HSC Public Health Agency

agenda

Title of Meeting	114th Meeting of the Public Health Agency Board
Date	19 September 2019 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 15 August 2019		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.45	Finance Report	**PHA/01/09/19**	Mr Cummings

items for approval

8 1.55	ALB Self-Assessment	**PHA/02/09/19**	Chair

items for noting

9 2.10	Director of Public Health Annual Report	**PHA/03/09/19**	Dr Mairs
10 2.25	Presentation on Outcomes and Impacts of HSC R&D Funding		Dr Mairs
11 2.50	Sexually Transmitted Infection Surveillance in Northern Ireland 2019	**PHA/04/09/19**	Dr Mairs
12 3.05	Update on EU Exit		Mr McClean

closing items

13 Any Other Business
3.15

14 Details of next meeting:

Thursday 17 October 2019 at 1.30pm

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

HSC Public Health Agency

minutes

Title of Meeting	113th Meeting of the Public Health Agency Board
Date	15 August 2019 at 1.30pm
Venue	Board Room, Tower Hill, Armagh

Present

Mr Leslie Drew	-	Non-Executive Director (*in the Chair*)
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Stephen Bergin	-	Acting Assistant Director (*on behalf of Dr Mairs*)
Alderman William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Mr Robert Graham	-	Secretariat
Ms Jenny Redman	-	Boardroom Apprentice
Ms Nicola Woods	-	Boardroom Apprentice

Apologies

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Dr Adrian Mairs	-	Acting Director of Public Health
Ms Deepa Mann-Kler	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Paul Cummings	-	Director of Finance, HSCB

60/19	**Item 1 – Welcome and Apologies**
60/19.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Andrew Dougal, Mrs Valerie Watts, Dr Adrian Mairs, Ms Deepa Mann-Kler, Professor Nichola Rooney and Mr Paul Cummings.
60/19.2	The Chair welcomed Ms Jenny Redman to her first meeting as a Boardroom apprentice.

61/19 **Item 2 – Declaration of Interests**

61/19.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

62/19 **Item 3 – Minutes of previous meetings held on 11 June 2019 and 20 June 2019.**

62/19.1 The minutes of the previous meetings, held on 11 June 2019 and 20 June 2019, were approved as an accurate record of those meetings.

63/19 **Item 4 – Matters Arising**

Plan re Staffing

63/19.1 Mr Stewart asked when the plan regarding staffing and vacancies would be brought to the Board. Mr McClean suggested that this could be done at the September meeting. He stressed that it is not a "point in time" plan, but will be continually kept under review and that it would also be discussed with sponsor branch. Mr Stewart suggested that an overarching plan for the Agency is important, particularly given the number of retirements that are taking place.

64/19 **Item 5 – Chair's Business**

64/19.1 The Board noted the Chair's Business which was distributed at the meeting.

65/19 **Item 6 – Chief Executive's Business**

65/19.1 Mr McClean advised members that following a Serious Adverse Incident review investigation carried out by an independent panel following the tragic deaths of Michael and Marjorie Cawdery, the Permanent Secretary met with the family to offer his unreserved apologies on behalf of the HSC system. He added that the family would be meeting with RQIA and two Trust Chief Executives, as well as the HSCB Chief Executive.

65/19.2 Mr McClean informed members that Mrs Briege Quinn would be taking over as Interim Director of Nursing following the retirement of Mrs Hinds, until her permanent successor takes up post.

66/19 **Item 7 – Finance Report (PHA/01/08/19)**

66/19.1 The Board noted the Finance Report.

67/19	**Item 8 – Draft Annual Progress Report 2018-19 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order (PHA/02/08/19)**
	Ms Karen Beattie from the BSO Equality Unit joined the meeting for this item.
67/19.1	Ms Beattie began her presentation with an overview of the legislative context which explains why PHA is required to submit this Annual Report. She also noted the Disability Discrimination Order, which gives disabled people the opportunity to give their voice to the work of statutory bodies. She said that PHA is required to have a Disability Action Plan.
67/19.2	Ms Beattie highlighted four areas of work where PHA demonstrated its equality duties. Under "access of information", she gave examples of PHA providing translations of its leaflets and the browse aloud feature of the PHA website. Within "access to and uptake of services", she highlighted work undertaken with the Roma community to increase uptake of vaccinations. The third area she focused on was "new and innovative approaches", where PHA has used digital technologies to improve the health of older people, and also the use of mannequins as part of the breast cancer awareness public information campaign. Finally, with regard to "promotion of equality issues with non-statutory partners", she explained that PHA has been part of a drive to ensure that the contract specification for recruitment agencies puts an obligation on agencies to take account of equality issues.
67/19.2	Ms Beattie raised the number of equality screenings that are carried out. She advised that during 2018/19, there were seven equality screenings carried out and no EQIAs.
67/19.3	Ms Beattie reported on PHA's work in undertaking its disability duties, and said that PHA is part of the Tapestry disability staff network, and that PHA has participated in the disability placement scheme. She added that an evaluation of the scheme has shown that there are direct benefits for both the participants, and the hosting organisations and it has helped to change attitudes towards disabled people.
67/19.4	Ms Beattie said that PHA's priorities for 2019/20 will focus on increasing the number of equality screenings and EQIAs as well as monitoring of policies and programme areas. She said that further equality training was required as only 32 staff in PHA completed online training during 2018/19.
67/19.5	Mr Clayton said that Ms Beattie's overview clearly highlighted all of the key messages and the good work that has been done, but he agreed that without evidence of equality screenings or EQIAs PHA may be vulnerable to challenge.

67/19.6 Alderman Porter felt that with regard to the obligation of employment agencies to ensure they take disability into consideration, that PHA is enforcing policy towards organisations who already operate under a legislative framework. Ms Beattie said that PHA works with the Procurement and Logistics Service (PALS) and is responsible for overseeing different contracts. As part of that, she said that organisations are scored against various criteria, including training and equality issues. Mr McClean added that through applying this series of governance checks, PHA is ensuring that these organisations are engaging with all sectors and are therefore fit and competent and cognisant of PHA's objectives.

67/19.7 Alderman Porter sought clarity on the view that there is a higher risk of mental disorder for LGBT people in the workplace. He asked whether all staff had access to mental health wellbeing and support. Mr McClean said that there is evidence that LGBT people are of significant higher risk. He said that all staff have access to a counselling service.

67/19.8 Alderman Porter asked whether the needs of rural communities, but also religious communities, are taken into account as they can feel isolated. Mr McClean said that in terms of rural needs, there is a separate legislative process, and that a report on this work will come to the Board.

67/19.9 Mr Stewart said that while supportive of Section 75, he felt that the completion of the templates within this report feels more like compliance rather than implementation.

67/19.10 Alderman Ashe felt that one disability placement was a very low number. Mr McClean acknowledged that one was fewer than the PHA would like, but there are practical challenges, both in terms of developing a meaningful opportunity for someone, but also having the appropriate physical space to place individuals. Both Ms Roulston and Mrs Hinds confirmed the points raised by Mr McClean and said that ideally they would like to offer more opportunities.

67/19.11 Mr Clayton said that training is a key area and that this should be targeted in the first instance to those who are leading in particular policies or areas of work. He also suggested that there should be a focus on equality in a future Board workshop.

67/19.12 The Board thanked Ms Beattie for completing this comprehensive report.

67/19.13 The Board **APPROVED** the draft Annual Progress Report 2018-19 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order.

68/19 **Item 9 – Draft Commissioning Plan 2019/20 (PHA/03/08/19)**

68/19.1 Dr Miriam McCarthy thanked members for the opportunity to come to the PHA Board meeting to present the draft Commissioning Plan for 2019/20. She explained that the purpose of the Plan is to provide an overview of key priorities and investment decisions for 2019/20. She said that the Plan is the "what", but that the Trust Delivery Plans (TDPs) will explain the "how".

68/19.2 Dr McCarthy advised that Section 4 of the Plan outlines the Commissioning Plan Direction themes with Section 5 focussing on individual objectives. She said that the HSC is operating within a difficult financial context with very little additional money some of which may be non-recurrent. She added that Trusts are also being asked to deliver on savings targets. She explained that although there is also Transformation funding, it is non-recurrent and is dealt with outside of the Commissioning Plan process. In total, she advised that there are 71 objectives, and 171 priorities within the Plan.

68/19.3 Dr McCarthy explained that the 2019/20 Plan contains a section on population health for the first time and added that she would like this section strengthened to show the linkages with each of the Commissioning Plan Direction targets. She said that the development of the Plan is a 6-month process.

68/19.4 Mr Clayton said that he had some issues in relation to the process for the development of the Plan. He noted that the Trusts have to make savings and referred to the consultation process that took place last year in that regard. He was concerned that the ability of the Trusts to break even goes against what is set out in the Plan. He said although the Plan has outcomes and details inequalities, there are no resources to deliver services to respond to this. In his view, Trusts may have to cut staffing, reduce the number of operations or the amount of domiciliary care packages, but there is no assessment in the Plan of the impact that these measures would have. He felt that the process should have been reversed with Trusts being told at the outset of the Plan and the financial allocation against it. He also felt that the Equality Screening is flawed as it doesn't highlight the points he has covered, and that a full EQIA is needed. He asked about the impact of Trust savings and inequalities.

68/19.5 Dr McCarthy acknowledged that there is a delicate balance between what the HSC would like to do and what it can do and the system is affected by the political situation and challenges to long term financial planning. She said that the HSCB will have a round of discussions with the Trusts regarding their TDPs, and she is aware of some of the areas that will potentially be flagged up, but not the detail of what might be suggested in the savings plans.

68/19.6 Dr McCarthy said that for some of the objectives in the Plan, the work in 2019/20 will build on existing work. Alderman Porter was unsure as to

whether this Plan could deliver the best outcomes in the current financial climate, given issues such as the ageing population. He asked specifically about special needs. Ms Roulston said that there is an ongoing learning disability review across both adult and children's services and there is an action plan around the issue of long stays.

68/19.7 Mr Clayton noted that there has been more focus on health inequalities, but he asked whether focusing on improvements in specific areas could result in exacerbating the inequality. Dr McCarthy acknowledged this risk and agreed that better informed and better educated people will avail of opportunities, which may create inequalities. She said that it is important to target those who are most at need, citing the example of screening programmes where there needs to be focus in areas of deprivation to improve uptake.

68/19.8 The Chair thanked Dr McCarthy and her team for putting together the draft Plan.

68/19.9 The Board, with the exception of Mr Clayton, **APPROVED** the draft Commissioning Plan for 2019/20.

69/19 Item 10 – Consultation Report for Northern Ireland Diabetic Eye Screening (PHA/04/08/19)

69/19.1 Dr Bergin began his presentation of the Report by outlining the current trends in relation to diabetes in Northern Ireland. He advised that rates are going up markedly, and that by the middle of the next decade over 100,000 people will be required to attend for screening. He explained that one of the consequences of diabetes is eye disease, so the point of this screening programme is to detect any changes in the eye. He said that the current model of using GP practices to carry out the assessments is becoming unsustainable, hence the consultation exercise to consult on different models, with a preference for a fixed site model. He added that this is the sort of model using for the AAA Screening Programme.

69/19.2 Dr Bergin advised that the consultation exercise ran from January to March 2019 and that 268 responses were received. Of the three models proposed – fixed GP sites, fixed HSC sites or High Street optometrists, he said that the preference identified by respondents was for fixed HSC sites.

69/19.3 Mr Stewart felt that the response rate was low given the potential numbers of people who would be affected, and expressed concern about proceeding with this type of model. He said that the Board is being asked to approve this model, but without knowing where the locations of the sites would be. Dr Bergin said that to identify the proposed sites as part of the consultation could have prejudiced the outcome of the consultation. He explained that there are certain criteria the sites must meet based on concerns raised in the consultation about

issues such as transport links, opening hours and there is a need to ensure that the tests, which are technical, can be carried out robustly and to a high standard. He added that the initial proposal is for 4-6 sites in each Trust area and pointed out that this model is already in place in the Western Trust, and that this Trust area has the highest uptake. He said that the next stage would be to discuss the model with key stakeholders including service users, Trusts and Local Commissioning Groups (LCGs).

69/19.4 Mr Clayton felt that this paper represented a direction of travel and that the Board would need to see more detail on the next stage. He noted that although the proposed direction of travel is a fixed HSC site model, he queried whether it could be a mix of HSC sites and GP practices. Dr Bergin said that there are practical issues with a mixed site model, but it could be an option.

69/19.5 Alderman Ashe said that if the target is to improve attendance, then it is important to ensure that the sites are in convenient locations. Ms Woods pointed out that the lowest uptake is among young people so extended opening hours should be considered.

69/19.6 The Board **APPROVED** the consultation report for Northern Ireland Diabetic Eye Screening.

70/19 Item 11 – Northern Ireland Cervical Screening Programme – Annual Report for 2016/17 (PHA/05/08/19)

70/19.1 Dr Bergin introduced what he said is the penultimate report in this current cycle of screening programme annual reports. He advised that the cervical screening programme is aimed at all women between the ages of 25 and 49 on a three-yearly basis and between the ages of 50 and 64 on a five-yearly basis. He said that this equates to over 100,000 screening invitations per year.

70/19.2 Dr Bergin said that there are approximately 80 cases per year of cervical cancer, but this number would be higher if it were not for the screening programme. Going forward, he explained that the programme will start to use the HPV test, and that as school children have begun to be immunised against HPV since 2008, there should be a reduction in the number of cases found.

70/19.3 Dr Bergin stated that the programme is functioning well with 76.8% of eligible women screened, however this is a slight reduction on the previous year. He added that the Belfast Trust area saw the lowest uptake, and he expressed concern about inequalities, but said that PHA is increasing its efforts and is looking to develop communications strategies, e.g. adopting social media campaigns. He also noted the work of the Women's Resource Development Agency (WRDA) who target disadvantaged communities to encourage people to come forward for screening. He explained that an evaluation of their work has been

completed and a decision will be made regarding extending their contract.

70/19.4 Mr Stewart expressed concern about the timelines and the number of samples reported within 14 days, and also the increasing number of inadequate samples from GP and community clinics. Dr Bergin said that the main target for reporting is 28 days, but he assured members that there is an electronic pathway whereby abnormal findings identified within a laboratory are communicated directly to a diagnostic centre. With regard to the adequacy of samples, he highlighted some issues within general practice where the test has not been conducted as required. Mrs Hinds said that as a result of some SAIs in this area, PHA has rewritten the guidance for nurses, and that the Chief Nursing Officer has asked PHA to continue to monitor this.

70/19.5 Mr Clayton asked why the Board was only seeing the 2016/17 report at this stage. Dr Bergin conceded that there have been delays, and that following a recommendation from Internal Audit there will be an improvement in the timeliness of reporting. He added that it does take several months to analyse a year's worth of information.

70/19.6 Mr Clayton asked about the high percentage of inadequate samples from the laboratory in Antrim. Dr Bergin said he was aware of this issue, but it was not a critical issue in terms of the delivery of the programme.

70/19.7 The Board **APPROVED** the Cervical Screening Annual Report for 2016/17.

71/19 Item 12 – 25 Years' Service Award Proposal (PHA/06/08/19)

71/19.1 Mr McClean indicated that as a responsible employer, the PHA kept under review how it retained staff and rewarded those who had made a commitment to the HSC over a long period of time. He said that in keeping with a number of Trusts, HR Directors had proposed that staff who have more than 25 years' service an additional 5 days of annual leave on a one-off basis.

71/19.2 Members noted the advice from BSO HR on this matter and confirmed the appropriateness of this approach as consistent with making the PHA an employer of choice.

71/19.3 The Board **APPROVED** the proposal for the 25 years' service award.

72/19 Item 13 – Any Other Business

72/19.1 Ms Woods noted that this was her last meeting as part of the Board apprentice scheme, and thanked members for the opportunity to work with them.

72/19.2 The Chair said that he hoped that Ms Woods had enjoyed the

experience and wished her well for the future.

73/19 **Item 14 – Details of Next Meeting**

Thursday 19 September 2019 at 1:30pm

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

Signed by Chair:

Date: 19 September 2019

Public Health Agency

Finance Report

2019-20

Month 4 - July 2019

PHA Financial Report - Executive Summary

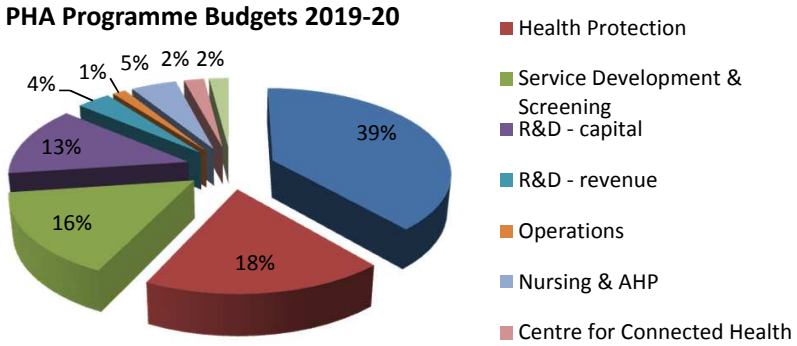
Year to Date Financial Position (page 2)

At the end of month 4 PHA is reporting an underspend (£0.9m) against its profiled budget. This underspend is primarily the result of year-to-date underspends on PHA Direct budgets (page 4) and Administration budgets (see page 5).

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.

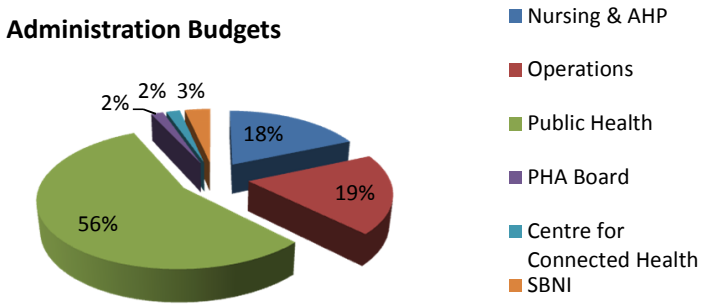


Administration Budgets (page 5)

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, however management expect this to be used to fund a range of in-year pressures and initiatives. Ringfenced funds, including Confidence and Supply Transformation Funds, are being monitored closely to ensure full spend by year end.

Public Health Agency
2019-20 Summary Position - July 2019

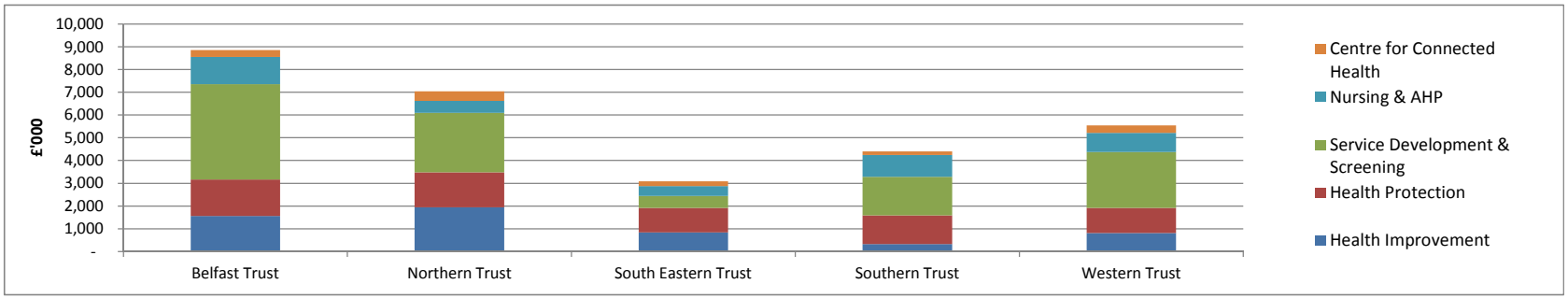
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	28,848	49,431	9,925	20,680	**108,883**	9,616	6,522	2,329	6,886	**25,352**
Revenue Income from Other Sources	-	68	-	714	**782**	-	68	-	238	**306**
Total Available Resources	28,848	49,499	9,925	21,394	**109,667**	9,616	6,590	2,329	7,124	**25,658**
Expenditure										
Trusts	29,076	-	4,278	-	**33,354**	9,692	-	1,426	-	**11,118**
PHA Direct Programme *	-	50,608	5,647	-	**56,255**	-	6,138	921	-	**7,059**
PHA Administration	-	-	-	20,058	**20,058**	-	-		6,558	**6,558**
Total Proposed Budgets	29,076	50,608	9,925	20,058	**109,667**	9,692	6,138	2,347	6,558	**24,734**
Surplus/(Deficit) - Revenue	(228)	(1,108)	-	1,336	-	(76)	452	(19)	566	**923**
Cumulative variance (%)						***-0.79%***	***6.86%***	***-0.80%***	***7.94%***	***3.60%***

The year to date financial position for the PHA shows an underspend of £0.9m, which consists primarily of year-to-date underspends on PHA Direct budgets (page 4) and Administration budgets (see page 5).

The current year-end breakeven forecast is predicated on the in-year delivery of non-recurrent programmes in line with PHA priorities; this expenditure will balance out the forecast surplus in the administration budget, and ensure the organisation achieves its breakeven obligation.

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

Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,560	1,944	843	327	814	-	-	**5,488**	1,841	1,829	12
Health Protection	1,600	1,536	1,068	1,261	1,102	-	-	**6,567**	2,145	2,189	(44)
Service Development & Screening	4,195	2,618	538	1,697	2,457	-	-	**11,505**	3,835	3,835	0
Nursing & AHP	1,202	527	431	958	840	-	-	**3,958**	1,319	1,319	(0)
Centre for Connected Health	298	422	206	159	327	-	-	**1,411**	451	470	(19)
Other	39	30	28	28	22	-	-	**147**	25	49	(24)
Total current RRLs	**8,894**	**7,077**	**3,114**	**4,430**	**5,561**	**-**	**-**	**29,076**	**9,616**	**9,692**	(76)
Cumulative variance (%)											***-0.79%***

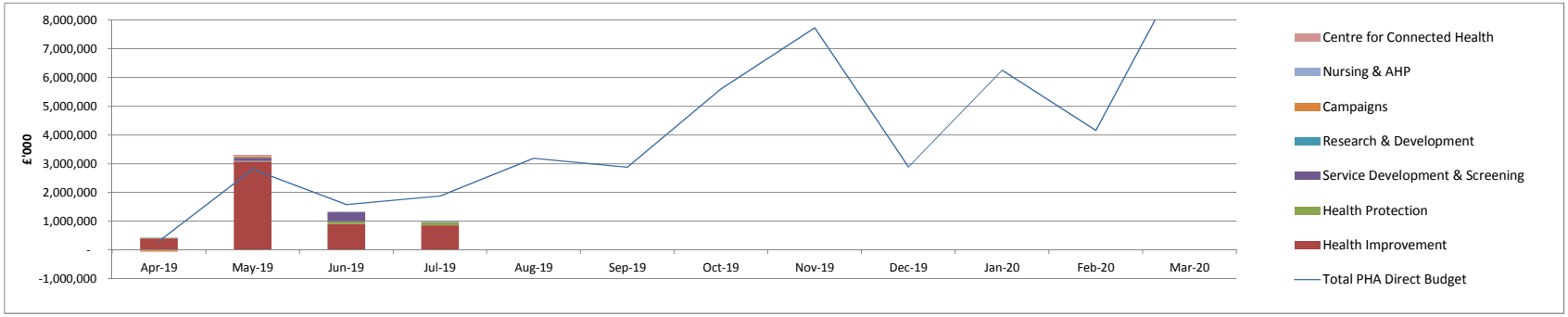
	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
Ringfenced	**825**	**1,057**	**758**	**739**	**806**	**93**	**-**	**4,278**	**1,426**	**1,426**	0
											0.00%

The above table shows the current Trust allocations split by budget area. A small deficit is shown for the year to date as funds initially held against PHA Direct budgets on page 4 have now been issued to Trusts. This is a timing issue only, and will be eliminated when the quarterly budget refresh is carried out.

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

Ringfenced funds allocated to Trusts have been assumed at breakeven.

