HSC Public Health Agency

**MINUTES**

**Minutes of the 81st Meeting of the Public Health Agency board held on Thursday 21 January at 1:30pm, in Conference Rooms 2, 3+4, 12/22 Linenhall Street, Belfast, BT2 8BS**

**PRESENT:**

| | | |
|---|---|---|
| Mr Andrew Dougal | - | Chair |
| Dr Eddie Rooney | - | Chief Executive |
| Dr Carolyn Harper | - | Director of Public Health/Medical Director |
| Mrs Mary Hinds | - | Director of Nursing and Allied Health Professionals |
| Mr Edmond McClean | - | Director of Operations |
| Mr Brian Coulter | - | Non-Executive Director |
| Mr Leslie Drew | - | Non-Executive Director |
| Mrs Julie Erskine | - | Non-Executive Director |
| Mr Thomas Mahaffy | - | Non-Executive Director |
| Alderman Paul Porter | - | Non-Executive Director |

**IN ATTENDANCE:**

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

**APOLOGIES:**

| | | |
|---|---|---|
| Councillor William Ashe | - | Non-Executive Director |
| Mrs Fionnuala McAndrew | - | Director of Social Care and Children, HSCB |

| | | Action |
|---|---|---|
| **1/16** | **Item 1 – Welcome and Apologies** | |
| 1/16.1 | The Chair welcomed everyone to the meeting and noted apologies from Councillor William Ashe and Mrs Fionnuala McAndrew. | |
| **2/16** | **Item 2 - Declaration of Interests** | |
| 2/16.1 | The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared. | |

**3/16 Item 3 – Minutes of previous meeting held on 17 December 2015**

3/16.1 The minutes of the previous meeting, held on 17 December 2015, were approved as an accurate record of the meeting.

**4/16 Item 4 – Matters Arising**

4/16.1 There were no matters arising.

**5/16 Item 5 – Chair's Business**

5/16.1 The Chair advised that he had attended a launch in the Long Gallery of a prevention campaign which seeks to reduce the number of preventable deaths in NI by 25%. He made reference to the Change of Heart campaign in 1987 which was a positive development at that time.

5/16.2 The Chair said that he had attended a recent meeting of the Chairs' Forum at which the Comptroller and Audit General had raised concerns about the volume of paperwork which Boards receive and a need to streamline this.

5/16.3 The Chair suggested to members that more PHA Board meetings should be held offsite across Northern Ireland and he was proposing hosting a meeting at the Arc Healthy Living Centre in Irvinestown.

5/16.4 The Chair asked Dr Harper about developments in relation to the tax on sugary drinks. He noted that this had been ruled by the Prime Minister, but it seemed there had been a change in his stance and a new strategy being developed. Dr Harper said that a tax has not been ruled out but she noted that there have been a number of interventions to reduce intake of sugar and reduce obesity. She advised that in Mexico, a recent study showed that a 10% tax on sugar had resulted in a 17% reduction in consumption within the lower socio-economic groups and a 9% reduction in consumption in more affluent groups. She said that this debate in a similar position to the debate within tobacco, but she added that price is not such a factor with regard to tobacco as it is more addictive.

5/16.5 The Chair asked about e-cigarettes, noting the recent

developments in England where e-cigarettes had been approved by the Medicines and Therapeutic Products Agency and may be given out on prescription. Dr Harper said that PHA's view remains that if e-cigarettes are licensed and regulated in the context of a stop smoking service then they could be a possible mechanism for quitting. However, she went on to say that recent studies have questioned their effectiveness. She explained that on the one hand, e-cigarettes could be offered alongside gum and patches as a stop smoking aid, but on the other hand, the electric coil within them could cause cell damage and that the prolonged use of vapour could lead to cancer. She said that as the evidence remains contradictory PHA would not endorse e-cigarettes.

**6/16 Item 6 – Chief Executive's Business**

6/16.1 The Chief Executive advised members that, along with the other Executive Directors, he had met with the Chair of the Expert Review Panel, Professor Rafael Bengoa and that the meeting had been useful. He said that the Panel was working to inform the political summit, due to take place in February.

