HSC Public Health Agency

agenda

95th Meeting of the Public Health Agency Board

Thursday 21 September 2017 at 1:30pm

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

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 17 August 2017		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Finance Update	**PHA/01/09/17**	Mr Cummings

items for approval

8 2.00	Draft PHA Investment Plan 2017/18	**PHA/02/09/17**	Mr McClean
9 2.15	Draft Commissioning Plan 2017/18	**PHA/03/09/17**	Mr Cummings

items for noting

10 2.45	Northern Ireland AAA Screening Programme Annual Report 2015/16	**PHA/04/09/17**	Dr Harper
11 3.05	Re-tender of Youth Engagement Services (previously known as One Stop Shop Service)	**PHA/05/09/17**	Dr Harper
12 3.15	Campaigns Update		Mr McClean

closing items

13 3.30	Any Other Business	Chair
14 3.35	Details of next meeting: *Thursday 19 October 2017 at 1:30pm* *Conference Rooms 3+4, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

94th Meeting of the Public Health Agency Board

Thursday 17 August 2017 at 1:30pm

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

Present

Mr Andrew Dougal	-	Chair
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Brian Coulter	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mrs Valerie Watts	-	Interim Chief Executive
Councillor William Ashe	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Mrs Joanne McKissick	-	External Relations Manager, PCC

48/17 **Item 1 – Welcome and Apologies**

48/17.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Valerie Watts, Councillor William Ashe, Mr Leslie Drew and Mrs Joanne McKissick.

49/17 **Item 2 - Declaration of Interests**

49/17.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

50/17 **Item 3 – Minutes of previous meeting held on 13 June 2017**

50/17.1 The minutes of the previous meeting, held on 13 June 2017, were **approved** as an accurate record of the meeting.

51/17 **Item 4 – Matters Arising**

34/17.2 *Public Awareness Campaign on Anti-Microbial Resistance (AMR)*

51/17.1 Mr Coulter noted that Public Health England is undertaking a campaign in relation to AMR, and asked if PHA has a similar plan for Northern Ireland. Mr McClean indicated AMR was an important issue to the PHA, however the Department had put in place a "temporary pause" on PHA public information campaigns, with the removal of the associated budget to assist wider HSC funding pressures.

51/17.2 Alderman Porter asked whether the loss of campaigns had reduced PHA's expectation in achieving targets. Dr Harper explained that the Commissioning Plan Direction outlines targets for PHA, particularly in areas such as obesity, but these are longer term targets. She added that evaluations of previous PHA campaigns show where they have had benefit. She assured Board members that PHA did actively engage with the Department before the decision to pause campaigns was made, but ultimately the financial context took priority.

51/17.3 Ms Mann-Kler asked whether the difference between short term pain and long term gain was articulated to the Department. Mr McClean advised that this did happen, but that the overall financial challenge was the determining factor. The Chair pointed out that if PHA adopted media campaigns from Public Health England with Northern Ireland accents voiced over this would save considerable design costs, although the media buying costs would not be reduced.

51/17.4 Mr Cummings said that, by virtue of having received an indicative allocation letter, PHA knows what its financial position is for 2017/18, but that HSC Trusts are currently being asked to publicly consult on their savings plans. He added that in a few weeks, we would more fully understand the situation facing the HSC as a whole.

51/17.5 Mr Coulter said that the point he wished to raise related to AMR, and that in the light of there not being a campaign, PHA should not be silent on what is a significant public health issue. He suggested that countries should work together on a campaign. Dr Harper said that PHA does work with colleagues across the rest of the UK, and it was her understanding that the other countries are still purchasing media coverage. Mr McClean advised that PHA had used campaigns developed in other countries before, although the call to action needed to reflect local circumstances.

51/17.6 The Chair said that this is an issue that is of grave concern to the PHA Board, and this is the reason he raised it at the recent Accountability Review meeting.

51/17.7 Ms Mann-Kler asked if PHA submitted proposals for savings which did not focus on campaigns. Mr Cummings explained that PHA was asked to

submit proposals for savings of 2% and 5% from its budget, but such was the magnitude of savings required across the system that approaches were determined by the Department . He added that ultimately, savings had to made from areas where funds could be obtained quickly. Dr Harper added that campaigns were not explicitly discussed during those 2 days.

51/17.8 The Chair reiterated the concern of the PHA Board in this matter.

52/17 Item 5 – Chair's Business

52/17.1 The Chair outlined to members the work undertaken in Coventry as it participated in the UK Marmot Network. He said that since 2003, the life expectancy gap between the most and least affluent has decreased, and that there have been other improvements. He advised that he had contacted the individuals concerned with the research in order to obtain more information.

52/17.2 The Chair advised that he had attended a meeting of the Disability Champions network, and that this group was working with recruitment agencies to encourage applications from people with disabilities.

52/17.3 The Chair said that Public Health England (PHE) is currently subject to a review by the Cabinet Office, and that he and the Chief Executive, had recently met with Richard Parish, a non-executive Director of PHE. He added that PHE is shortly commencing a campaign regarding AMR, but this had been referenced previously.

52/17.4 The Board noted the Chair's Business.

53/17 Item 6 – Chief Executive's Business

53/17.1 In the absence of the Chief Executive, Mr McClean updated the Board on some current issues.

53/17.2 Mr McClean said that he, along with a number of colleagues had attended meetings at the Department of Health with regard to transformation funding. Mr Cummings said that key to this was establishing clarity in terms of how the funding can be used, and when it will be available.

53/17.3 Mr McClean advised that from 1 June 2018, PHA will fall under the scope of the Rural Needs Act, and he outlined what this will entail for PHA in terms of "rural proofing" its work and completing monitoring templates. Ms Mann-Kler asked if there will be training for non-executives. Mr McClean said that when sessions are being organised for staff, non-executives will be invited.

53/17.4 Mr McClean said that PHA had received correspondence from the Department of Health regarding Controls Assurance Standards. He said that these will cease from 1 April 2018, however, suitable alternative

assurance arrangements are expected to be put in place.

53/17.5 The Board noted the updates from the Deputy Chief Executive.

54/17 Item 7 – Finance
PHA Draft Budget (PHA/01/08/17)
PHA Finance Report up to 30 June 2017 (PHA/02/08/17)

54/17.1 Mr Cummings informed members that PHA had received an indicative allocation letter because no budget has been approved, however PHA can proceed based on the amounts outlined in the letter.

54/17.2 Mr Cummings noted the comments received from Mr Drew on the draft budget. The variation in budget is due to the removal of non-recurrent funding which will be received in future allocation letters.

54/17.3 Mr Cummings advised that PHA's opening allocation totals £94m, but there are retractions totalling £0.35m. He went through the budgets relating to Trust and non-Trust expenditure, and PHA administration, and explained any increases are solely due to adjustments for inflation and demography funding. He added that a more detailed breakdown of the programme expenditure will be presented at the next meeting.

54/17.4 The Chair asked if R&D had been affected in the budget cuts, but Mr Cummings explained that R&D is funded from capital which is a separate issue.

54/17.5 Alderman Porter asked how the PHA can be assured that Trusts are spending their allocations appropriately. Mr Cummings explained that there is a process whereby PHA monitors the outputs and if objectives are not met, then funding is not provided. Dr Harper said that there is an agreement in place for what is to be delivered, and Mr McClean added that a business case would also be prepared setting out service requirements.

54/17.6 Mr Coulter noted that the screening budget in the South Eastern Trust is lower than that of other Trusts. Dr Harper explained that this is due to the configuration of services and where the screening centres are located. Mr Coulter asked if the distribution of funding is in line with capitation. Mr Cummings said that the distribution of funding as outlined for both Trust and non-Trust expenditure does not reflect capitation, because some of the contracts are regional contracts.

54/17.7 The Board **APPROVED** the PHA budget for 2017/18.

54/17.8 Mr Cummings presented the Finance Report for the period up to 30 June 2017, but said that there are no areas of underspend to be concerned about at this stage. He said that the delay in confirming the budget is the main factor.

54/17.9 Mr Coulter asked about the underspend in the Lifeline budget. Dr Harper explained that recent data has shown that the levels of activity are more appropriate to the service.

54/17.10 Mr Coulter asked about the number of vacant posts which are making up the underspend in management and administration, and if there are difficulties in getting these posts recruited. Dr Harper said that the recruitment process had not commenced now that funding has been confirmed, but that the recruitment process can be lengthy.

54/17.11 The Board noted the Finance Report.

54/17.12 Mr Cummings updated members on the process for developing the Commissioning Plan for 2017/18. He advised that the Commissioning Plan Direction had been received by the Chief Executive on 26th July, but that the timescale for development is very narrow. He said that the Plan will drive the Trust Delivery Plans, which will be developed after the Trusts have gone out to public consultation on their savings plans.

54/17.13 Mr Cummings proposed that a joint HSCB/PHA workshop to consider the draft Plan take place on 13th September. Members expressed concern at the tight timescale, but Mr Cummings explained that the Commissioning Plan Direction for 2017/18 is similar to that for 2016/17.

55/17 Item 8 – Procurement of Services in line with Protect Life 2 Strategy (PHA/03/08/17)

55/17.1 Dr Harper said that the Project Initiation Document (PID) outlined the steps which would be undertaken to complete the procurement of services and manage the transition to any services, all within a period of 18 months. She noted Mr Drew's comment about internal capacity, and advised that some of the underspend in the management and administration budget will be utilised to support this work in the short term.

55/17.2 The Chair asked if there will be user involvement. Dr Harper said that PHA would take advice from PALS (Procurement and Logistics Service). The Chair asked if refresher training was needed on procurement, but Dr Harper advised that Health Improvement are frequently involved in procurement exercises.

55/17.3 Alderman Porter asked about promotion and advertising. Mr McClean said that PHA will be promoting this work widely and encouraging potential providers to come forward.

55/17.4 Ms Mann-Kler asked whether there was some work that evaluates what PHA will get from this contract. Dr Harper explained that the monitoring process consists of both written returns and visits to organisations, and there are escalation policies in place if there are any issues. She went on to say that in terms of outcomes, there are 4 or 5 strategic areas within mental health, each with their own strategic objectives. Mr McClean

suggested that this area could be the focus of a future PHA Board workshop.

55/17.5 Ms Mann-Kler asked if there was a co-production/co-design element to this, or if providers could be asked if they have met their PPI obligations. Mr McClean said that as part of the procurement, a detailed specification will be prepared, and these elements (such as PPI) would be included in that.

55/17.6 The Board noted the PID for the procurement of services in line with the Protect 2 Strategy.

56/17 Item 9 – Programme Expenditure Monitoring Report (PHA/04/08/17)

56/17.1 Mr McClean said that the PEMS Report allows for members to see in a different way from the monthly finance reports where PHA's budget was spent. Members welcomed the report, but asked if the report could be tabled more frequently. Mr McClean explained that previously this report would have been brought to the Board on a monthly basis, but for the first half of the year, the details were so similar as to render the report of doubtful value, given the increased amount of programme-related activity in the latter half of the year.

56/17.2 Mr Cummings noted that the information contained in the PEMS Report would not be directly compatible with the Finance Report, but over the course of the year the two reports would converge. In response to a query from the Chair, he advised that the PEMS report is compiled by PHA staff, while the Finance report is compiled by HSCB staff.

56/17.3 Mr McClean agreed to review the frequency of the report coming to the PHA Board. The Chair asked that in future reports, the sections on directorate expenditure included percentages in addition to the figures.

56/17.4 The Board noted the Programme Expenditure Monitoring Report.