PHA Direct Programme Expenditure



	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	249	2,369	963	1,972	2,783	1,062	2,471	3,523	1,156	3,415	3,111	6,452	**29,526**	5,554	5,242	312	*5.6%*
Health Protection	38	353	79	- 249	179	1,275	2,987	2,479	1,373	1,195	62	418	**10,189**	221	247	(25)	*-11.5%*
Service Development & Screening	2	65	517	112	112	527	124	95	336	44	292	560	**2,787**	697	538	159	*22.8%*
Research & Development	-	-	-	-	-	-	-	1,563	-	1,483	-	165	**3,211**	-	-	-	*0.0%*
Campaigns	23	23	23	23	23	23	23	47	31	102	678	256	**1,277**	93	10	83	*88.9%*
Nursing & AHP	-	-	-	1	98	-	3	32	1	17	23	220	**395**	1	75	(74)	*100.0%*
Centre for Connected Health	-	-	-	25	-	-	-	-	-	-	-	490	**515**	25	25	-	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	1,699	**1,699**	-	1	(1)	*100.0%*
Total PHA Direct Budget	**312**	**2,810**	**1,583**	**1,885**	**3,196**	**2,888**	**5,609**	**7,739**	**2,897**	**6,256**	**4,165**	**10,260**	**49,599**	**6,590**	**6,138**	**452**	
Cumulative variance (%)																***6.86%***	
Actual Expenditure	**364**	**3,398**	**1,365**	**1,011**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**6,138**				
Variance	**(52)**	**(588)**	**218**	**874**									**452**				

Ringfenced Budgets	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Profiled Ringfenced PHA Direct Budget	**-**	**-**	**572**	**331**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**903**	**903**	**921**	**(19)**
																-2.08%
Actual Expenditure	**(38)**	**461**	**134**	**364**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**921**			
Variance	**38**	**(461)**	**437**	**(33)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(19)**			

The year-to-date position shows a £0.5m surplus, which is mainly due to expenditure behind profile on a number of Health Improvement budgets.

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

In 2019/20 an amount of £1.9m has been recurrently removed from the programme budgets. This consists of £1m of savings initially allocated against the administration budget (£0.5m in each of the two years 18/19 and 19/20) and a further £0.9m 2018/19 programme savings target, achieved non-recurrently through CCH budgets last year and now applied recurrently. DoH have given the PHA permission to vire the £1m administration savings against Programme budgets. In achieving these savings the PHA will continue to protect, where possible, core programmes that are central to PHA and Departmental priorities. In addition, the Agency will utilise an expected in-year surplus in the Administration budget to further address Programme priorities.

PHA Administration

2019-20 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	3,793	2,727	11,484	316	339	370	**19,029**
Goods & Services	169	1,332	403	37	58	365	**2,365**
Total Budget	**3,962**	**4,060**	**11,888**	**353**	**397**	**735**	**21,394**
Budget profiled to date							
Salaries	1,264	929	3,828	80	113	123	**6,337**
Goods & Services	58	444	131	12	19	122	**786**
Total	**1,322**	**1,374**	**3,959**	**92**	**132**	**245**	**7,124**
Actual expenditure to date							
Salaries	1,130	881	3,642	38	120	125	**5,936**
Goods & Services	58	361	125	(7)	27	58	**622**
Total	**1,188**	**1,242**	**3,767**	**31**	**147**	**183**	**6,558**
Surplus/(Deficit) to date							
Salaries	133	48	186	42	(7)	(2)	**401**
Goods & Services	1	83	6	20	(8)	64	**165**
Surplus/(Deficit)	**134**	**131**	**192**	**61**	**(15)**	**62**	**566**
Cumulative variance (%)	*10.13%*	*9.56%*	*4.85%*	*66.66%*	*-11.11%*	*25.23%*	***7.94%***

PHA's administration budget is showing a year to date surplus , which has been generated by a number of long standing vacancies. In 2018/19 this surplus was used to achieve non-recurrently the £0.5m savings target for the organisation. However, following DoH approval the 2018/19 savings target has been removed recurrently from Programme budgets, thus leading to an opening non-recurrent surplus in Administration budgets. This was carried out with the permission of the DoH, in order to protect the funded staffing structure within the PHA, but will leave the organisation with an in-year forecast surplus for which non-recurrent plans are being developed.

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

July 2019

Public Health Agency
2019-20 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	PHA Direct	Mgt & Admin	Total	Trust	PHA Direct	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Capital Grant Allocation & Income	7,546	4,455	-	**12,001**	2,515	300	-	**2,815**
Expenditure								
Capital Expenditure - Trusts	7,546			**7,546**	2,515			**2,515**
Capital Expenditure - PHA Direct		4,455		**4,455**		365		**365**
	7,546	4,455	-	**12,001**	2,515	365	-	**2,880**
Surplus/(Deficit) - Capital	-	-	-	-	-	**(65)**	-	**(65)**
Cumulative variance (%)								

PHA has received a Capital budget of £12.0m in 2019-20, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £2.9m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	July 2019 Value	July 2019 Volume	Cumulative position as at 31 July 2019 Value	Cumulative position as at 31 July 2019 Volume
Total bills paid (relating to Prompt Payment target)	£2,708,788	544	£13,642,280	2,184
Total bills paid on time (within 30 days or under other agreed terms)	£2,682,680	498	£13,115,160	2,027
Percentage of bills paid on time	**99.0%**	**91.5%**	**96.1%**	**92.8%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although performance on volume is slightly below target in July. Overall PHA is making good progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 89.3% by value for the year to date, which significantly exceeds the 10 day DoH target for 2019-20 of 60%.

HSC Public Health Agency

item 8

Title of Meeting	PHA Board Meeting
Date	19 September 2019
Title of paper	ALB Self-Assessment
Reference	PHA/02/09/19
Prepared by	Robert Graham
Lead	Andrew Dougal
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the ALB Self-Assessment for 2018/19.

2 Background Information

The Public Health Agency is required to complete an annual self-assessment tool. In previous years it was a requirement to send the completed tool to the Department of Health, but while this is not the case, reference is made to it in PHA's Governance Statement.

3 Key Issues

The tool is in the same format as previous years, with the good practice section in the first half of the document and then PHA's responses to that in the second half. There is also a case study at page 89.

4 Next Steps

An action plan will be developed in relation to any gaps.

Department of Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Updated 16th June 2016

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

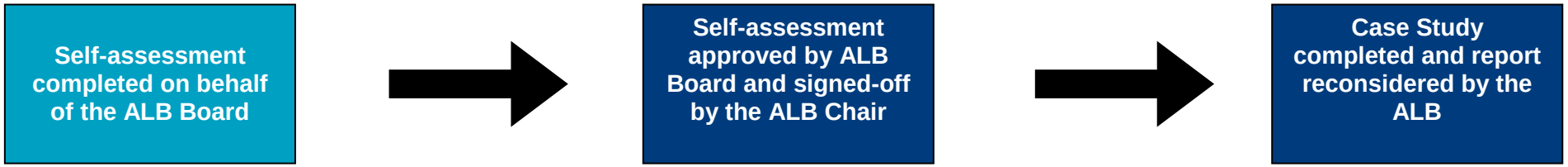
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*. 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 3. The Board takes collective responsibility for the performance of the ALB. 4. NEDs are independent of management. 5. The Chair has a positive relationship with Sponsor Branch of the Department. 6. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 7. The Board operates as an effective team. 8. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 9. Board members respect confidentiality and sensitive information. 10. The Board governs, Executives manage. 11. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 12. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 13. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 14. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 15. The Board is aware of and annually approves a scheme of delegation to its committees. 16. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation • The Board Scheme of Delegation/ Reservation of Powers

2. Board evaluation, development and learning

2.2 Whole Board development programme

Red Flag	Good Practice
1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. 2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. 2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities. 3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues. 4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: • The focus and balance of Board time; • The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; • How the Board responded to any service, financial or governance failures; • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; • The robustness of the ALB's risk management processes; • The reliability, validity and comprehensiveness of information received by the Board. 5. Time is 'protected' for undertaking this programme and it is well attended. 6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.
Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme • Attendance record at the Board Development Programme

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the "On Board" training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

	including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

Red Flag	Good Practice
1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements regularly.	1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board. 2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured. 3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc 4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services. 5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate. 6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Risk management policy and procedures • Risk register • Evidence of review of risks, e.g. Board minutes • Evidence of review of governance structures, e.g. Board minutes • Board Assurance Framework (BAF) • Clinical and Social care governance policy

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed – (To be confirmed)

Approved by Andrew Dougal (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2019

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board has now a full compliment of a Chair, 7 Non-Executive Directors and 4 Executive Directors. It should be noted that the Agency has had an Interim Chief Executive and Interim Deputy Chief Executive since October 2016.	The non-executive directors have been undertaking an extensive program of induction. They are most anxious to understand the business and the programs for which the agency is responsible. All non-executive directors are anxious to play a key role in influencing the strategy, policies and outcomes of the work of the agency.		
GP2 Green	The Board is content that it is provided with the appropriate guidance, support and advice to effectively discharge its responsibilities. This is done through its present membership and if required, others have been invited to attend to ensure informed decisions.			
GP3 Green	The process for voting, and who the voting members are is outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through			

	guidance from the chair.			
GP4 Green	The composition of the Board is set out in the Standing Orders and accords with the establishing legislation. The responsibility for appointing non-executive board members lies with the Public Appointments Unit for approval by the Minister, therefore ensuring that the composition is in accordance with legislation is outside the remit of PHA. Executive Board Members are in line with DoH requirements. Membership of Board and committees complies with the terms of reference set out in the PHA Standing orders.			
GP5 Green	The non-executives on the Board have variation in terms of appointment. However, the process of appointments from requisition to interviews can take up to 12 months. Terms of appointment are determined by the Minister.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2019

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The current balance of skills, knowledge and experience amongst Board members is appropriate to effectively govern the PHA. There are members witih backgrounds in public health, research, finance, procurement, legal, human resources and clinical psychology.			
GP2 Green	The PHA board members have backgrounds from the public, private and voluntary sectors as well as local councillors. (biographical information on Board members in Annual Report). Members terms of appointment and renewal dates are staggered.			
GP3 Green	Non Executive Board members are appointed through the PAU, who have responsibility for complying with Section 75. Executive Board members are appointed through the HSC recruitment and selection processes which are compliant			

	with Section 75. The Board understands its responsibility in relation to Section 75 and regularly meets with Equality staff to ensure compliance of its statutory obligations and good practice. Members of the board are most anxious that they have a greater grasp of the work on section 75 and on the effectiveness And the efficiency of the equality proofing work.			
GP4 Green	Several non executive directors have a background related to health care/ health improvement. Non-executive backgrounds also include governance and financial management. (biographical information on Board members in Annual Report)			
GP5 Green	As per legislation, the board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			
GP6 Green	There is a balance between Executive and non-Executive members which ensures an excellent mix of skills and knowledge etc			

GP7 Green	Board members (both executive/non-executive) have served on boards for a number of years, some at the level of Chair. (biographical information on Board members in Annual Report)			
GP8 Green	The Chair has 32 years' experience of working in a large voluntary organisation in the health sector at Chief Executive level.			
GP9 Green	The Chair has 10 years' non-executive experience in the private sector and other voluntary organisations e.g. UK Health Forum and World Heart Federation.			
GP10 Green	There is a member appointed to the Board with financial experience.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

RF6		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2019

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually with the last update approved at the Board meeting of March 2019.			
GP2 Green	Ministerial/Departmental policies and expectations are communicated to members, through Board meetings, workshops and the issue of papers. This is also included in the business planning and strategy processes which include full Board involvement. The closure of HSCB and its implications for the future work of the PHA will continue to be an area of focus for PHA Board members given that PHA will take on the functions of the social care and children's directorate.			

GP3 Green	There is a clear understanding of the distinct roles of the executive officers and the non-executive board members as this is outlined in job descriptions and the scheme of delegation within Standing Orders.	Non-executive directors will be supplied with copies of the job descriptions of all four executive directors and the job Descriptions of other directors who attend the agency board meetings.		
GP4 Green	The Board recognises fully its collective responsibility in relation to the performance of the PHA. This is outlined in Standing Orders, Management Statement / Financial Memorandum and in the induction process. The chair reminds members on a regular basis of this responsibility			
GP5 Green	NEDs are totally independent of management but work with Executive Directors when required.			
GP6 Green	The previous Chairs have had a positive relationship with the Minister and sponsor department. The current Chair has not yet had the opportunity to meet with the Minister since his appointment but is anxious to do so. However, given the current political situation, this is not possible at present.			

	The Chair and the Chief Executive have Accountability Review meetings with the Permanent Secretary and Chief Medical Officer twice a year.			
GP7 Green	At Board and Committee meetings, NEDs regularly and constructively challenge members on the papers and verbal updates given. This can be seen in the minutes of the meetings.			
GP8 Green	The Agency Board works as an effective team. A series of learning and development workshops is currently under way to improve even further the effective functioning of the Board.			
GP9 Green	The PHA board shares corporate responsibility for decisions taken and makes its decisions based on best evidence available.			
GP10 Green	Board members are aware of which papers are brought to public sessions and which are brought to confidential sessions and the need to respect confidentiality and sensitive information.			
GP11 Green	Yes, Executive Directors have responsibility for operational management of the PHA, while			

	the PHA board governs as set out in the PHA Standing Orders. The Chair has stated to the Chief Executive that if he or any other Non-Executive Director strays into operational territory this matter should be drawn to his attention.			
GP12 Green	The Board members contribute openly and fully to deliberations and exercise a healthy challenge function.			
GP13 Green	The Chair acts as first port of call for any advice, help or support. If he is not able to provide the help himself, he will refer members on as appropriate.			
GP14 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP15 Green	The PHA considers the needs of all its stakeholders and fully participates in partnership and public involvement to ensure excellent relationships.			

GP16 Green	The PHA Board clearly understands the scheme of delegation; it is brought to the Governance and Audit Committee and Board for review and approval annually			
GP17 Green	The Board receives timely and robust post-evaluation documentation, when appropriate, in relation to major projects.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2019

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Terms of reference for board Committees are clear and specified in Standing Orders. They are systematically reviewed.	There is a need to clarify the functions of the Remuneration Committee. The chair has written to the Department of health requesting that it clarifies some of the functions of this committee and that it might be permitted to have a more extensive role in human resources policies and organisation development.		
GP2 Green	Tasks, functions and responsibilities are delegated to appropriate committees as per Standing Orders, but the members of Board in totality recognise that they carry the ultimate responsibility for the actions of Committees. The Chair often reminds members of their liabilities as Directors.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of reporting and accountability in respect of each Committee with			

	the Board receiving full minutes and a verbal update.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the board.			
GP6 Green	The Committee Chair provides a verbal update to the board at the meeting following the Committee meeting. This can be seen in the board minutes. Minutes of the committee meetings are brought to the next board meeting after their approval. PHA attempts, where possible, to synchronise Committees so that they give timely updates to the PHA Board.			
GP7 Green	The Governance and Audit Committee has undertaken the Audit Committee Self-Assessment for a number of years taking action to address gaps. An annual GAC Report is included in the Annual Report.			
GP8 Green	The terms of reference for the Governance and Audit Committee and Remuneration			

	Committee highlight who is responsible for reporting to Board. The terms of reference are included within Standing Orders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2019

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings. The Chair discusses attendance with members as part of their appraisal.			
GP2 Green	Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings and general background reading, 2 days for reading papers and 1 day available for any other ad hoc events and launches			
GP3 Green	Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of NEDs.			

GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days. Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2019

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board completed its annual self-assessment in 2017/18.	The PHA Board will continue to undertake the DHSSPS ALB Board self-assessment annually.		
GP2 Green	The PHA Board continues to review itself to ensure improvement and development. To assist with Board effectiveness members were each issued with a copy of the recent Northern Ireland Audit Office publication, "Board Effectiveness: A Good Practice Guide" (Nov 2016). The Chair also shared with members a copy of the ICSA publication, "Effective Board Reporting", and the FRC's "Guidance on Board Effectiveness" and "UK Corporate Governance Code".	The PHA Board will continue to use the self-assessment and other tools as a basis for identifying further improvements / changes.		
GP3 Green	The PHA Board undertook a Board effectiveness programme in early 2017. This			

	was undertaken by On Board training. The Board monitors the action plan that emanated from this review. A follow up review commenced in 2018/19, facilitated by Anne McMurray.			
GP4 Red	The Board has not obtained the perspective of staff or external stakeholders in the completion of this questionnaire.			
GP5 Green	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3	The Board will undertake a survey of those outside the Board as part of its self-assessment in 2019/20.	
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2019

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	Following the review of Board effectiveness, a paper was prepared during 2018/19 outlining a suggested series of workshops on a range of public health topics. It is hoped that these workshops will take place during 2019/20.	The Board Development Plan will be developed and monitored during 2019/20.		
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement, which is brought to a board meeting annually. The Management Statement and Financial Memorandum was updated by the Department of Health in 2018, with the updated version signed by the Interim Chief Executive.			
GP3 Green	Reports on action plans to address governance issues arising from internal audit reports or other significant control issues are reported to			

	the GAC. GAC minutes are brought to the PHA board, and the Chair of the GAC also provides a verbal update to board members. The GAC also prepares an Annual Report.			
GP4 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP5 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP6 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2019

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction which includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee. The Chair and Non-Executive Director Alderman William Ashe undertook a refresher course on governance and audit on 14 September 2018.			
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation. As part of the Board effectiveness review, the induction process was			

	reviewed.			
GP4 Amber	Deputising arrangements are specified within Standing Orders. An Interim Deputy Chief Executive has been appointed, but the role of Deputy Chair is currently vacant as the previous Deputy has resigned from the Board.	This will be reviewed in 2019/20.		
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.	In the context of changes within the HSC, a sub-Committee will look at succession planning.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2019

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU. The Chair has initiated a series of more regular 1:1 meetings with members.	A number of meetings of the non-executive directors has taken place in recent months in order to advance board effectiveness. It is the hope of the Board that we strive to implement the recommendations of the report on "Effective Board Reporting" by the Institute of Chartered Secretaries and Administrators in July 2018.		
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from the Chief Medical Officer.			
GP4 Amber	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development.			

	Not all will have been given specific responsibilities, this will be reviewed by the Chair.			
GP5 Green	Board members appraisals allow members to highlight development needs.	It is proposed by the Chair that 1:1 meetings shall be held at least annually with members to ensure communication and any issues can be openly discussed.		
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	Where appropriate, this is the case.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2019

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board receives regular financial and performance monitoring reports, the layout of which has been shaped by the business needs of the Board and for ease of use by NEDs. This sets out • performance against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted, explained and mitigating actions identified • Issues regarding future performance are highlighted The PHA Corporate Strategy, Annual Business Plan including commissioning direction targets (evidence, board papers & internal audit report) set the parameters for performance reporting.			

GP2 Green	The board receives a biannual performance report outlining progress against objectives in the Business Plan. It also receives monthly financial report.			
GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.	There is a need to expand the role of the Remuneration and Terms of Service Committee to include more general issues regarding human resource management and organisation development.		
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee. The Board is reviewing how corporate risks outside the control of PHA might better be managed. Long standing risks are regularly reviewed to ensure they remain within PHA's risk appetite.			
GP5 Amber	Actions should be better recorded in the minutes of Board meetings so that named officers can provide updates at	Actions arising from Board workshops should be recorded with details of the PHA officer responsible for following up.		

	the next meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2019

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care family.			
GP2	Not applicable			
GP3	Not applicable			
GP4	Not applicable			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2019

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive presents a report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required.			
GP2 Green	The board considers the impact of any actions arising from findings as well as the learning outcomes to ensure continuous organisational improvement.			
GP3 Green	The Board actively contributes to the development of the Business Plan through its workshop and strategic days. When all parties / stakeholders etc. have been consulted with, it is brought to the Board for formal approval.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is			

	also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board			
GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic risks, (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and/or amendments brought back through Executive Directors for the Risk Register. The Chair emphasised the importance of the external environment as a key influence in the development of the Corporate Plan.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2019

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	A plan of Board and Committee meetings is set annually to ensure diary management, for example Board meetings are normally scheduled for the third Thursday of each month. Deadlines such as Annual Reports and Accounts and Governance Statements are also taken account of to ensure completion in a timely manner.			
GP2 Green	Board and Committee papers are issued at least one week in advance of the meeting to ensure adequate time for reading etc. It is hoped that during 2019/20 the Board will go fully "paperless" as i-pads have been procured and given out to members.			
GP3 Green	Board papers have a cover sheet which clearly outlines	The Board wishes to draw up a system whereby written guidance		

	what decision is required of the Board i.e. noting or approval. The format of Board cover sheets was further reviewed during 2018/19 to ensure that papers clearly outlined the reason why papers are coming to the Board, the key points, the recommendation for the Board, and next steps.	will be issued to those commissioned to write reports for the Board. This will outline the emphasis on strategy, policy, risk and other issues in which the Board wishes to be briefed. Through the Executive Directors the Board will give guidance as to the length and content of such reports. In accordance with the recommendations of the Institute of Chartered Secretaries and Administrators, the Directors will review and edit reports before they are dispatched to the Board.		
GP4 Green	Biannual performance reports are brought to the board. If members wish to raise a specific item at a board meeting, they can do so. The PHA has clearly defined procedures for bringing significant issues to the Board's attention outside the formal monthly meetings.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			

GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee have the opportunity to challenge and question data provided. Internal and External Audit consider data quality in relevant audits.			
GP7 Green	Board minutes clearly demonstrate where members have challenged and questioned information brought in relation to performance management and the grading of same.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			

GP9 Green	Board members can clearly demonstrate that they understand information presented and openly challenge the collection and presentation of same.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2019

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board.	The Governance and Audit Committee has suggested that there should be a Board workshop in 2018/19 which focuses on risk management.		
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board. The risk register is brought to the GAC each quarter, where it is scrutinised. It is also brought to the Board annually.			

GP3 Green	The Assurance Framework identifies a range of sources of assurance for the board, including internal and external audit.			
GP4 Green	The Board regularly reviews/updates governance arrangements and practices against DoH standards, good practice and good governance standards for public service.			
GP5 Green	Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registers and are subject to systematic review.			
GP6 Green	The Director of Public Health is responsible for professional issues in respect of medical staff, and the Director of Nursing and AHP for nursing and AHP staff.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

RF3		
RF4		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2019

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has an approved PPI consultation scheme and has had service users present to the Board.	The board is keen to see a requirement included in every job description regarding PPI, following the example of the Southern Health and Social Care Trust.		
GP2 Green	A variety of methods is used across the PHA to engage with service users and the wider public. Board members can attend a range of activities/events/conferences of voluntary, community organisations as well as other HSC events. The Chair and Chief Executive report at monthly board meetings in respect of events etc they have attended. Executive Directors will also have direct contact with a range of external stakeholders. It is the plan to consult with those users who are in “hard to			

	reach" groups.			
GP3 Green	When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA's future strategic direction.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2019

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The organisation culture is reviewed by the Remuneration committee bi-annually and discussed at confidential session. Follow up actions in respect of organisational culture are discussed at committee/board. Staff events are regularly held. There are also "away days" held in different directorates. There are other mechanisms for staff to input their views, e.g. through OWD or the Staff Health and Wellbeing Group.			
GP2 Green	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan.			
GP3 Green	This is communicated through Directors to their teams, and is the basis for appraisals.			

GP4 Green	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate. A new weekly staff newsletter, inPHA, was launched in June 2016 and this highlights and acknowledges achievements of PHA staff.			
GP5 Green	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6 Green	Staff are informed about major risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2019

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Board members attend a range of events and launches across the PHA. Board workshops provide the opportunity for staff to present to board members and discuss programme areas in more depth and with a wider range of staff involved than would be possible at a formal board meeting.			
GP2 Green	Board members, and in particular the Chair and Chief Executive attend a range of meetings and events with external stakeholders.			
GP3 Green	Board members regularly attend events which would include high profile events.			
GP4 Green	NEDs regularly meet stakeholders and service users through events / presentations etc.			

GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA website.			
GP6 Green	Yes			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

Summary Results **ALB Name - Public Health Agency** **Date – 31 March 2019**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Green	
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	
1.5 Board member commitment	Green	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	Amber	
2.2 Whole Board development programme	Amber	
2.3 Board induction, succession and contingency planning	Green	
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	
3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	

3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1	Green	
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2019

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	
Brief description of issue	There are delays in the implement of PHA's social care procurement plan with almost 200 contracts requiring to be reviewed as at August 2018.
Outline Board's understanding of the issue and how it arrived at this	This issue has been on PHA's Corporate Risk Register with regular updates at both Governance and Audit Committee and at PHA Board meetings.
Outline the challenge/scrutiny process involved	A paper was approved by the PHA Board which contained a proposal to establish a short term task and finish group, which would report to the PHA Board. The remit of this group included a review of existing pre-procurement planning and procurement processes, identifying the knowledge and skills required, assessing options for cross-directorate working to improve the management of future procurements, enabling the development and maintenance of an agreed plan, and agreeing the right scale and mix of staff with the knowledge and skills required to plan, implement and manage procurements.
Outline how the issue was resolved	The short life task and finish group, which included membership from PHA, HSCB and BSO PALS held several meetings and engaged with relevant stakeholders, producing a report with a number of recommendations. Rosemary Taylor, Assistant Director, Planning and Operational Services presented the findings to the Board at a workshop in June 2019.
Summarise the key learning points	The task and finish group considered the issues impacting on delivery of the procurement plan, and recommended specific areas for further action, to help address these issues. These included the development of thematic plans by multi-disciplinary groups, re-categorisation and reprioritisation of the procurement plan, recruitment of additional specialist staff to support pre-procurement planning work and developing the skills and knowledge of existing staff.
Summarise the key improvements made to the governance arrangements directly as a result of above	There will be more regular and structured reporting to PHA AMT and the PHA Board on the thematic plans, the procurement plan and its implementation .

