HSC Public Health Agency

agenda

Title of Meeting	163rd Meeting of the Public Health Agency Board
Date	18 April 2024 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 20 March 2024	Chair
4 1.35	Actions from Previous Meeting / Matters Arising • PHA Business Plan 2024/25	Chair
5 1.40	Reshape and Refresh Programme	Chair
6 1.50	Reports of New or Emerging Risks	Chief Executive
7 1.55	Raising Concerns	Chief Executive
8 2.00	Updates from Committees: • Governance and Audit Committee **[PHA/01/04/24]** • Remuneration Committee • Planning, Performance and Resources Committee • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs
9 2.20	Operational Updates: • Chief Executive's and Executive Directors' Report	Chief Executive/ Executive Directors
	• Finance Report **[PHA/02/04/24]**	Ms Scott
10 2.40	Complaints Report **[PHA/03/04/24] (For noting)**	Chief Executive

11 2.45	Substance Use Strategic Commissioning and Implementation Plan – Consultation Response **[PHA/04/04/24] (For approval)**	Dr McClean
12 3.00	Chair's Remarks	Chair
13 3.10	Any Other Business	Chair

14 Details of next meeting:

Thursday 16 May 2024 at 1.30pm

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

HSC Public Health Agency

minutes

Title of Meeting	162nd Meeting of the Public Health Agency Board
Date	20 March 2024 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Colin Coffey	-	Chair
Dr Joanne McClean	-	Director of Public Health
Ms Leah Scott	-	Director of Finance and Corporate Services
Ms Geraldine Teague	-	Interim Head AHP / Deputy Director (*on behalf of Ms Reid*)
Mr Stephen Wilson	-	Interim Director of Operations
Mr John Patrick Clayton	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Robert Graham	-	Secretariat

Apologies

Mr Aidan Dawson	-	Chief Executive
Ms Heather Reid	-	Interim Director of Nursing, Midwifery and Allied Health Professionals
Mr Craig Blaney	-	Non-Executive Director Non-Executive Director
Mr Robert Irvine	-	Director of Quality Improvement
Dr Aideen Keaney	-	Director of Community Care, SPPG
Mr Brendan Whittle		

27/24	**Item 1 – Welcome and Apologies**
27/24.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Aidan Dawson, Ms Heather Reid, Mr Craig Blaney, Mr Robert Irvine, Dr Aideen Keaney and Mr Brendan Whittle.
27/24.2	The Chair welcomed Ms Leah Scott to her first meeting as Director of Finance and Corporate Services, and thanked Mr Stephen Wilson as this was his last meeting as Interim Director of Operations.

28/24	**Item 2 – Declaration of Interests**
28/24.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda.
28/24.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.
29/24	**Item 3 – Minutes of previous meeting held on 16 February 2024**
29/24.1	The minutes of the Board meeting held on 16 February 2024 were **APPROVED** as an accurate record of that meeting.
29/24.2	Mr Clayton said that he had followed up directly with Ms Reid on a matter he was seeking clarity on with regard to the review of Serious Adverse Incidents and the involvement of affected families.
29/24.3	The Chair said that going forward, he would keen to ensure that there is a clearly defined Board cycle and he would like relevant officers to be attending meetings to present their work. He added that he was also keen to hold PHA Board meetings in other locations.
30/24	**Item 4 – Actions from Previous Meeting / Matters Arising**
30/24.1	An action log from the previous meeting was distributed in advance of the meeting. There were no other matters arising.
31/24	**Item 5 – Reshape and Refresh Programme**
31/24.1	The Chair reported that the Chief Executive had completed a series of engagements with staff in each of the local offices and the feedback from those is being collated. He said that he would like the Agency Management Team to give a presentation to the Board on the recommendations from the EY Report and how these have been adapted and to have this formally recorded. He advised that the Chief Executive is due to meet with EY shortly. It was agreed that the final EY reports would be shared with members to ensure completeness **(Action 1 – Secretariat)**.
31/24.2	The Chair advised that he had met with EY earlier that day. He said that there is a sense that PHA staff wish to be engaged in the Reshape and Refresh programme. Dr McClean agreed saying that staff can being to see how this work is shaping up and it is important that staff can take this work forward themselves. Ms Teague also agreed saying that staff welcomed the opportunity to hear from the Chief Executive and they felt that they were being listened to.
31/24.3	Ms Henderson asked what proportion of staff will be affected by the restructuring. Mr Wilson replied that it may be around 30 staff, mainly those working at Assistant Director level or the level below.

31/24.4 Professor Rooney welcomed that going forward there will be a greater emphasis in PHA's work on outcomes and impact. The Chair said that PHA will have operational activities in its Plan, but there will also be pillars, one of which will be people. He added that staff must be recognised and given the opportunity to develop.

31/24.5 Mr Clayton commented that engagement with Trade Unions should continue. He added that it is important that the right staff have the time to look at health inequalities.

32/24 Item 6 – Updates from Board Committees

Governance and Audit Committee

32/24.1 Mr Stewart advised that the Governance and Audit Committee has not met since the last Board meeting.

Remuneration Committee

32/24.2 The Chair advised that the Remuneration Committee has not met since the last Board meeting.

Planning, Performance and Resources Committee

32/24.3 The Chair advised that the Planning, Performance and Resources Committee has not met since the last Board meeting.

Screening Programme Board

32/24.4 The Chair noted that the Screening Programme Board has not met since the last Board meeting.

Procurement Board

32/24.5 Ms Henderson advised that she had met with the Chair, Mr Stewart, Mr Wilson and Mr Stephen Murray to discuss matters around procurement and that there was a useful presentation. She said that there is around £20m worth of contracts which need to be re-tendered and there is a lot of work to be done. Mr Wilson acknowledged that the procurement/commissioning cycle does not have a quick fix, and that there are areas where there is not a research plan in place.

32/24.6 The Chair said that there needs to be a plan in place and if the plan is not delivering against the timescales, that should be brought to the attention of the Board. He added that he was aware that are a lot of Direct Award Contracts (DACs) in place, and that the Chief Executive wishes to see these reduced. He reiterated that the Board needs to be content with the plan and that if more resources are needed, this can be raised with the Chief Executive.