6/16.2 The Chief Executive said that he had attended a workshop on the development of the next Programme for Government which he advised has to be signed off by the Northern Ireland Assembly within one week of its resitting after the election. From a PHA perspective, he said that there were discussions on health and public health with a framework to be developed with emphasis on outcomes and interventions in all aspects of social development. He added that joined-up working was being promoted and that this was a positive development.

**7/16 Item 7 – Finance Update – PHA Financial Performance Report (PHA/01/01/16)**

7/16.1 Mr Cummings presented the Finance Report and said that PHA's financial position is currently showing a surplus which is due to two main factors; a better than expected outturn within the management and administration budget, and within programme expenditure a surplus within the Lifeline budget. He said that the management team were seeking to utilise this surplus in other non-recurrent priority areas, but that as not all of the surplus could be used DHSSPS had been advised that £600k would be

available for redistribution within the HSC system.

7/16.2 The Chair asked about the reductions in expenditure in these two areas. Mr Cummings said that there had been good management action to ensure that posts had not been replaced where they were not needed, and that within the Lifeline budget there were more appropriate referrals being made which had caused a reduction in PHA's expenditure, and that the programme was value for money. Mr McClean added that PHA would continue to ensure that the expenditure remained in line and that additional resources had been put in to monitor the budget.

7/16.3 Mr Drew asked whether it was possible to carry forward its surplus into 2016/17. Mr Cummings said that this was not possible but he noted that the Comptroller and Audit General had recently expressed a view that health organisations in Northern Ireland should operate their finances on a 3-year cycle as is in the case in England. Alderman Porter noted the additional savings within management and administration can be carried forward into 2016/17 but he did not agree that HSC should operate on a 3-year cycle as this could encourage organisations to build up surpluses which would be detrimental to smaller third sector organisations seeking additional funding.

7/16.4 Mr Coulter asked whether the underspend would be £600k or could be liable to change. The Chief Executive said that each year there are challenges for PHA, particularly within demand-led services to judge what the financial outturn will be, but he said that once any surplus has been identified, PHA always seeks to invest it in non-recurrent priority areas. He added that there are meetings held with budget managers which give a good indication of what the year-end outturn may be and that PHA has improved its performance in terms of getting funding out more quickly. Mr Cummings said he was confident that £600k was the appropriate figure.

7/16.5 Mr Coulter asked about the retraction of R&D funding to the Belfast Trust. The Chief Executive said that if a large scale R&D project slips, it does have an impact, but that historically the R&D budget has always delivered. The Chair expressed concern that the Research Governance Committee may be the cause of the delay. Dr Harper said that R&D staff report delays in getting IT

or office space established, but she advised that Professor Ian Young had taken up post as Director of R&D and that one of his priorities will be to engage with the Trusts. She said that R&D is an important area and that the previous Health Minister had seen the economic benefits of HSC R&D in Northern Ireland.

7/16.6 Members noted the Finance Report.

**8/16 Item 8 – Unscheduled Care Update**

8/16.1 The Chief Executive informed members that the work of the joint Unscheduled Care Group between PHA and HSCB was continuing and that there had recently been an increase in the number of 12-hour breeches due to increased attendances at Emergency Departments. He said that older and sicker people were presenting at EDs and that a review of the 12-hour breeches showed that there is a delicate balance within the system, both from a demand-side into the service, and on the discharge side out of the service. He added that there is a genuine willingness to review all processes and that to this end, a meeting had been held with Professor John Bolton, the outcome of which showed that although progress has been made, there remains a long way to go.

8/16.2 The Chair asked about placing GP Out of Hours Services on the same sites as Emergency Departments. He asked what the uptake on GP OOH is. Dr Harper said that utilisation is currently at 110%. She added that there are issues around call back with patients waiting up to 9 hours for a return call when they telephone the service.

8/16.3 Mr Drew asked about the new ED facilities at the Royal Hospitals. Mrs Hinds said that the physical environment is much better and that staff are happier, but that there remain some issues with patient flow.