6. Board impact case studies ALB Name.....Date.....

6.2 Case Study 2

Organisational Culture Change	
Brief description of area of focus	
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

6. Board impact case studies ALB Name.....Date.....

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	19 September 2019
Title of paper	Director of Public Health Annual Report
Reference	PHA/03/09/19
Prepared by	Anna McKeever and Jenny Mack
Lead Director	Adrian Mairs
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to note the 2018 Director of Public Health Annual Report.

2 Background Information

The Director of Public Health is required to produce an annual report on the health of the population of Northern Ireland. This is the 10th annual report.

3 Key Issues

The theme of this year's Director of Public Health Annual Report is 'Public Health in Partnership'. As reflected in the strategic framework 'Making Life Better', a holistic, integral approach is required to effectively improve public health and wellbeing, which comes from creating, maintaining and building strong partnerships with many different stakeholders. The report highlights examples of partnership working that have taken place across Northern Ireland in 2018, demonstrating the breadth of collaborative working across the health service.

4 Next Steps

It is intended that the Director of Public Health Annual Report will be launched at the public health research conference in November 2019.

Director of Public Health
Annual Report
2018

HSC Public Health Agency

Contents

Foreword

Foreword

Dr Adrian Mairs

It was Ban Ki-moon, the eighth Secretary General of the United Nations, who said that "broad partnerships are the key to solving broad challenges".[1] The Public Health Agency's ambition is to create the conditions in which all people living in Northern Ireland can achieve their full health and wellbeing capacity, and in order to meet this broad challenge we are committed to creating, maintaining, and building broad partnerships with many different stakeholders.

Welcome to the 10th annual report of the Director of Public Health. The theme of this year's report is 'Public Health in Partnership', an approach that has defined the work of the Public Health Agency (PHA) since its inception. The PHA works in partnership with health and social care trusts (HSCTs), the community and voluntary sector, international funding bodies, universities, national, regional and local government, and many other organisations and individuals.

Partnership working aims to achieve something that we could not do alone; the acknowledgement that we work better when we work together. A shared vision is required, with common goals and a practical way of achieving those goals collectively. Communication of that vision is imperative, as is ensuring collective ownership and commitment. Partnership working allows multiple voices to contribute, makes best use of individual knowledge and skills, inspires new ideas, allows sharing of experiences, provides new opportunities, helps reach new audiences, strengthens relationships, and provides new insights into old problems. Partnership working is not only preferred but necessary to achieve the healthier Northern Ireland that we all aspire to.

The Northern Ireland Executive's draft Programme for Government and *Making Life Better*, the strategic framework for public health, set out the broader context for working together.[2,3] These documents highlight the inter-relationships between health, economic growth, deprivation, inequality, childhood development, education, and the social and physical environment. A collaborative, cross governmental approach is necessary to build a healthier society, and it is through partnership in both policy and practice that we influence these wider determinants that have such a significant impact on our health. There is a part for everyone to play in this journey, from individuals to communities, to the public, private and third sectors. Collaboration, engagement, and empowerment are key values set out in *Making Life Better*, underlining the importance of including all voices in the conversations about our future.[3]

This year's annual report highlights some of the 'Public Health in Partnership' work that has taken place across Northern Ireland in 2018, demonstrating the breadth and depth of collaborative working across the service and the region. Included are programmes aimed at giving children the best start in life such as the comprehensive work to tackle antimicrobial resistance in secondary care; equipping them through life with projects such as THRiVE which aims to improve outcomes for children and young people in Rathcoole and Monkstown; empowering healthy living with campaigns such as '#hackthepain', a social media campaign for supported pain self-management; creating the conditions for good health with the cervical screening social media campaign; empowering communities with such projects as the Twilight Arts and Wellbeing project, a regional arts project for looked after young people in residential care settings; and of course developing collaboration through projects such as the Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN).

Dr Adrian Mairs
Acting Director of Public Health

Further information

Dr Adrian Mairs
Acting Director of Public Health
adrian.mairs@hscni.net

Overview

Overview

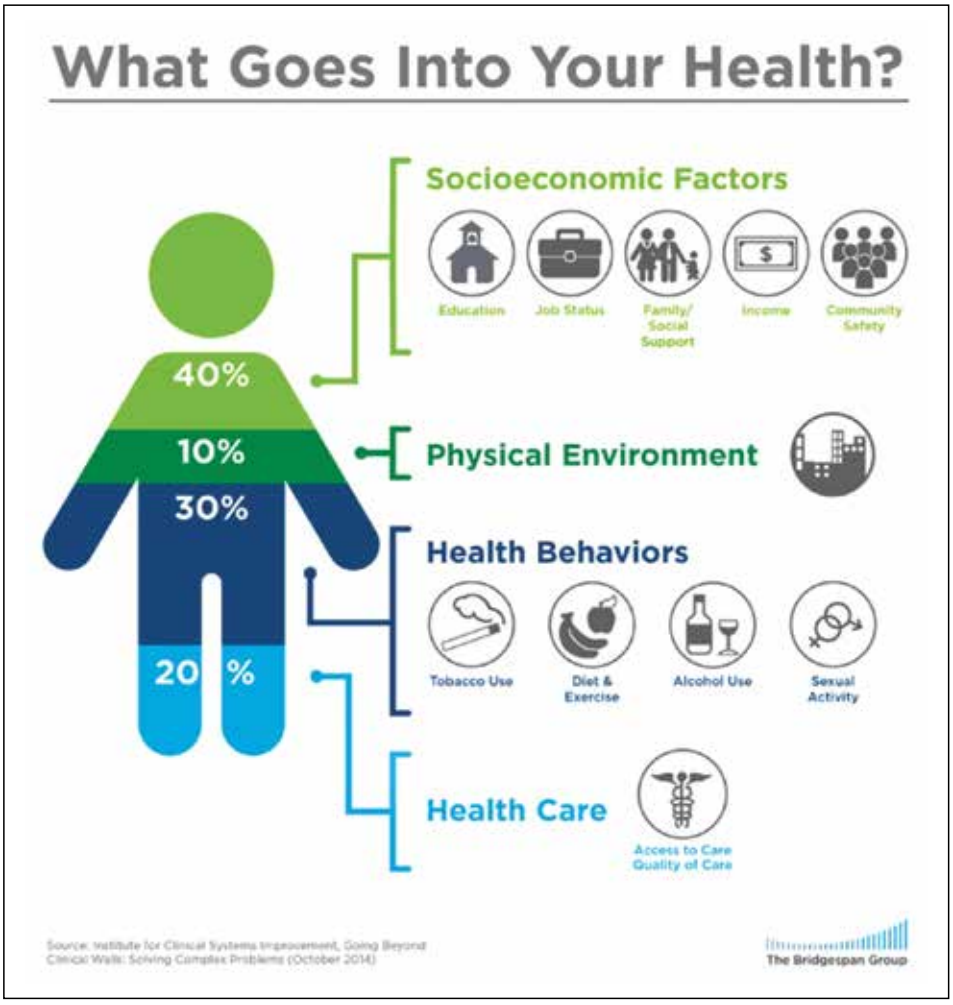
Overview

Overview

'Public Health in Partnership' is an apt theme for this year's Director of Public Health report, as it recognises that to effectively improve public health and wellbeing we require a holistic, integral approach. This is reflected in the strategic framework *Making Life Better*.[3] The message is clear and consistent throughout the life-course. We must empower our population from an early age by imparting the knowledge and skills required to enable people to take care of their own physical and psychological health, and fundamentally enhance their own wellbeing within an environment that facilitates this.

It is widely acknowledged that individual health behaviours account for only 30% of overall health outcomes (Fig 1), with the remainder accounted for by the physical environment in which we live (10%), clinical care (20%) and socioeconomic factors (40%).[4]

Figure 1: Factors affecting health outcomes



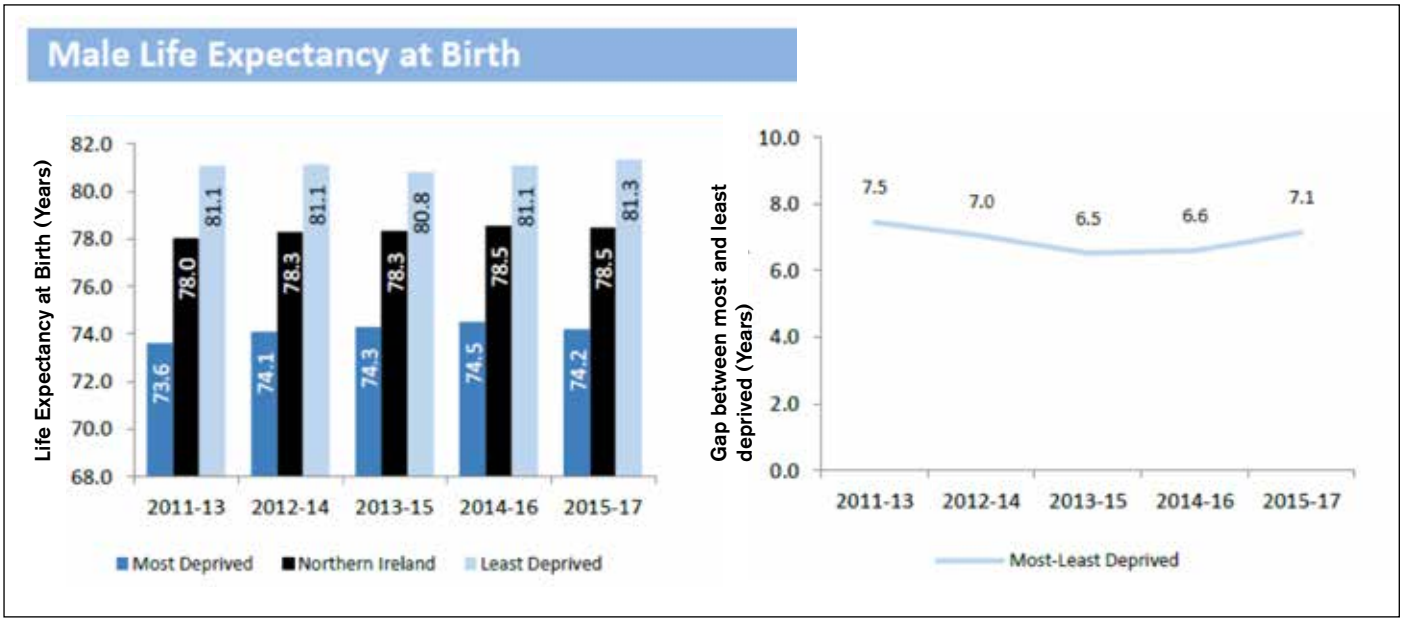
(Source: https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-(1) Infographic created by The Bridgespan Group)

Empowering individuals to make healthier choices is therefore only one component (albeit an important one) of improving overall health and wellbeing. Vital relationships exist between health, inequality, education, employment, social, physical and economic environments that contribute to overall health outcomes.

Optimal health and wellbeing is most likely to be achieved when health and social care services work in partnership with other sectors to allow every individual to thrive in ways that are meaningful to themselves, their family, and the community. Resilience is widely accepted as an integral component of overall emotional health and wellbeing. Most commonly, it has come to mean "an individual's ability to overcome adversity and continue his or her normal development".[5] As with individuals, resilience is an integral part of an effective health and social care system. This report gives current examples of the PHA working in partnership to create this resilient system, with partners spanning health and social care trusts, and local councils to the community and voluntary sector.

There are many challenges faced by the health and social care system in Northern Ireland which makes partnership working between those who work within and beyond the system so important. Substantial differences in the health of those who live in the 20% most and least deprived areas in Northern Ireland still exist, a difference known as a health inequality gap. Having consistently increased over many years, the growth in life expectancy at birth in both males and females has recently flattened. For males the life expectancy inequality gap has widened slightly in recent years and now stands at 7.1 years (Fig 2), a concerning trend that is not unique to Northern Ireland but is being seen across the UK.[6,7]

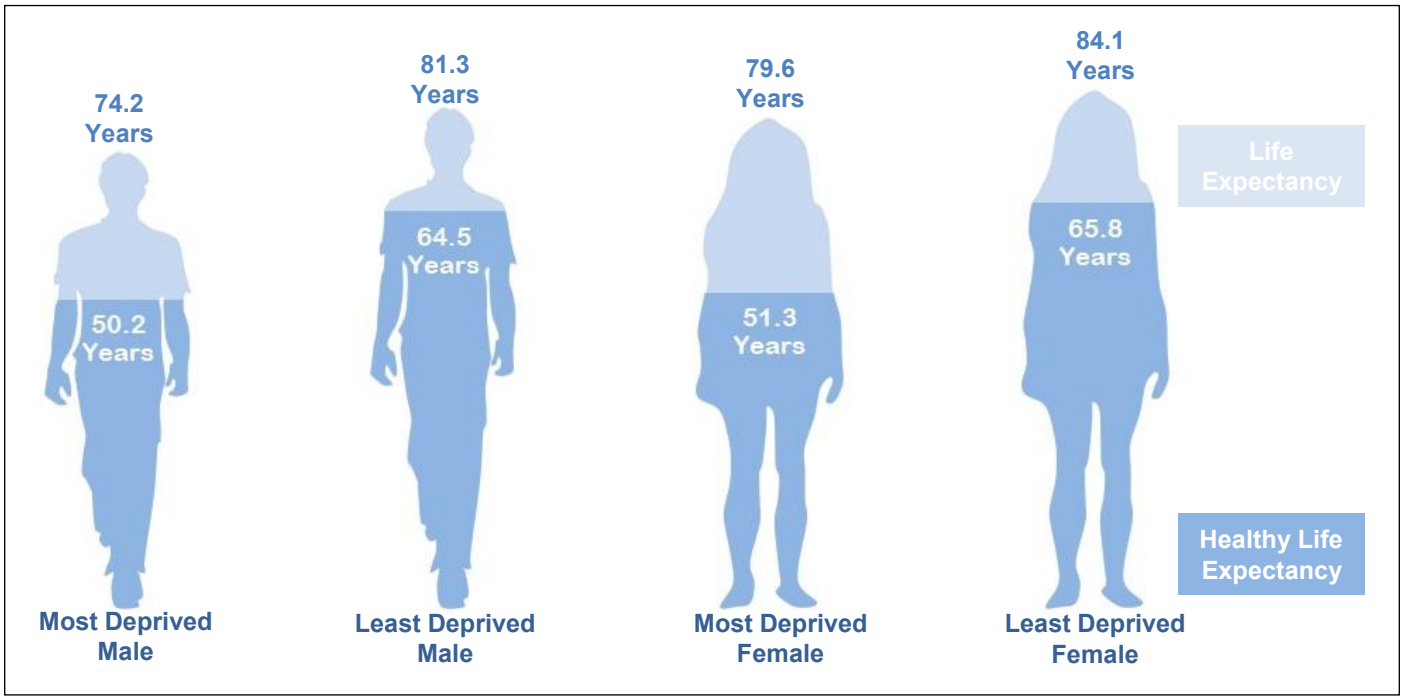
Figure 2: Differences in life expectancy for males born in the most and least deprived areas of Northern Ireland



(Source: Health Inequalities Annual Report 2019, Department of Health)

The inequality gap for female life expectancy is smaller at 4.5 years and has remained fairly stable over recent years.[6] In terms of healthy life expectancy, the average number of years a person can expect to live in good health, males in the most deprived areas on average can expect to spend 68% of their life in good health, while their counterparts in the least deprived areas can expect to live 79% of their life in good health (Fig 3).[6] The gap is larger for females, with those in the most deprived areas on average spending 64% of their life in good health, compared to 78% in the least deprived areas.

Figure 3: Differences in healthy life expectancy for males and females born in the most and least deprived areas of Northern Ireland



(Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2019-infographic.pdf)

While standardised death rates in Northern Ireland have improved, every year approximately 3,500 people die prematurely from potentially avoidable causes.[8] These deaths are avoidable either by medical intervention or lifestyle change and substantial inequality issues remain. In comparison to those living in the least deprived areas, people living in the most deprived areas in Northern Ireland are:

- 2.5 times more likely to die from lung cancer;
- 3.5 times more likely to be admitted to hospital due to self-harm;
- 3.5 times more likely to die from suicide;
- 4.5 times more likely to die from alcohol or drug related causes.

Rates of mental illness in Northern Ireland continue to be approximately 25% higher than the rest of the UK, with around 45,000 children here suffering a mental health problem at any one time.[9,10] Unique to Northern Ireland, we continue to see the impact of the Troubles, whereby generational trauma is recognised as a risk factor for poor mental health outcomes. As for other non-communicable diseases, identifiable and modifiable risk factors exist for mental illness, such as loneliness and isolation. The impacts of these risk factors on mortality are comparable to that of other well known risk factors (such as smoking, alcohol and poor diet) and have been shown to increase the likelihood of mortality by up to 26%.[11]

Although this report highlights ongoing challenges, it is important to recognise that when we consider subjective indicators of health and wellbeing it paints a brighter picture of the health of our population. In the Northern Ireland Health survey 2017-2018 over two thirds of respondents rated their general

health as good or very good, 88% were either satisfied or very satisfied with life, and 86% described the life they lead as fairly or very healthy.[12] The importance of self-reported measures of wellbeing cannot be overlooked, as it allows for a single rating which encompasses both physical and mental health from the perspective of the individual.

Early successes have demonstrated that greater impact can be achieved by all sectors of society working together toward a common goal. For the PHA and its partners, this goal is a healthy and happy population and this report showcases examples of strong partnership working. Together we strive to realise the global public health vision – to build healthy bodies and minds, not merely fix broken parts.

Further information

Dr Jenny Mack
Public Health Registrar
jenny.mack@hscni.net

Dr Anna McKeever
Public Health Registrar
anna.mckeever@hscni.net

Health improvement

Using the arts to promote health and wellbeing

THRiVE: improving outcomes for children and young people in Rathcoole and Monkstown

Twilight Zone Arts and Wellbeing Project: regional arts project for looked after young people in residential care settings

Using the arts to promote health and wellbeing

Who?

The PHA in partnership with key strategic agencies has been able to provide a wide range of arts and health interventions across Northern Ireland. Key to delivery of this work have been partnerships with the Arts Council of Northern Ireland, Arts Care, the Baring Foundation, local councils, health and social care trusts and the community and voluntary sector.

What?

The challenge is to improve the mental health and emotional wellbeing of the most disadvantaged and marginalised people in the community who often experience stigma and discrimination, isolation and loneliness.

Research by the New Economics Foundation on the 'Foresight Project on Mental Capital and Wellbeing' concluded that connecting, being active, taking notice, keeping learning and giving, are the behaviours required to maintain and improve emotional wellbeing.[13] This approach has been adopted regionally by the PHA under its 'Take Five' campaign.

How?

The PHA, the Arts Council and the Baring Foundation delivered the Arts and Older People programme across Northern Ireland. A range of small to medium size grants were awarded to 19 projects. The projects covered all art forms such as music, writing, circus, craft and drama. All of the projects aligned themselves with the strategic themes which were isolation and loneliness, older men, carers and area of need.

As part of its 50th anniversary celebrations, the QFT in Belfast has been working with three over 60s community groups in an arts project based on memories of cinema over the last 50 years, supported by the Arts Council of Northern Ireland's Arts & Older People Programme. Pictured (L-R) are participants Diane Weiner, Jane McCarthy and Sue McCrory.

The PHA also supported the Arts Council to deliver the Young People and Wellbeing project 'ARTiculate', a regional small grants programme focusing on the mental and emotional wellbeing of disadvantaged young people. In total 21 projects were funded, addressing stigma and discrimination and providing young people with a platform to raise awareness around these issues.

In partnership with Arts Care, the Here and Now Festival has delivered 235 workshops with 3,000 participants across the five health and social care trusts, providing access to high quality arts activities across a variety of art forms such as dance, music, drama, art, film making and photography.

In 2018-19, 19% of the 451 small grants awarded by the PHA under the 'Take Five' banner had arts as a core element, including dance, visual art, music, literature, film, craft, photography, drama, digital arts.

Pictured (L-R) are participants John Carlin, Paddy Tyre, Raymond Finnegan and Brendan Molloy, from the Derry City & Strabane District Council's 'Music to Your Ears' project who performed for guests at the recent Art of Dementia Conference.

Lisnaskea Ladies perform work developed with Arts Care dancer in residence Carmel Garvey, in an event organised for older people from rural areas at Seamus Heaney Home Place as part of the Here and Now festival.

Key messages

- Research shows that arts and health programmes can positively impact mental health and emotional wellbeing.
- These initiatives have demonstrated that impact through enhanced lifelong learning, reduced social isolation, better relationships, increased levels of physical activity and a heightened sense of happiness and belonging.

Further information

Siobhan Sweeney
Health Improvement and Social Wellbeing Manager
siobhan.sweeney@hscni.net

THRiVE: improving outcomes for children and young people in Rathcoole and Monkstown

Who?

This project involved the PHA, Department of Education, Education Authority Northern Ireland, Controlled Schools Support Council, Stranmillis University College, Department for Communities, Antrim and Newtownabbey Borough Council, Northern Health and Social Care Trust, Barnardos, Monkstown Boxing Club, Abbey Sure Start and local schools (one post primary and five primary). All partners are represented on the THRiVE Project Board, which is chaired by the PHA.

What?

Educational attainment and the aspirations of children and young people in Rathcoole and Monkstown are significantly below the Northern Ireland average.[14] The areas also have a higher than average proportion of pupils entitled to free school meals and with special educational needs. Both of these measures are linked to poverty and deprivation which are acknowledged as presenting barriers to children's education. This means that they are likely to enter post primary school with lower than average attainment and dealing with social and emotional problems which impact on their ability to learn.

How?

The THRiVE Project Board has secured investment and is overseeing this work which includes:

- supporting a Schools' Group (of all six schools involved) which has been established to contribute to and influence the work in schools through an agreed development plan. The plan includes actions around goal setting and wellbeing, attendance and procedures, and additional support for potential underachievers (outcomes to be tracked);

Top left to right – Caroline Woods, Education Authority, Hilary Johnston, PHA, Maria Quinn, Abbey Community College, Frazer Bailie, Education Authority. Middle left to right - Paul Johnston, Monkstown Boxing Club, Hugh Nelson, NHSCT, Brenda Doherty, Abbey Sure Start, Sara McCracken, Controlled Schools Support Council. Front left to right - Audrey Curry, Stranmillis University College, Carl Frampton, Courtney Cooper, Abbey Community College, Claire Humphrey, Barnardo's, Elaine Manson, Antrim and Newtownabbey Borough Council

Pupils from Kings Park Primary with their banner showing what THRiVE means to them.

- recruitment and support for community and parent champions to involve parents as educators;
- support for early interventions and positive parenting, including Adverse Childhood Experience and Solihull Approach training;
- a community campaign which has been developed to support aspirational messages at community level;
- facilitating research and evaluation of the interventions through measuring impact on the achievements of the pupils.

The learning from this project and the evaluation will be formally documented and shared across government departments.

Key messages

- THRiVE is committed to improving outcomes for children and young people in the key areas of aspiration, attainment and wellbeing.
- THRiVE supports children and young people to believe that together WE CAN learn, be well and be connected.
- THRiVE involves local parents to spread key messages about helping children and young people to be healthy and well, and to engage in learning and get involved in what interests them.
- THRiVE facilitates a social media campaign to spread messages of aspiration and achievement, and to inspire young people to make positive life choices.

Further information

Hilary Johnston
Health Improvement and Social Wellbeing Manager
hilary.johnston@hscni.net

Twilight Zone Arts and Wellbeing Project: regional arts project for looked after young people in residential care settings

Who?

This looked after young people's arts and wellbeing project is delivered through PHA funding by Arts Care artists, musicians and creative writers in partnership with Trust social workers in 18 residential units across the five health and social care trusts involving 50 young people.

What?

Looked after children and young people are at greater risk of suffering from poorer physical and mental health and having lower educational outcomes than their peers.[15,16] In particular such children and young people can have lower self-esteem and confidence resulting in low motivation and a higher risk of self-harm and substance abuse. On leaving the care system they are also at greater risk of unemployment and homelessness.[17]

How?