32/24.7 Ms Henderson said that priority areas across the organisation need to be identified for how PHA spends it funding, and she thought that this would be led by the Strategic Planning Teams (SPTs), but these are still in their infancy. Professor Rooney said that PHA needs to have a Corporate Plan, but the Chair noted that PHA will not have a Corporate Plan before 2025. Professor Rooney asked why it would take that long, the Chair said that as part of the Business Plan for 2024/25, there is a timeline for the development of a new Corporate Plan. Mr Stewart said that the end of the next financial year is too far away for and he could not accept that PHA has to wait to be told by the Department when it can develop its Corporate Plan. He added that he would be surprised if the Permanent Secretary was aware that PHA was waiting him to instruct PHA in this regard given that many of the work programmes will not change.

32/24.8 The Chair said that the next Corporate Plan will include the Reshape and Refresh programme as well as elements of data and digital, and that it will contain more than what is in the Business Plan. He added that the current Corporate Plan was extended due to COVID. Professor Rooney said that PHA needs to have a Corporate Plan and a timeline needs to be agreed. The Chair commented that the Corporate Plan will be for the period 2025/30 and will have a long-term vision. Professor Rooney said that the Corporate Plan needs to set out PHA's priorities.

Information Governance Steering Group

32/24.9 Mr Clayton advised that the Information Governance Steering Group met on Tuesday and look at the year end report for the Information Governance Action Plan for 2023/24 as well as the draft Action Plan for 2024/25.

32/24.10 Mr Clayton reported that a recent Internal Audit report on information governance had given PHA a satisfactory level of assurance, but that it was important to ensure that any of the Priority 2 recommendations were included in the new Action Plan. He advised that there was a discussion around the review of contracts.

32/24.11 Mr Clayton said that another ongoing issue is one that relates to information governance training as the target is not being met for new starts. He advised that there is a proposal to have an induction day.

32/24.12 The Chair asked about wider training such as cyber security. Mr Wilson advised that there is a range of training which is managed by HR.

Public Inquiries Programme Board

32/24.13 Professor Rooney advised that the Public Inquiries Programme Board met on two occasions since the last Board meeting. She reported that Dr McClean will be appearing at the COVID Inquiry soon and that PHA has applied, and obtained, core participant status for the module relating

to care homes. She added that PHA's submission for Module 4 was submitted last week.

32/24.14 Professor Rooney reported that, in relation to the Muckamore Inquiry, 2 previous employees of the PHA have been written to and they will receive support from PHA.

32/24.15 Professor Rooney advised that for Inquiries which have been completed, PHA has not yet had the opportunity to look back to see if it has implemented any of the recommendations due to capacity issues. The Chair asked if PHA has accepted the recommendations and if there should be a separate meeting to discuss this. Mr Wilson said there are pressures on staff to look at historic recommendations. The Chair proposed that the Board should receive an update. Mr Wilson assured members that PHA is committed to addressing recommendations using its resources as effectively as it can. He undertook to bring a paper to the Board **(Action 2 – Mr Wilson)**.

32/24.16 Mr Clayton asked which Inquiries are being referred to and Mr Wilson replied that it is the Neurology and Hyponatraemia Inquiries. Mr Stewart agreed that it would be useful to have a short paper and then PHA can decide if it needs to bring in resources to deal with this.

32/24.17 Mr Stewart expressed concern about the professional guidance that PHA gives and how this is recorded as this has become an issue in terms of the Muckamore Inquiry when the Board had been previously advised that PHA was not involved in Muckamore, but it is now in front of the Inquiry. Mr Wilson reiterated that a paper will be prepared.

33/24 Item 7 – Operational Updates

Chief Executive's and Executive Directors' Report

33/24.1 The Chair asked if members could receive this Report sooner.

33/24.2 Dr McClean gave an overview of the Report and began with an update on the Area Integrated Programme Boards (AIPBs) saying that these will now have more of a focus on public health.

33/24.3 Ms Henderson asked for more information about the new joint commissioning groups. Dr McClean explained that there will be 7 or 8 new groups and they will help reformulate PHA's role into commissioning. Mr Clayton said that there remains an issue in terms of clarity around PHA's role because previously the PHA Board would have had a role in approving the Commissioning Plan and PHA would have provided professional advice to HSCB. He added that while he understood that AIPBs were operating along Trust boundaries, he was unclear around the regional piece and he asked PHA's role would be in that regard. He noted that PHA had previously contributed to the pilot that was run in the Southern Trust area.

33/24.4 Mr Clayton declared an interest in this area because he had been involved in completing a consultation response for Unison with regard to the new arrangements.

33/24.5 Dr McClean said that this work is still in flux. She advised that the AIPBs will look at prevention and PHA will have a joint role in commissioning, as per legislation. She added that there is currently no Commissioning Plan but that PHA will continue to provide professional advice as it had done so previously, but will push more on the public health agenda. She explained that her team would become involved in providing advice where a service may be at risk, but that the establishment of the new groups PHA will be work on priority areas.

33/24.6 Mr Stewart said that he agreed with Dr McClean that there is a lot of conflation between PHA's role and that of SPPG and that there needs to be an MOU regarding PHA providing professional advice. He commented that this was supposed to have been completed before SPPG was created. Mr Clayton noted that is on PHA's Corporate Risk Register. The Chair advised that he met with Ms Sharon Gallagher last week and that he will continue to raise the issues around AIPBs with the Chief Executive. He said that Ms Gallagher is keen to work closely with PHA. He advised that he would ask the Chief Executive for a further update **(Action 3 – Chair)**.

33/24.7 Mr Stewart said that PHA should be providing professional public health advice and that it needs to be clear on what its responsibilities are and be assured that it is executing them.

33/24.8 Dr McClean updated members on the cervical screening review and advised that a sample SITREP had been included with the Report. She reported that progress is being made against the backlog and it is hoped that this will be completed by the end of August.

33/24.9 Dr McClean advised that the health protection team is continuing to deal with a range of issues, including pertussis and an outbreak of eColi in the Omagh area.