57/17 Item 10 – Update on PHA Social Care Procurement Plan (PHA/05/08/17)

57/17.1 Mr McClean said that this update allows members to see all of the different procurement exercises which are ongoing. He reminded member that the need to this type of plan came from an audit recommendation, due to the high number of contracts PHA is dealing with.

57/17.2 Alderman Porter noted that there is the possibility that carrying out a new procurement could see all of the current providers replaced with new providers, which would result in previous providers going out of business. Mr Cummings acknowledged that this is always a possibility. Mr McClean said that in procurement exercises contracts are broken into "lots" to reflect different population needs and provide a broader provider base.

57/17.3 Mr Mahaffy asked if it would be possible to see the outputs from the TIG working group on social care procurement clauses. Mrs McAndrew said that she could share this.

57/17.4 Mr Coulter asked what the interest was in the public information sessions. He added that this update was very useful from a governance perspective, but noted the volume of work. Mr McClean said that it will take a number of years for all of this work to be completed, and that there have been capacity issues. He added that there had been good interest from the public in the awareness sessions.

57/17.5 The Board noted the update on the PHA Social Care Procurement Plan.

58/17 Item 11 – Board Effectiveness – Update on Implementation

58/17.1 The Chair went through the latest version of the Board Effectiveness Action Plan, and noted that various meetings are to be arranged to keep the recommendations on track.

58/17.2 The Board noted the update on Board Effectiveness.

59/17 Item 12 – Any Other Business

59/17.1 The Chair asked Dr Carolyn Harper about the new bowel cancer screening test and the delay in its implementation in Northern Ireland. Dr Harper explained that in January 2016, the National Screening Centre recommended the adoption of a new test (FIT) for bowel cancer screening. She said that while the test is being rolled out across the UK, no decision had been made in Northern Ireland due to the absence of a Health Minister, however staff were working on a proposal for the new test.

59/17.2 Dr Harper explained that the new test requires patients to submit one sample, instead of 3, and could therefore increase uptake by 7-10%. She added that the new test is slightly more expensive, but could reduce the number of colonoscopies carried out.

59/17.3 The Chair said that the failure to introduce this new test should be of concern to the PHA Board.

59/17.4 The meeting concluded at 3.10pm.

60/17 Item 13 – Date and Time of Next Meeting

Thursday 21 September 2017 at 1:30pm

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

Signed by Chair:

Date: 21 September 2017

Public Health Agency

Finance Report

2017-18

Month 4 - July 2017

PHA Financial Report - Executive Summary

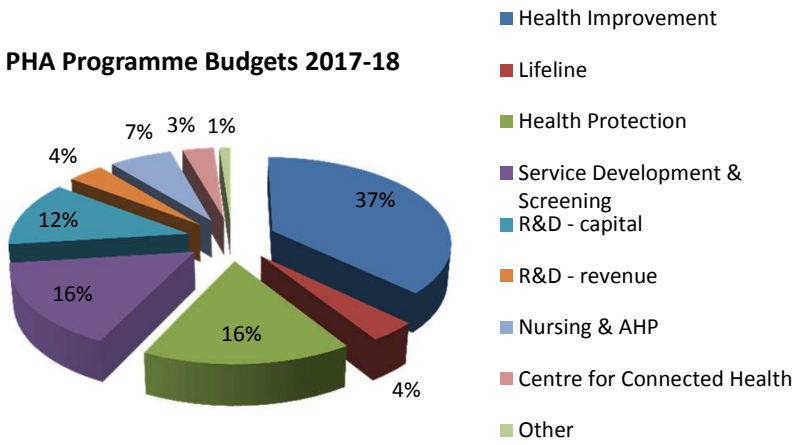
Year to Date Financial Position (page 2)

At the end of month 4 PHA is underspent against its profiled budget by approximately £0.7m (£0.5m from Administration budgets, £0.2m from Programme budgets). Whilst this is not unusual for this stage of the year due to the complexities of expenditure profiling, budget managers will continue to review variances on their budgets and take the necessary action to minimise underspends.

As detailed on page 2, the underspend is primarily caused by underspends on salaries budgets across the Agency, combined with slippage on Health Improvement budgets.

Programme Budgets (pages 3&4)

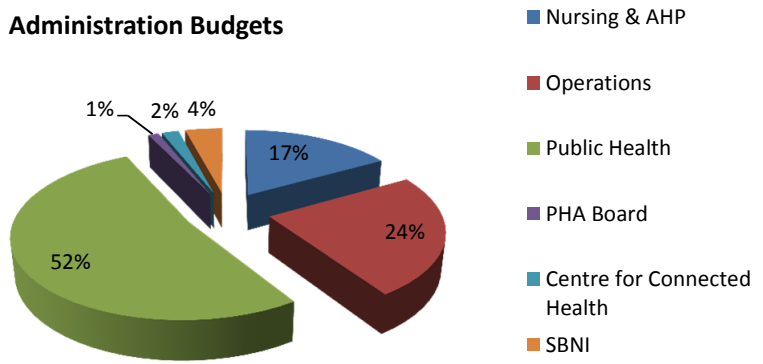
The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.



Administration Budgets (page 5)

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

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



Full Year Forecast Position & Risks (page 2)

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

An Investment Plan is being developed which will incorporate the necessary actions to enable the PHA to achieve a breakeven position for the year.

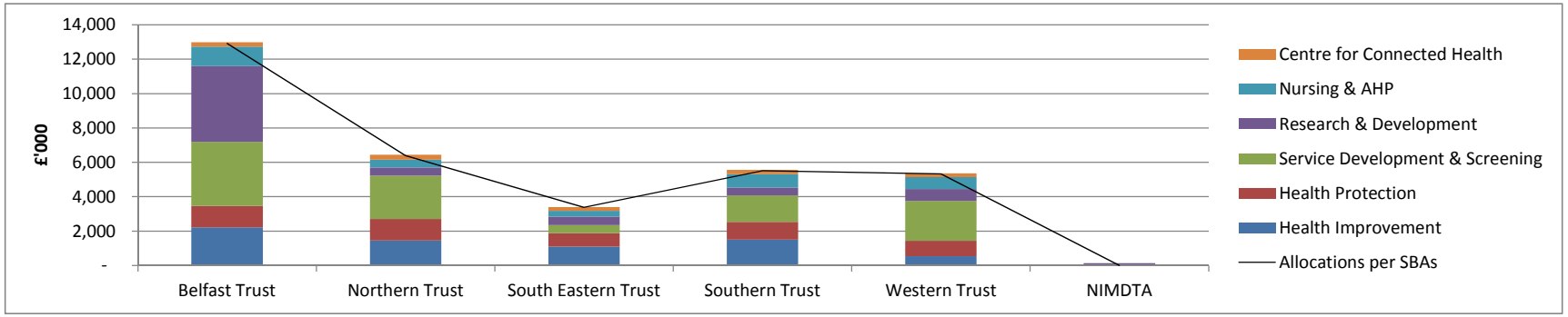
Public Health Agency
2017-18 Summary Position - July 2017

		Annual Budget				Year to Date			
		Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
		Trust	PHA Direct			Trust	PHA Direct		
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources									
Departmental Revenue Allocation		27,230	47,138	19,162	**93,529**	9,003	5,269	6,263	**20,534**
Revenue Income from Other Sources		-	90	345	**434**	-	9	112	**122**
Capital Grant Allocation & Income		6,663	3,779	-	**10,442**	2,221	2,483	-	**4,703**
Total Available Resources		33,893	51,007	19,507	**104,406**	11,224	7,762	6,375	**25,361**
Expenditure	***Page***								
Trusts	*3*	33,893	-	-	**33,893**	11,298	-	-	**11,298**
PHA Direct Programme *	*4*	-	51,007	-	**51,007**	-	7,509	-	**7,509**
PHA Administration	*5*	-	-	19,507	**19,507**	-	-	5,869	**5,869**
Total Proposed Budgets		33,893	51,007	19,507	**104,406**	11,298	7,509	5,869	**24,676**
Surplus/(Deficit) - Revenue		-	-	-	-	(74)	244	506	**676**
Cumulative variance (%)									***3.27%***
Surplus/(Deficit) - Capital		-	-	-	-	-	8	-	**8**
Cumulative variance (%)									***0.17%***

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

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £0.7m, mainly due to a year to date underspend on Administration budgets (see page 5) and also spend behind profile on Revenue Budgets within Health Improvement (notably the demand-led Lifeline contract). It is currently anticipated that the PHA will breakeven for the year.

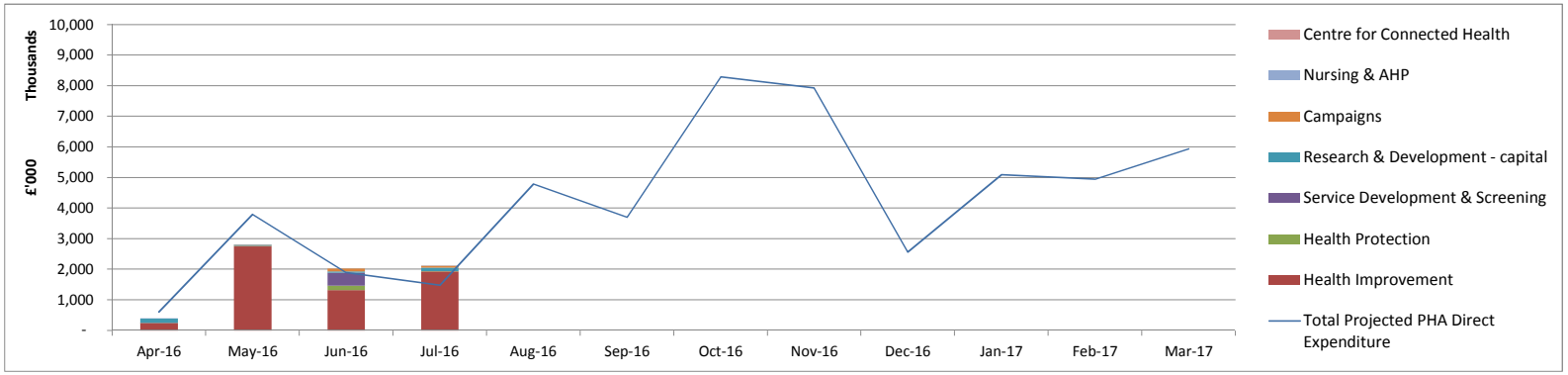
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	2,208	1,451	1,097	1,511	534	-	**6,801**	2,249	2,267	(18)
Health Protection	1,257	1,262	781	1,019	909	-	**5,227**	1,728	1,742	(14)
Service Development & Screening	3,724	2,515	469	1,548	2,311	-	**10,567**	3,494	3,522	(29)
Research & Development	4,407	479	491	447	697	143	**6,663**	2,221	2,221	-
Nursing & AHP	1,132	455	335	790	692	-	**3,404**	1,125	1,135	(9)
Centre for Connected Health	254	284	229	241	221	-	**1,230**	407	410	(3)
Total current RRLs	**12,981**	**6,446**	**3,401**	**5,557**	**5,365**	**143**	**33,893**	**11,224**	**11,298**	**(74)**
Cumulative variance (%)										***-0.66%***

The above table shows the current Trust allocations split by budget area. These amounts are primarily Revenue Resource Limits (RRL) but also include the Capital Resource Limit (CRL) for Research and Development. Expenditure for the year to date is slightly ahead of the profiled budget, but this is a timing issue only.