The project, now in its eighth year, commenced with an arts-based induction day for healthcare staff. Following this, a series of arts activities and workshops were organised across all trust areas from October through to December. The children and young people and social work staff were then able to showcase their artwork at a celebratory regional art exhibition in December with every young person receiving a certificate and taking their artwork back to display in their room or elsewhere. Bursaries were awarded to those young people who excelled in their commitment and artistic expression, enabling them to purchase arts material and equipment, with some availing of the opportunity to enrol in other community art classes to further develop their interest in the arts.

One young person who has enjoyed the project for a number of years stated: "Taking part in the Twilight Zone and trying out the different types of art has definitely helped me to decide that I want a career in music and already I have been working towards making my future as a DJ."

Another young person taking part in the project said: "I find every year that although I struggle continuously with suicidal thoughts, when I take part in the Twilight Zone Project it gives me a safe place to express exactly how I feel. This year I have created about eight paintings of all the different ways in which I feel. It is such a release."

Some examples of artwork created by children and young people taking part in the Twilight Zone project, which were exhibited at Arts Care in Belfast in December 2018.

Key messages

- Many of the art works and music/creative writings that the young people produce deal directly with suicidal thoughts, feelings of isolation, low value, alienation from society, self-harm and loathing.
- The project has reduced levels of frustration, and through self-expression resulted in an increased level of respect for self, others and the environment.
- Some of the young people report that taking part in the project over a number of years has given them a definite direction in terms of what they would like to do for their future careers.

Further information

Andrew Gamble
Health Improvement and Social Wellbeing Senior Officer
andrew.gamble@hscni.net

Health protection

Opportunistic MMR vaccination in the Northern Ireland New Entrants Service (NINES)

Tackling AMR: the development of a national "one stop shop" for local information about gram-negative bacteraemias and antimicrobial consumption in secondary care

Partnership working in emergency response and crisis management

Opportunistic MMR vaccination in the Northern Ireland New Entrants Service (NINES)

Who?

The PHA has been working in partnership with the Northern Ireland New Entrants Service (NINES) in the Belfast Health and Social Care Trust (BHSCT). NINES is a nurse-led service, which was set up in 2012 to provide a regional, holistic service supporting the health and social wellbeing of new migrants, asylum seekers and refugees entering Northern Ireland. This includes screening for communicable diseases and the provision of health promotion advice and support. The service is based in the trust's Maureen Sheehan Centre.

What?

Northern Ireland is part of a UK-wide commitment to meet World Health Organization (WHO) European targets to eliminate measles and rubella infection by 2020.[18] This will be facilitated by high uptake of the safe, effective and inexpensive combined measles, mumps and rubella (MMR) vaccine. Evidence shows that both children and adults from some migrant groups, for example asylum seekers, refugees, individuals from the Roma community, and undocumented migrants, have lower uptake of vaccinations than the general population. This is for a variety of reasons including awareness of, and

difficulty accessing, a new healthcare system. As such they are an important group to focus on in achieving the WHO target.[19] In 2016 the Department of Health issued recommendations to all relevant health professionals to establish MMR immunisation history in all children and adults born after 1970, and to offer MMR vaccine to those with a history of less than two doses.[20] This is particularly important for new arrivals into Northern Ireland.

How?

Opportunistic vaccination at dedicated migrant health clinics, such as NINES, is one intervention that can increase coverage in this vulnerable group. A project was thus developed aiming to facilitate MMR vaccination being offered and administered to those that need it within NINES clinics. The PHA worked with NINES staff to identify and address barriers to implementation of this service, including issues around vaccine storage and management, training requirements and staff capacity. The plan and supporting information are now outlined in the service specification, which has been successfully implemented within NINES in the Belfast Trust.

Key messages

- NINES has successfully implemented this service, obtaining a vaccination history during consultation with clients and offering opportunistic MMR as appropriate.
- The pilot started at the end of November 2018. By the end of March 2019, 61 clients were eligible and had been offered vaccination, with 52% uptake.
- This intervention supports Northern Ireland's commitment to achieving WHO European targets to eliminate measles and rubella infection by 2020.

Further information

Dr Claire Neill
Public Health Registrar
claire.neill@hscni.net

Dr Jillian Johnston
Consultant in Public Health
jillian.johnston@hscni.net

Tackling AMR: the development of a national "one stop shop" for local information about gram-negative bacteraemias and antimicrobial consumption in secondary care

Who?

This project was developed by the PHA's Healthcare Associated Infection and Anti-microbial Resistance Team in collaboration with infection control teams, consultant microbiologists and pharmacists from the health and social care trusts, the Department of Health (DoH), the Business Services Organisation and a regional pharmacist manager.

What?

One of the roles of the Health Protection Service is to support the five trusts in monitoring progress towards reductions in healthcare associated infections (infections which are contracted in a hospital or other healthcare setting) and use of antibiotics, in an effort to reduce antimicrobial resistance (AMR). Over the years, targets have been set for a number of infections, and more recently for reducing the use of antibiotics, where trusts must not exceed a set number of infections for a particular time period. The role of Health Protection is to ensure that trusts know how many infections they've had or can tell when they have had an unusually high number, which allows them to take action and to continue to work towards achieving the target.

In 2018, a target was introduced for healthcare associated gram-negative bacteraemias (GNBs) and for antibiotic consumption in hospital settings. While there are many gram-negative organisms, the most medically important ones include *Escherichia coli*, *Pseudomonas aeruginosa*, and *Klebsiella pneumoniae*. These bacteria can cause a range of symptoms from mild disease to life threatening conditions when the bacteria get into the blood (bacteraemia). GNBs are a major public health problem as they are responsible for prolonging illness in individuals and causing death. This type of infection has been increasing in Northern Ireland year on year. The milder infections are also an issue as they are much higher in number and result in the prescription of many antibiotics, which is a driver for AMR. It is therefore a priority to reduce GNBs, to reduce antibiotic prescribing and ultimately reduce the threat of AMR.

At the time the target was introduced there was no system in place to monitor the occurrence of these infections. Understanding of what causes GNBs was also limited and therefore it was going to prove challenging reducing these infections.

Healthcare professionals can examine the data for their trust to help guide decision-making.

How?

The PHA Health Protection Service set about developing a web-based platform which was built in-house, to create a "one-stop shop" for health professionals to access information to help guide the decisions they make when treating patients. The system also allows health professionals to enter information that may help identify what causes the infections. This will ultimately help patients by providing the knowledge to try and prevent infections occurring in the first place.

The system was developed through engagement with healthcare professionals across a number of disciplines. The PHA also hosted a workshop in February 2018 for infection control doctors and nurses, information analysts, antimicrobial pharmacists and DoH colleagues. In March 2018, the PHA conducted a series of trust visits to meet with local teams and conducted training/took feedback and made further updates to ensure that the system was fit for purpose for healthcare professionals.

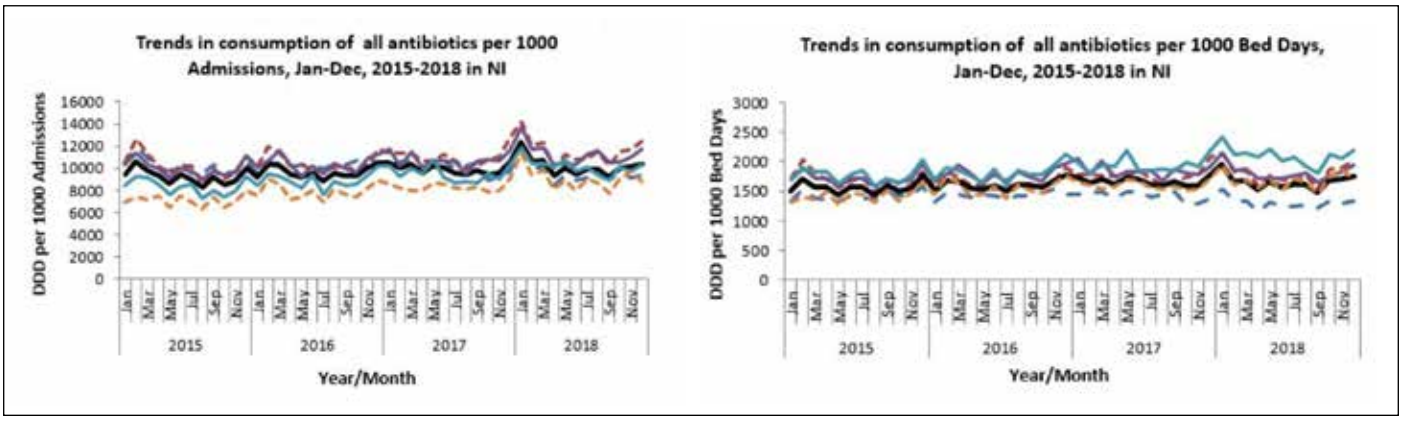


Figure 4: Graphs showing the consumption of antibiotics over time for the five trusts in Northern Ireland.

The unit of measurement in Figure 4 is the defined daily dose (DDD) which is a standardised measure of antibiotic consumption which allows for comparison across trusts. Two rates are shown: admissions, which allows healthcare professionals to examine how many people get antibiotics when they are admitted to hospital and bed days, which takes into account the duration of hospital stay and therefore allows healthcare professionals to consider the total amount of exposure to antibiotics.

Key messages

- Healthcare professionals now have access to antimicrobial usage data. This is encouraging the appropriate use of antibiotics in hospital settings.
- Using the data, healthcare professionals are starting to understand the profile of patients who have GNB, which will help to prevent similar infections happening in the future.
- Developing this solution within the PHA has allowed staff to enhance their own skills and enabled the creation of a responsive system that ensures the right information is available to benefit the patient.

Further information

Dr Lynsey Patterson
Head of Health Protection Surveillance
lynsey.patterson@hscni.net

Dr Muhammad Sartaj
Consultant in Public Health
muhammad.sartaj@hscni.net

Partnership working in emergency response and crisis management

Who?

In adherence to the processes outlined in the Civil Contingencies Framework NI, the PHA Health Protection Team is involved in multi-agency coordination and participates in special emergency arrangements required to deliver a response to severe weather events.[21] The PHA Health Protection Team has well established partnerships with multiple agencies and is involved in the development of plans as part of the Regional Community Resilience Group, members of which include the Department of Agriculture, Environment and Rural Affairs, local councils, the Met Office, Northern Ireland Water, the Police Service for Northern Ireland, Northern Ireland Fire and Rescue Service and the Department for Infrastructure.

What?

Severe weather, hot or cold, can have a big impact on people's health. The role of the Health Protection Team is to work with partner organisations as part of planning and response and ensure that vital services can cope during severe weather. The team's responsibility is to ensure that public health advice is accessible to members of the public and to advise what measures people can take to protect themselves and others against the impacts of the weather. Communication may include information about:

- seasonal flu and vaccination programmes;
- the dangers of carbon monoxide poisoning and how to prevent it;
- keeping warm during adverse weather;
- looking after the vulnerable and elderly;
- what to do if flooding occurs;

Severe weather, such as heavy snow or flooding, can have a big impact on people's health.

- using emergency water supplies;
- water use following restoration of supplies.

How?

Good partnership working was demonstrated on several occasions in 2018 with the activation of the multi-agency response in adherence to the Civil Contingencies Group Northern Ireland (CCGNI) Protocol for the Northern Ireland Central Crisis Management Arrangements (Sept 2016). During storms Ophelia, Emma and Ali, the PHA Health Protection Team participated in a number of multi-agency teleconferences and face to face meetings as determined by the incident response. Working with partner organisations, the PHA supported a response that:

- protected people and infrastructure from the effects of the cold weather;
- advised people on how they can protect themselves and elderly neighbours;
- supported recovery for the community.

Post event debriefs with partners facilitated shared learning and review of emergency response and planning arrangements across all organisations.

Key messages

- Severe weather, hot or cold, can have big impact on people's health.
- Well established working relationships with multi-agency partners allow the PHA Health Protection Team to respond promptly to adverse weather events.
- Working collaboratively ensures that public health advice is accurate and timely, and that the public can be signposted to other appropriate sources of information.

Further information

Catherine Curran
Emergency Planning Coordinator
catherine.curran@hscni.net

Research and development

Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN)

Improving services for people living with dementia in Northern Ireland through research partnerships

Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN)

[c h i t i n]
kite-tin
Cross-border Healthcare Intervention Trials in Ireland Network

Who?

The Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN) project is supported by European Union funding (through the EU INTERREG VA Programme). In total €8.84m, including a 15% contribution from the Department of Health in Northern Ireland and Health Service Executive in the Republic of Ireland, has been awarded to this unique cross-border partnership between the HSC Research and Development Division of the PHA and the Health Research Board (HRB) in the Republic of Ireland, to fund interdisciplinary teams working in partnership to deliver health intervention trials.

What?

Public health outcomes can be enhanced by evidence-based health research, including health intervention research, which can investigate if a new intervention is safe, determine if it is better than current practice, or direct resources to improve and protect people's health and reduce health inequality. In Ireland there is inequity of access to some health and care services and in the opportunity for involvement in health intervention research, particularly in more rural areas. This inequity is exacerbated by the existence of a border.

How?

CHITIN has enabled the PHA and HRB to fund 11 health intervention trials recruiting in excess of 3,500 participants in Northern Ireland and the Republic of Ireland border counties in the priority areas of population health, primary care and older people's services, mental health, acute services, disability services and children's services. The trials include interventions for medicines management, healthy neurocognitive ageing, improving mental health in at-risk young people, tackling adolescent inactivity and addressing obesity in pregnancy. They aim to provide citizens and HSC professionals with greater breadth and reach of opportunity to participate in and deliver health intervention research.

The knowledge and understanding generated will impact service users and the HSC professionals delivering the services. Interdisciplinary trial delivery teams, working in partnership, will form a network

wherein mentoring, training and skills development will be supported, resulting in enhanced capability and capacity to plan and deliver further health intervention trials, creating a legacy for future research in the region.

CHITIN – HITs

Trial Icon	Trial Name	Lead Partner	Trial Title
	BRAIN-Diabetes	Queen's University Belfast	BRAIN-Diabetes: Border Region Area lifestyle Intervention study for healthy Neurocognitive ageing in diabetes
	10 Top Tips	Queen's University Belfast	Delivery of a habit-based intervention '10 Top Tips for a Healthy Weight' to overweight or obese pregnant women on the Island of Ireland: a feasibility study exploring integration into existing antenatal care pathways
	WISH	Ulster University	The Walking In ScHools (WISH) Trial: a cross-border trial to evaluate a walking intervention in adolescent girls
	Murray Trial	Ulster University	Improving mental health among at-risk young people in a challenging border region
	PolyPrime	Queen's University Belfast	A randomised pilot study of a theory-based intervention to improve appropriate polypharmacy in older people in primary care (PolyPrime)
	My COMRADE PLUS	NUI Galway OÉ Gaillimh	MY COMRADE PLUS: A pilot cluster randomised controlled trial, for patients with multimorbidity, of the MultimorbiditY COllaborative Medication Review And DEcision Making intervention (MY COMRADE), practice based pharmacists (PBP's) or PBP's plus an adaptation of MY COMRADE
	REFLECTS	Ulster University	A randomized controlled trial (RCT) of mirror box therapy in upper limb rehabilitation with sub-acute stroke patients
	PAIGE2	Belfast Health and Social Care Trust	Pragmatic Lifestyle Pregnancy and Post pregnancy Intervention for Overweight Women with Gestational Diabetes Mellitus: a randomised controlled clinical trial (PAIGE2)
	ACP	Queen's University Belfast	Anticipatory Care Planning Intervention for Older Adults at Risk of Functional Decline: A Primary Care Feasibility Study
	WORtH	Ulster University	The feasibility of a walking intervention to increase activity and reduce sedentary behaviour in people with serious mental illness
	INCA-Sun	RCSI	The use of digital technologies to enhance adherence and inhaler technique and guide treatment among patients with severe asthma

The Cross-border Healthcare Intervention Trials in Ireland Network: participating organisations, working in partnership to deliver health intervention trials.

Key messages

- The Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN) is enhancing involvement in health intervention research.
- Through strong and enduring cross-border collaboration the PHA and HRB can improve and protect people's health, and reduce health inequality.
- Evidence generated from research can be used to change lifestyles, prevent illness, improve care and drive policy change.

Further information

Dr Rhonda Campbell
CHITIN Programme Manager, HSC R&D Division
rhonda.campbell@hscni.net

Improving services for people living with dementia in Northern Ireland through research partnerships

Who?

HSC R&D Division collaborated with The Atlantic Philanthropies to commission a research programme in dementia care, to take forward the research recommendations from the Northern Ireland Dementia Strategy. The Atlantic Philanthropies was founded by entrepreneur Chuck Feeney, who maintains that people of wealth should use it to better the world during their lifetimes.

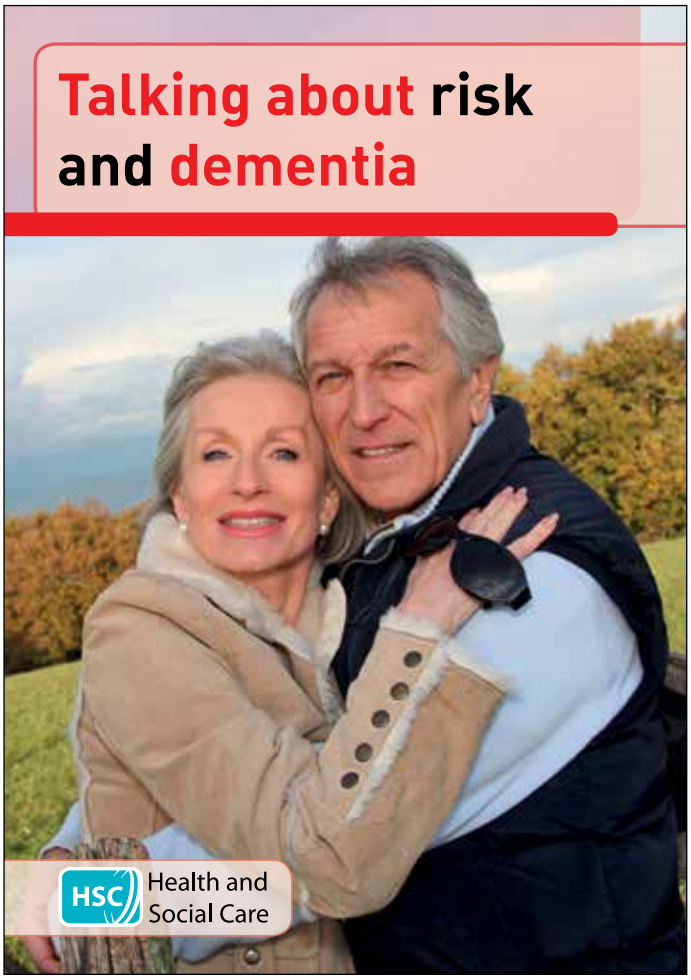
What?

It is estimated that at present in Northern Ireland 23,735 people live with dementia, of whom 1,269 have early-onset dementia.[22] In common with other parts of the developed world, as the local population ages, dementia is increasingly becoming a major public health and social issue. The number of people living with a dementia is projected to rise to around 57,500 by 2051.[22] If it is considered that each of these people will have a network of lay and professional carers then it can be estimated that, by 2051, upwards of 500,000 people could be coping with the impact of dementia in their everyday lives in Northern Ireland.

How?

To develop the local priority areas for this programme, consultation with key stakeholders (including service users, health professionals and commissioners) used topics initially identified by national priority setting exercises in the UK. These were led by the James Lind Alliance and the Alzheimer's

These artworks were created by people living with a dementia in focus groups carried out as part of the TESA project. The art was displayed at a recent event organised to share the research findings.



Society in order to derive a list of topics for which robust evidence was currently unavailable. Topics agreed following the consultation included staff and training; quality of care; coordination of care; information and communication; management of behaviour and management of symptoms. Seven projects were awarded funding for up to three years. Questions addressed advanced care planning in nursing homes, pain management at the end of life, evaluation of a healthcare passport, risk communication, facilitated reminiscence, medicines management and technology assisted living. The research findings are available at pha.site/dementia-care-research

This leaflet was developed by researchers focusing on risk communication in dementia care, in partnership with the PHA, and the HSCB, to help people living with a dementia and their carers to manage risk in everyday life.

Key messages

- This programme brought together over 30 different organisations.
- People living with a dementia and their carers helped co-design and carry out the studies.
- Findings from the projects have been published in journals, disseminated in leaflets, produced as a play, commissioned as an app and displayed in art exhibitions.

Further information

Gail Johnston
Programme Manager, HSC R&D Division
gail.johnston@hscni.net

Screening

The Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme

Cervical screening social media campaign

The Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme

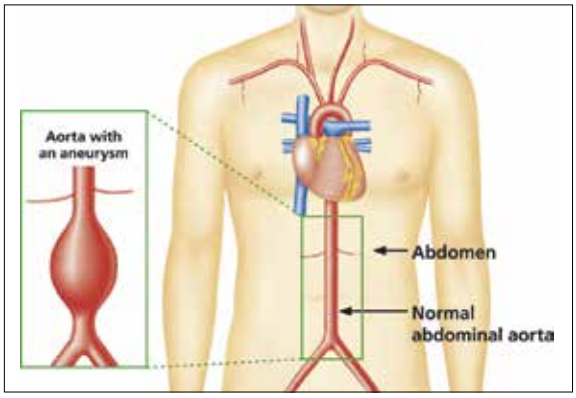
Who?

The Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme was introduced in 2012. It aims to reduce deaths from ruptured abdominal aortic aneurysms through early detection, monitoring and treatment among men aged 65 and over. Since implementation, staff in the PHA and BHSCT (who provide this regional screening service across all trust areas) have fostered effective partnership working with the programme's main service users – men aged 65 and over, alongside their partners/spouses.

What?

An AAA is an enlargement of the aorta. This is the main artery that supplies blood to the body, running from the heart, down through the chest and into the abdomen (belly). Most people with an AAA have no symptoms. However, if an aneurysm is rapidly increasing in size or rupturing, there will be symptoms which can include: severe abdominal, back or flank pain (this can radiate to the chest, groin or leg); shock or low blood pressure (due to loss of blood) and a pulsating abdominal mass.

The screening programme offers a quick, free and painless scan to all men in their 65th year. Men over the age of 65, who have never attended for AAA screening, can self-refer by calling the Programme Office on 028 9063 1828.



As some people get older, the wall of the aorta in the abdomen can become weak and balloon out to form an aneurysm, rather like a bulge in a worn car tyre.
Diagram courtesy of the NHS AAA Screening Progamme.

How?

To ensure provision of safe, effective, high quality and equitable screening – with continuous service improvement built into service delivery – programme staff realised that input from men aged 65 and over was essential. Fostering engagement was, however, initially challenging due to:

- men being traditionally less likely to interact with healthcare providers than women;
- lack of awareness about what an AAA is and its implications;
- the risks associated with screening and treatment;
- lack of funding for a publicity campaign following programme implementation;
- service users being unaware of the pivotal role they play in ensuring effective service transformation.

Nevertheless, programme staff were also aware that such challenges strengthened the case for partnership working. Therefore, in April 2013, men screen-detected with an AAA – along with their wives/partners – were invited to meet programme team members at the first service user event to discuss what was good about the programme and what could be improved.

Six years later, programme staff are preparing for their seventh event as the programme – and its service users – continue to benefit from outcomes from previous events. This has included appointing three patient representatives to the programme's main management group to help embed partnership working. Participation rates at these annual events have also increased from 18 service users in 2013 to 73 in 2017.

Pictured (L-R) are Mr Gerard Quinn, PHA Chair Mr Andrew Dougal, Mr Frank Mills and Mr Jim Kenny at the 2018 service user event in Belfast.

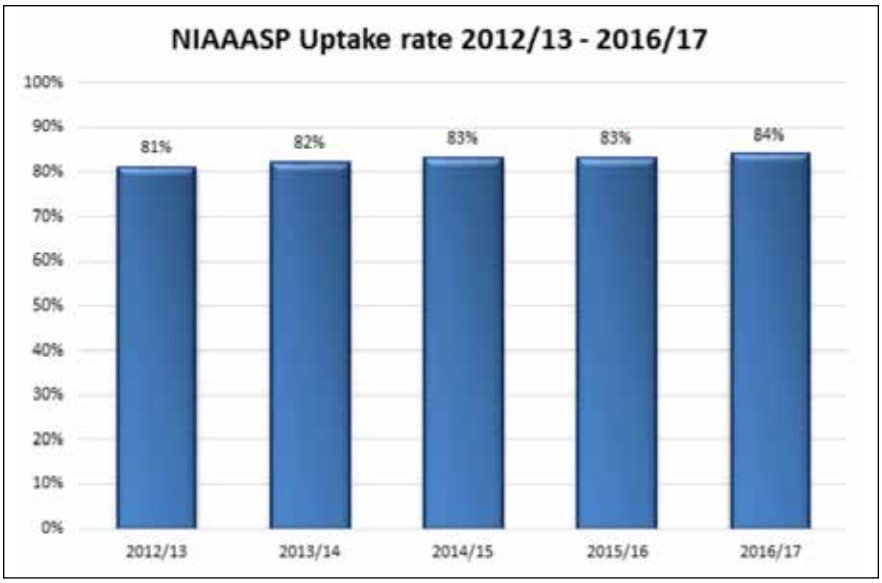


Figure 5: Uptake rates for the AAA screening programme from its inception in 2012. Engagement/ promotional work with partners has helped improve uptake: 81% in 12/13 – 84% in 16/17 (and just under 84% in 17/18). High uptake rates help ensure the screening programme is as effective as possible.