33/24.10 Mr Clayton asked about the peer evaluation of PHA's quality assurance processes in relation to screening. He noted that terms of reference have been agreed, but he asked if the review could make recommendations that are outside's PHA remit, or if the focus is on PHA's internal processes. Dr McClean explained that NHS England had previously advised that they would unable to complete this piece of work, but now they are in a position to do so. She advised that they will look at PHA's quality assurance processes and how they compare. She noted that in the Southern Trust PHA had previously made recommendations regarding the performance of screeners, but the Trust is not accountable to PHA. The Chair said that PHA needs to be clear in terms of what quality assurance looks like and he asked about escalation. Dr McClean replied that this issue was reported to the

Southern Trust Board. She said that if primary HPV had been introduced 5/6 years ago, this incident would not have happened.

33/24.11 Professor Rooney said that PHA has known since 2014 that uptake rates of measles vaccinations were declining so it should have acted sooner. Dr McClean replied that a catch-up exercise was undertaken prior to the pandemic and the current exercise was planned last summer. She said that there has been a general reduction in uptake rates across the UK and Europe. Professor Rooney asked if PHA should have acted more quickly, but Dr McClean reiterated that PHA had planned to carry out this catch-up exercise as it was in the Business Plan. Professor Rooney asked for how many years the rates would have to fall before action is taken. Dr McClean explained that the World Health Organisation guidance is that rates should be around 95%, and that in Northern Ireland there are specific issues in Belfast and in certain population groups. She added that it would help if the GP Contract was changed. Professor Rooney said that this is a major area of work for PHA. The Chair commented that there should be a KPI in this area, and then a discussion around what action to take if the KPI is not being met.

33/24.12 Ms Henderson asked about a campaign around measles. Mr Wilson replied that PHA was given dispensation to carry out a small-scale campaign. The Chair said that PHA needs to look at the issue of the GP Contract. Dr McClean said that PHA relies heavily on primary care and added that the reduction in the number of health visitors has not helped.

33/24.13 Mr Wilson said that the next section of the Report focus on work within the Operations directorate and that the team is working on corporate governance areas in preparation for the year end.

33/24.14 Ms Teague advised that the Nursing and AHP section gave an update on work, including a report on a workshop which had taken place regarding dysphagia. She explained that there was a lot of data available from Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs), and it was noted that 50% of AIs took place in care homes. She said that a workshop was held to look at areas of good practice and learning. She added that there is now a Swallow Aware campaign. Mr Clayton advised that members of his Trade Union would work in care homes and he would be content to assist in disseminating any learning.

*Finance Report **[PHA/01/03/24]***

Mr Lindsay Stead joined the meeting for this item.

33/24.15 Mr Stead reported that the financial position at the end of month 10 is similar to that of previous months with a familiar pattern emerging of there being a degree of slippage in the management and administration budget offset by pressures on the programme budget, but that PHA is still projecting a year-end break-even position. He said that PHA cannot carry forward any slippage so meetings are taking place every week to

monitor the situation. He advised that while the year to date position is showing a surplus of £800k, there is some funding that has yet to be allocated so there is simply a timing issue. He advised that for the year-end, Directors have been advised to ensure there is no unauthorised spending.

33/24.16 For 2024/25, Mr Stead acknowledged that PHA needs to develop a Financial Plan and a process has commenced to pull this together and getting an understanding of the risks. He noted that for the previous year, PHA did not receive its opening allocation letter until May.

33/24.17 The Chair asked if there is any indication of how the Department will fund pay awards. Mr Stead replied that any pay awards for 2023/24 will be met by the Department, but he was not sure about the situation for 2024/25. Mr Clayton declared an interest at this point in his role as a Trade Union representative. The Chair said that he believed that pay awards for 2023/24 are part of the recent settlement, but for 2024/25 organisations will have to fund pay awards while only receiving a flat cash budget. Mr Stead said that this is an issue that need to be kept under consideration as well as whether the 2023/24 pay award will be funded recurrently.

33/24.18 Ms Scott said that she would be working with Mr Stephen Bailie to develop a set of working assumptions. The Chair noted that the budget for 2024/25 will be based on the new structures. Mr Stead noted that the new structure includes a new directorate so this would need to be costed as soon as possible.

33/24.19 The Chair asked if there was any risk around the £1.7m that is still owed to PHA. Mr Stead replied that there is a low element of risk as the money will be paid. The Chair asked if the auditors will be content. Mr Stewart advised that there was a timing issue and this was the subject of criticism by auditors. Ms Scott advised that there were some issues within SEUPB (Special EU Programmes Body), but they are now working to resolve this.

33/24.20 Professor Rooney asked about the cost of the new digital directorate and Mr Stead said that it will be approximately £1m. She asked if some of the external costs that are PHA is paying will move in-house and Mr Stead confirmed that where PHA can reduce its dependency on external contracts, this will reduce those costs.

33/24.21 Ms Henderson asked if the new digital directorate will up and running during 2024/25. Mr Wilson advised that job descriptions are being finalised and will be completed soon, but he noted that there is limited capacity within HR to review these with ongoing work in relation to Epic. He clarified that this will not be an entirely new directorate, but will have staff from the existing health intelligence and R&D teams. Professor Rooney noted that it was difficult for the Remuneration Committee to sign off on the job description in the absence of the new structure.

Reports of New or Emerging Risks

33/24.22 There were no reports of new or emerging risks.

Raising Concerns

33/24.23 There were no reports of any concerns.

34/24 Item 8 – Complaints Report

34/24.1 Mr Wilson advised that, as per the Chief Executive and Directors' Report, there were no new complaints.

35/24 Item 9 – PHA Business Plan [PHA/02/03/24]

35/24.1 Mr Wilson explained that the Business Plan aims to capture key initiatives outside of those which can be deemed "business as usual" as they will be picked up on directorate business plans. He said that these are the high level key priority areas and there has been an effort to limit the number of KPIs and to ensure they have precise end dates. He advised that this is not a final draft as some amendments are still being done so he proposed that an updated Plan is approved by members via e-mail as PHA is required to submit this Plan to the Department by the end of March.