PHA Direct Programme Expenditure



	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000	Dec-16 £'000	Jan-17 £'000	Feb-17 £'000	Mar-17 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Projected Expenditure																
Health Improvement	306	3,457	1,058	753	3,584	1,089	2,365	4,188	397	1,752	3,535	2,259	**24,743**	5,574	5,600	(26)
Lifeline	264	264	264	264	264	264	264	264	264	264	264	264	**3,173**	1,058	639	418
Health Protection	-	27	31	131	424	1,429	1,764	1,343	942	844	613	1,034	**8,582**	189	174	14
Service Development & Screening	34	47	456	34	65	456	222	78	500	158	78	762	**2,890**	571	606	(36)
Research & Development - capital	-	-	64	259	432	432	432	432	432	432	432	432	**3,779**	323	314	8
Research & Development - revenue	-	-	-	-	-	-	-	1,600	-	1,600	-	-	**3,200**	-	-	-
Campaigns	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	155	(155)
Nursing & AHP	1	1	12	35	1	15	1,840	1	7	15	5	204	**2,134**	48	20	28
Centre for Connected Health	-	-	-	-	20	20	1,398	20	20	20	20	20	**1,539**	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	966	**966**	-	-	-
Total Projected PHA Direct Expenditure	**605**	**3,795**	**1,885**	**1,476**	**4,790**	**3,706**	**8,285**	**7,927**	**2,562**	**5,085**	**4,948**	**5,942**	**51,007**	**7,762**	**7,509**	**253**
Cumulative variance (%)																***3.26%***
Actual Expenditure	**433**	**2,844**	**2,062**	**2,170**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7,509**			
Variance	**172**	**951**	**(177)**	**(694)**									**253**			

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

Expenditure is £0.3m behind profile for the year to date. The underspend is primarily due to Lifeline, offset by small overspends in other areas. Budget managers should review variances closely throughout the remainder of the year to ensure PHA meets its breakeven obligations.

PHA Administration

2017-18 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	3,075	3,458	9,841	230	317	508	**17,430**
Goods & Services	203	1,206	326	33	51	297	**2,116**
Price Inflation				62			**62**
Savings target				(100)			**(100)**
Total Budget	**3,279**	**4,665**	**10,167**	**225**	**368**	**805**	**19,508**
Budget profiled to date							
Salaries	1,021	1,152	3,279	64	106	147	**5,770**
Goods & Services	50	403	109	7	6	31	**605**
Total	**1,071**	**1,555**	**3,388**	**71**	**112**	**178**	**6,375**
Actual expenditure to date							
Salaries	919	1,059	3,065	31	113	147	**5,333**
Goods & Services	52	396	84	(33)	6	31	**536**
Total	**971**	**1,455**	**3,149**	**(2)**	**119**	**178**	**5,869**
Surplus/(Deficit) to date							
Salaries	102	93	214	33	(7)	(0)	**437**
Goods & Services	(2)	7	25	39	0	0	**69**
Surplus/(Deficit)	**100**	**100**	**239**	**73**	**(6)**	**(0)**	**506**
Cumulative variance (%)							***7.93%***

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

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

PHA Prompt Payment

Prompt Payment Statistics

	July 2017 Value	July 2017 Volume	Cumulative position as at 31 July 2017 Value	Cumulative position as at 31 July 2017 Volume
Total bills paid (relating to Prompt Payment target)	£2,601,938	386	£12,385,231	1,750
Total bills paid on time (within 30 days or under other agreed terms)	£2,558,503	352	£12,201,949	1,623
Percentage of bills paid on time	**98.3%**	**91.2%**	**98.5%**	**92.7%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95%, although on volume performance is slightly below target at 92.7%. 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 91.0% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2017-18 of 60%.

HSC Public Health Agency

board paper

Draft Investment Plan 2017/18

date	21 September 2017	**item**	8	**reference**	PHA/02/09/17

presented by Mr Ed McClean, Director of Operations

action required For approval

Summary

The draft Investment Plan sets out the PHA's approach for managing the budget in 2017/18.

In summary, it has been possible to develop a budget plan that makes available sufficient funding to allow the inescapable pressures and Ministerial priority developments identified in the 2016/17 plan to be progressed in 2017/18. New areas of recurrent investment proposed are as follows:

- Diabetic Retinopathy £0.24m
- Public Health initiatives for Older People £0.2m
- Weigh to Healthy Pregnancy Programme £0.16m

Funding has also been identified to cover a number of in-year service pressures. In addition, plans are being developed to re-invest any funding that may become available from the Lifeline contract.

The overall budget position will continue to be closely monitored during 2017/18 and the Agency Management Team will manage any additional in-year funding that may arise, to best meet agreed strategic priorities.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the draft Investment Plan for 2017/18.

HSC Public Health Agency

Draft Investment Plan 2017/18

1. PHA Baseline Budget

PHA has been allocated a recurrent revenue budget of £85.455m for 2017/18. A further allocation of capital has been received for R&D expenditure of £10.442m.

Further allocations and income are expected during 2017/18 of £8.508m in areas such as R&D to fund the National Institute for Health Research (£3.2m), Early Intervention Transformation Project (£3.0m), and Safeguarding Board NI (£0.7m). This will bring the total resource available to the PHA in 2017/18 to £104.406m, which consists of £19.507m in management and administration and £84.899m for the programme budget.

Key changes to the opening baseline allocation for 2017/18 are set out in table 1 below.

Table 1: Changes to Baseline Allocation	Programme (£m)	M&A (£m)	Total (£m)
Uplift for 2017-18 price inflation	1.115	0.062	1.177
Re-alignment of 2016-17 price inflation	0.670	(0.670)	-
Additional funding for demography	0.310	-	0.310
Unscheduled care team	-	0.408	0.408
DoH baseline savings	(0.250)	(0.100)	(0.350)
Retraction of campaigns budget*	(1.195)	-	(1.195)
Reduction in telehealth budget	(0.350)	-	(0.350)
Total	0.300	(0.300)	-

*temporary retraction for 2017/18 only

2. Funding Context 2017/18

In light of the significant pressures on the wider HSC budget, PHA has had its baseline budget recurrently reduced by £0.350m and the campaigns budget of £1.195m withdrawn on a non-recurrent basis in 2017/18. Whilst additional funding of £0.310m has been provided to help address demographic pressures, no new funding has been allocated to address inescapable service pressures or progress Ministerial priorities in 2017/18.

As part of the allocation for 2017/18, PHA received a price uplift of £1.177m on its baseline budget. In line with HSCB, PHA will apply the uplift to Trust Service and Business Agreements. Further to reviewing possible options for managing contracts with non-Trust providers, PHA has awarded a pay and price uplift of 1.33% to core contracts that PHA has with partners in the community and voluntary sector and other statutory sectors but applied a productivity saving to other budget areas. By doing this, it will be possible to redirect some funding to help address wider budget pressures and progress a small number of important new developments.

3. Service Pressures and Priorities 2017/18

In the PHA Investment Plan 2016/17, approved by the board in June 2016, it was noted that PHA would have a recurrent pressure of £1.84m from 1 April 2017, if all inescapable pressures and Ministerial priorities identified were progressed as planned. Following a review of the budget position in December 2017, the scale of the pressures to be managed was revised to £1.44m (this was due mainly to the funding for costs linked to establishing an unscheduled care team being agreed with HSCB).

Given the financial outlook for 2017/18, PHA did not commit to progress, on a recurrent basis, the initiatives set out in table 2 below.

Table 2: Planned Investment	£m
Making Life Better	0.80
Bowel Screening	0.30
Diabetic Retinopathy	0.24
Newborn Bloodspot Screening	0.10
Total Curtailed Investment	1.44

Agreement was, however, given to progress with a limited number of initiatives under Making Life Better and as a result PHA has a small budget deficit for 2017/18 of £0.1m to be managed.

4. Recurrent Funding Available for Investment 2017/18

In addition to the £0.31m that has been allocated to address demographic pressures in 2017/18, it is recommended that an efficiency saving is applied to baseline programme budgets by limiting the price uplift awarded to essential service areas only. By taking this approach PHA is able to release £0.64m. This gives the PHA a

total of £0.95m (£0.31m + £0.64m) to address demographic pressures and to support wider priorities.

5. Recurrent Investment Priorities

It is recommended that the first call against the £0.95m is to address the recurrent deficit of £0.1m carried forward from 2016/17 and to cover the £0.25m savings that was removed from the baseline programme budget by DoH to meet wider HSC budget pressures. This leaves PHA with £0.6m to meet demographic pressures and progress priorities from 2017/18.

Table 3: Utilisation of Recurrent Funding Available	£m
Recurrent funds available (demography & excess price inflation funding)	0.95
Recurrent savings required	(0.25)
2016/17 recurrent deficit carried forward	(0.10)
Recurrent funding available for 2017/18 pressures	0.60

In reviewing the pressures and priorities to be addressed, PHA has been advised that DoH plans to provide the £0.1m required to address the Newborn Blood Spot Screening pressure. A review of the Bowel Screening Programme has also indicated that the level of baseline funding allocated to this service in 2016/17 is sufficient to deal with the expected level of activity presenting in 2017/18. The position will be kept under review and, if required, additional funding sought in 2018/19 to meet further growth in demand.

On the basis that the above pressures can be managed, PHA has allocated the available recurrent funding to address the remaining pressures from 2016/17 as outlined below in table 4.

Table 4: Service Pressure/Priority	£m
Increased demand for Diabetic Retinopathy service	0.24
Public Health initiatives to support older people (MLB)	0.20
Expansion of the Weigh to Healthy Pregnancy programme (MLB)	0.16
Total pressures funded	0.60

6. In-year Funding 2017/18

6.1 During 2017/18 it is projected that if demand for Lifeline continues at current levels it will provide the opportunity to invest some additional funding in other related suicide prevention services and, potentially, support additional programmes. Plans are being developed to enable this funding to be utilised in the current year.

6.2 As a planning assumption, it is anticipated that the new programmes awarded recurrent funding in 2017/18 will not be operational until January/February 2018. On this basis it is reasonable to assume that there will be in-year slippage of circa £0.5m.

6.3 Based on current projections, it appears that there may be some underspend, on an in-year basis, on the management & administration budget, due to staff vacancies. This funding may be available for re-investment in priority programmes during the current year. PHA will manage this situation as the year progresses.

6.4 PHA has a number of in-year pressures that need to be addressed as set out in table 5 below.

Table 5: In-year Pressure	£m
Shortfall in campaigns budgets	0.22
Delivering Social Change contracts	0.15
Safety Forum	0.09
Health improvement programmes	0.30
Total	0.76

It is proposed to proceed with the above investments on a phased basis and that the additional Health Improvement programmes will not progress until a source of funding is confirmed. AMT will continue to closely monitor the in-year funding position and re-direct funding, where appropriate, to meet agreed strategic priorities.

7.0 Implementation

7.1 There are a number of risks with the proposed Investment Plan that will need to be actively managed as the financial year progresses, for example, demand led services may increase which will require additional funding to be found in-year.
In order to manage the risks and to ensure that a breakeven position is achieved, budget leads will be required to provide regular assurance on expenditure plans and on demand-led areas of service.

7.2 The new programme expenditure proposals will be taken forward by respective programme leads across the PHA Directorates. This will includes agreeing SLAs/contracts as appropriate, performance review and reporting to senior management and the board of the PHA.

7.3 Regular monitoring of all contracts will continue to be undertaken in 2017/18 to ensure agreed key performance indicators are achieved and funding is being invested as agreed.

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HSC Public Health Agency

board paper

Northern Ireland AAA Screening Programme Annual Report 2015/16

date 21 September 2017 **item** 10 **reference** PHA/04/09/17

presented by Dr Carolyn Harper, Director of Public Health

action required For noting

Summary

This is the fourth annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was introduced in June 2012. All men in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65 can self-refer by contacting the screening programme office on 02890 631828.