Key messages

- The AAA screening programme invites all men aged 65 to have an ultrasound scan of their abdomen to check for an abdominal aortic aneurysm. Men over the age of 65, who have not been screened previously, can phone the screening office on 028 9063 1828 for an appointment.
- Successful partnership working has been key to sustained programme delivery and improvement in AAA screening.
- Partnership working with service users is an opportunity to help meet their needs and effect positive programme change through, for example, the provision of patient centred post- operative information leaflets.

Further information

Jacqueline McDevitt
QA and Commissioning Support Manager for the NI AAA Screening Programme
jacqueline.mcdevitt@hscni.net

Cervical screening social media campaign

Who?

The Cervical Screening Team worked with the PHA Communications Team and a number of national and local charities and organisations, including Jo's Cervical Cancer Trust, Cancer Research UK, the Women's Resource & Development Agency and the Northern Ireland Cancer Network (NICaN) to develop a social media campaign aimed at promoting cervical screening.

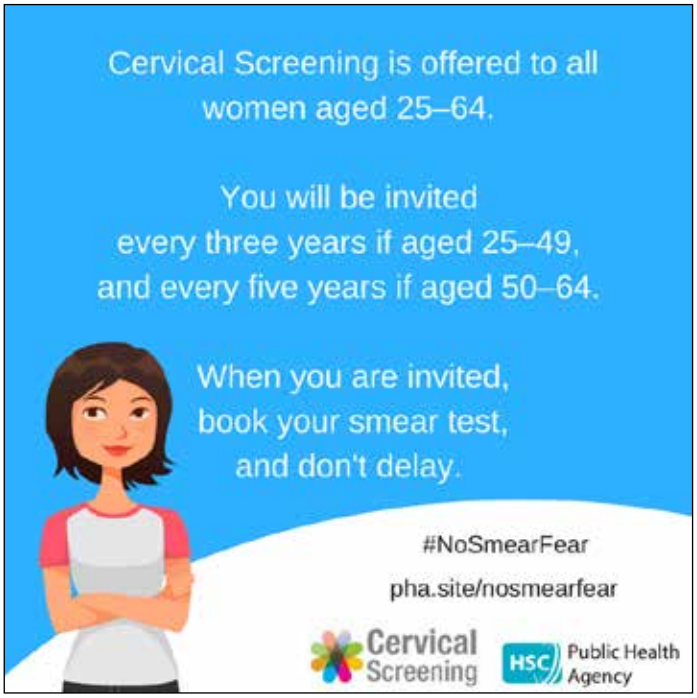
What?

The Northern Ireland Cervical Screening Programme invites eligible women to have a regular cervical screening test. Screening is offered to women aged 25–49 every three years and to women aged 50–64 every five years. The test is intended to detect abnormalities within the cervix that could, if left untreated, develop into cancer. Early detection and treatment can prevent up to 75% of cases of this cancer.

Coverage is used as a measure of the population's participation in the screening programme, defined as the proportion of eligible women, aged 25–64 who have at least one adequate test result recorded in the previous five years. Coverage in Northern Ireland is currently lowest in the 25–29 age group at 64.4%, compared to 76.4% overall.[23]

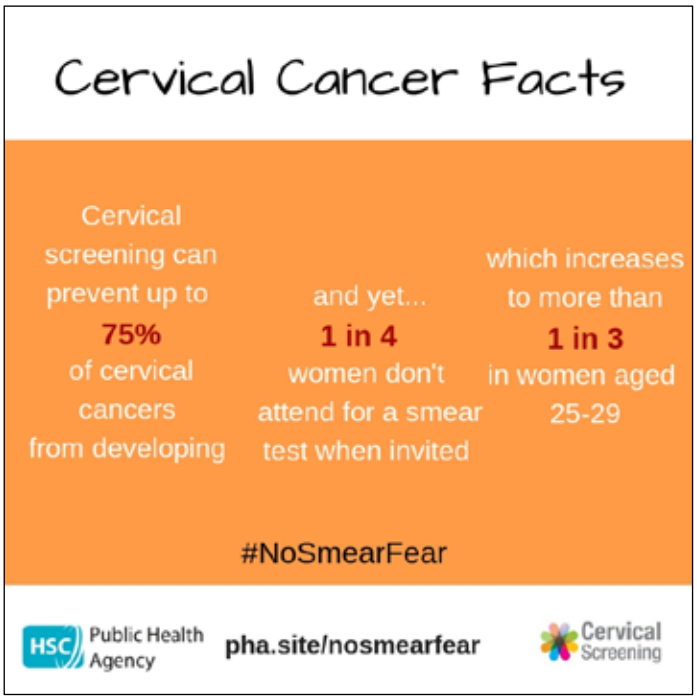
How?

To address the lower numbers in the younger age group attending for screening, a social media campaign was developed, engaging with relevant stakeholders. Service user input from Jo's Cervical Cancer Trust volunteers and service users from the NICaN Gynaecology Group helped ensure the campaign was as relevant and engaging as possible.



The campaign aimed to highlight the importance of screening in preventing cervical cancer as well as helping to tackle feelings of embarrassment or fear that may discourage younger women from attending their cervical screening appointment.

A series of posts and infographics were developed and shared via the PHA Facebook, Twitter and Instagram platforms. Two videos were also shared on these platforms as part of the campaign. The campaign ran from September 2018 to February 2019 and targeted women in the 25–29 age range and those living in geographical areas where coverage is known to be lowest. The campaign had a 'reach' of over 510,000 on Facebook.



Key messages

- Cervical screening can prevent 75% of cervical cancers from developing, yet 1 in 3 women in the younger age group (25–29) do not attend.
- The cervical screening social media campaign targeted younger women, aiming to promote cervical screening and tackle recognised barriers, such as embarrassment and fear.
- A video of Alison, a local service user telling her story *'Going for a Smear Test Could Save Your Life'* may be viewed at pha.site/smear-test-save-life
- A video showing *'What Happens at Cervical Screening'* may be viewed at pha.site/cervical-screening-what-happens

Further information

Dr Catherine Bane
Project Manager, Young Person and Adult Screening Team
catherine.bane@hscni.net

Service development

#hackthepain: a MyNI social media campaign for supported pain self-management

Sexual health clinic for young people

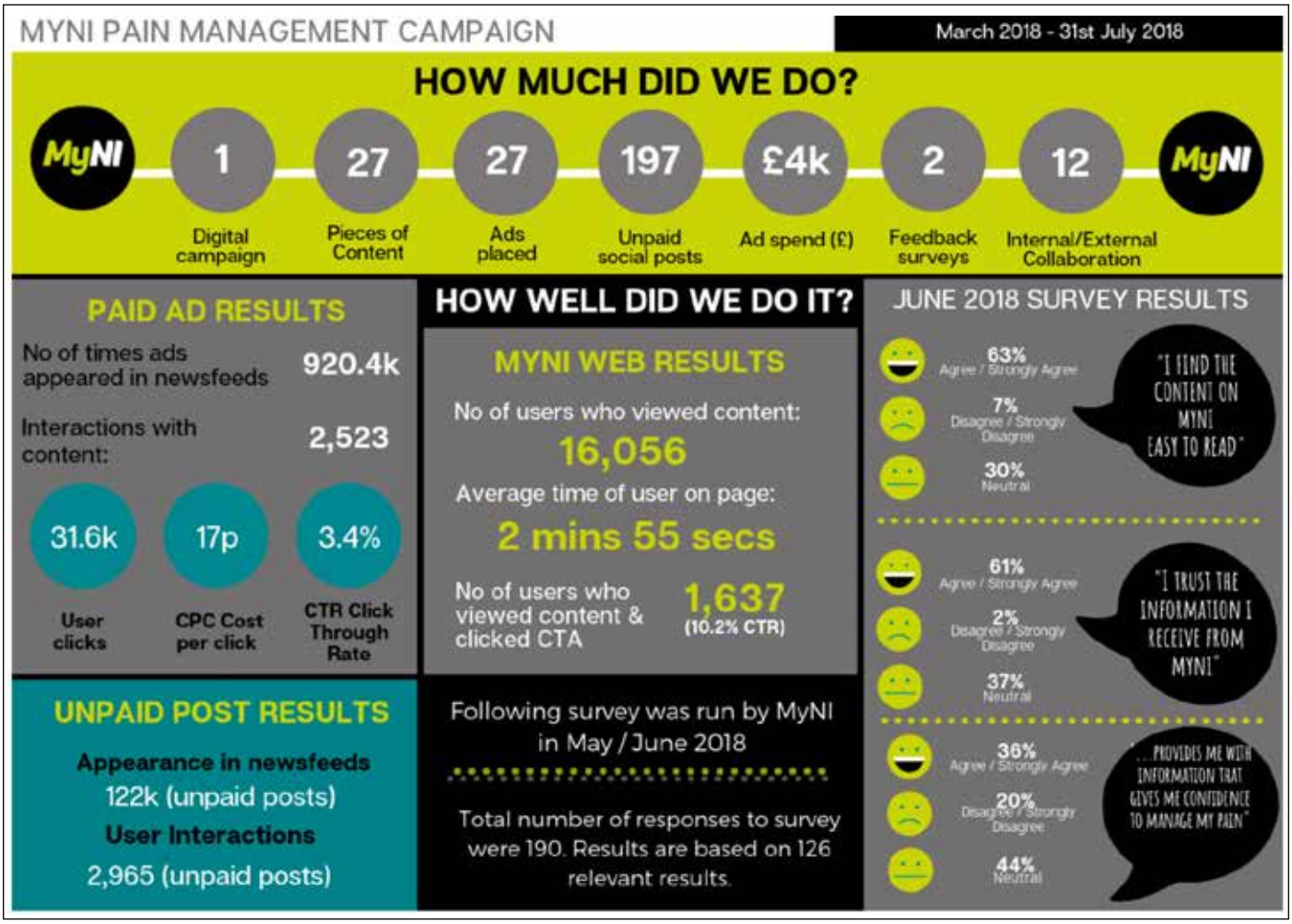
#hackthepain: a MyNI social media campaign for supported pain self-management

Who?

Following publication of *The Painful Truth* report by the Patient Client Council (PCC), the PHA developed and continues to lead the Northern Ireland Pain Forum.[24] This is a multidisciplinary practitioner and patient network for persistent pain prevention, supported self-management and service improvement. The Pain Forum brings together health and social care trusts, the HSCB, the PHA, the PCC, the Business Services Organisation, Integrated Care Partnerships, GP Federations, the Healthy Living Centre Alliance, the Pain Alliance for Northern Ireland and Versus Arthritis. It works with academics, artists, private entrepreneurs, several government departments and international pain experts.

What?

Persistent pain costs between 3 and 10% of GDP.[25] Alongside mental health problems, it is the most common disabling condition and often the most troubling for patients.[26] Almost 500,000 people in Northern Ireland are believed to be affected.[27] Numbers are rising due to obesity, multi-morbidity and an ageing population, but information on prevention and good pain management is scarce.



The campaign evaluated positively, with a high click through rate (CTR) and a relatively high average time spent on each web page. This shows that both the campaign and the website were successful in getting users to engage with the content.

Insights into the needs of people living with pain were brainstormed by 45 coders, pain service providers and service users at the #hackthepain participatory hackathon held at the QUB Computer Sciences Building on 3 June 2017.

Pictured at the end of the MyNI pain management social media campaign are (L-R) Ms Joanne McKissick, External Relations and Policy Manager with the Patient Client Council, Ms Rebecca Walsh, service design engineer with the Department of Finance Innovation Lab, and Dr Christine McMaster, Public Health Consultant with the PHA.

Key messages

- The Forum has supported Healthy Living Centres to offer pain support groups that are helping people to live better with pain.
- It has facilitated the development of a fibromyalgia pathway and its implementation in the Western HSCT.
- It has invested in pain management services to improve equitable access for patients, outcomes and staff morale.

Most people can self-manage with GP support and community health care to remain active and well, but many need peer and multidisciplinary support for a good quality of life, and some require hospital pain services, complex treatments and rehabilitation. These are difficult to access, and there is an overreliance on prescribed pain medication, which contributes to a rising tide of dependency, addiction, expenditure, suffering and death. Many patients lose employment and educational opportunities, friends and family as well as hobbies and social lives.

How?

With colleagues from the Department of Finance Innovation Lab, the PCC and a £5,000 PHA grant, the Pain Forum organised a participative hackathon in 2017 to test digital solutions for better information about pain and supported self-management (see pha.site/pain-hackathon). In 2018, the Forum worked with the Department of Finance Digital Transformation Service to deliver a social media campaign.

Its content was coproduced by Pain Forum members and was very successful, receiving almost 17,000 unique page views and a high click through rate. The evaluation survey indicates that 37% of respondents tried alternative and complementary therapies, connected with others living in pain or started attending support groups as a result of the pilot.

The Forum has now secured funding to develop a sustainable and innovative solution for the remaining information challenges in partnership with private industry and researchers. This aims to meet the specific needs of patients with persistent pain.

Further information

Dr Christine McMaster
Public Health Consultant
christine.mcmaster@hscni.net

Sexual health clinic for young people

Who?

This project demonstrated partnership working between colleagues in HSCB, PHA, BHSCT and Queen's University Belfast to provide weekly, term time, walk-in sexual health clinics in the Students' Union.

What?

Some sexually transmitted infections (STIs) continue to increase locally.[28] In 2017, the most recent year for which surveillance data are available, the highest diagnostic rates of the common STIs occurred in 16–24 year old females and 20–34 year old males. Young people aged 16–34 years old account for 82% of new STIs. A further at-risk group is men who have sex with men (MSM) who are at a disproportionate risk of contracting certain STIs. The challenge is therefore to ensure that young people are aware of the safe sex messages and are enabled to seek help and get tested if they feel that they have put themselves at risk.

How?

Earlier diagnosis and treatment reduces the risk of onward transmission of any infectious disease, so improving access to services will help to reduce STIs. Funding was secured for a weekly walk-in clinic in the Students' Union during term time. The university provides accommodation for the clinic, support for the running of the clinic and promotes it via various social media outlets. The trust provides the staff, treatments and follow up. Patients are assessed and offered full STI testing, sexual health advice and signposting to other services as appropriate.

Key messages

- This clinic provides a large number of young people with information, support and a clinical service in a convenient venue.
- It is targeting at-risk young people, 72% of whom have never previously attended a genito-urinary medicine clinic, and significant levels of infection have been diagnosed and treated.
- Feedback from students has been extremely positive; they felt their needs had been met. This is an important new service reaching high risk young people.

Further information

Dr Louise Herron
Consultant in Service Development and Screening
louise.herron@hscni.net

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List of core tables 2017

List of core tables

Page numbers refer to the PDF of Core Tables 2017, which is available to download from the PHA website at www.publichealth.hscni.net

Created by:
Health Intelligence Unit,
Public Health Agency

Further information

Adele Graham
Senior Health Intelligence Manager
adele.graham@hscni.net

Public Health Agency

Public Health Agency
12-22 Linenhall Street, Belfast BT2 8BS.
Tel: 0300 555 0114 (local rate).
www.publichealth.hscni.net

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item 11

Title of Meeting	PHA Board Meeting
Date	19 September 2019
Title of paper	Sexually Transmitted Infection Surveillance in Northern Ireland 2019
Reference	PHA/04/09/19
Prepared by	Neil Irvine
Lead Director	Adrian Mairs
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to note the Sexually Transmitted Infection Surveillance in Northern Ireland 2019 report based on data for the calendar year 2018.

2 Background Information

Under PHA's Corporate Objective 3, "All individuals and communities are equipped and enabled to live long healthy lives", PHA will develop and implement a wide range of multi-agency actions to improve the sexual health of the population. This report aims to provide an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2018.

3 Key Issues

Overall, the number of new STI diagnoses made in GUM clinics increased by 6% between 2017 and 2018. In particular, diagnoses of gonorrhoea increased by 30% (from 679 in 2017 to 882 in 2018), and infectious syphilis by 72% (from 50 to 86).

The majority of the increase in gonorrhoea and infectious syphilis was seen in men who have sex with men (MSM). This may be due at least in part to significantly increased STI testing levels among MSM during 2018, coinciding with the introduction of HIV PrEP through the Risk Reduction Clinic in Belfast Trust. A direct association with taking PrEP cannot be ruled out, however, and this will continue to be monitored.

While MSM account for the majority of the increase in gonorrhoea diagnoses, there are smaller but still important upward trends among heterosexuals. Gonorrhoea continues to give particular concern due to its potential to show resistance to antibiotics. As elsewhere in the UK, analysis of antimicrobial sensitivity patterns in Northern Ireland has shown a significant level of resistance to azithromycin, including the emergence of high-level azithromycin resistant disease. This has led to a change in UK treatment guidelines such that azithromycin is now no longer recommended first line treatment.

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

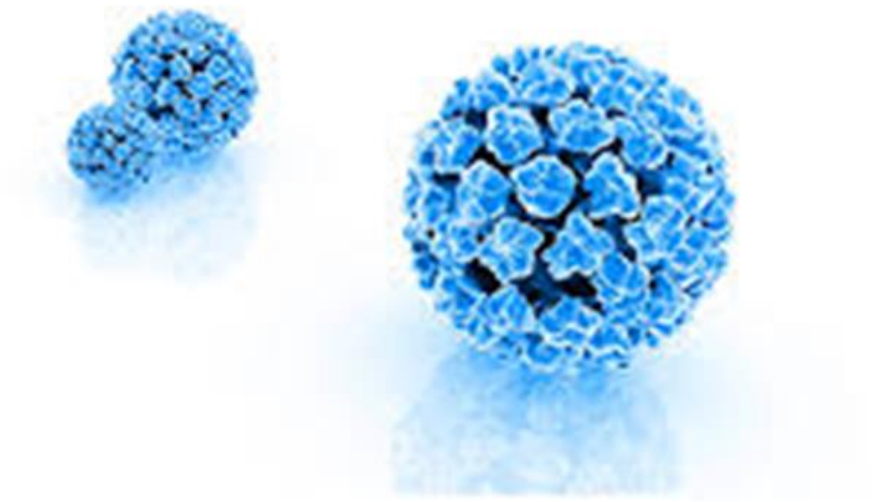
4 Next Steps

The report recommends that safer sex messages should continue to be promoted to the general population, young people and MSM; and that commissioners should continue to seek to expand access to STI testing opportunities.

The Report has been published on the PHA website.

Sexually Transmitted Infection Surveillance in Northern Ireland 2019

An analysis of data for the calendar year 2018



HSC Public Health Agency

Contents Page

This report aims to provide an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2018.

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

Summary points

In Northern Ireland Genito-Urinary Medicine (GUM) clinics in 2018

- New diagnoses of chlamydia increased by 6%; 1,787 diagnoses in 2018 compared with 1,684 in 2017.
- New diagnoses of gonorrhoea increased by 30%; 882 in 2018 compared with 679 in 2017.
- New diagnoses of genital herpes simplex (first episode) increased by 8%; 501 in 2018 compared with 463 in 2017.
- New diagnoses of genital warts (first episode) decreased by 10%; 1,436 in 2018 compared with 1,600 in 2017.
- New diagnoses of infectious syphilis increased by 72%; 86 in 2018 compared with 50 in 2017.

Surveillance arrangements and sources of data

GUMCAD

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

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

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

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

Laboratory reporting

Laboratory data represent an important complementary source to clinician-initiated surveillance arrangements. Laboratory reporting of *Chlamydia trachomatis* in Northern Ireland is provided for 2006–2018. Antibiotic susceptibility information for *Neisseria gonorrhoeae* isolates is provided for 2018.

Enhanced syphilis surveillance

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

1: Diagnoses provided in Northern Ireland GUM clinics in 2018

During 2018:

• 6,086 new STI diagnoses were made, an increase of 6% compared with 2017 (5,726);

• 65% (3,970/6,086) of new STI diagnoses were in males;

• three types of infection accounted for 70% of **new STI diagnoses** – chlamydia (29%), genital warts (first infections) (24%) and non-specific genital infection (17%);

• 1,725 **other STI diagnoses** were made;

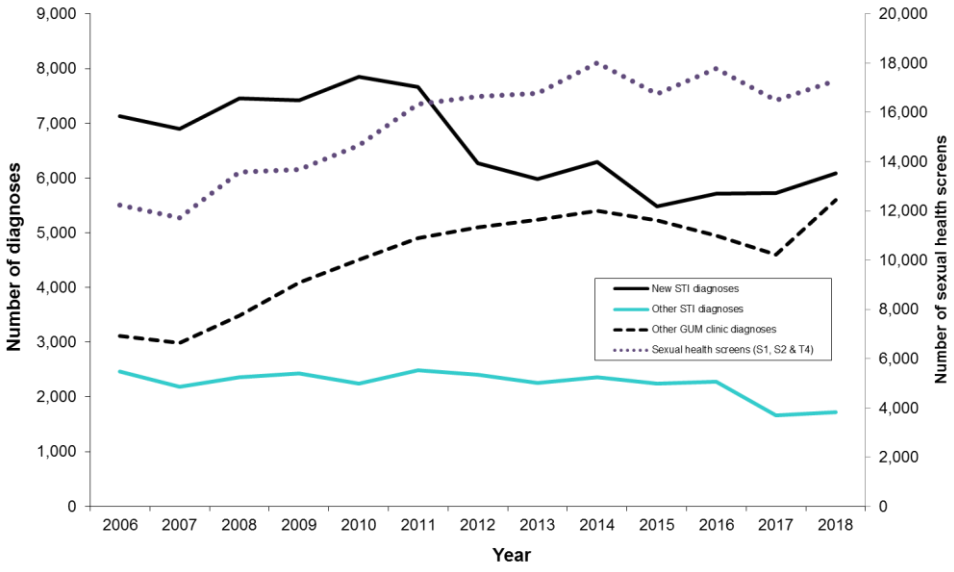
• 5,600 **other diagnoses made at GUM clinics**.

Trends: 2006–2018

Between 2006 and 2011 the number of **new STI diagnoses** remained relatively stable. Between 2011 and 2017, the numbers have decreased reflecting a steep decline in new diagnoses of complicated and uncomplicated non-specific genital infection (NSGI) (Figure 1.2). This decrease is likely to be due to the change in test technology within GUM clinics, whereby the more sensitive dual platform PCR test for gonorrhoea and chlamydia has largely replaced the invasive urethral culture in asymptomatic patients[1]. This has resulted in more detections of organisms with proven pathogenicity, particularly gonorrhoea and thus NSGI diagnoses have fallen (Figure 1.2). However, diagnoses of new STIs have been increasing again since 2015, with a further 6% increase in 2018 when compared to 2017 (Figure 1.1).

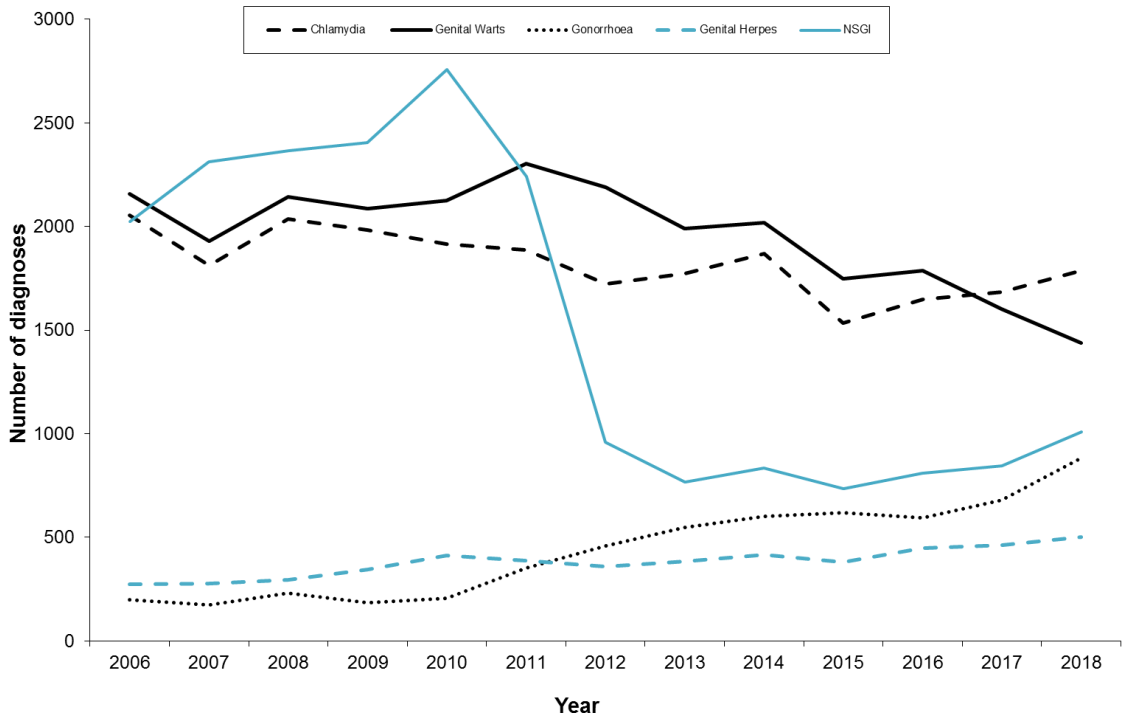
The number of **other STI diagnoses** has remained largely stable since 2006. An explanation of STI categories is provided in Appendix 1.