35/24.2 Professor Rooney asked about Early Years and links with the Mental Health Strategy and where that fits in. Mr Wilson explained that KPI 8 relates to this and is a key deliverable within the Mental Health Action Plan. Professor Rooney asked for more information about what the mental health hub is and its ownership. Mr Wilson replied that it is a PHA solution to an identified need and its development will meet actions 1 and 2 from the Mental Health Action Plan. He clarified that it is not competing with what is already available. Professor Rooney asked who owns it and Mr Wilson advised that PHA will have a lead role, but will work in partnership with other organisations. Dr McClean said that the KPI is too specific and that this work is really a scoping exercise about what will be an online hub and a resource to signpost people. Mr Wilson advised that the Department has indicated that it will resource it.

35/24.3 Mr Stewart said that the Business Plan is moving forward in the right direction and he welcomed that there will be further amendment. He sought clarity on what is meant by the Early Years knowledge hub and who the audience for it will be. Mr Wilson explained that his hub would underpin the work of the Early Years Strategic Planning Team (SPT) as data and evidence in this area is disparate at present. Professor Rooney said that this should sit within the digital directorate and commented that there is no point in collecting data, if not for strategic purposes.

35/24.4 Ms Henderson advised that she also welcomed the slimmed down

	Business Plan and asked about KPI 9 relating to the framework for drugs and alcohol and if that will be achieved. She added that there needs to be some focus on Protect Life 2. Dr McClean said that she held a business planning day with her directorate and it was agreed that some of the KPIs need to be reviewed with more detail being put into directorate business plans.
35/24.5	Ms Henderson said that she would like to see KPIs in relation to the establishment of 2 of the SPTs, mental health and one other, and that in future they will be linked to finance and resources. The Chair said that there is an issue for the Board in terms of knowing where resources are applied. Dr McClean advised that one of her staff has developed a map which shows where PHA is spending its funding and linking it with areas of deprivation. She suggested that there could be a demonstration of this at a future workshop.
35/24.6	Mr Clayton said that the Corporate Plan needs to be more front and centre and the development of a new Plan should be accelerated. He added that the introductory section of this Plan should indicate that this is a priority. He welcomed that there are more overt references to dealing with health inequalities. He commented that it is not clear how PHA intends to use equality data, particularly with regard to vaccine hesitancy. He asked whether those actions that were rated either "red" or "amber" in this year's Business Plan would be carried forward. He commented that PHA should be using data to inform Government policy.
35/24.7	The Chair advised that he has asked for a stakeholder engagement plan and said that PHA needs to be more proactive in this area and this should be a target within the Plan.
35/24.8	Mr Clayton said that for KPI 16 relating to a further 10% of independent sector care homes implementing the falls pathway, it would be useful to know what the current uptake level is. He noted that there is no reference in the Plan to implementing Internal Audit recommendations, but said that this may be seen as "business as usual".
35/24.9	Professor Rooney said that when the restructuring is in place, the names of responsible Directors will need to be reviewed. Dr McClean advised that this is unlikely to happen in-year. She added that at her directorate business planning day staff were bought into the new Plan and the focus on inequalities and there is an aim to develop some training for staff in this area, which will include Board members. Mr Clayton added that rural needs also need to be factored in.
35/24.10	Ms Henderson asked if there is any way of capturing the amount of work that PHA does in the area of commissioning. Dr McClean agreed that it should be included and it would feature within the introductory narrative.
35/24.11	Ms Teague said that this Plan represents an evolving process and staff feel that this is a more collaborative process. The Chair suggested that

in terms of not naming Directors in the plan, it should indicate departments, but Mr Wilson said the Chief Executive is keen to ensure that, while these are corporate priorities, there is a lead Director for the purposes of his quarterly accountability meetings. Ms Henderson asked about the role of the chairs of the SPTs and how they will push forward their work. Dr McClean advised that there will be a bigger focus on the SPTs and that the Chief Executive is considering changing the format of the weekly Agency Management Team meetings to reflect this.

35/24.12 The Chair said that in his view there were still too many KPIs. For KPI 19, he said that the Board should be involved in a review of the Business Continuity Plan and understand the terms of reference of any review. He felt that KPI 20 regarding procurements was vaguely worded. He added that KPI 21 relating to the Partnership Agreement would not be achieved by June, and that he did not understand KPI 22 around the Digital and Data Strategy.

35/24.13 The Chair commented that for KPI 25, he would like to see a plan for the development of a new Corporate Plan as soon as possible. He said that there should be a pillar within the Plan for people, and one for digital.

35/24.14 The Chair asked if members were content with the Plan and that a new draft would be issued within the coming days.

35/24.15 Professor Rooney asked about KPI 26 on the R&D Strategy. Mr Stewart said that there needs to be a proper discussion about R&D in the context of the new Corporate Plan. Dr McClean explained that there are R&D offices in each Trust, but PHA should be applying for R&D funding to set up its own R&D office. She added that the new directorate will not solely be focused on digital, but on information as well. She said that Dr Janice Bailie has some good ideas for how to take R&D forward.

35/24.16 The Chair said that the Board needs to understand what PHA is about and its role within the HSC family. He noted that PHA is doing a lot of work in the area of AIPBs.

36/24 Item 10 – Vaccine Management System [PHA/03/03/24]

36/24.1 Dr McClean advised that members had previously received a presentation on the Vaccine Management System (VMS) but had asked for more of an understanding regarding the costs. She said that this paper gives an overview of the elements that make up VMS. She advised that the funding for VMS runs out on 31 March and that a business case has been prepared because it will be at least 4 years before the system can be moved onto Encompass. She said that the business case is with Digital Health and Care (DHCNI) and she expected that it will be approved. She outlined that the cost is £4.7m over 4 years which is a reduction as PHA is reducing the external support costs.