Throughout 2015-16, the programme continued its work to consolidate and develop existing services. The previous annual report set out a number of core objectives for the programme. These objectives have either been met in full or are on target, as evidenced throughout this report.

Overall performance of the programme remained high (refer to Section 5 of the Report for more detail). Of note:

- Over **9,300** men in their 65th year were invited to attend for screening
- Uptake remained high with **83%** of those invited attending for screening
- **In addition 784** self-referrals (men over 65) were screened
- **158** men screened had a newly detected AAA
- **21** of these men had a large aneurysm and were referred to the vascular team to consider treatment options

The 2014-15 annual report set out a number of future developments for the programme to focus on in 2015-16. Progress on this work is outlined below.

- A pilot **External Quality Assurance (EQA) Desktop Review Exercise** of the programme took place in October 2015. This was a positive exercise, demonstrating significant levels of commitment from staff within the programme. Subsequent recommendations made to the Trust have either been introduced or are on target to be implemented.
- A **review of information materials** was undertaken, with input from a wide range of stakeholders including service users. The new leaflets and supporting promotional materials were finalised in March 2016.

- A further **update to the programme's AAA information website** was made to make it accessible via mobile devices. Other useful resources, including a video animation outlining what an AAA is and an updated map of screening locations, were also added.
- The programme continued to liaise with both Magilligan and Maghaberry prisons to offer screening to eligible men. Throughout the year, a number of men eligible for screening attended their local clinic accompanied by prison staff. A clinic scheduled to take place within Maghaberry in March 2016 took place in April 2016.
- The programme team undertook a wide range of **promotional activities** to raise awareness of the screening programme. This resulted in increased numbers of self-referrals from men who may not otherwise have known about the programme (please see Section 8 for more detail).
- **Engagement with GPs and Primary Care teams** continued; examples of this work are highlighted in Section 7.
- One **additional screening venue** was secured during the year for regular screening clinics in Lagan Valley Hospital in Lisburn.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Northern Ireland AAA Screening Programme Annual Report 2015/16.

Northern Ireland
Abdominal Aortic Aneurysm (AAA) Screening Programme

Annual Report 2015-16

Abdominal Aortic Aneurysm Screening

HSC Public Health Agency

HSC Belfast Health and Social Care Trust

Version 2: 29/8/17

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- NI AAA Screening Programme Team - Belfast Health and Social Care Trust
- Chief Executive - Public Health Agency
- Director of Public Health - Public Health Agency
- Assistant Director of Screening and Professional Standards - Public Health Agency
- NI AAA Screening Programme Team - Public Health Agency
- NI AAA Screening Programme Co-ordinating Group

Contents

Page

Appendices

Section 1:

Summary and Highlights for 2015-16

This is the fourth annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was introduced in June 2012. It has been produced jointly by the Belfast Health and Social Care Trust and the Public Health Agency.

The Belfast Health and Social Care Trust is responsible for the management and delivery of the programme, whilst the Public Health Agency (PHA) is responsible for commissioning and quality assuring it. The two organisations work closely together to provide an effective, safe and accessible service.

All men in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65 can self-refer by contacting the screening programme office on 02890 631828.

Throughout 2015-16, the programme embarked on work to consolidate and develop existing services. The previous annual report set out a number of core objectives for the programme. These objectives have either been met in full or are on target, as evidenced throughout this report.

Overall performance of the programme remained high (refer to Section 5 for more detail). Of note:

- Over **9,300** men in their 65th year were invited to attend for screening
- Uptake remained high with **83%** of those invited attending for screening
- In addition, **784** self-referrals (men over 65) were screened
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The 2014-15 annual report set out a number of future developments for the programme to focus on in 2015-16. Progress on this work is outlined below.

- A pilot **External Quality Assurance (EQA) Desktop Review Exercise** of the programme took place in October 2015. This was a positive exercise, demonstrating significant levels of commitment from staff within the

programme. Subsequent recommendations made to the Trust have either been introduced or are on target to be implemented.

- A **review of information materials** was undertaken, with input from a wide range of stakeholders including service users. The new leaflets and supporting promotional materials were finalised in March 2016.

- A further **update to the programme's AAA information website** was made to make it accessible via mobile devices. Other useful resources, including a video animation outlining what an AAA is and an updated map of screening locations, were also added.

- The programme continued to offer screening to eligible men within the **prison setting**. Throughout the year, a number of men eligible for screening attended their local clinic accompanied by prison staff. The clinic planned for March 2016 was rescheduled to April.

- The programme team undertook a wide range of **promotional activities** to raise awareness of the screening programme. This resulted in increased numbers of self-referrals from men who may not otherwise have known about the programme (please see Section 8 for more detail).

- **Engagement with GPs and Primary Care teams** continued; examples of this work are highlighted in Section 7.

- One **additional screening venue** was secured during the year for regular screening clinics in Lagan Valley Hospital in Lisburn.

Section 2:

Introduction

2015-16 has seen further development and improvement within AAA screening. It has similarly been another year of continued work amongst staff to ensure the programme is as effective and equitable as possible. Much has also been done to maintain and progress a high quality of service, with the programme benefitting from the input of a wide range of service users.

One notable achievement included a pilot Desktop Review of the programme in October 2015. The PHA Public Health Lead and QA Manager undertook this exercise, the aim of which was to assess the performance of the programme - with regard to national quality standards - and to test the suitability of the desktop review process prior to a full External Quality Assurance Visit taking place at a later date.

AAA screening staff from the PHA and the Belfast HSC Trust also worked closely with service users, men's groups, the Patient Client Council, HSC and NHS colleagues and a wide range of other stakeholders to update the programme's existing information materials. The new suite of promotional materials was launched in spring 2016. You can read more about this initiative and the contributions our service users continue to make to help shape specific aspects of AAA screening, and the service overall, in Section 6 of this report.

Finally, I would like to acknowledge the consistently high standard of care provided by the programme team at the Belfast Trust whose dedication and professionalism remains integral to the programme's success.

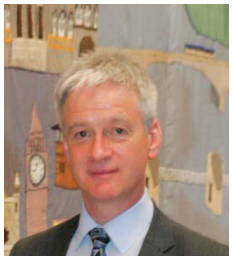
As Clinical Lead for the NI AAA Screening Programme, I am pleased to present this annual report outlining some of the work that has taken place during 2015-16.

Patient Safety is particularly important and ensuring that men diagnosed with a large AAA are treated within eight weeks is a priority for both the programme and the wider vascular team within the Trust. I am very pleased that during 2015-16 the vascular team was able to meet this timeline, given the ever increasing pressure on our service. Within the screening programme, 89% of men diagnosed with a large AAA were operated on within the eight weeks. This required significant support and co-operation from clinicians and other healthcare professionals and I am extremely grateful to them in helping to meet this standard.

This year has seen a great deal of effort by the programme team to promote AAA screening; it is pleasing to see this work pay off with almost 800 self-referrals being screened.

The programme has also provided a unique opportunity for engagement with our service users. Their feedback has undoubtedly led to improvements in the programme and also for all patients diagnosed with an AAA in Northern Ireland.

Thank you for your continued interest and support of the programme and taking the time to read this report.



Mr Paul Blair
Consultant Vascular Surgeon / Clinical Lead NI AAA Screening Programme

Section 3:

Background and Programme Objectives

What is an AAA?

The aorta is the main vessel that circulates blood from the heart, through the abdomen to the rest of the body. Over time, the walls of the aorta can weaken, causing it to balloon out. This results in an abdominal aortic aneurysm (AAA).

AAAs usually cause no symptoms, therefore most people who have one will not feel anything. As the aneurysm grows so too does the risk of it rupturing if left untreated. Rapidly expanding or ruptured aneurysms do produce symptoms (typically severe abdominal, back or flank pain, low blood pressure or shock and a mass in the abdomen which pulsates; however only a minority of patients have all of these features). Patients with a ruptured AAA have a very low chance of survival. In contrast, those detected who undergo planned surgery for a non-ruptured AAA have an excellent rate of survival.

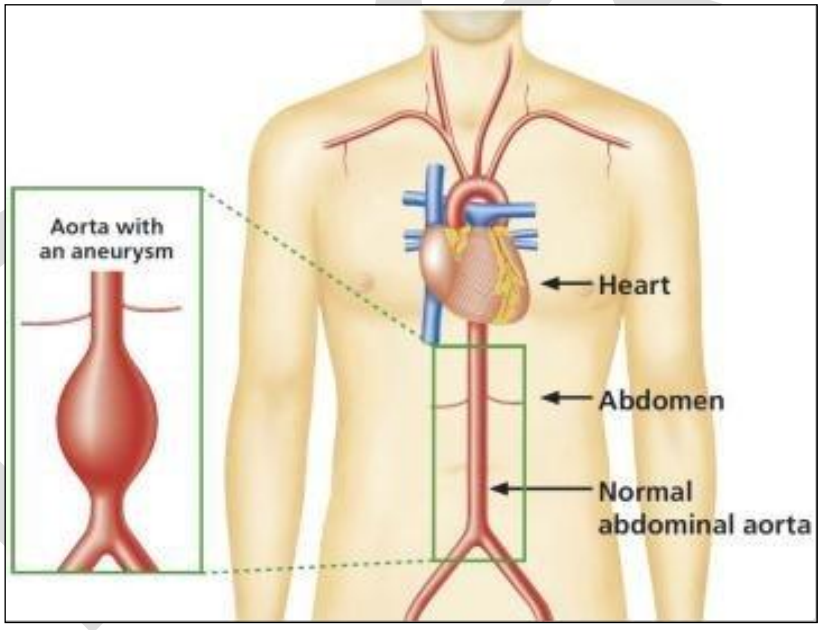


Image courtesy of English NHS AAA Screening Programme

AAAs are more common in men aged 65 and older. Other factors known to increase the risk of developing an AAA are smoking, high blood pressure and high blood cholesterol. Close relatives of someone who has been diagnosed with an AAA are also more likely to develop one.

Aim of the Northern Ireland AAA Screening Programme

The overall aim of the Northern Ireland AAA Screening Programme is to reduce deaths from ruptured abdominal aortic aneurysms through early detection, monitoring and treatment.

On average, compared to men, women are six times less likely to develop an AAA. In addition, women tend to develop an AAA ten years later than men. The NI AAA Screening Programme is therefore targeted at men in keeping with the recommendations of the UK National Screening Committee.[1]

Programme Objectives

The Public Health Agency and the Belfast Health and Social Care Trust work together to meet the programme's core objectives. These include:

- Monitoring delivery of the programme against national quality standards and taking appropriate action where performance is not on target
- Ensuring appropriate failsafe systems are in place at each stage of the screening process
- Ensuring all staff are appropriately trained on all aspects of the programme, including the Health and Social Care organisations' mandatory training
- Actively engaging with stakeholders at relevant events and opportunities, particularly in those geographical areas where uptake rates are lower than the programme average
- Ensuring information materials remain relevant and up-to-date, with a particular emphasis on promoting self-referral for men aged 65 or over who have never attended for AAA screening
- Continuing to explore opportunities for Personal and Public Involvement (PPI)
- Ongoing review and development of the Northern Ireland AAA Screening Programme website, including engagement with stakeholders, as appropriate

[1] Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: www.screening.nhs.uk/aaa Accessed 24 August 2017.

- Continuing to develop and formalise an appropriate quality assurance structure and function in collaboration with the English NHS AAA Screening Programme

- Continuing to build on existing relations with the other three UK AAA Screening Programmes

- Identifying and addressing health inequalities to ensure all eligible men can make an informed decision about whether or not to attend for screening

- Identifying and disseminating examples of regional and national best practice with regard to all elements of programme delivery

- Promoting and participating in research initiatives

Section 4:

Programme Delivery and the Screening Pathway

The programme is run by a multidisciplinary team of staff (see **Appendix 1**). All staff play an important role at various stages in the screening pathway.