8/16.4 Mr Coulter asked about the segregation of patients who attend due to alcohol-related reasons. Dr Harper said that a very low number of patients fall into this category, and Mrs Hinds said that that there only been small numbers of patients presenting at the Alcohol Recovery Centre. Dr Harper expressed concerns about the safety of these types of units as there had been SAIs reported.

8/16.5 Members noted the update on Unscheduled Care.

**9/16 Item 9 – Lifeline Consultation Response (PHA/02/01/16)**

9/16.1 The Chair noted the original consultation proposals and the variety of submissions received. He also noted the various workshops held to give consideration to the comments received and the extent to which PHA might be able to positively reflect these.

9/16.2 The Chair also acknowledged the huge amount of meticulous work that had gone into to the preparation of the final report on the consultation on the Lifeline Crisis Response Service. He asked that members consider each of the proposals in turn and to confirm their contentment or concerns with each of the recommendations being made.

9/16.3 Members considered the two options for the proposed telephone crisis helpline service model; namely:

*Option 1: To signpost callers to relevant follow-on Lifeline Crisis Service support dependent on their level of need and, in exceptional circumstances, the helpline provider could directly refer the individual into the appropriate Lifeline Crisis follow-on support; or*

*Option 2: Following clinical assessment and, dependent on the level of need, the helpline operator would refer the client directly into the relevant Lifeline follow-on support service. For those of low or no-risk of suicide or self-harm, they would then be signposted into other appropriate community based services. The Lifeline Crisis Helpline will also include the provision for check-in/safety checks if deemed clinically appropriate.*

9/16.4 Members **approved** the recommendation that the model proposed in the SOBC should be amended and that Option 2 is recommended as first preference, with Option 1 as second preference.

9/16.5 Members considered the recommendations for the proposed model for psychological therapy service, namely:

*Option 1: As proposed in the SOBC, a crisis intervention model with an average of 5 sessions per client (maximum 12 in line with NICE guidelines); or*

*Option 2: A crisis intervention model with an average of 5 sessions (maximum 12 as per NICE guidelines) plus and additional session for family/carer support.*

9/16.6 Members **approved** the recommendation that the model proposed in the SOBC should be amended and that Option 2 is recommended as first preference, with Option 1 as second preference.

9/16.7 Members considered the recommendations for the proposed model of follow-on support to include complementary therapies, namely:

*Option 1: A lifeline service model that included the provision of service user evidence informed non-invasive complementary therapy services (average of 2 sessions per person) for those with high anxiety to help them access talking therapies; or*

*Option 2: A model that provided only clinically evidence based interventions such as psychological therapies as part of the Lifeline service and therefore excludes complementary therapies.*

9/16.8 Members **approved** the recommendation that the model proposed in the SOBC should be retained and that Option 1 is recommended as first preference, with Option 2 as second preference.

9/16.9 Members considered the proposal that the model should include face-to-face de-escalation as part of the service and the two options for this service element, namely:

*Option 1: A service model that includes community based walk-in de-escalation, with on-ward signposting to the helpline to access psychological therapies if appropriate; or*

*Option 2: A model that focused the funding available for de-escalation and assessment by the telephone helpline only and excluded funding for community walk-in de-escalation*

9/16.10 Members **approved** the recommendation that the SOBC model should be amended to remove this element from the Lifeline Crisis Intervention service model and the identified funding should be invested in the telephone helpline crisis element to ensure the provision of the proposed safety check-in element with Option 2 recommended as a first preference, with no second