Figure 1.1: Trends in diagnoses and sexual health screens made in Northern Ireland GUM clinics, 2006–2018



During 2006–2018, chlamydia infection, non-specific genital infection (NSGI) and genital warts (first infections) accounted for the highest proportion of new STI diagnoses (70%) made in Northern Ireland GUM clinics (Figure 1.2). Specific disease trends will be examined in chapters 2 to 6.

Figure 1.2: Trends in new diagnoses of STIs in Northern Ireland GUM clinics, 2006–2018

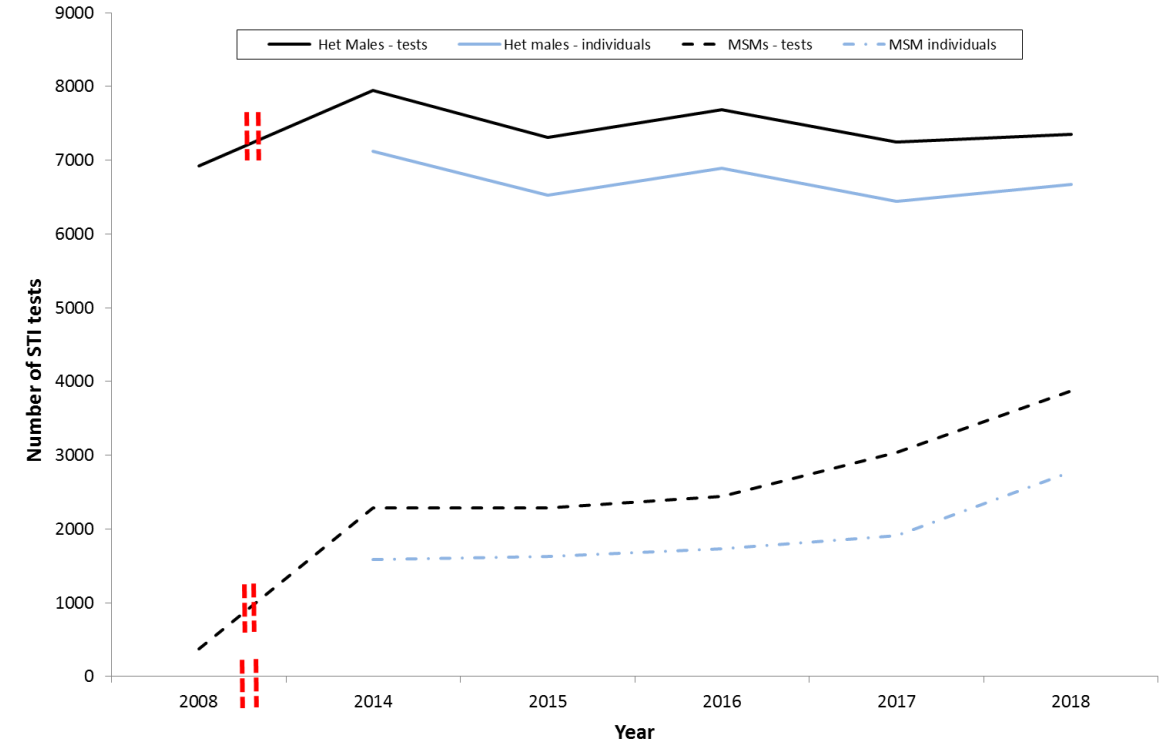


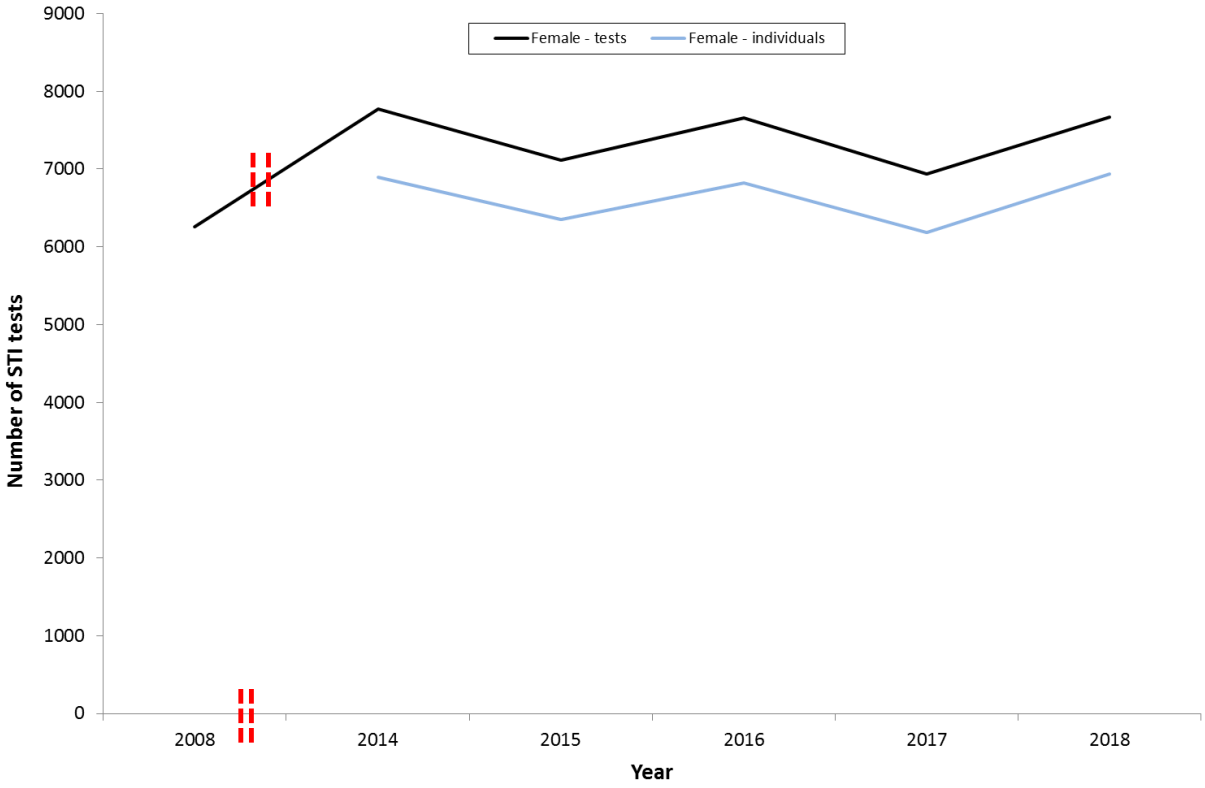
Sexual health screens

The number of sexual health screens performed annually has increased significantly since 2008, but has reached a plateau since 2014 reflecting a capacity ceiling within GUM clinics. This, however, masks an increase in test activity in MSM. There has been a particular increase in MSM testing since 2017, likely to represent increasing attendance at GUM clinics by those seeking HIV pre-exposure prophylaxis (PrEP), as well as the more frequent routine testing in those being prescribed PrEP.

Since July 2018, HIV PrEP has been available, through the Risk Reduction Clinic in Belfast Trust to those meeting certain risk criteria. At each clinic attendance, patients are offered a sexual health screen.

Figure 1.3: Trends in sexual health screen activity in Northern Ireland GUM clinics, by gender and male sexual orientation, 2008, 2014-2018





2: Chlamydia

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

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

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

Diagnoses made in GUM clinics during 2018

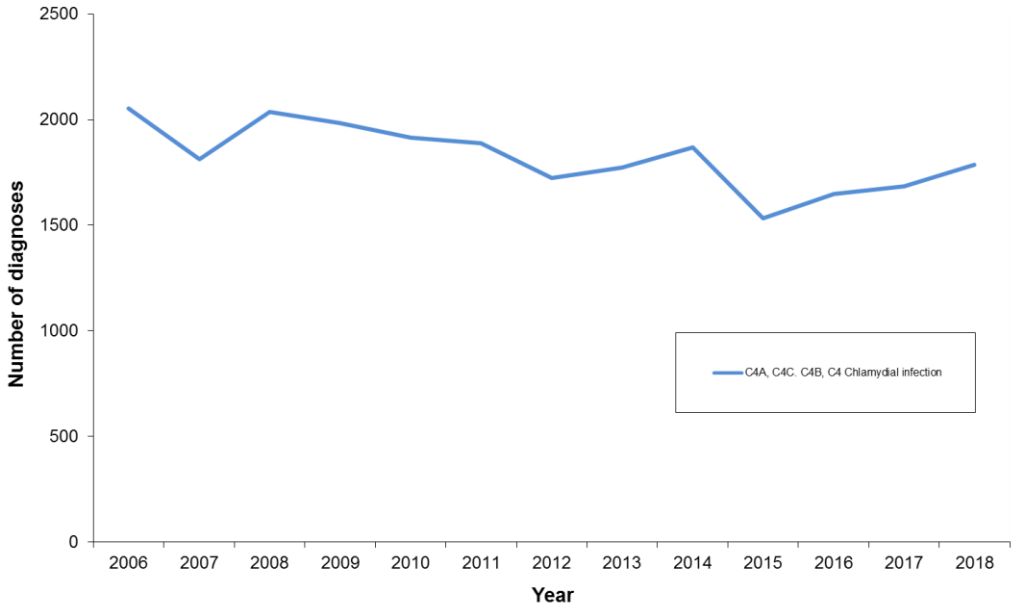
Chlamydial infection accounted for 29% (1,787/6,086) of all new STI diagnoses made in Northern Ireland GUM clinics during 2018.

- There were 1,787 new episodes of chlamydial infection diagnosed in Northern Ireland GUM clinics in 2018, compared with 1,684 in 2017.
- 1,035 (58%) of these were diagnosed in males.
- The highest rates of infection in both males and females were in the 20–24 years age group, accounting for 35% of male and 46% of female diagnoses.
- The rate of diagnoses in the 16–19 years age group is more than double in females as in males.
- 29% (303/1,035) of the total male diagnoses occurred in men who have sex with men (MSM).

Trends: 2006–2018

Between 2006 and 2015, diagnoses of chlamydial infection decreased by 25%, from 2,053 diagnoses in 2006 to 1,534 in 2015, however diagnoses have increased each year from 2016 to 2018 (Figure 2.1).

Figure 2.1: Diagnoses of chlamydia in Northern Ireland, 2006–2018



Age and gender trends: chlamydia

From 2012–2018, diagnostic rates in females were consistently highest in the 16–24 years age group, peaking between 20 and 24 years (Figure 2.2). In males, the highest rates were in the 20–34 years age group, again peaking between 20 and 24 years.

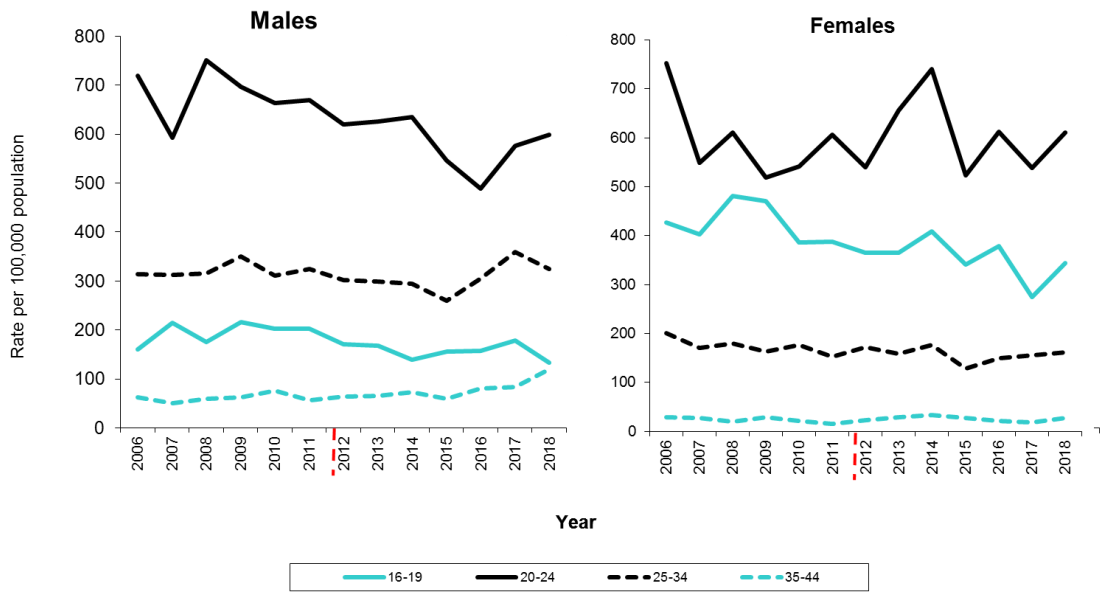
Diagnostic rates in those under 25 years of age were consistently higher in females, with rates in those aged 25 years and over consistently higher in males. Diagnostic rates in females aged over 24 years decrease due to changes in sexual behaviour, as well as decreased susceptibility.

Diagnoses in those under 16 years of age accounted less than 1% (35/12,013) of all diagnoses made during the period 2012–2018.

Diagnoses in the 45+ years' age group accounted for 3% (404/12,003) of all diagnoses made during the period 2012–2018.

The proportion of male chlamydia diagnoses attributed to MSM has ranged from 6% in 2006 to 29% in 2018.

Figure 2.2: Rates of chlamydial infection in Northern Ireland, by gender and age group, 2006–2018



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

Genital chlamydia trachomatis laboratory reporting, 2006–2018

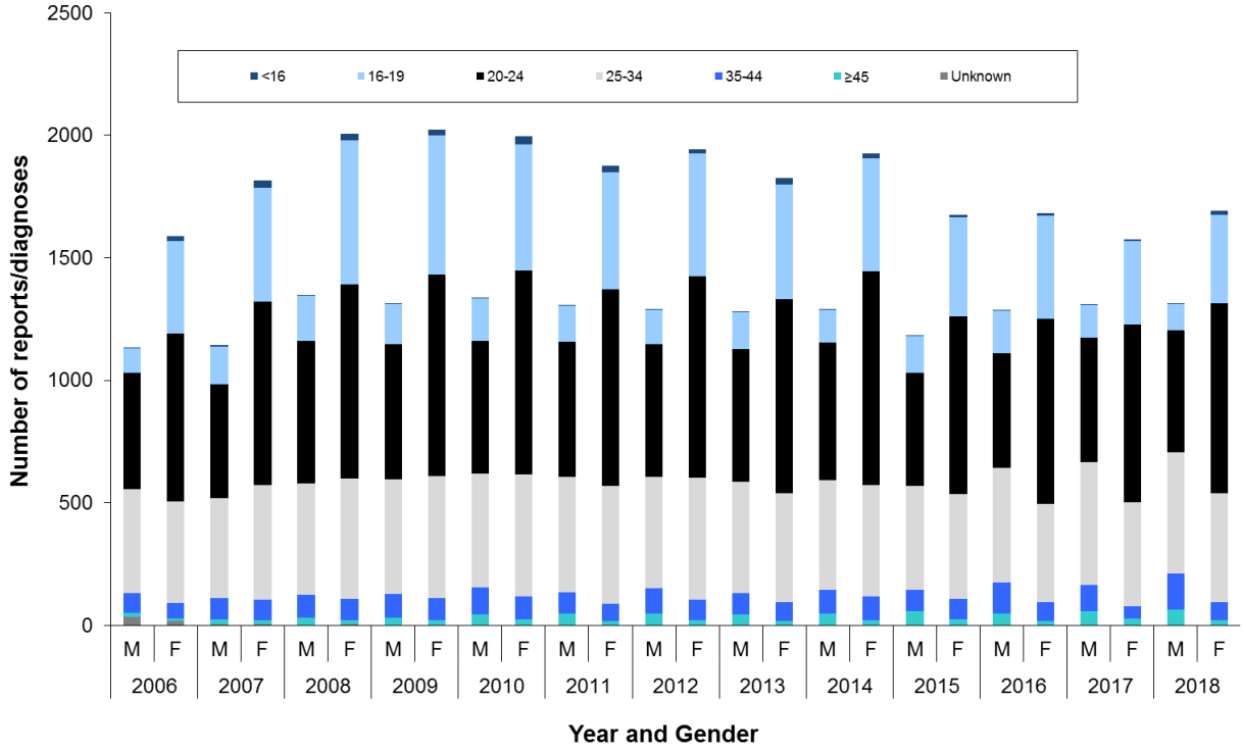
During 2018, 3,063 laboratory confirmed cases of genital chlamydia trachomatis were reported, an increase of 6% compared with 2017. GP specimens accounted for 30% (911/3,063) of cases reported during 2018 (Table 2.1). Between 2006 and 2018, confirmations from GP specimens increased by 27%.

Table 2.1: Referral source of genital *Chlamydia trachomatis* specimens, 2006–2018

Referral Source	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
GP Number (%)	720 (26.1)	894 (29.7)	979 (29.0)	1025 (30.3)	1124 (33.5)	1096 (34.3)	1207 (37.1)	1102 (35.2)	1093 (33.9)	1028 (35.8)	977 (32.8)	968 (33.5)	911 (29.7)	13,124
Other	2,036	2,121	2,396	2,353	2,231	2,104	2,044	2,023	2,130	1,836	1,998	1,921	2,152	27,345
Total	**2,756**	**3,015**	**3,375**	**3,378**	**3,355**	**3,200**	**3,251**	**3,125**	**3,223**	**2,864**	**2,975**	**2,889**	**3,063**	**40,469**

Higher numbers of diagnoses are consistently reported in females, accounting for 55% (1,691/3,063) of all cases reported by laboratories during 2018. The majority (68%; 16,102/23,620) of female cases reported in the period 2006–2018 were aged between 16 and 24 years. Between 2006 and 2018 females accounted for 79% of the diagnoses made by a GP. Males accounted for between 38% and 45% of cases reported annually since 2006. The majority of male cases reported since 2006 were in the 20–34 years age group (Figure 2.3). Information on gender was missing for 1% of cases reported during the period 2006–2018.

Figure 2.3: Laboratory reports of genital *Chlamydia trachomatis*, by age and gender, 2006–2018



3: Gonorrhoea

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

Diagnoses made in GUM clinics during 2018

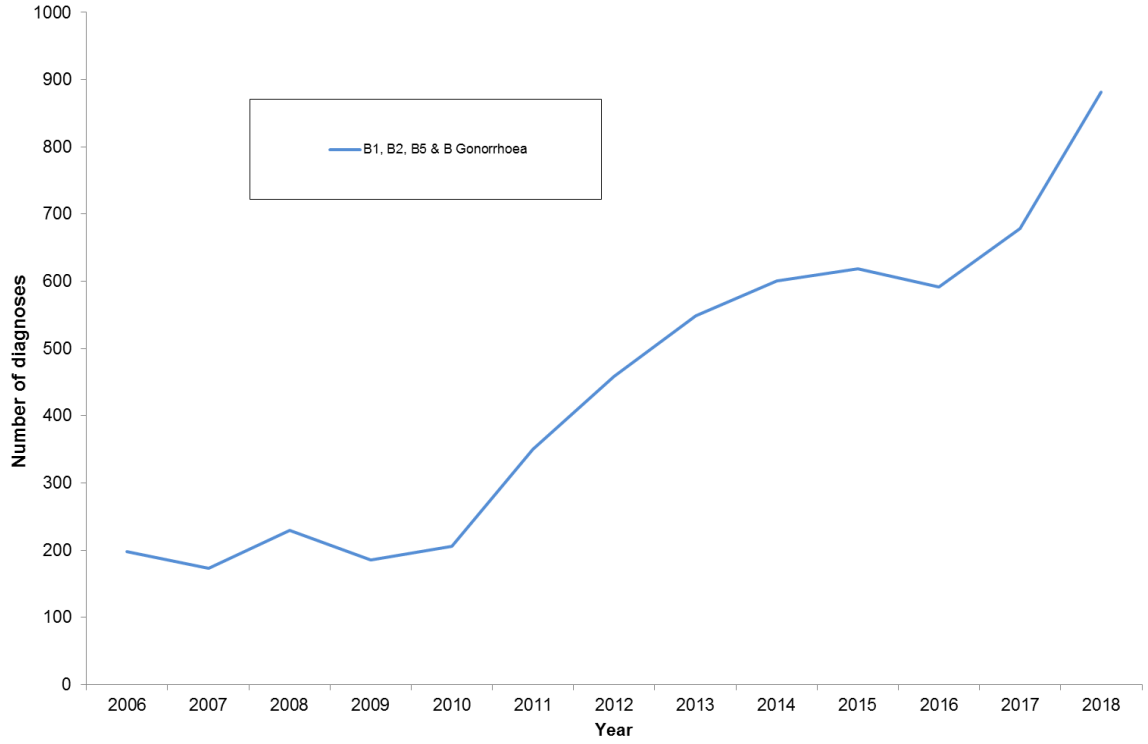
Gonorrhoea accounted for 14% (882/6,086) of all new STI diagnoses made in Northern Ireland GUM clinics during 2018.

- There were 882 new episodes of gonorrhoea diagnosed in Northern Ireland GUM clinics in 2018, compared with 679 in 2017, an increase of 30%.
- 709 (80%) of these were diagnosed in males.
- The highest diagnostic rates in both men and women were in the 20–24 years age group.
- 69% of female diagnoses were in the 16–24 years age group and 25% were in the 25–34 years age group.
- 32% of male diagnoses were in the 16–24 years age group and 40% were in the 25–34 years age group.
- 72% (511/709) of male diagnoses were attributed to MSM.

Trends: 2006–2018

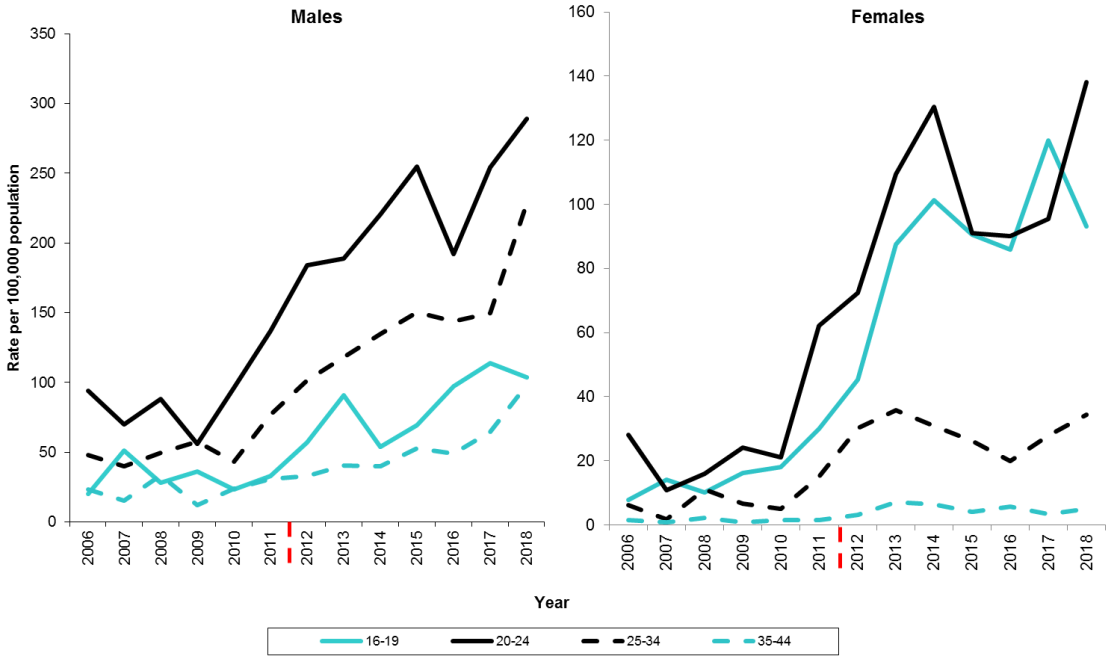
The annual number of diagnoses of gonorrhoea has shown very little change between 2006 and 2010. However diagnoses rose dramatically between 2010 and 2015 with a 200% increase; 619 diagnoses in 2015 compared with 204 in 2010 (Figure 3.1). The number of diagnoses increased again in 2018 (882), the highest ever recorded in Northern Ireland. The proportion of male diagnoses attributed to MSM ranged from 24% in 2006 to 65% in 2016, with 72% in 2018.