The programme office is based in the Royal Victoria Hospital within the Belfast Trust.

Seven full-time screening technicians run clinics on a daily basis. There are currently 22 clinic locations across Northern Ireland, including health and wellbeing centres and community hospitals (see **Appendix 2**). Lagan Valley Hospital in Lisburn was a new venue set up during 2015-16; it had been specifically identified as a geographical area with a significant population who would be eligible for screening.

Appendix 3 provides an overview of the whole screening pathway. The key stages within the pathway are:

- Screening Invitation
- The Scan
- The Result
- Surveillance
- Referral and Treatment

Screening Invitation

The programme office sends an initial invitation letter to all men during the year in which they turn 65. All eligible men registered with a GP are invited to attend a local screening clinic; men over 65, who have not previously been scanned as part of the programme or been told they have an aneurysm, can self-refer by calling the programme office (*Tel: 02890 631828*).

The Scan

The screening test involves a simple ultrasound scan of the abdomen. It is quick and painless. The screening technician measures the widest part of the abdominal aorta. The whole process usually lasts less than fifteen minutes.

The Result

All men will be informed of their results verbally at the clinic. Both the man and his GP will then be sent a letter confirming the result. If a man is identified as having an aneurysm his GP practice will also be informed by telephone the same day.

There are **FIVE** possible results from screening:

- **NORMAL**: **aortic diameter less than 3cm**

Over 98% of men will have a normal result. This means that the aorta is not enlarged (there is no aneurysm). No treatment or monitoring is needed and the men will be discharged from the screening programme. They will not need to be screened again.

- **SMALL AAA**: **aortic diameter measuring between 3cm and 4.4cm**

Men who have a small aneurysm detected will be invited back every twelve months for a surveillance scan to monitor the size of the aneurysm. Some small aneurysms will grow in size over time and become medium or large aneurysms.

- **MEDIUM AAA**: **aortic diameter measuring between 4.5cm and 5.4cm**

Men who have a medium aneurysm detected will be invited back every three months for a surveillance scan to monitor the size of the aneurysm. Some medium-sized aneurysms will grow over time to become large aneurysms.

- **LARGE AAA**: **aortic diameter measuring 5.5cm or over**

Men who have a large aneurysm detected are referred to a vascular surgeon within the Royal Victoria Hospital at the Belfast Health and Social Care Trust for further investigation and to discuss treatment options. All men referred are required to be seen at outpatients within two weeks of the initial scan.

- **NON-VISUALISATION**: sometimes the aorta cannot be fully visualised and a man will be invited to come back on a different day for another scan.

Surveillance

As indicated above, if a man has either a small or medium-sized aneurysm he will be invited back for surveillance appointments on a regular basis to monitor its size.

Men under surveillance are also offered an appointment with a vascular nurse specialist for additional support and advice. The nurse will contact every man who has an AAA detected within two working days and offer either a face to face appointment or a telephone consultation. The nurse will explain the significance of having an AAA and offer lifestyle advice (including advice on smoking cessation) and advice on blood pressure control (if relevant) to help decrease the risk of the aneurysm growing. The man will also be asked to attend his GP to have measurements taken for height, weight and blood pressure and to discuss the need for any medication.

Referral and Treatment

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust. Vascular units are required to meet national standards set by the Vascular Society of Great Britain and Ireland (VSGBI)[2]. The regional vascular service in the Royal Victoria Hospital within the Belfast Trust meets these standards.

All men referred to the vascular service are required to be seen by a consultant vascular surgeon within two weeks of the initial scan. During this period, the man will have a CT scan to confirm the size of the aneurysm. All men diagnosed with a large AAA are discussed at a weekly vascular multidisciplinary team meeting (MDT) and also undergo vascular pre-assessment by a specialist nurse and vascular anaesthetist. The vascular consultant will then discuss treatment options at outpatient review. The two main treatment options are open surgery or endovascular (EVAR) surgery. Open surgery requires a longer hospital stay and initial recovery period while endovascular treatment, with a stent graft, allows for quicker recovery but a longer follow-up period with X-ray surveillance. The decision regarding the choice of operation depends on many factors and is discussed in detail by the vascular team. The nominated consultant will then discuss the appropriate options with the man to enable him to make an informed choice. In some men further investigation and optimisation of underlying medical issues may be required prior to treatment of their AAA.

[2] https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/VSGBI-AAA-QIF-2011-v4.pdf

Section 5:

Programme Performance

The current population of Northern Ireland is just over 1.85 million. Within this, the number of men aged 65 and over in 2015 was 130,008 of which 8,950 were men aged 65[3].

During its fourth year, the Northern Ireland AAA Screening Programme invited all men who turned 65 between 1 April 2015 and 31 March 2016 for screening.

This section of the report focuses on the performance of the programme for the 2015-16 cohort, the self-referrals and others offered screening through the programme as at end of March 2016[4]. All data outlined within this report have been provided by the Belfast Trust programme team and quality assured by the Public Health Agency.

The table below outlines the number of men who were eligible to be offered AAA screening by the programme during 2015-16.

Table 1: Numbers / categories of men to be offered screening in 2015-16

Category / Men:	**Number:**
Screening cohort for 2015-16 downloaded **(all men who had their 65th birthday during the year 1 April 2015 – 31 March 2016)**	9,563
Cohort not eligible for screening **(these men were not eligible for screening as they either (a) died before being offered an appointment; (b) were no longer registered with a GP; (c) had previously had surgery for an AAA; or (d) had previous imaging to confirm they did not have an AAA)**	227
Eligible screening cohort 2015-16	**9,336**
Self-referrals (men over 65 who were screened)	**784**
TOTAL:	**10,120**

[3] www.NISRA.gov.uk

[4] Data for the 2015-16 cohort are as at 30/06/2016 to allow time for screening episodes to be completed; all other data are as at 31/03/2016

Table 2 below shows the number of men actually screened and the number of AAAs detected during the year.

All men who turned 65 between 1 April 2015 and 31 March 2016, and who were registered with a GP in Northern Ireland, were sent at least one screening appointment by the end of March 2016. All men who did not attend their first appointment were offered a further appointment by the end of June 2016.

Table 2: Number of men screened and AAAs detected in 2015-16

			TOTAL[5]
2015-16 eligible men and self-referrals aged 65 and over			10,120
Those screened:			
Total men 65 and over screened for the first time	**2015-16 cohort**	**7,771**	8,555
	Self-referrals	**784**	
Uptake (calculated using 2015-16 cohort only)			83%
Aneurysms detected:			
Aneurysms newly detected by the programme	**2015-16 cohort**	**134**	158
	Self-referrals	**24**	
Referrals to the Vascular Unit (all)			21
Prevalence (calculated using 2015-16 cohort only)			1.7%

[5] A detailed breakdown of some data is not provided to ensure no patient is identifiable

The table below compares the programme's overall performance against national pathway standards for 2015-16.

Table 3: Performance against Pathway Standards for 2015-16:

	Programme Performance	Pathway Standard - Acceptable	Pathway Standard - Achievable
Uptake for initial screening	83%	**≥ 75%**	≥ 85%
Uptake for surveillance	99%	**≥ 90%**	**≥ 95%**
Definitive outcome of scan (screening encounters where aorta could not be visualised)	1.9%	**≤3%**	≤1%
Timely referral (men with AAA ≥ 5.5cm referred within one working day)	100%	**≥ 95%**	**100%**
Timely intervention (men with aorta ≥ 5.5cm seen by a vascular specialist within two weeks)	90%	**≥ 90%**	≥ 95%
Timely treatment (men with AAA ≥ 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within eight weeks)	89%	**≥ 60%**	**≥ 80%**
30 day mortality (following elective surgery on screen-detected AAAs)	0%	n/a	n/a

Along with the above national pathway standards, the NI programme has adopted an additional standard outlined below in relation to AAAs measuring over 7cm.

Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)	86%

Surgery by Type

The vascular team within the Belfast Trust performed surgery on 19 men referred during 2015-16. Of these, 47% had an elective open repair of their abdominal aortic aneurysm, compared to 53% having endovascular surgery.

Section 6:

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) is about people and communities influencing the planning, commissioning and delivery of health and social care (HSC) services. It means actively engaging with the public, specifically those who use services such as screening.

The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HSC organisations within Northern Ireland.

In 2015-16, the Northern Ireland AAA Screening Programme continued to develop existing PPI projects to help the programme meet the needs of its eligible population. Several projects were completed while new opportunities for engagement were identified. Ongoing interaction with service users will ensure the programme provider continues to learn about service user expectations of the programme and how these might be met. Details on these initiatives are outlined below.

Complete

- The **fourth service user event for men** with an AAA newly detected during 2015-16 was held in April 2016. As in previous years, the event was well-attended by service users, programme staff and other stakeholders. Participants were updated on how suggestions for service development and improvement from attendees at the 2015 event had been taken forward. An additional break-out session was incorporated within the programme to facilitate discussion amongst participants regarding future options for establishing additional advice and support for men recently screen-detected with an AAA.

Left to right: Gerald and Freda Monaghan with Mildred and Martin McStravick at the AAA Screening Programme 2016 Service User Event in Belfast

- A **review of NI AAA Screening Programme information materials** successfully concluded in April 2016. Contributors included programme staff from the PHA and the Belfast HSC Trust, as well as colleagues from the PHA communication team, service users and representatives from local men's groups. The aim of the review was to re-format and update materials with new images and statistics (based on data from the Northern Ireland AAA Screening Programme) and include some testimonials from service users. The exercise benefitted considerably from the input of service users whose experience of the programme, and the information available to them, helped shape the style and content of the updated publications. Particular thanks are extended to Mr Ken and Mrs Roberta McFarland and Mr Barry Dalzell (service users), as well as Mr Colin Fowler (Director of Operations, ***Men's Health Forum Ireland***) and Mr Michael Lynch (Director of Services and Development, ***Men's Action Network***) and ***Patient and Client Council*** colleagues. A professional information pack containing the new materials was sent to every GP practice in NI.

- **Thematic analysis of feedback** was undertaken from the three previous service user events to help inform future PPI initiatives.

Ongoing

- Production of an **easy-read version** of a general information leaflet on AAA screening to ensure all eligible men with a learning disability are able to make an informed choice about whether or not to attend for screening.

- A variety of contributions from the programme's **three Patient Representatives** (Mr Peter Bullick, Mr Tommy Canning and Mr Kieron Maguire). These included attendance at, and participation in, the programme's Co-ordinating Group meetings and service user event, as well as input into the revised information materials.

- Ongoing engagement with service users to help develop and **promote the programme**. This included service users providing feedback on website content and featuring in a number of articles in the programme newsletter.

- Production of a **Personal and Public Involvement Strategy and Action Plan (2015)** jointly produced by the PHA and the Belfast HSC Trust.

Section 7:

Role of Primary Care

Primary Care teams are integral to the successful delivery of the NI AAA Screening Programme.

During 2015-16, further editions of the newsletter The AAA Team were produced. This newsletter, aimed at healthcare professionals, is an important vehicle for the programme to continually engage with primary care teams.

Since the programme began in 2012, the considerable contribution and partnership working with primary care team has been invaluable, particularly in the areas outlined below.

Supporting men with a screen-detected AAA

When an aneurysm is detected, the programme informs the man's GP practice by telephone on the same day. This is followed up in writing.

GPs are then asked to arrange to take measurements for height, weight, BMI and blood pressure, and consider commencing the man on anti-platelet and statin therapy (unless contra-indicated).