| | |
|---|---|
| | preference. |
| 9/16.11 | Members considered the proposed separation of the delivery of telephone crisis help from the delivery of the follow-on support services and the two options, namely:<br><br>*Option 1: A fully integrated service model which was procured through public tender; or*<br><br>*Option 2: A model with separated service elements which could be either procured or directly commissioned.* |
| 9/16.12 | Members **approved** to retain the model as set out in the SOBC and select Option 2 as the preferred choice. There is no second preference in this instance. |
| 9/16.13 | Members considered the proposal to commission the telephone helpline of the service from the Northern Ireland Ambulance Service and the two options, namely:<br><br>*Option 1: Directly commission the telephone service from NIAS as outlined in the SOBC; or*<br><br>*Option 2: Procure the telephone helpline service via public tender* |
| 9/16.14 | Members **approved** the recommendation that the model proposed in the SOBC should be amended and that Option 2 is recommended as first preference, with Option 1 as second preference. |
| 9/16.15 | Members considered the proposed procurement of the Lifeline follow-on support services through competition from non-HSC organisations based on the five LCG/Trust boundaries, and the two options, namely:<br><br>*Option 1: Procure the follow-on support services as a single regional contract; or*<br><br>*Option 2: Procure the follow-on support services as five local contracts reflecting the HSC Trust boundaries.* |
| 9/16.16 | Members **approved** the recommendation that Option 2 is the first preference and Option 1 the second preference. |
| 9/16.17 | Finally, members considered the communications/public |

| | |
|---|---|
| | relations, monitoring and evaluation options, namely: |
| | *<u>Option 1</u>: The provider of the telephone helpline service will be manage the Comms/PR for the whole service; or* |
| | *<u>Option 2</u>: The budget would be split between the various providers to work collectively the promotion of the service; or* |
| | *<u>Option 3</u>: The Comms/PR element is brought in-house to the PHA and made part of the wider Protect Life Strategy Comms/PR service; or* |
| | *<u>Option 4</u>: An independent provider is procured to provide the Comms/PR work* |
| 9/16.18 | Members **approved** the recommendation that the Communications/PR work should be brought into the PHA as part of the wider Protect Life communications strategy and that Option 3 is recommended as a first preference, with Option 4 as a second preference, and Option 1 as a third preference. |
| 9/16.19 | Mrs Erskine expressed her thanks to the staff involved in preparing this submission. The Chair repeated these views and acknowledged how important it had been for the Board to consider the earlier drafts in its workshop and to give full and proper consideration to the broad variety of views put forward. |
| 9/16.20 | The Chair also thanked non-executive Directors for their distinct and challenging input. |
| 9/16.21 | Alderman Porter said that exercise showed the value of consultation. He asked when PHA would report back to all of those who responded to the consultation. Dr Harper said that there will be a paper submitted to the Minister and this will be published on the PHA website. Mr McClean added that it is good practice to publish a summary report and the aim was to have this finalised as quickly as possible and available on the PHA website. |
| 9/16.22 | Mr Coulter said that he wanted to emphasise the importance of the independent monitoring and that when the service is being procured there are clear standards which will be audited against. He asked whether the CORE standards were robust. Mr Bonner said that they are internationally recognised. The Chair asked if there was a link between CORE and NICE guidance. Mr Bonner |

| | |
|---|---|
| | said that NICE guidance are derived from CORE. |
| 9/16.23 | Mr McClean said that there was further work to be done in terms of the procurement as this is a complex issue, which will be framed within procurement and legal advice from BSO and which has to be delivered within very tight timescales. He anticipated that further updates would be brought back to the PHA Board. |
| **10/16** | **Item 10 – Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2013/14 (PHA/03/01/16)** |
| 10/16.1 | Dr Harper welcomed Dr Adrian Mairs and Mrs Jacqueline McDevitt to the meeting. |
| 10/16.2 | Dr Mairs explained that this was the second Abnormal Aortic Aneurysm (AAA) Screening report and represents the year 2013/14. He said that the programme is delivered by the Belfast Trust in 19 locations across the whole of Northern Ireland and is targeted at men who are 65 and over. During 2013/14, he advised that 9,415 men had presented for screening among whom 132 aneurysms were detected of which 16 were large and required treatment. Dr Mairs explained that those men who present with an aneurysm that is classed as medium or low risk are monitored regularly. |
| 10/16.3 | The Chair asked how many men cumulatively are being monitored and what the uptake level is for the programme, compared to other programmes. Dr Mairs said that there are approximately 400 men being monitored and that the uptake for the programme is 82% which is very high, but this may be because it is a smaller programme. |
| 10/16.4 | Mrs Erskine thanked Dr Mairs for the report and asked about whether there was a requirement to produce such a detailed report, albeit that it is useful, particularly given that PHA is required to make savings and staff are under further pressure. Mrs McDevitt said that there is a streamlined process for producing this report, given that PHA now has better access to the data that is required to complete it. She added that the report has become more succinct and user friendly. |
| 10/16.5 | Dr Mairs acknowledged the comments made by Mrs Erskine and |

