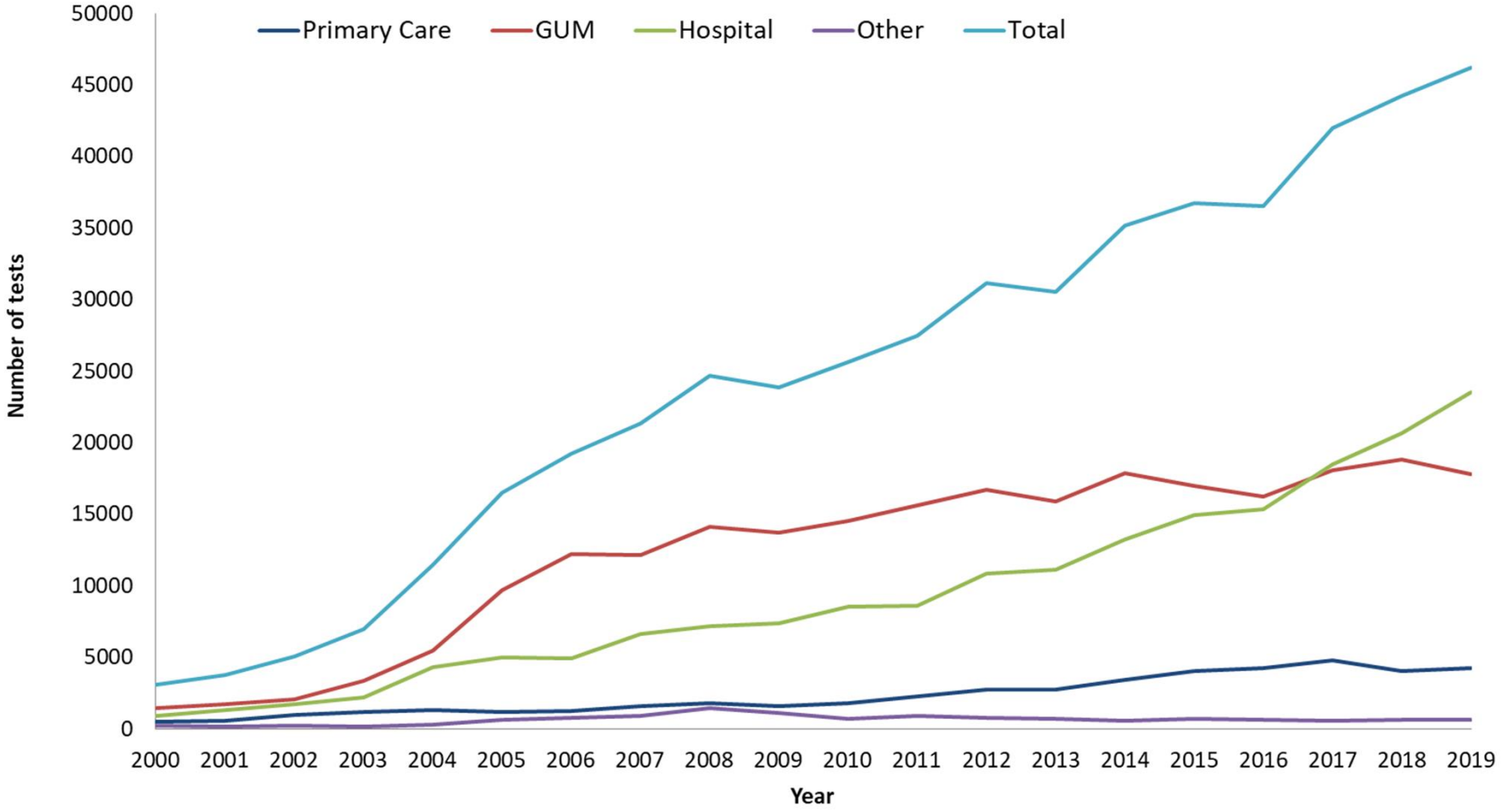