For men with a large AAA, GPs are also asked to make a standard referral to the vascular team for further intervention / treatment and to arrange an urgent blood test (U&E).

GPs are the key providers of aftercare for men who have undergone surgical repair.

Providing information to facilitate screening appointments for eligible men

The programme continually liaises with primary care on a range of issues such as:

- Ensuring patient records are accurate – information is downloaded into the programme's IT system on eligible men registered with GPs; programme staff liaise with practices about any discrepancies

- Seeking information about particular needs of men invited for screening, e.g. a physical or sensory disability, limited mobility or a learning disability

– this helps facilitate the screening appointment and allows appropriate arrangements to be made, e.g. extra time for the appointment if required

- Organising an appropriate interpreter or signer when required to facilitate an appointment

Promoting screening

People often rely on the advice of primary care teams when making health decisions. It is therefore important that these teams are well informed about the programme and can discuss the benefits and harms of AAA screening to enable eligible men to make an informed choice.

GPs are notified when a man does not attend his screening appointment. Some GP practices, upon being informed of non-attendance, will either talk to the men opportunistically about screening or proactively contact men to specifically encourage attendance.

Primary care teams have continued to actively promote the programme during 2015-16 to those over 65 and eligible to self-refer. Approximately half of all men who contact the programme to self-refer do so after being advised of the programme by their GP / pharmacist, or after seeing a poster in the practice waiting area. In particular, GPs have recommended screening to eligible men who have a strong family history of AAAs. One particularly good example of working in partnership with GPs is the work with Randalstown Health Centre as noted in Section 8 of this report.

During 2015-16 the programme also worked with a number of pharmacies to actively promote screening. This included:

- Belcoo Pharmacy using promotional materials for a local information event

- Production of the first edition of *The AAA Team* newsletter specifically aimed at pharmacies

- Publication of an article on the programme in Pharmacy in Focus magazine

- Publication of an article on the programme on the Community Pharmacy NI website

Section 8:

Programme Promotion

Evidence of the successful promotion of the programme in 2015-16 is demonstrated by the 784 men who self-referred for AAA screening. This has been the highest number of self-referrals the programme has had to date in any year.

The whole programme team has been involved in a range of activities to raise awareness of AAA screening. A number of highlights are noted below.

Men's Sheds

Partnerships have been developed between AAA screening and a number of Men's Sheds across the country.

Men's Sheds originated in Australia to help improve the health and wellbeing of all males. Similar initiatives since have seen some Sheds target older men to reduce the potential risks of social exclusion and any reduced access to healthcare they might encounter with aging.

Typically, a Shed is a larger version of what a man might have in his back garden – a place where he feels at home, pursuing practical interests on his own terms. A Shed offers this to a group of interested men where they share tools and resources to work on projects they've chosen at their own pace in a safe, friendly and inclusive venue. Many also welcome information sharing initiatives on a wide range of topics including healthcare.

During 2015-16, staff attended a number of Men's Sheds local meetings to talk about the programme to members; this resulted in almost 40 self-referrals from the Sheds being screened by the end of March 2016.

During Men's Health week in 2015 the programme ran its first clinic in a non-clinical setting. This took place in Cloona House, Belfast, in association with Colin Neighbourhood Partnership and Colin Area Men's Shed.

Working in partnership with Randalstown Health Centre at flu vaccination clinics

The programme worked in partnership with Randalstown Health Centre to promote the programme at their local flu vaccination clinics. Almost 100 men signed up to, and attended for, AAA screening. The primary care team at Randalstown worked with the programme to run four clinics within the Health

Centre allowing the programme to screen men in their local area. The clinics were well attended with an 89% uptake rate.

Providing outreach clinics in partnership with Health Promotion teams and the Healthy Living Alliance

The programme is committed to tackling health inequalities. For example, through providing screening in non-clinical environments, this encourages men who may not otherwise attend.

During 2015-16, links were made with Health Promotion teams across Trusts and the Healthy Living Alliance (a neighbourhood-based, community-led approach to health improvement providing services and support in communities experiencing disadvantage and health inequalities). In February and March, this partnership enabled the programme to run three clinics identified by the Healthy Living Alliance in Portadown, Craigavon and Kircubben in Newtownards. In total, 79 men were screened; these are men who may not otherwise have been aware of AAA screening. More clinics are planned for 2016-17.

The clinics provided an opportunity to raise the profile of AAA screening among the local community. It also consolidated links to the voluntary sector and community staff who work in the area and who are keen to continue to work to promote screening locally.

Maximising promotional opportunities at existing screening locations

Screening technicians attend 22 venues all over NI and continue to identify opportunities to promote the programme in these locations. In early 2016 the programme team put together a promotional plan to ensure all the venues were well stocked with posters, promotion packs and leaflets. Screening technicians also took some time out to speak with staff in the venues and nearby GP surgeries, dental practices and pharmacies to make sure they were aware of the work of the programme. There has been a significant increase in self-referrals within some areas as a direct result of this work.

Promotion at other healthcare venues and events

The administration team worked with local contacts in other healthcare venues to organise promotional stands in the foyers of the main hospital sites. These were initially focussed in the Belfast Trust, but the programme hopes to link in with other Trusts to do something similar across Northern Ireland.

Other promotional activities

The team was also involved in a range of other events such as:

- Setting up promotional stands at various supermarkets across the country - this resulted in over 50 self-referrals

- Submitting promotional articles to some sports clubs' newsletters, etc. including tennis, golf and bowling clubs

- Libraries NI distributed literature for display in all libraries across the country

- Attending events such as those for International Men's Day, Men's Health Fayres and Older People's events

Contact was also made with the Patient and Client Council (PCC) who promoted the programme in their January 2016 newsletter. This promotional work resulted in over 20 self-referrals.

Section 9:

Governance and Accountability

The Public Health Agency

The Public Health Agency has a number of key functions in relation to screening programmes including:

- Leading on the implementation of screening policy, including the introduction of new screening programmes and any changes required to existing screening programmes

- Ensuring the delivery of high quality, safe, effective and equitable screening programmes for people in Northern Ireland

- Supporting continuous quality improvement through programme monitoring and evaluation, and adverse incident investigation and management

Specifically, the Agency takes lead responsibility for external quality assurance (QA) of the programme, focussing on the establishment of a robust QA structure and function to ensure it meets the responsibilities outlined above.

To help fulfil its core quality assurance function, the PHA has ensured:

- A formalised process is in place for the timely appointment/re-appointment of a clinical lead and an imaging lead

- The establishment of an AAA Screening Co-ordinating Group, chaired by the Public Health lead for AAA screening, including PHA staff, patient representatives and all relevant members of the Belfast Health and Social Care Trust NI AAA Screening Programme team

- Regular monitoring of QA data is undertaken

- Appropriate fail-safe mechanisms are in place to ensure screening is offered to all eligible men and that those men requiring surveillance and referral are followed up in a timely and appropriate way

- There is an agreed programme of equipment monitoring

- A programme of formal, external quality assurance visits will be established in collaboration with the English NHS AAA Screening Programme

The Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust is responsible for the operational management and delivery of the NI Abdominal Aortic Aneurysm Screening Programme.

The Trust ensures all eligible men are invited to attend for screening in their 65th year and that they are provided with appropriate information, support and advice, particularly those men who have an AAA detected through the programme.

Staff who have responsibility for the operation of the programme are employed by the Trust and carry out all of the scans, including rescans and surveillance scans.

The surveillance programme for men identified with a small or medium AAA is provided by the Trust as part of the NI AAA Screening Programme. Similarly, those men who are identified with a large AAA are referred to the vascular surgery team at the Royal Victoria Hospital within the Belfast Trust to discuss potential treatment options.

The Trust also has responsibility for:

- Setting operational policy for the programme
- Liaising with GPs regarding secondary care, particularly when a man is detected as having an aneurysm
- Local (internal) quality assurance of the entire screening process
- Ensuring appropriate failsafe systems are in place
- Providing reports on the performance of the programme and data for quality assurance purposes
- Engaging with stakeholders regarding development of the programme
- Organising and taking part in promotional activities for the programme

Audit and Research

Both organisations take joint responsibility for developing and facilitating audit and research activities related to the programme.

Appendix 4 details the PHA's governance and accountability reporting arrangements.

Appendix 5 details the Belfast Trust's governance and accountability reporting arrangements.

Section 10:

Future Developments

The NI AAA Screening Programme remains committed to continued development of the programme, building on achievements to date and continuing to improve the AAA screening experience for service users.

Whilst continuing to deliver on the core objectives of the programme as outlined in Section 3 of this report, during 2016-17 the programme will:

- Continue to develop the External Quality Assurance process, learning from the pilot External Quality Assurance (EQA) Desktop Review Exercise which took place in October 2015

- Develop alternative formats of the new versions of the information materials with input from stakeholders including service users; specifically, translated versions of appropriate materials and relevant easy read materials for men with a learning disability will be developed

- Build on previous work with Men's Sheds across NI to promote the screening programme and encourage men to self-refer

- Continue to work in partnership with the Healthy Living Centres to offer screening and run clinics within identified local areas

- Work in partnership with appropriate prison healthcare providers to facilitate screening clinics for eligible men

- Consider any further opportunities to raise general awareness of the programme and encourage further self-referrals, e.g. promotional opportunities within healthcare and non-healthcare facilities, etc.

- Continue engagement with GPs and other primary care teams to raise awareness of the programme and continue to promote the self-referral pathway

- Identify additional appropriate venues to enable AAA screening to be provided within local areas

- Explore the potential for uploading results letters from men's screening appointments to the Electronic Care Record system; this will ensure that all healthcare providers are made aware when a man has an AAA

Appendices

1 NI AAA Screening Programme Staff

2 Map of Screening Locations

3 The Screening Pathway

4 Governance and Accountability Structure: Public Health Agency

5 Governance and Accountability Structure: Belfast Health and Social Care Trust

Appendix 1 – NI AAA Screening Programme Staff:

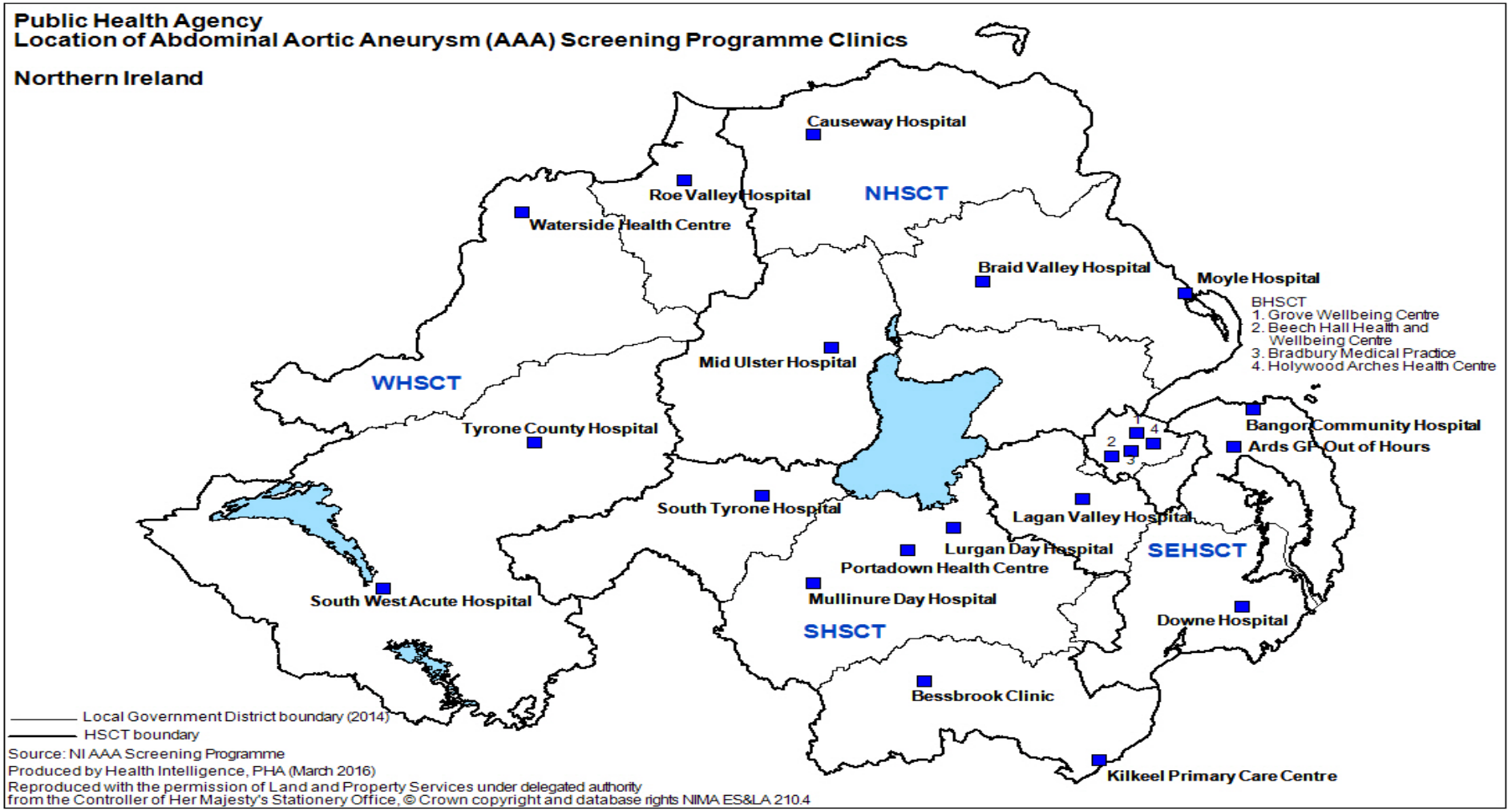
Belfast Health and Social Care Trust

Paul Blair	Clinical Lead
Janet Callaghan	Clinical Co-ordinator
Lisa Campbell	Administrative Assistant
Ciara Conway	Screening Technician
Sarah Davidson	Administrative Assistant
Trez Dennison	Vascular Nurse Specialist
Elaine Donnelly	Screening Technician
Peter Ellis	Imaging Lead
Deborah Galloway	Screening Technician
Paula Heaney	Screening Technician
Heather Hoosima (from Jul 15)	Screening Technician
Deirdre Kearns	Lead Screening Sonographer
Pauline McMahon	Screening Technician
Roisin Monan (until Oct 15)	Assistant Programme Manager
Karen McClenaghan	Specialist Surgery Services Manager
Kathy McGuigan	Vascular Nurse Specialist
Gillian Newell	Screening Technician
Diane Stewart	Programme Manager
Gill Swain	Vascular Nurse Specialist

The Public Health Agency

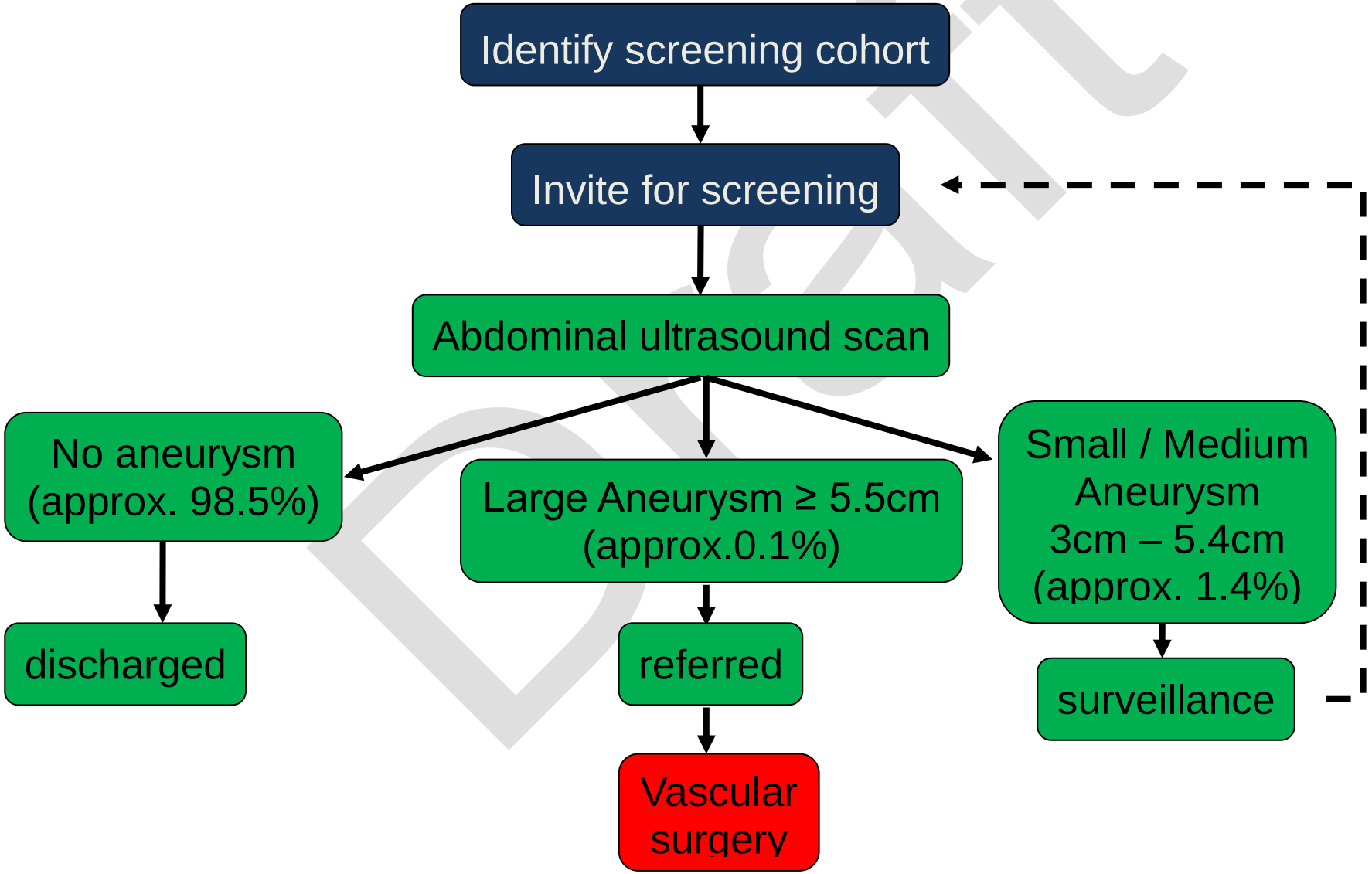
Adrian Mairs	Public Health Lead
Jacqueline McDevitt	QA and Commissioning Support Mgr
Helen McCann	Administrative Support