Figure 3.1: Diagnoses of gonorrhoea in Northern Ireland, 2006–2018



Age, gender and sexual orientation trends: gonorrhoea

Figure 3.2: Rates of gonorrhoea in Northern Ireland, by age group, 2006–2018

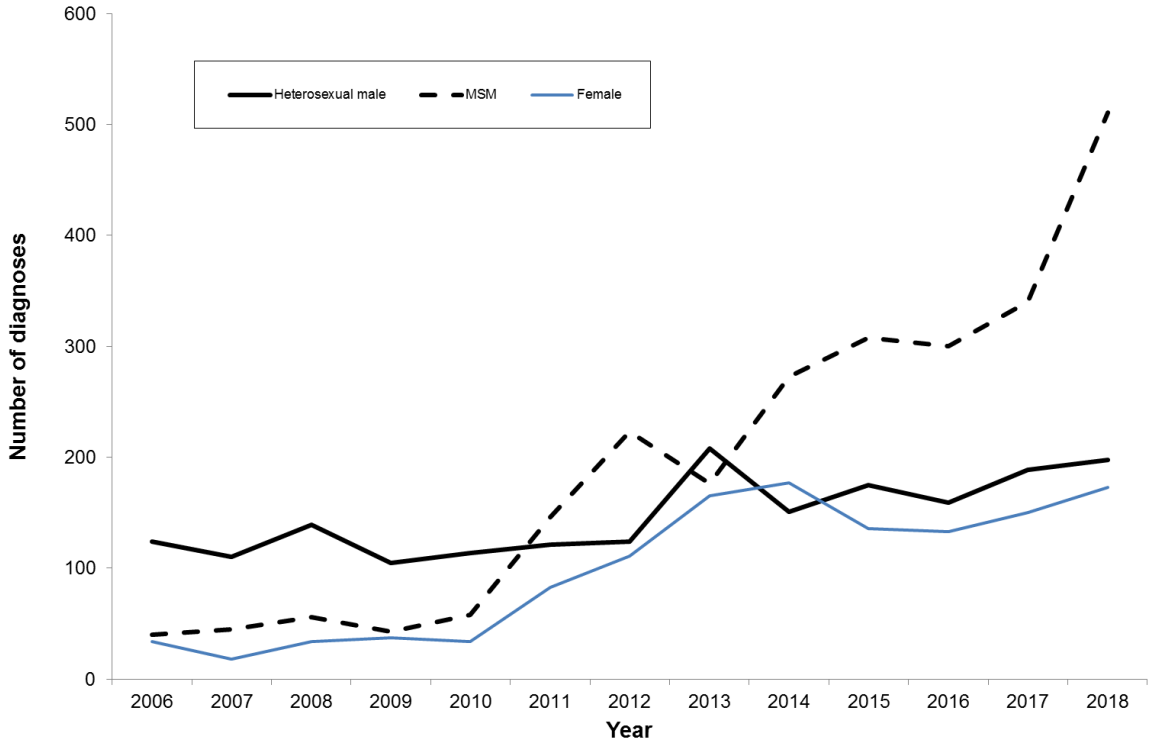


Footnote: Rates have been re-calculated from 2012 to include KC60 code B5 Complicated gonorrhoea

In males there has been an increased trend in diagnostic rates across all age groups since 2011. The largest increases and highest diagnostic rates have consistently been in the 20–24 years age groups, followed by the 25-34 years age group (Figure 3.2). From 2012–2018, fewer than 10 diagnoses were made annually in males aged under 16 years. Males aged 45 years and over accounted for 11% (372/3,335) of all male diagnoses during the period 2012–2018.

In females, the increases since 2011 have mostly affected the 16-19, and 20-24 age groups (Figure 3.2). In 2018, the number of diagnoses in females has increased by 15% when compared to 2017.

Figure 3.3: Diagnoses of gonorrhoea by sexual orientation in Northern Ireland, 2006-2018



The increase in diagnoses since 2010 has largely affected MSM and females. The number of MSM diagnoses continue to increase with 511 diagnosis made in 2018, the highest number recorded in Northern Ireland to date. There has been a much smaller though still generally upward trend in heterosexual males. While diagnoses in females stabilised after 2013, there have been consecutive annual increases in 2017 and 2018.

The increase in diagnoses of gonorrhoea seen between 2010 and 2013 is likely to largely reflect the introduction across Northern Ireland of combined chlamydia and gonorrhoea PCR testing in both GUM and community settings at this time. This dual platform test has increased the numbers of people tested for gonorrhoea, and is more sensitive compared with traditional culture methods, particularly at extra genital sites.

The further large increase in MSM seen in 2018 maybe at least partly due to increased testing in MSM as a result of increased attendance of those seeking PrEP, and more frequent testing in those prescribed PrEP.

Neisseria gonorrhoeae antimicrobial susceptibility reporting 2018

Gonorrhoea is of particular concern due to its ability to develop resistance to successive antimicrobial agents. Treatment guidelines during 2018 continued to recommend the use of a combination of oral azithromycin and intra-muscular ceftriaxone, and that treatment should be followed by a test of cure. By combining antibiotics in this way it was hoped to slow the development of resistance to each component.

In 2019, however, in the context of continuing low level resistance to azithromycin and the spread of high-level azithromycin resistant (HL-AZiR) *Neisseria gonorrhoeae* (minimum inhibitory concentration (MIC) >256 mg/l), new UK guidance was issued to recommend IM ceftriaxone as monotherapy[2].

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

During 2018, laboratories reported antibiotic susceptibility data for 387 isolates as part of routine laboratory surveillance. Ninety eight percent of isolates were tested against azithromycin and 99% tested against ceftriaxone. 9% (33) were identified as resistant to azithromycin and all were susceptible to ceftriaxone (Table 3.1).

From 2016 to the end of 2018, the reference laboratory has confirmed 16 HL-AZiR cases in Northern Ireland, affecting mostly young heterosexuals. While to date there is no evidence of widespread transmission, enhanced surveillance will continue.

During 2018, 30 isolates were tested within the Euro-GASP programme. Seven percent of isolates showed resistance or high level resistance to azithromycin. All were susceptible to ceftriaxone.

Table 3.1: *Neisseria gonorrhoeae:* local Trust reported antibiotic susceptibility data, Northern Ireland, 2018

Antibiotics	Susceptible		Resistant		Intermediate		Total specimens Reported	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Azithromycin	305	80.1	33	8.7	43	11.3	381	100
Cefotaxime	1	100	0	0	0	0	1	100
Ceftriaxone	385	100	0	0	0	0	385	100
Ciprofloxacin	214	60.8	138	39.2	0	0.0	352	100
Doxycycline	169	57.1	114	38.5	13	4.4	296	100
Penicillin	68	20.1	131	38.8	139	41.1	338	100

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

- all primary diagnostic laboratories should test gonococcal isolates for susceptibility to first line antimicrobials and refer azithromycin and/or ceftriaxone resistant isolates to the PHE reference laboratory for confirmation;

- all cases of gonorrhoea should be treated and managed within GUM services;

- GUM services should ensure all patients with gonorrhoea are treated and managed according to national guidelines and be alert to changes in antimicrobials recommended for front line use;

- anyone having sex with new or casual sexual partners should be advised to use condoms consistently and correctly and test regularly for sexually transmitted infections.

4: Genital herpes

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

Diagnoses made in GUM clinics during 2018

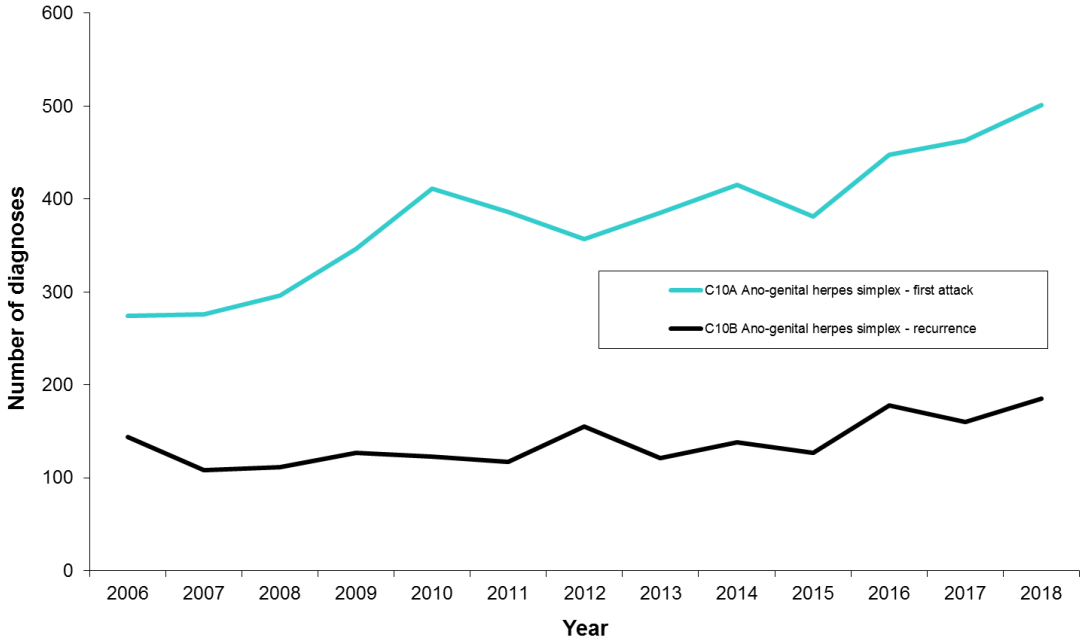
Genital herpes (first episodes) accounted for 8% (501/6,086) of all new STI diagnoses made in Northern Ireland GUM clinics during 2018.

- There were 686 episodes (first infections and recurrent infections) of genital herpes diagnosed in Northern Ireland GUM clinics in 2018.
- 434 (63%) of these were diagnosed in females.
- 501 (73%) of the total attendances for herpes in 2018 were for treatment of first infection and 185 (27%) were for treatment of recurrent infection.
- 27% of male diagnoses (68/252) and 27% (117/434) of female diagnoses were recurrent infections.
- The highest diagnostic rates of first infection in men were in the 20-34 years age group and in women were in the 16-24 years age group.
- Diagnostic rates of first infection in most age groups were higher in females, but most particularly in the 16-19 age group.
- 18% (34/184) of male first diagnoses occurred in MSM.

Trends: 2006–2018

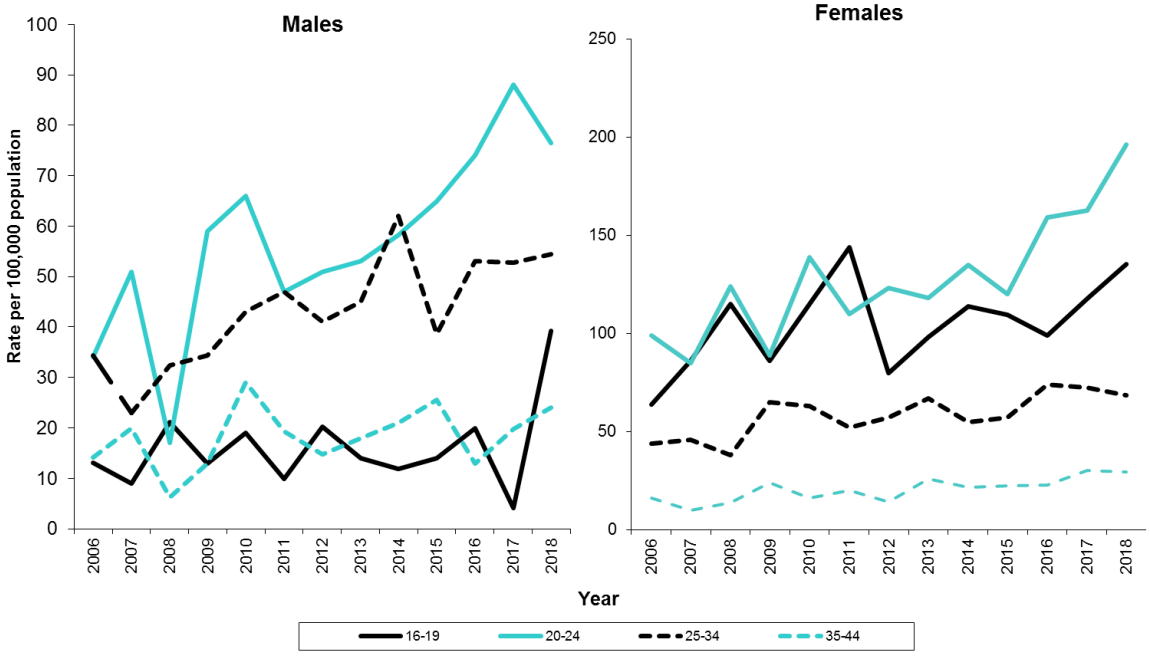
Annual numbers of first diagnoses of genital herpes increased each year between 2008 and 2010 with numbers remaining similar between 2011 to 2015. However, figures have increased by 31% in 2018 (501) when compared with 2015 (381). (Figure 4.1)

Figure 4.1: Diagnoses of genital herpes in Northern Ireland, 2006–2018



Age and gender trends: genital herpes (first episode)

Figure 4.2: Rates of diagnosis of genital herpes (first episode) in Northern Ireland, by age and gender, 2006–2018



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

Males under 20 years of age accounted for 6% (108/1,736) of all male diagnoses of genital herpes (first episode) made during the period 2006–2018, with diagnoses in the 45+ years age group accounting for 12% (203/1,736).

Females under 16 years of age accounted for 1% (43/3,203) of all female diagnoses made during the period 2006–2018, with diagnoses in the 45+ years age group accounting for 7% (224/3,203).

5: Genital warts

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

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

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

Diagnoses made in GUM clinics during 2018

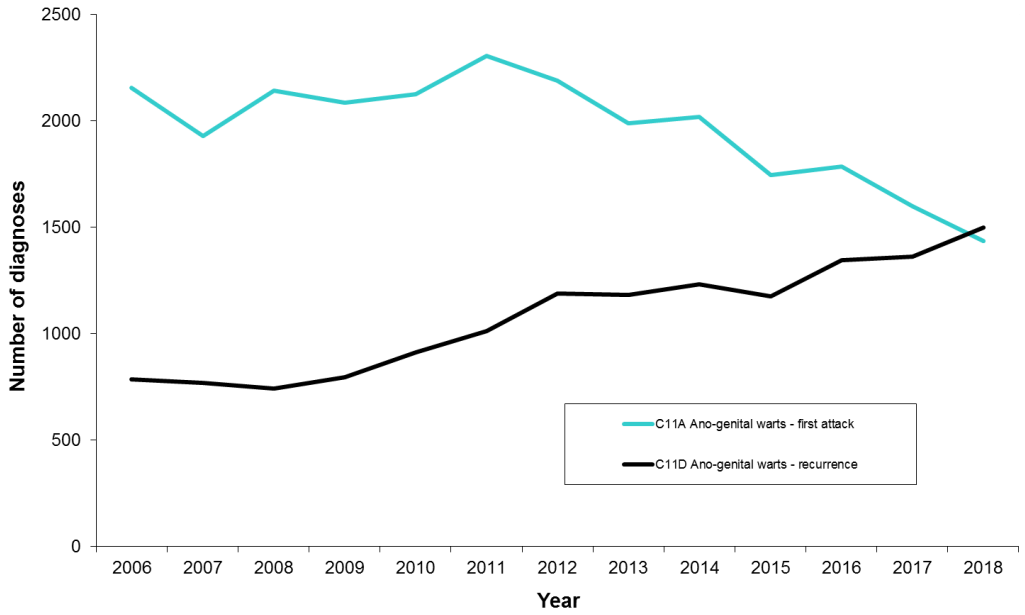
Genital warts (first episodes) accounted for 24% (1,436/6,086) of all new STI diagnoses made in Northern Ireland GUM clinics during 2018.

- There were 2,936 episodes (first infections and recurrent infections) of genital warts diagnosed in Northern Ireland GUM clinics in 2018.
- 1,792 (61%) of these were diagnosed in males.
- 1,436 (49%) of the total attendances for genital warts in 2018 were for treatment of first infection and 1,500 (51%) were for treatment of recurrent infection.
- 53% of male diagnoses (943/1,792) were recurrent infections, compared with 49% (557/1,144) of female diagnoses.
- The highest diagnostic rates of first infection in both men and women were in the 20–24 years age group.
- 36% of male diagnoses and 38% of female diagnoses of first infection were in the 20–24 years age group.
- The diagnostic rate in females aged 16–19 years (144/100,000) is higher than that of males the same age (104/100,000). However, diagnostic rates in those aged over 19 years were higher in males.
- 10% (82/849) of male first diagnoses occurred in MSM.

Trends: 2006–2018

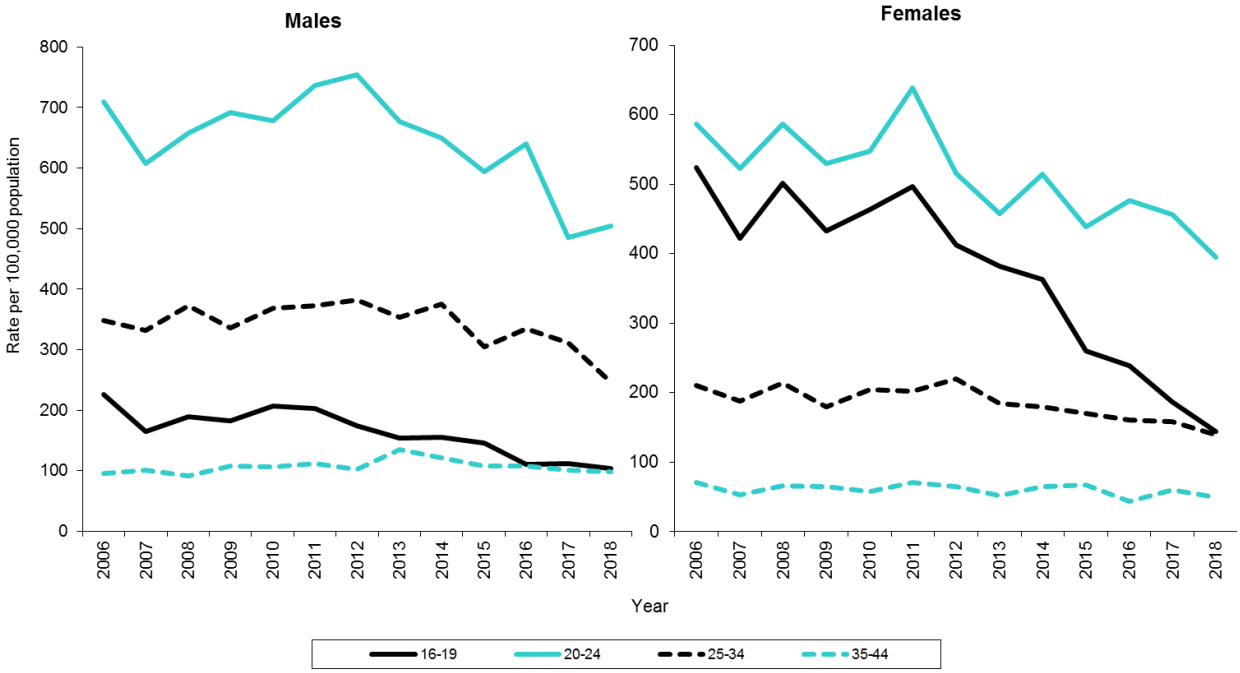
The number of annual diagnoses of first infections of genital warts has shown little variation between 2006 and 2011. There has been a 38% decrease in first episodes of infection since 2011 (Figure 5.1).

Figure 5.1: Diagnoses of genital warts in Northern Ireland, 2006–2018



Age and gender trends: genital warts (first episode)

Figure 5.2: Rates of diagnosis of genital warts (first episode) in Northern Ireland, by age and gender, 2006–2018



Between 2006 and 2018, diagnostic rates have been consistently highest in 20-24 year old males and females, followed by 16-19 year old females and 25-34 year old males. Individuals under 16 year old accounted for 0.4% (98/25,512) of diagnoses (first episode) made during 2006-2018, while the 45+ year age group accounted for 7% (1,674/25,512).

During 2006-2018, the proportion of male diagnoses attributed to MSM ranged from 2% in 2006 to 10% in 2018.

The decline in diagnostic rates from 2011 has been greatest in females aged 16-19 years (71%) and in males in the same age group (49%).

6: Syphilis

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

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

Diagnoses made in GUM clinics 2018

During 2018:

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

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

• 79% (68/86) were diagnosed in MSM.

Enhanced surveillance 2018

Information from enhanced surveillance arrangements is available for 66 cases:

• 62 episodes occurred in Northern Ireland residents and, in 50 episodes, syphilis was likely to have been acquired through exposure within Northern Ireland;

• 21% (14/66) also reported being HIV positive;

• diagnosed co-infections also included chlamydia, gonorrhoea, herpes and warts;

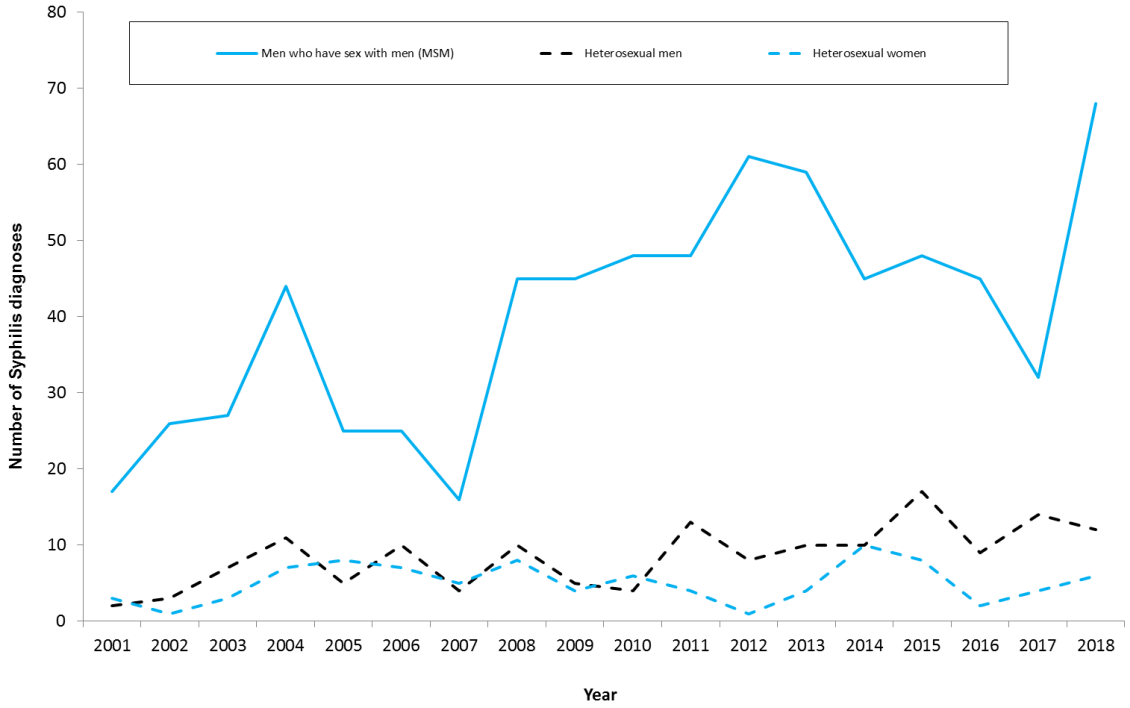
• 14% (9/66) reported having had two sexual partners in the three months preceding diagnosis.

Trend information

Infectious syphilis is now endemic within Northern Ireland. Annual numbers of new diagnostic episodes have been consistently highest in MSM (Figure 6.1). Following an annual decrease from 2004 to 2007, numbers had increased from 2008 to 2016. 2018 saw the annual number of diagnoses in MSM increase to 68, the highest recorded in Northern Ireland. Numbers in females have remained relatively constant, while there is an upward trend in heterosexual males.

As is the case with gonorrhoea, the large increase in MSM seen in 2018 may be at least partly due to increased testing in MSM as a result of increased attendance of those seeking HIV PrEP, and the more frequent testing routine in those prescribed PrEP.