36/24.2 Mr Stewart welcomed the paper and the reduction in the costs. He asked whether it will cost £3m to address the alternative strategies referenced in the paper. He asked for more information about GCloud and what assurance there is that Encompass will be able to pick this up in 4 years' time. Dr McClean explained that it is unlikely that anything will happen that will cause the system to crash. She added that GCloud is a Government procurement framework for IT services. Mr Stewart suggested that it is similar to a Direct Award Contract, but Mr Wilson said that it is a Government-backed system. Ms Scott added that it is a more straightforward means of procurement. Dr McClean said that at this stage PHA has no other way of completing the procurement on time. With regard to Encompass, Dr McClean advised that PHA has recently begun to engage with Encompass at a senior level and that it will be approaching Encompass to outline its priorities. She noted that most vaccines are administered in primary care and it will not have access to Encompass. She added that Encompass will have solutions that will assist with screening programmes. Professor Rooney said that she welcomed the reduction in the costs and she hoped that Encompass will be able to deliver.

36/24.3 Ms Henderson said that this was a useful paper and asked if the funding was ringfenced. Dr McClean explained that PHA needs to identify savings from the overall vaccine budget and that there is still some work to do with the Department in terms of looking at roles and responsibilities. She added that there is a meeting taking place on Thursday.

36/24.4 The Chair commented that the baseline data is based on the 2019 Census. Dr McClean advised that PHA uses a population estimate, but said that it is more difficult to work out the number of individuals under the age of 65 are who are deemed "at risk".

36/24.5 The Board noted the paper on the Vaccine Management System.

37/24 Item 11 – Chair's Remarks

37/24.1 The Chair reported that he had recently met with the Chief Medical Officer and has a further meeting scheduled next week. He added that he had also met with the Chair of the UK Health Security Agency and that there is the possibility of PHA hosting a meeting of the 4 UK nations public health bodies.

37/24.2 The Chair advised that he had met with the Chair and Chief Executive of RQIA to discuss HSCQI. He said that he had met with the Chair of the Southern Trust and that all HSC Chairs have expressed a keenness to have a co-ordinated approach in dealing with issues.

37/24.3 The Chair said that he and the Chief Executive had visited a primary school near Coleraine.

37/24.4	The Chair reported that he had met with the Chair and Chief Executive of the Patient Client Council and that he would like to invite them to attend PHA Board meetings. He advised that there is a further meeting coming up. He added that he had met with Ms Sharon Gallagher in SPPG.
37/24.5	The Chair advised that he had met with the Chair of the Institute for Public Health in Ireland and that they are keen to work with PHA. Professor Rooney noted that Ms Reid will be taking up a place on their Board.
37/24.6	The Chair said that he is commencing a series of meetings with the Chief Executives of Local Councils.
38/24	**Item 12 – Any Other Business**
38/24.1	There was no other business.
39/24	**Item 12 – Details of Next Meeting**
	Thursday 18 April 2024 at 1.30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast
	Signed by Chair:
	Date:

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	1 February 2024 at 10am
Venue	Fifth Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Joseph Stewart	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director

In Attendance

Mr Stephen Wilson	-	Interim Director of Operations
Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Ms Tracey McCaig	-	Director of Finance and Corporate Governance, SPPG
Ms Claire Devine	-	Assistant Director of Finance, SPPG
Ms Caren Crockett	-	Head Accountant, SPPG
Mr David Charles	-	Internal Audit, BSO
Mr Ryan Falls	-	Cavanagh Kelly
Mr Roger McCance	-	NIAO
Mr Robert Graham	-	Secretariat

Apologies

None

1/24	**Item 1 – Welcome and Apologies**
1/24.1	Mr Stewart welcomed everyone to the meeting. There were no apologies.
2/24	**Item 2 - Declaration of Interests**
2/24.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda.
2/24.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

3/24 **Item 3 – Minutes of previous meeting held on 10 October 2023**

3/24.1 The minutes of the previous meeting, held on 10 October 2023 were **approved** as an accurate record of that meeting, subject to an amendment in paragraph 56/23.6.

4/24 **Item 4 – Matters Arising**

4/24.1 Mr Graham went through the action log noting that all of the actions had been completed with the exception of action 6 relating to risk management training.

4/24.2 Mr Stewart asked for an update on the audit clinics where were to take place. Mr Wilson advised that these had taken place and had been very productive. He said that the focus of these was on outstanding audit recommendations and that evidence is now being compiled to support the updates given with the hope that many of the recommendations can be completed by the end of the year.

5/24 **Item 5 – Chair's Business**

5/24.1 The Chair advised that he had no business to update on.

6/24 **Item 6 – Corporate Governance**

Dr Joanne McClean joined the meeting for this item

Corporate Risk Register as at 31 December 2023 [GAC/01/02/24]

6/24.1 Mr Wilson advised that two risks have been removed from the Corporate Risk Register and a new risk added around the financial planning context for 2024/25. He added that no risks have had their rating altered.

6/24.2 Mr Clayton noted that there is a presently one risk on staffing and while at a time it was deemed sensible to consolidate that risk, he felt that as there is a particular issue around the recruitment of public health consultant posts, it should be a separate risk. He added that the Department has placed this issue on its own risk register.

6/24.3 Mr Wilson explained that a decision has not been taken to not separate the risk, but rather the risk was left as is because the other element of it relates to HSCQI and Dr Aideen Keaney is presently on leave and Directors did not wish to change this risk without her input. He added that is likely that it will change following the next review at the end of March. Mr Clayton suggested that the risk could be a separate risk altogether to a risk on staffing and Mr Wilson acknowledged that there is value in that, particular in the context of the Reshape and Refresh work.

6/24.4 Ms Mann-Kler asked about future proofing this risk because it is an area

that will continue to be a challenge. She asked if there is a task force looking at a creative solution to get more public health consultants, or if there is any work being done with education. Dr McClean advised that some of this was covered in the paper that went to the Board earlier this week. She said that as part of the Reshape and Refresh programme, a public health skills framework will be developed to measure people's skills. She noted that there is a particular issue with regard to health protection but over the last few months programme managers have been employed who can carry out project management work and therefore free up consultants' time to focus on their role. She advised that staff across the PHA are participating in the health protection module of a Masters through Queen's. Ms Mann-Kler asked how quickly the impact of these initiatives will be felt, but Dr McClean said that it will a medium-term gain as it will take time to fill specialist posts. She added that PHA will aim to do a campaign, but previously this had limited success. She said that the staff on the ground are delivering good work, but there is a lot to be done. She added that when the first report from the COVID Inquiry is published, it may recommend that there needs to be more funding in public health.