Appendix 2 – Map of Screening Locations

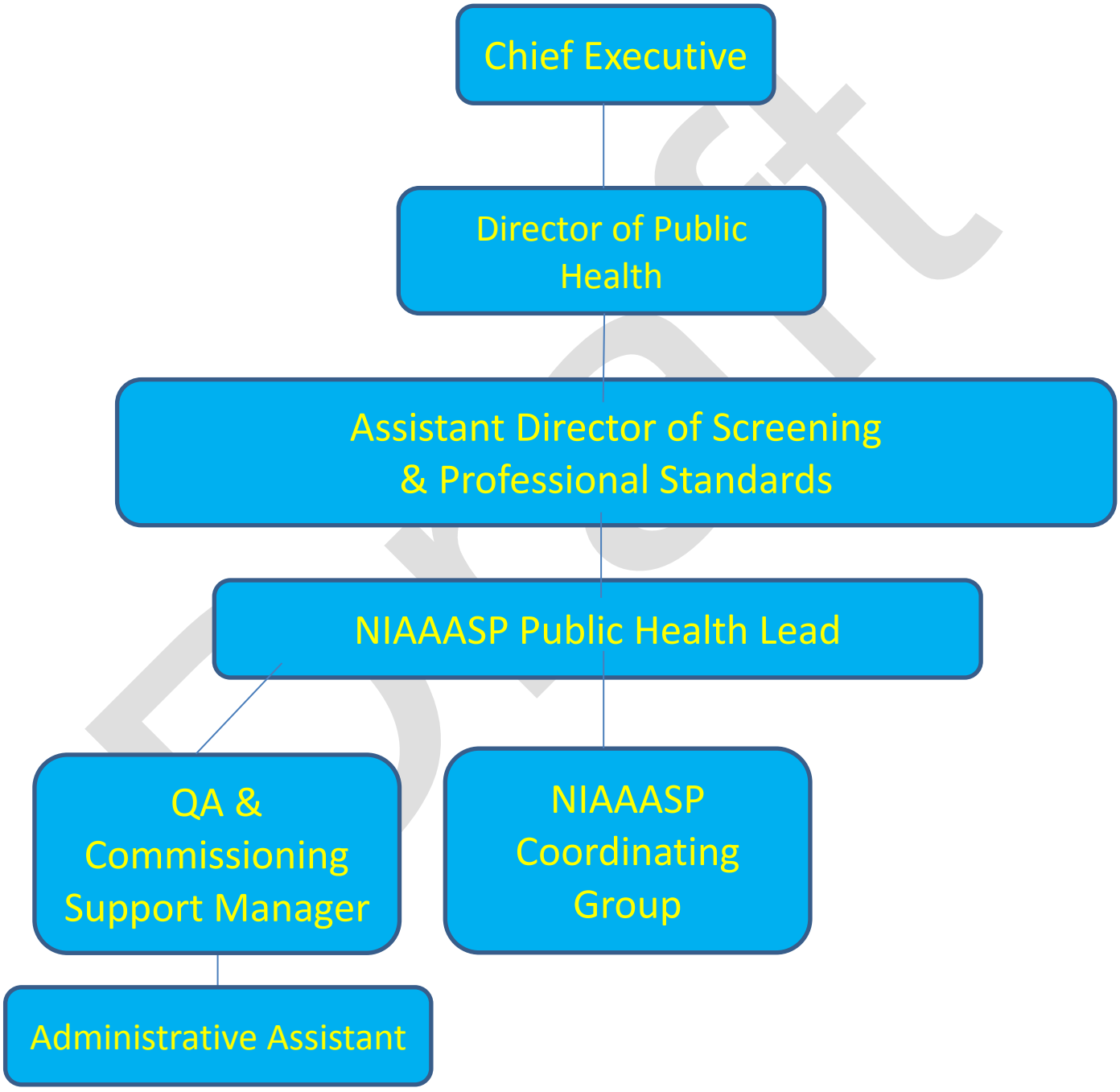


Version 2: 29/8/17

Appendix 3 – The Screening Pathway

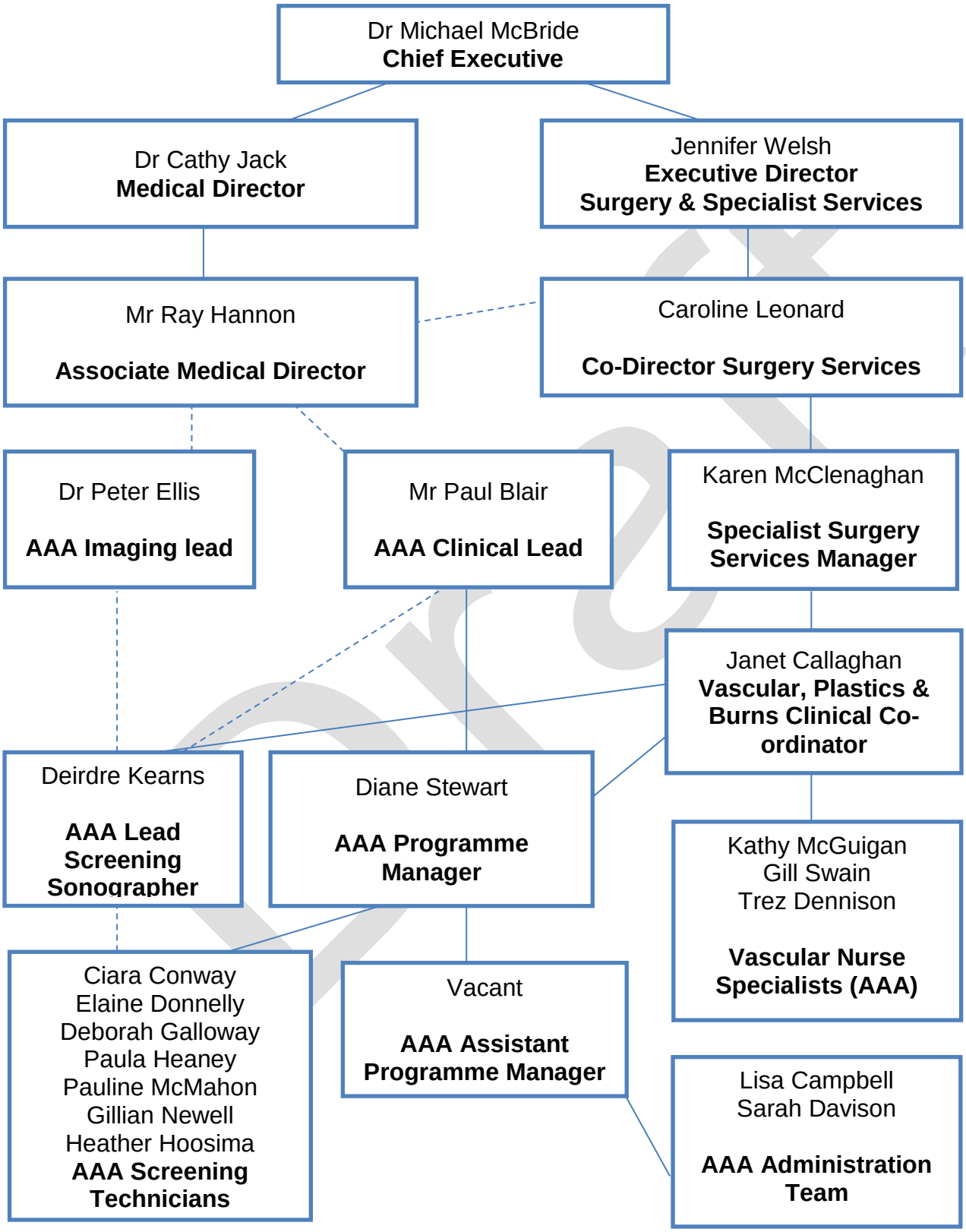


Appendix 4 – Governance and Accountability Structure: Public Health Agency



Appendix 5 – Governance and Accountability Structure: Belfast Health and Social Care Trust

Organisational chart as at March 2016



If you are interested in finding out more about being screened please contact the Screening Programme Office on 02890 631828.

HSC Public Health Agency

board paper

Re-tender of Youth Engagement Services
(previously known as One Stop Shop Service)

date	21 September 2017	**item**	11	**reference**	PHA/05/09/17

presented by Dr Carolyn Harper

action required for noting

Summary

This PID sets out the process to be followed for re-tendering of the Youth Engagement Service.

Further to a detailed evaluation of the current One Stop Shop Service, it is proposed that the service is continued for a further 5 year period but renamed as the Youth Engagement Service (YES). A position paper and business case detailing any specific changes to the service model will be submitted to AMT for approval prior to the specification and tender process being formally initiated.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Project Initiation Document.

Project Initiation Document for the Re-tendering of Youth Engagement Service (previously known as One Stop Shop Service)

Introduction

In 2010 four One Stop Shops (OSSs) were commissioned, at the request of the Minister for Health, Social Services and Public Safety, to cater for the health improvement needs of children and young people aged 11-25 years. Since then the service has been developed and refined, informed by a three stage evaluation process. There are now 8 centres in Belfast, Bangor, Carrickfergus, Ballymena, Banbridge, Newry, Enniskillen and L/Derry.

The Youth Engagement Service (YES – formerly known as OSS) aims to provide a youth friendly, holistic health and well-being service. The service is a hub where young people have opportunities to socialise in an alcohol and drug-free environment and connect into information, advice and support on a range of issues from relevant services both on-site and off-site, with the support of staff of the YES. YES centres have a local identity and their specific provision is tailored to local need. YES has now become a valued part of the landscape for services supporting children and young people.

Purpose of this document

The purpose of this document is to:

- Set out the objectives of the project;
- Define the scope of the project;
- Identify the key products that will need to be developed;
- Set out the activities, resources, responsibilities and outputs required to facilitate the completion of the project;
- Set out the management structure for the project; and
- Act as a base document against which AMT can assess project progress on an on-going basis.

Project definition

Objectives

- By June 2018, ensure that YES resources are invested in a service model that will most effectively achieve the outcomes identified in the three-year evaluation of the existing model.
- Provide service users with access to a consistent style of service that will meet their needs.

- Provide stability to service users and providers by awarding contracts that will be in place from June 2018, for a 3-5 year period, subject to the performance standards being achieved.
- Ensure that there is a clear transition pathway in areas where services are transferred from existing service providers to the new providers following award of tenders in March 2018.
- Continue to develop a strong stakeholder network that shares knowledge and expertise and identifies opportunities for working collectively to achieve better outcomes.

Project Scope

This project covers all elements involved in the strategic planning and re-tendering of the YES service for young people.

Tasks are:

- To agree the future profile of services to be developed across the region, taking into account the current pattern of services in place, an assessment of needs and the wider financial limitations;
- To use the literature review, evaluation findings and monitoring information to determine the model going forward;
- To carry out meaningful engagement with stakeholders to ensure there is an understanding of the key issues to be addressed in delivering the service going forward;
- To consider the possible impact of any decisions taken around the Service on the 9 specified equality categories and promote equality of opportunity and good relations by way of an equality screening;
- To develop a business case that robustly considers possible options for delivering the services required, identifies the financial requirements, and ensures that the preferred option provides value for money;
- To provide the necessary information to develop the tender strategy, including detailed understanding of existing contract awards and the potential impact changes in proposed future service delivery models may have e.g TUPE;
- To develop tender documentation including specifications and award criteria that will deliver the best outcomes possible;
- To robustly evaluate the tender responses received and award contracts to successful providers;
- To ensure transition between new and old service providers is managed in a reasonable manner so there is limited impact on existing service users; and
- Maintain good communication with all stakeholders during the tender process to ensure there is clarity on the proposed way forward and an understanding of any changes that will potentially impact on service users and providers.

Project Deliverables

Product / Task	Description
Phase one, planning process – development of direction – including external stakeholders	
Planning & Procurement Group Established.	Planning group established including staff from Health Improvement, Operations and PALs with advice from DLS.
Prepare a position paper on the delivery of YES service.	The paper will: 1) outline the current level of service and clarify the key learning from the evaluation and analysis of existing data; 2) review existing contractual commitments and provide assessment of the impact proposed changes in service models will have on existing services and providers; 3) outline the context within which the YES service sits, in relation to a range of health improvement strategies and the wider issues affecting young people's health and well-being; 4) Take into account the information provided by stakeholders as part of the Evaluation Report.
Develop a proportionate business case to access the best Service model within the financial limitations and ensure best value for money is achieved. An equality screening will also need to be undertaken.	Business case will be developed in line with NIGEAE guidance. Options for how services should be secured and how they should be assessed to identify how VfM can be achieved. Any wider community benefits to be realised through the investment should also be identified.
Phase two, procurement process – development of commissioning specifications and tender documentation. Internal to PHA.	
CAG established and trained.	Ensure all CAG members are aware of their responsibilities.
Develop a tender strategy setting out timelines for progressing the tender and development of a tender pack for the service.	Working with PALs, a tender pack will be developed for the YES. This will include the development of detailed service specifications, award criteria and agreement on specific issues such as a lotting strategy, community benefits to be realised and social clauses.
Tender advertised and responses received.	• Tender advertised via e-tenders. • CAG will undertake evaluation of tender

Evaluation completed by CAG and all Tenderers notified of outcome.	responses. • All Tenderers notified of outcome of evaluation process and feedback provided. • Contract award letters issued and acceptance received from successful provider.
Manage transition of services from old contract providers to new contract providers.	Identify any bridging funding required to support the transition and set up robust monitoring arrangements with new providers to ensure new contracts are managed appropriately.

Timescales

It is proposed that the project is completed by September 2018. A breakdown of timescales for completing individual elements of the work is outlined in the Gantt chart attached as Appendix 1.

Project organisation and support

A proposed structure for managing the project is set out below.

Function/ position	Role & Responsibilities
Project Board	Review and approve PID. Agree and authorise resources. Agree timeline, receive updates, and agree any changes. Approve final business case. Approve the structures, timescale, tender documentation etc for procurement.
SRO	Provide advice Authorise resources Sponsor papers brought to project board and recommend action as required.
Project Team	Provide functional expertise and leadership for the project The team will be responsible for developing the policy paper for the service. This will include reviewing information from existing services; engaging providers in discussion on possible service models, reviewing existing contract arrangements and recommending options for delivering best outcomes. Ensure all statutory duties are met. Review project timelines and escalate any difficulties to Project Board. Review options for delivering the best outcomes, based on the resources available and make recommendations to Project Board. Quality assure all key documentation produced prior to consideration by Project Board.
Project Manager/co-ordinator	Provide support to Project team. Maintain good communication across the process, ensure agreed work is progressed as required.

	Co-ordinate production of core information and quality assure prior to consideration by Project Team. Assist with writing key documentation.
Contract Adjudication Group	Development of the tender documentation including specification and selection and award criteria. Assessment of tender responses. Processing of any queries that arise during tender process.
Project Support	Administrative tasks, including: Document and arrange meetings Prepare papers for meetings Maintain comprehensive document management systems

AMT has considered and agreed this approach, Directors noting the requirement for identified staff to have sufficient time allowed in their wider work schedules to enable them to deliver inputs in a timely manner

Appendix 1

Draft Timetable for Completion of Re-tendering of YES																								
Stages of planning and procurement process	**17/18**												**18/19**											
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Planning and Procurement group established to manage the process.																								
Develop position paper on key areas of need and possible approaches for how these can be addressed.																								
Develop (PPI) position paper on the engagement with service providers and service users on local needs and potential models of service provision based on evaluation report.																								
PIN issued and engagement with the market.																								
Identification of service priorities proposed service models.																								
Equality Screening completed																								
Development of Business Case to ensure best options for delivering service are progressed																								

TUPE information sought and implications assessed																								
CAG established and training completed																								
Tender Strategy developed																								
Development of Service Specification and award criteria																								
Finalisation of Tender pack																								
Approval of Tender by Procurement Board																								
Tenders advertised																								
Tender Responses received																								
Tender Evaluation																								
Tender Award allowing for standstill period																								
Transition period between old contracts ceasing and new contracts starting																								