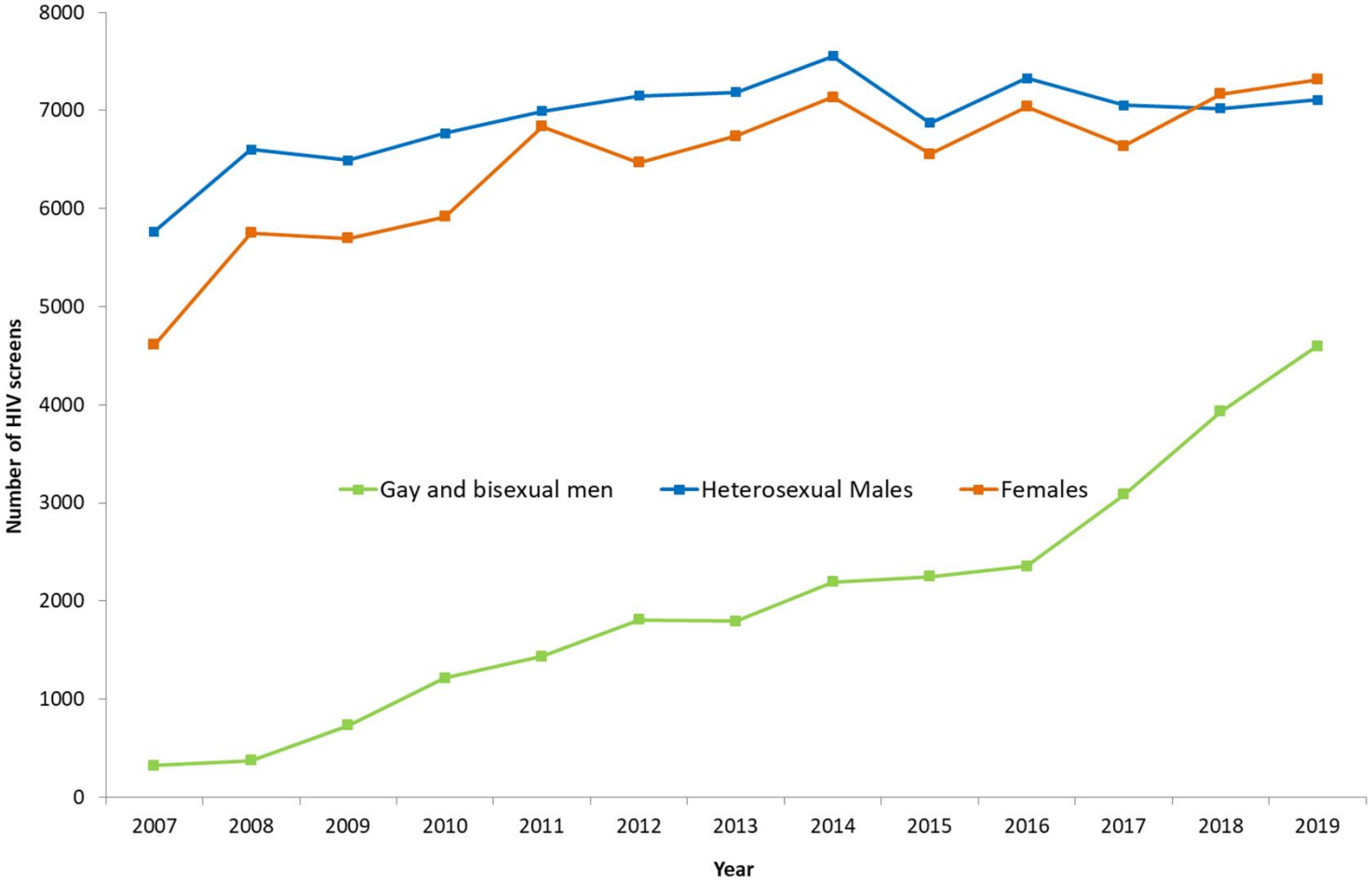