6/24.5 Ms Mann-Kler asked about developing an interim model, for example collating a group of experts. Dr McClean advised that this was also referenced in the paper that went to the Board. She explained that PHA has an arrangement with the UK Health Security agency (UKHSA), that if it requires cover, it can get help. She added that is useful that general public health consultants are stepping into health protection roles as it widens their range of expertise.

6/24.6 Mr Stewart thanked Dr McClean for the lateral thinking that has been applied to help the situation which he said is far from ideal. He added that it is helpful that the staff have been open to the ideas.

6/24.7 Ms Mann-Kler noted that there is a higher number of Public Inquiries in Northern Ireland and asked if there has been any assessment of why this is the case. She said that it gives a bad perception, and that Inquiries are very resource intensive. Mr Stewart said that he attended the meeting of the Public Inquiries Programme Board on Wednesday and there are presently 4/5 Inquiries that PHA is dealing with and he is not aware of any overarching reasons as to why there are so many, but staff are having to get on with responding to them. Mr Wilson agreed that there are a lot of Inquiries, and queried how long the public purse can sustain them. He noted that the COVID Inquiry will take many years to complete. Ms Mann-Kler said that the COVID Inquiry is likely to be re-traumatising for staff, but Mr Wilson advised that PHA has been looking at support for staff. Mr Wilson added that there is a lot of pressure on the staff who left in PHA because they have had to replace the staff who have left. Mr McCance commented that from a meeting he had attended with representatives from across the UK, there is an element of "Inquiry fatigue".

6/24.8 Members **APPROVED** the Corporate Risk Register.

Public Health Directorate Risk Register as at 31 December 2023 [GAC/02/02/24]

6/24.9 Mr Stewart thanked Dr McClean for attending the meeting and bringing forward a radically altered directorate risk register. Dr McClean said that the register requires further work and that the main issues on it relate to staffing, screening and vaccination uptake.

6/24.10 Mr Clayton noted that screening features on both the Corporate Risk Register and directorate risk register and asked for some further insight in the IT issues given there are different issues across the different programmes and that this has been discussed at both the Committee and the Board for a number of years. Mr Stewart said that he had an issue with the timelines and asked if the systems are on the verge of collapse.

6/24.11 Dr McClean advised the introduction of Encompass will help. She said that a scoping exercise has been carried out by Mr Paul McWilliams and that Mr Gary Loughran has been brought to in to help. She advised that to date, PHA's engagement with Encompass has been of an ad hoc nature but that a workshop is taking place next week. She said that the work undertaken by Mr McWilliams should be reviewed and then a plan brought to the Board.

6/24.12 Ms Mann-Kler said that she was pleased to hear that this additional resource has been brought in. She asked about Breast Screening Select. Dr McClean explained that the delay with that software is with NHS England. Ms Mann-Kler asked if NHS England is under high demands and what the implications of the delay are for people here. Dr McClean assured members that women are still being screened, but the issue is with the system.

6/24.13 Mr Clayton noted that there are many different systems and different timelines and suggested that it may be helpful to have an update brought to the Committee or the Board to see what the Board can do to assist. With regard to quality assurance, he said that Dr McClean had given an update on this at the Board meeting and felt it would be helpful for that to reflected in the register.

6/24.14 Ms Mann-Kler said that there is a governance gap because if something goes wrong, it is not PHA's responsibility. Mr Stewart added that in his view, these systems are at the heart of PHA is about and if something did go wrong, it would be detrimental for the reputation of the PHA. He said that there needs to be a clear timeline of what needs done, when it will be achieved and what the risks are and that this should be brought to the Board with the right officers in attendance. He added that the PHA Chair should be aware of the issues, and if necessary the Permanent Secretary and the Minister. Dr McClean advised that many

	of the systems are hosted by BSO and their staff are doing their best, but for cervical system, she acknowledged that there are different systems and so there is a need to get all the issues articulated into a paper. Mr Clayton said that this would be helpful. Ms Mann-Kler added that there is also a need to future proof the system as much as possible.
6/24.15	Ms Mann-Kler asked about the drop rate in vaccinations and if PHA is managing that and has an understanding of why this is happening. Dr McClean replied that she does not know the reason why there is a drop off, but added that this is not unique to Northern Ireland. She cited deprivation as a factor and being able to access harder to reach communities. She advised that she had attended an All-Party Group meeting on cervical screening and there is a need to focus on health inequalities and be smarter in ways to increase uptake. She said that in England there is work looking at behaviours. She advised that there will be a focus on MMR over the next few months with extensive engagement with the Health Improvement team and with GPs. Ms Mann-Kler asked what scope there is to be creative. Dr McClean replied that it is hoped to have pop up clinics, but she noted that the majority of vaccines are carried out in GP practices.
6/24.16	Ms Mann-Kler asked what Dr McClean's biggest concerns are and Dr McClean replied that her main concern is around measles and while there have been no cases to date here, the situation in the West Midlands is concerning. Dr McClean added that a sustained response to a measles outbreak would impact on PHA as it would be the same staff who would be involved as it was during the pandemic. She advised that there is a meeting taking place with Trusts today to plan for this. She said that another area of concern is seeing the cervical screening review completed in the Southern Trust.
6/24.17	Mr Clayton asked about vaccination, and also PHA's capacity to respond to a measles outbreak given the concerning reports in England and PHA's experience with COVID. He noted that PHA now has a lead role in vaccination and has the Vaccine Management System (VMS) which can show where there is low uptake. He asked what engagement PHA is having with the Department and Trusts, and with other bodes, for example the Education Authority. Dr McClean replied that PHA is keeping the Department informed and is already planning an MMR "catch up" campaign. She added that he Department is supportive. With regard to the Education Authority, she advised that there is a meeting taking place today to continue preparation for a measles campaign, and there is a steering group, of which the Education Authority will be a part. She added that as part of the legacy of COVID, there are staff who can now step in and help out as required and also that PHA has developed a good relationship with Education.
6/24.18	Mr Stewart asked when a paper giving an update on the screening IT issues can be brought to the Board. Dr McClean replied that it would be the March meeting. Mr Stewart suggested that there should be a

meeting to discuss what should be in the paper. Dr McClean noted that it will be Mr Loughran, Mr McWilliams and Dr Owen who will be writing the paper **(Action 1 – Dr McClean)**.