Figure 6.1: Number of infectious syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001-2018

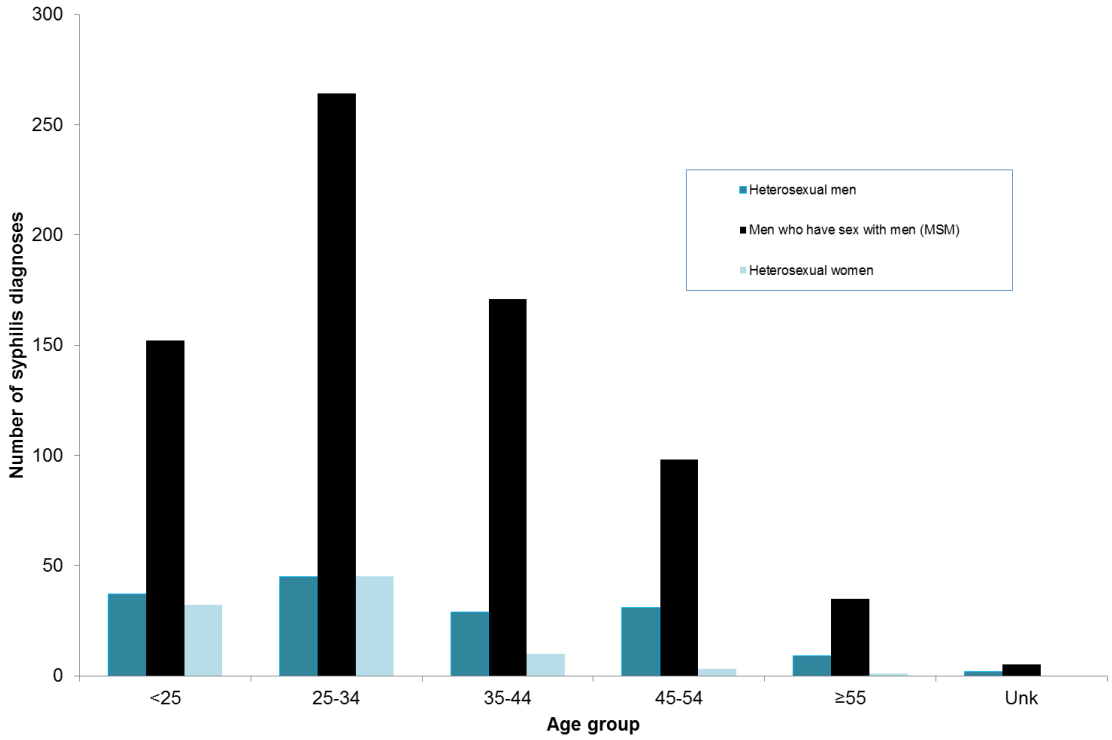


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011- 2018

Age and sexual orientation

Analysis of cumulative data by age and sexual orientation shows the highest number of episodes in heterosexual females was in the 25–34 years age group (49%; 45/91). In MSM, the highest number of episodes was in the 25–44 years age group (60%; 435/725). In heterosexual males, diagnoses were more evenly spread across the age bands, with those aged 25+ years accounting for 75% (114/153) of diagnoses. Information on age was missing for seven episodes (Figure 6.2).

Figure 6.2: Age distribution of syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001–2018

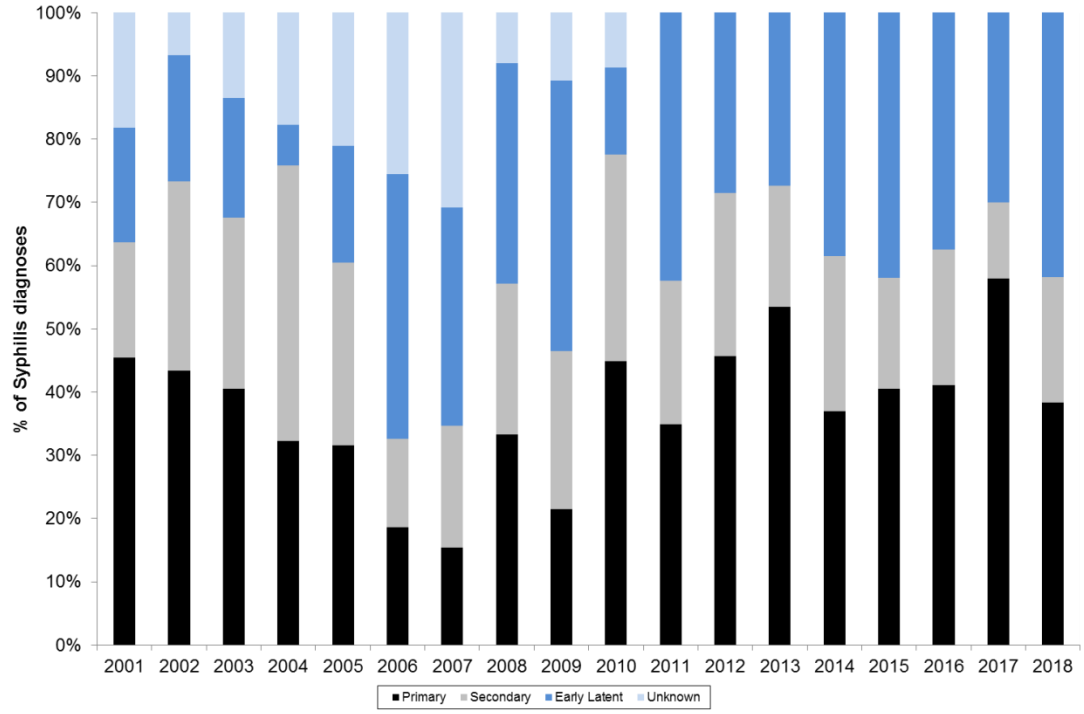


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011 -2017

Stage of disease

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

Figure 6.3: Infectious syphilis - stage of disease, by year of diagnosis, Northern Ireland, 2001-2018



Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from GUMCAD for 2011-2018

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7: Summary and conclusions

There was a 6% increase in the number of new STIs reported through Northern Ireland GUM clinics in 2018 when compared with 2017. Increases were noted in infectious syphilis (72%), gonorrhoea (30%), genital herpes (8%) and chlamydia (6%).

The highest diagnostic rates of the common STIs occur in 16-24 year old females and 20-34 year old males. People aged 16-34 year old account approximately 80% of new STIs.

MSM are at disproportionate risk of contracting some STIs accounting for 79% of male infectious syphilis, 72% of male gonorrhoea, 18% of male herpes and 29% of male chlamydia infections. It follows that MSM have accounted for the majority of the increase seen in syphilis and gonorrhoea diagnoses during 2018. This may be due at least in part to significantly increased STI testing levels among MSM during 2018, coinciding with the introduction of HIV PrEP through the Risk Reduction Clinic in Belfast Trust. A direct association with taking PrEP cannot be ruled out, however, and this will continue to be monitored.

While MSM account for the majority of the increase in gonorrhoea diagnoses, there are smaller but still important upward trends among heterosexuals. Gonorrhoea continues to give particular concern due to its potential to show resistance to antibiotics. As elsewhere in the UK, analysis of antimicrobial sensitivity patterns has shown a significant level of resistance to azithromycin, including the emergence of high-level azithromycin resistant disease. This has led to a change in UK treatment guidelines such that azithromycin is now no longer recommended first line treatment. This highlights the importance of culturing specimens for antibiotic susceptibility, adhering to current treatment guidelines, and performing a test of cure for all cases of gonorrhoea. All cases of gonorrhoea should be managed within the GUM service.

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

Recommendations

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

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

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

Commissioners should continue to seek to expand access to STI testing opportunities.

References

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

2. British Association for Sexual Health and HIV national guideline for the management of infection with Neisseria gonorrhoeae (2019). Available at : www.bashguidelines.org.media/1208/gc-2019.pdf

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

Appendix 1: STI groupings

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

Appendix 2: Number of new episodes of selected diagnoses by gender and age group, Northern Ireland, 2010-2018

		2010			2011			2012			2013			2014			2015			2016			2017			2018		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Chlamydia	<16	*	*	11	0	9	9	0	*	*	*	*	8	0	6	6	*	*	5	*	*	*	0	*	*	*	*	11
	16-19	105	192	297	104	191	295	87	177	264	85	175	260	70	194	264	78	162	240	78	176	254	86	124	210	64	155	219
	20-24	423	338	761	424	374	798	390	329	719	387	396	783	391	443	834	336	309	645	298	354	652	346	304	650	360	345	705
	25-34	373	220	593	390	191	581	366	217	583	362	200	562	359	223	582	318	162	480	374	187	561	441	195	636	400	202	602
	35-44	96	28	124	71	20	91	77	29	106	78	35	113	85	42	127	70	34	104	94	27	121	97	22	119	139	33	172
	45+	*	*	46	47	9	56	39	*	*	*	*	44	45	9	54	*	*	60	*	*	*	55	*	*	*	*	78
	Total	**1,036**	**796**	**1,832**	**1,036**	**794**	**1,830**	**959**	**764**	**1,723**	**946**	**824**	**1,770**	**950**	**917**	**1,867**	**856**	**678**	**1534**	**891**	**757**	**1648**	**1,025**	**659**	**1,684**	**1,036**	**751**	**1,787**
	% in MSM	*14%*			*15%*			*10%*			*12%*			*17%*			*14%*			*21%*			*24%*			*29%*		
Gonorrhoea^	<16	0	*	*	*	*	*	0	*	*	*	*	*	*	*	5	*	0	*	0	*	*	0	0	0	0	*	*
	16-19	12	9	21	17	15	32	29	22	51	46	42	88	27	48	75	35	43	78	48	40	88	55	54	109	50	42	92
	20-24	61	13	74	87	38	125	116	44	160	117	66	183	136	78	214	157	54	211	117	52	169	153	54	207	174	78	252
	25-34	51	6	57	93	19	112	123	38	161	143	45	188	164	39	203	183	33	216	176	25	201	184	35	219	281	43	324
	35-44	*	*	32	*	*	40	*	*	44	48	9	57	47	8	55	*	*	67	57	*	*	*	*	79	*	*	120
	45+	*	*	*	*	*	*	*	*	*	*	*	*	*	*	49	*	*	*	61	7	68	*	*	65	*	*	*
	Total	**172**	**32**	**204**	**259**	**77**	**336**	**347**	**111**	**458**	**384**	**165**	**549**	**424**	**177**	**601**	**483**	**136**	**619**	**459**	**133**	**592**	**529**	**150**	**679**	**709**	**173**	**882**
	% in MSM	*34%*			*56%*			*64%*			*46%*			*64%*			*64%*			*65%*			*64%*			*72%*		
Syphilis	<16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	16-19	0	0	0	*	*	*	*	0	*	*	0	*	*	*	*	*	*	*	*	0	*	0	0	0	0	0	0
	20-24	*	*	12	5	0	5	15	0	15	*	*	13	*	*	13	8	0	8	*	*	9	6	0	6	*	*	8
	25-34	18	0	18	11	0	11	18	0	18	*	*	19	*	*	13	*	*	16	*	*	14	*	*	16	*	*	17
	35-44	6	0	6	*	*	*	8	0	8	*	0	*	*	*	*	*	*	*	*	0	*	7	0	7	12	0	12
	45+	*	*	10	10	0	10	*	0	*	10	0	10	5	0	5	9	0	9	7	0	7	*	0	6	13	0	13
	Total	*****	*****	**46**	*****	*****	**38**	**50**	**0**	**50**	*****	*****	**52**	**34**	**7**	**41**	**40**	**5**	**45**	*****	*****	**35**	*****	*****	**35**	*****	*****	**50**
	% in MSM	*75%*			*78%*			*90%*			*83%*			*76%*			*75%*			*88%*			*61%*			*79%*		
Herpes	<16	*	*	*	0	6	6	0	5	5	0	0	0	0	*	*	0	*	*	0	7	7	0	*	*	*	*	9
	16-19	10	57	67	5	71	76	10	39	49	7	47	54	6	54	60	7	52	59	10	46	56	*	*	55	19	61	80
	20-24	42	87	129	30	68	98	32	75	107	33	71	104	36	81	117	40	71	111	45	92	137	53	92	145	46	111	157
	25-34	52	79	131	56	65	121	50	72	122	55	85	140	76	69	145	47	71	118	65	93	158	65	91	156	67	86	153
	35-44	36	21	57	24	26	50	18	18	36	21	32	53	24	27	51	30	28	58	15	28	43	23	37	60	28	36	64
	45+	*	*	*	14	21	35	17	21	38	14	20	34	14	*	*	17	*	*	23	24	47	*	*	*	*	*	38
	Total	**153**	**258**	**411**	**129**	**257**	**386**	**127**	**230**	**357**	**130**	**255**	**385**	**156**	**259**	**415**	**141**	**240**	**381**	**158**	**290**	**448**	**165**	**298**	**463**	**184**	**317**	**501**
	% in MSM	*12%*			*11%*			*10%*			*23%*			*16%*			*14%*			*14%*			*16%*			*18%*		
Warts	<16	*	*	11	*	*	10	0	10	10	0	6	6	0	*	*	*	*	*	*	0	*	*	0	*	*	*	8
	16-19	107	230	337	104	245	349	88	200	288	78	183	261	78	172	250	73	123	196	55	111	166	54	85	139	50	65	115
	20-24	432	342	774	467	394	861	475	314	789	419	276	695	401	308	709	365	259	624	390	275	665	292	258	550	303	223	526
	25-34	442	255	697	448	254	702	462	278	740	427	232	659	456	226	682	371	214	585	409	200	609	384	198	582	303	175	478
	35-44	135	74	209	138	91	229	124	82	206	160	64	224	142	81	223	126	83	209	126	53	179	117	73	190	114	61	175
	45+	*	*	98	*	*	154	99	58	157	89	55	144	100	*	*	*	*	*	*	62	*	*	52	*	*	*	134
	Total	**1,179**	**947**	**2,126**	**1,237**	**1,068**	**2,305**	**1,248**	**942**	**2,190**	**1,173**	**816**	**1,989**	**1,177**	**843**	**2,020**	**1,016**	**730**	**1,746**	**1,085**	**701**	**1,786**	**935**	**665**	**1,600**	**849**	**587**	**1,436**
	% in MSM	*8%*			*8%*			*10%*			*9%*			*9%*			*9%*			*8%*			*9%*			*10%*		
Total diagnoses		7,304	5,222	12,526	7,046	5,729	12,775	6,117	5,000	11,117	5,728	4,752	10,480	5,953	4,937	10,890	5,481	4,186	9,667	5,692	4,375	10,067	5,341	3,888	9,229	5,728	4,206	9,934
Total workload		13,242	10,542	23,784	14,035	11,704	25,739	16,140	11,887	28,027	15,720	11,381	27,101	16,955	12,129	29,084	15,446	10,842	26,288	16,811	11,403	28,214	21,148	11,835	32,983	26,252	15,941	42,193

Notes on using these tables:

% in MSM represents the propotion of the total male diagnoses attributed to men who have sex with men (MSM)

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

* Data is confidential

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

Due to a GUM clinic migrating to new GUMCAD software using SHHAPT codes figures from 2012 have been recalculated to include B5 (complicated gonorrhoea) and C4B (complicated chlamydia)

Definitions of selected conditions:

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

Appendix 3: Rates of new episodes of selected diagnoses by gender and age group, Northern Ireland, 2010-2018

		2010			2011			2012			2013			2014			2015			2016			2017			2018		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Chlamydia	<16	*	*	14.9	0.0	25.0	12.2	0.0	*	*	*	*	11.2	0.0	17.7	8.6	*	*	7.4	*	*	*	0.0	*	*	*	*	16.1
	16-19	203.0	386.2	292.8	203.1	387.7	293.6	171.6	364.3	265.9	167.9	365	263.8	139.0	409	269.9	155.8	342.3	246.4	155.8	371.8	260.8	178.1	275.2	225	135.5	349.8	239.2
	20-24	663.5	540.7	602.7	669.5	606.0	638.2	619.1	540.5	580.4	625.3	656.6	640.8	634.2	739.8	686.2	546.5	523.2	535.1	484.7	599.4	540.9	575.3	537.9	557.2	598.6	617.7	607.8
	25-34	311.0	176.3	242.3	324.6	152.1	236.4	302.4	172.0	235.9	299.1	158.5	227.3	295.0	176.9	234.9	260.2	128.8	193.6	306.0	148.7	226.3	358.4	155.6	256.1	323.8	161.5	242.1
	35-44	76.2	21.4	48.3	57.3	15.5	36.0	63.3	22.9	42.7	65.6	28.1	46.4	72.5	33.9	52.7	59.9	27.5	43.3	80.4	21.9	50.3	83.5	17.9	49.8	119.7	26.8	71.9
	45+	*	*	6.6	14.0	2.4	7.9	11.4	*	*	*	*	6	12.7	2.3	7.2	*	*	7.9	*	*	*	14.8	*	*	*	*	9.8
	Total	**117.1**	**86.5**	**101.5**	**116.5**	**85.8**	**100.9**	**107.2**	**82.2**	**94.5**	**105.4**	**88.4**	**96.7**	**105.2**	**97.8**	**101.4**	**94.2**	**71.9**	**82.8**	**98.0**	**80.3**	**89.0**	**111.4**	**69.3**	**90.0**	**111.9**	**78.6**	**95.0**
Gonorrhoea	<16	0.0	*	*	*	*	*	0.0	*	*	*	*	*	*	*	7.2	*	0	*	0.0	*	*	0.0	0	0	0.0	*	*
	16-19	23.2	18.1	20.7	33.2	30.4	31.9	57.2	45.3	51.4	90.9	87.6	89.3	53.6	101.2	76.7	69.9	90.8	80.1	95.8	84.5	90.3	113.9	119.9	116.8	105.8	94.8	100.5
	20-24	95.7	20.8	58.6	137.4	61.6	100.0	184.1	72.3	129.2	189.1	109.4	149.8	220.6	130.3	176.1	255.3	91.4	175	190.3	88.1	140.2	254.4	95.5	177.4	289.3	139.7	217.3
	25-34	42.5	4.8	23.3	77.4	15.1	45.6	101.6	30.1	65.1	118.2	35.7	76	134.7	30.9	81.9	149.7	26.2	87.1	144	19.9	81.1	149.5	27.9	88.2	227.5	34.4	130.3
	35-44	*	*	12.5	*	*	15.8	*	*	17.7	40.4	7.2	23.4	40.1	6.5	22.8	*	*	27.9	48.7	*	*	*	*	33.0	*	*	50.2
	45+	*	*	*	*	*	*	*	*	*	*	*	*	*	*	6.5	*	*	*	16.9	1.8	8.9	*	*	8.3	*	*	*
	Total	**19.4**	**3.5**	**11.3**	**29.1**	**8.3**	**18.5**	**38.8**	**11.9**	**25.1**	**42.8**	**17.7**	**30.0**	**47.0**	**18.9**	**32.7**	**53.1**	**14.4**	**33.4**	**50.5**	**14.1**	**32.0**	**57.5**	**15.8**	**36.3**	**76.5**	**18.1**	**46.9**
Syphilis	<16	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	16-19	0.0	0.0	0.0	*	*	*	*	0.0	*	*	0.0	*	*	*	*	*	*	*	*	0.0	*	0.0	0.0	0.0	0.0	0.0	0.0
	20-24	*	*	9.5	7.9	0.0	4.0	23.8	0.0	12.1	*	*	10.6	*	*	10.7	13.0	0.0	6.6	*	*	14.6	10.0	0.0	5.1	*	*	6.9
	25-34	15.0	0.0	7.4	9.2	0.0	4.5	14.9	0.0	7.3	*	*	7.7	*	*	5.2	*	*	6.5	*	*	11.5	*	*	6.4	*	*	6.8
	35-44	4.8	0.0	2.3	*	*	*	6.6	0.0	3.2	*	0.0	*	*	*	*	*	*	*	*	0.0	*	6.0	0.0	2.9	10.3	0.0	5.0
	45+	*	*	1.4	3.0	0.0	1.4	*	0.0	*	2.9	0.0	1.4	1.4	0.0	0.7	2.5	0.0	1.2	1.9	0.0	1.9	*	*	0.8	3.4	0.0	1.6
	Total	*****	*****	**2.5**	*****	*****	**2.1**	**5.6**	**0.0**	**2.7**	*****	*****	**2.8**	**3.8**	**0.7**	**2.2**	**4.4**	**0.5**	**2.4**	*****	*****	**3.8**	*****	*****	**1.9**	*****	*****	**2.7**
Herpes	<16	*	*	*	0.0	16.7	8.1	0.0	14.0	6.8	0.0	0.0	0.0	0.0	*	*	0.0	*	*	0.0	21.3	10.3	0.0	*	*	*	*	13.2
	16-19	19.3	114.7	66.1	9.8	144.1	75.6	19.7	80.3	49.4	13.8	98.0	54.8	11.9	113.8	61.3	14.0	109.9	60.6	20.0	97.2	57.5	*	*	58.9	40.2	137.7	87.4
	20-24	65.9	139.2	102.2	47.4	110.2	78.4	50.8	123.2	86.4	53.3	117.7	85.1	58.4	135.3	96.3	65.1	120.2	92.1	73.2	155.8	113.7	88.1	162.8	124.3	76.5	198.7	135.4
	25-34	43.4	63.3	53.5	46.6	51.8	49.2	41.3	57.1	49.4	45.4	67.3	56.6	62.4	54.7	58.5	38.5	56.5	47.6	53.2	74.0	63.7	52.8	72.6	62.8	54.2	68.7	61.5
	35-44	28.6	16.1	22.2	19.4	20.2	19.8	14.8	14.2	14.5	17.7	25.6	21.8	20.5	21.8	21.2	25.7	22.7	24.1	12.8	22.7	17.9	19.8	30.1	25.1	24.1	29.2	26.8
	45+	*	*	*	4.2	5.6	4.9	5.0	5.5	5.3	4.0	5.2	4.6	3.9	*	*	4.7	*	*	6.4	6.0	6.2	*	*	*	*	*	4.8
	Total	**17.3**	**28.0**	**22.8**	**14.5**	**27.8**	**21.3**	**14.2**	**24.8**	**19.6**	**14.5**	**27.3**	**21.0**	**17.3**	**27.6**	**22.5**	**15.5**	**25.5**	**20.6**	**17.4**	**30.8**	**24.2**	**17.9**	**31.3**	**24.7**	**19.9**	**33.2**	**26.6**
Warts	<16	*	*	14.9	*	*	13.6	0.0	27.9	13.6	0.0	17.2	8.4	0.0	*	*	*	*	*	*	0.0	*	*	*	*	*	*	11.7
	16-19	206.9	462.7	332.3	203.1	497.3	347.4	173.6	411.6	290.1	154.1	381.7	264.8	154.9	362.6	255.6	145.8	259.9	201.2	109.8	234.5	170.4	111.8	186.4	147.8	105.8	146.7	125.6
	20-24	677.6	547.1	613.0	737.4	638.4	688.5	754.0	515.8	637	677.0	457.6	568.8	650.4	514.3	583.4	593.6	438.6	517.7	634.3	465.7	551.7	485.5	456.5	471.5	503.8	399.3	453.5
	25-34	368.6	204.3	284.8	372.8	202.3	285.7	381.7	220.4	299.4	352.8	183.8	266.5	374.7	179.2	275.2	303.6	170.2	235.9	334.7	159.0	245.6	312.1	158.0	234.3	245.3	139.9	192.3
	35-44	107.1	56.6	81.4	111.4	70.6	90.6	102.0	64.7	83	134.6	51.3	91.9	121.1	65.4	92.5	107.7	67.2	86.9	107.7	42.9	74.5	100.8	59.4	79.5	98.2	49.6	73.1
	45+	*	*	14.1	*	*	21.7	28.9	15.2	21.7	25.5	14.2	19.6	28.2	*	*	*	*	*	*	15.5	*	*	12.7	*	*	*	16.9
	Total	**133.3**	**102.9**	**117.8**	**139.1**	**115.5**	**127.0**	**139.5**	**101.4**	**120.1**	**130.7**	**87.5**	**108.7**	**130.4**	**89.9**	**109.8**	**111.8**	**77.5**	**94.3**	**119.3**	**74.4**	**96.5**	**101.6**	**70.0**	**85.5**	**91.7**	**61.4**	**76.3**

Notes on using these tables:

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

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

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

2018 rates calculated using 2018 mid year estimates

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Definitions of selected conditions:

Chlamydia	chlamydial infection, KC60 code C4a, C4c, SHHAPT code C4
Gonorrhoea	gonorrhoea, KC60 code B1, B2, SHHAPT code B
Syphilis	primary and secondary infectious syphilis, KC60 code A1, A2
Herpes	anogenital herpes simplex (first attack), KC60 & SHHAPT code C10a
Warts	anogenital warts (first attack), KC60 & SHHAPT code C11a

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