Figure 10: Annual number of HIV screens carried out in GUM clinics, 2007 – 2019, Northern Ireland
Source: GUMCAD - HIV tests KC60/SHHAPT codes S2, P1A, T4 & T7



Between 2007 and 2019, the annual number of first episode HIV screens in gay and bisexual men has increased by 1328% (322 to 4597). This compares with an increase of 23% (5765 to 7109) in heterosexual males and 59% in females (4613 to 7312). There have been large increases in testing activity in gay and bisexual men since 2017 (Figure 10).

PrEP

HIV pre-exposure prophylaxis (PrEP) is the use of antiretroviral drugs to protect individuals at risk of acquiring HIV. It is prescribed as either a daily dosing or event based (on-demand) regime. Both methods have been shown to be very effective at preventing HIV acquisition, with studies in men who have sex with men estimating a reduction in the risk of HIV acquisition by as much as 86%, with between 13 and 18 needing to be treated in a year to prevent one infection.

PrEP was introduced in Northern Ireland through a Risk Reduction Clinic (RRC) service in July 2018. The RRC service offers interventions aimed at reducing unsafe sexual behaviour, along with PrEP, to patients meeting risk-based criteria. Piloted in the Belfast trust for two years, uptake of the service went on to exceed initial expectations three fold. A second PrEP centre was then established in the Western trust in October 2019. Coinciding with the onset of the pandemic, the Belfast service ceased at the end of March 2020, but the Western trust service has continued to accept patients from across Northern Ireland and has maintained safe delivery of PrEP through an increasingly high reliance on online STI patient self testing. This innovative service model is currently being rolled out to all Health and Social Care trusts to improve access for patients and is continuing to be funded by the Department of Health.

Summary and conclusions

- The number of new diagnoses in 2019 has reduced significantly with a steep decline seen in gay and bisexual men diagnoses. This may reflect the impact of PrEP, which was introduced in Northern Ireland in July 2018. Improvements in testing, earlier diagnosis, and entry into treatment may also be reflected.

- There is a declining trend in the annual number of diagnoses in people born in the UK.

- There has been a gradual small reduction in the proportion of annual new diagnoses made at a late stage.

- The number of people living with HIV in Northern Ireland has increased in recent years as a consequence of new diagnoses, transfers of care into Northern Ireland, and improved survival rates due to the success of antiretroviral treatment.

- HIV testing activity has increased in 2019 to its highest level yet. Testing in the hospital setting has shown a year on year increase and 2019 has also seen an increase in tests done in primary care settings.

- The UNAIDS 90: 90: 90 HIV elimination strategy by 2020, targets for 1) the proportion of all people living with HIV being aware of their diagnosis, 2) the proportion of diagnosed individuals receiving treatment and 3) the proportion of those in treatment being virally suppressed have now been surpassed. In relation to the UNAIDS 95:95:95 HIV elimination strategy by 2030, the targets for treatment and viral suppression have been met. However, modelling suggests that the target for the proportion of individuals living with HIV being aware of their diagnosis has fallen short of the 95% target.

Recommendations

- Safer sex messages including the benefits of HIV testing should continue to be promoted to the general population, young people and gay and bisexual men.
- Frequent repeat HIV testing should be advised to those most at risk.
- There should be a renewed focus on the promotion of HIV testing guidelines in both primary and secondary care.
- Service commissioners should continue to ensure HIV testing outside health service settings, including use of online services.

New HIV diagnoses by clinic of diagnosis

Appendix 1: New HIV diagnoses in Northern Ireland by clinic of diagnosis, 2010 to 2019 Data to end of December 2019											
New diagnoses		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
HIV diagnoses	Male	72	68	75	89	75	87	66	72	62	39
	Female	15	13	20	14	22	24	14	18	22	15
	Subtotal	**87**	**81**	**95**	**103**	**97**	**111**	**80**	**90**	**84**	**54**

The above table has been provided for historical comparisons as new HIV diagnoses were based on clinic of diagnosis in previous surveillance reports.

Acknowledgements

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HSC Public Health Agency

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