6/24.19 Mr Stewart thanked Dr McClean for attending today's meeting.

6/24.20 Members noted the Public Health Directorate Risk Register.

Complaints Report [GAC/03/02/24]

6/24.21 Mr Wilson said that this report will be expanded into a "complaints and compliments report", but explained that a mechanism for capturing complaints is currently being looked at. He advised that this report is for the period from April until December 2023 and shows that PHA has received a low number of complaints during this time. He noted that there had been an increase in the number of complaints during the pandemic.

6/24.22 Mr Wilson explained that the report details KPIs which have been introduced as PHA seeks to improve its complaints process. He went through the tables in the report giving an overview of closed complaints, an update on open complaints and details regarding complaints which are with the Ombudsman.

6/24.23 Ms Mann-Kler said that she was interested to read the nature of the complaints as they are useful for learning. She added that it would be useful for Board members to see an example of a complaint and how it was responded to as the tone of responses is important. Mr Wilson agreed to follow up on this **(Action 2 – Mr Wilson)**.

6/24.24 Mr Clayton asked about PHA's role in terms of the complaint which related to cervical screening and if it would be possible to get more information. Mr Wilson noted that there was learning for PHA **(Action 3 – Mr Wilson).**

6/24.25 Members noted the Complaints Report.

Update on Use of Direct Award Contracts [GAC/04/02/24]

6/24.26 Mr Wilson reported that between April and December 2023, 48 Direct Award Contracts (DACs) were signed off by the Chief Executive. He added that the Chief Executive wishes to see this number curtailed as much as possible. He explained that the high number is in part due to a number of DACs where contracts have been extended in the area of Drugs and Alcohol following a request by the Department. He added that as the current Drugs and Alcohol Strategy is being reviewed, it was felt to hold off until the new Strategy was in place.

6/24.27 Mr Wilson advised that the contract for the R&D Grant Management System has now ceased due to a number of issues.

6/24.28 Mr Stewart asked about the DAC relating to community development capacity which is rated "red" and if all the funding is going to one organisation. Mr Murray explained that this is a Transformation programme with services commissioned through the Community Development Health Network (CDHN) and is a rolling contract. Mr Stewart asked if the amount of funding is one year, but Mr Murray advised that it is for 18 months. Mr Stewart asked it is judged if the initiative is a success, and Mr Murray replied that PHA will have contact management arrangements in place, but his understanding is that it has been a very successful programme.

6/24.29 Mr Stewart asked if the Department is aware of the number of DACs that PHA has in the area of drugs and alcohol. Mr Wilson reiterated has worked closely with the Department and it is aware of the situation.

6/24.30 Members noted the updated on Direct Award Contracts.

7/24 Item 7 – Internal Audit

Internal Audit Progress Report [GAC/05/02/24]

7/24.1 Mr Charles advised that he was presenting the reports of 3 audits at today's meeting which means that the only report to be completed this year is the end of year follow up and as indicated earlier there were audit clinics held to look at the outstanding recommendations.

7/24.2 Mr Charles reported that following an audit of Information Governance, a satisfactory level of assurance has been given with no significant findings and 4 key findings which related to contracts being GDPR compliant, information governance training, Information Asset Registers and strengthening the process for carrying out file audits. He advised that there were 5 Priority 2 recommendations and 3 Priority 3 recommendations, and all of these have been accepted by management.

7/24.3 Mr Clayton noted that there was discussion on this at the Information Governance Steering Group (IGSG). He said that it was helpful to see the timeline that had been developed for completing the work on getting contracts GDPR compliant with those deemed low risk completed by 31 July 2024 and those deemed higher risk by 31 December 2024. He queried whether it is the case that the lower risk legacy contracts would be simpler because the higher risk ones may require input from Legal and Procurement. Mr Murray said that would be his assessment and added that the higher risk ones are being reviewed at present.

7/24.4 Mr Clayton said that the issue of training had been discussed at both this Committee and at the Board and that it will be difficult to change the rating on the target relating to training from "red" until the proposed "induction day" is in place. He asked if there has been any engagement with HR regarding this and Mr Murray replied that there has been a

discussion with Ms Karyn Patterson and it is hoped to have a paper on this by the end of March. He noted that there are issues about this can be introduced from a practical point of view. Mr Clayton advised that in other HSC bodies, it is not possible to take up employment until all of the training is completed.

7/24.5 Mr Charles moved on to the second audit report which related to an audit of business continuity and advised that a limited level of assurance was being given based on 3 significant findings. He said that the focus of the audit was whether PHA would be able to respond to a cyber attack.

7/24.6 Mr Charles advised that the first significant finding related to the fact that while PHA has a corporate Business Continuity Plan (BCP), there are not directorate plans in place. He added that the overall Plan is largely unchanged since 2011 and no Business Impact Assessments have been reviewed since then. He explained that there needs to be more consideration of the impact of cyber attack scenarios.

7/24.7 Mr Charles said that the second significant finding relates to the Business Continuity Forum, which was set up in 2011, but has no terms of reference. In terms of the third significant finding, he explained that while BSO ITS is referenced as the main external stakeholder for PHA's response to a cyber attack, there needs to be more detail about what that response would look like.

7/24.8 Mr Charles advised that there were two key findings from the audit, the first of which was that no desktop exercise of PHA's BCP was carried out between 2019 and 2023, but he acknowledged that PHA was responding to the pandemic. However, he noted that for the last exercise in 2023, only 6 staff participated and not all directorates were represented. He said that the second key finding was that there has been no training needs analysis undertaken for PHA staff.

7/24.9 Mr Charles said while he appreciated that PHA has less patient-facing impact, this audit was about how PHA ensures that its corporate objectives are achieved if there is a loss of IT or telephony services. Mr Stewart sought clarity that the focus was therefore on a cyber attack. Mr Charles replied that the audit the robustness of the Business Continuity Plan to meet corporate objectives in the event of a loss of e-mail or telephone and it was felt that the Plan is not detailed enough and requires more work. He clarified that it was not a technical IT audit, but more around what local managers would do in the event that particular systems were down. He said that the question was around if there is enough familiarity with the Plan.