explained that this report is being brought to the Board as part of its role in the oversight of screening programmes. He added that it is useful to provide these reports as they are informative for people who do not understand the programme and that there is not a huge effort required to compile the information in the report as the data is easily available.

10/16.6 Mr Drew said that he found the Report to be helpful, and he asked whether it should be brought to the Governance and Audit Committee. Mr Coulter said that there has always been an issue in terms of the role of the Governance and Audit Committee vis-à-vis clinical governance. He asked whether GP practices would issue information to its patients and about the role of primary care in promoting the programme. Mrs McDevitt cited the example of a GP in Randalstown who ran sessions from his own practice.

10/16.7 Mr Mahaffy asked why the programme was targeted at men who are 65, and if there is a difference among different socio-economic groups. Dr Mairs explained that the prevalence of AAA among men who are aged 55 is so rare, it is not cost effective to undertake screening at an age earlier than 65 years.

10/16.8 Dr Harper returned to the issue of whether the Report should be brought to the PHA Board and. She said that screening and health protection are two of the biggest work areas for the PHA and it is through these reports that members receive assurance. She said that the report goes to DHSSPS after it has gone to the PHA Board. Mrs Erskine acknowledged the importance of the report but expressed concern about the time and effort required to produce it. Dr Harper reiterated earlier comments that the data is readily available and she added that there is a PPI element which shows how this programme is promoting outreach in lower uptake groups. She said that it is good practice to produce such a report. Dr Mairs pointed out that following a recent RQIA review of the Diabetic Eye Screening Programme, a recommendation had been made that there should be an annual report produced on its work. He acknowledged that there is a need to define the minimum requirement of the information needed for such reports.

10/16.9 The Chief Executive said that the information in this report is only a small subset of what is gathered routinely and it is presented in

an efficient and effective way. He said that he appreciates the value of this report as it provides that assurance, but he acknowledged the concerns about the level of detail coming through to the Board.

10/16.10 Members noted the AAA Screening Programme Report.

**11/16 Item 11 – Section 75 (2) Duty to Promote Good Relations: Good Relations Statement (PHA/04/01/16)**

11/16.1 Mr McClean explained the background for the development of the Good Relations Statement, which applies to PHA staff in terms of how they treat each other and the people with whom they work.

11/16.2 Members approved the Good Relations Statement.

**12/16 Item 12 - Patient and Client Experience Standards Biennial Report April 2013 to March 2015 (PHA/05/01/16)**

12/16.1 Mrs Hinds said that this Report was for the period April 2013 to March 2015 but that next year's report would be linked with the work on 10,000 Voices. She outlined the three-year cycle whereby in the first year the report would identify issues, the second year would focus on the action to mitigate the issues and the final year would revisit the issues to see if improvements had been made. She added that the recent reports on Mid Staffordshire emphasised the importance of listening to the voice of the patient.

12/16.2 The Chair asked if the multi-disciplinary group had been set up with the Northern Ireland Ambulance Service. Mrs Hinds said that NIAS had engaged with the process and was making a big contribution.

12/16.3 Members noted the Patient and Client Experience report.

**13/16 Item 13 – Any Other Business**

13/16.1 There was no other business.

**14/16** **Item 14 – Date and Time of Next Meeting**

Date: Thursday 18 February 2016
Time: 1:30pm
Venue: Conference Rooms 3+4
2nd Floor
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair:

Date: 18 February 2016