7/24.10 Mr Stewart explained that he raised this point because while he felt mostly on board with previous audits, this one did not look at process. He advised that he was present in the office on one occasion when the Plan had to be activated and it was done so swiftly and efficiently and he

asked whether the audit looked at instances when the Plan was activated to see if there were any gaps in process. Mr Charles said that the audit looked at the formality of the process and whether key stakeholders knew how to respond. Mr Stewart asked if staff were questioned and Mr Charles replied that as part of the testing some staff were spoken to from that he felt that while managers could work through the Plan, it was not sufficiently robust.

7/24.11 Mr Charles advised that there were detailed discussions with management around this audit. He said that the organisation has corporate objectives and it needs to have a mechanism to deliver on them. He added that management have accepted the recommendations. He noted that this was a new audit area for Internal Audit.

7/24.12 Mr Clayton said that he could understand why there is a need to have directorate plans in the event of a BCP incident. Mr Charles commented that within Internal Audit there were discussions around this, and it was considered from the perspective of "likelihood versus impact", with the view that if the likelihood is high, there needs to be robust formal arrangements.

At this point Mr Irvine left the meeting.

7/24.13 Mr Wilson advised that PHA was disappointed to receive this limited level of assurance given there were no Priority 1 recommendations. However, he said that PHA is looking to address the findings and get the directorate plans in place. He added that he wished to assure members that PHA's current arrangements are fit for purpose.

7/24.14 Mr Charles advised that the third audit report related to a Financial Review. He outlined the scope of the assignment and reported that a satisfactory level of assurance was being given with no significant findings and 4 key findings.

7/24.15 Mr Charles said that the first key finding related to business cases and the need for there to be a business case in advance for any new contracts or contract extensions, in line with the new DoH Circular. In 9 instances, he reported that the business case had not been reviewed by Finance or Operations. He advised that the second key finding related to agency staff, the third related to suppliers who did not have contracts in place with PHA, and the final one related to payments to staff. He said that there were 6 Priority 2 findings and 3 Priority 3 findings and that management have accepted all of the recommendations.

7/24.16 Ms Mann-Kler noted that some of the findings related to SBNI and she expressed concern that there could be other ongoing issues. Mr Charles advised that because External Audit had identified issues in SBNI last year, there was an increased focus on SBNI in the sample audit. He suggested that it was helpful for PHA that there was more

testing in SBNI.

At this point Ms McCaig joined the meeting.

7/24.17 Mr Clayton noted that the sample size was not large. Mr Charles advised that Internal Audit would normally look at off-contract expenditure as HSC as a whole has a lot of off-contract agency staff, therefore there is more risk, but in this audit nothing major was found. He added that the recommendations would strengthen the mitigations against any risks.

7/24.18 Members noted the Internal Audit Progress Report.

Internal Audit Strategy incorporating the Internal Audit Plan 2023/24 to 2025/26 [GAC/06/02/24]

7/24.19 Mr Charles advised that PHA is moving into the second year of a 3-year Plan. Following a review of the Corporate Risk Register to prioritise audit areas, he said that meetings took place with senior managers and the Committee Chair to finalise this Plan.

7/24.20 Mr Charles said that there will be a Financial Review as well as an audit of vaccination systems. He noted that there has not been a review of PPI for many years, and that it will also be timely to carry out a follow up review of Board Effectiveness. He added that once the governance arrangements around finance change, there will be a review of governance and assurance. He advised that there will be an audit of the management of contracts that PHA has with Trusts and that this is an area that has not been audited previously. He explained that it will be a big audit as it will look at the arrangements that are in place to ensure that PHA is receiving the services it has commissioned and if not, what escalation arrangements are in place. He said that included within the Plan are days for management time and contingency. He advised that Committee approval is sought for the Plan.

7/24.21 Mr Stewart advised that he had spoken to Mrs Catherine McKeown and it was agreed that it would be useful to defer a planned audit of screening given there is work being carried out in this area. He added that he has asked that the audit of vaccinations looks at procurement, value for money and systems. He said that an audit of the performance management arrangements with Trusts would have the support of all Non-Executive Directors as this is an area of interest to them.

7/24.22 Ms Mann-Kler agreed with the rationale for deferring the audit on screening, but asked whether 20 days was sufficient for the performance management audit, and whether some of the days allocated to PPI should be transferred. She said that it is important that this audit is done properly given Trust spend is a significant part of PHA's budget. Ms McCaig agreed that there has not been significant time spent on this area so it would be useful to allocate more days.

7/24.23 Mr Stewart suggested that the performance management audit may have to be undertaken in small sections. Mr Charles said that a specific area of service delivery could be chosen. He suggested that the 8 days for the PPI audit could be used, or there is the 8 days which are for contingency. Ms Mann-Kler said that it would be useful to bring a terms of reference for that audit back to the Committee. She added that there needs to be a correlation between this audit and an area where PHA spend most of its funding on. Mr Stewart noted that the biggest area of spend is screening.

7/24.24 Mr Clayton noted that the Board receives an Annual Report on PPI and queried what a review of PPI arrangements would look like.

7/24.25 Mr Stewart proposed that the number of days for the performance management audit is increased to 8 and that the Agency Management Team (AMT) considers what an audit of PPI would look like.

7/24.26 Subject to those amendments, members **APPROVED** the Internal Audit Strategy.

8/24 Item 8 – Information Governance

Information Governance Action Plan 2023/24 Update [GAC/07/02/24]

8/24.1 Mr Murray advised that this update was recently covered by the Information Governance Steering Group (IGSG) and that there has already been discussion at today's meeting around the issues of new starts and induction. He noted that new starts can find it difficult to get access onto the systems and this needs to be looked at. He said that this is due to managers not being prepared before staff start, or a delay in IT getting the set up completed.

8/24.2 Mr Murray noted that many of the other actions in the update are rated "amber" or "green". He advised that there has been an significant increase in the number of staff completing training as messages around mandatory training are being pushed out to staff. He noted that the other action which is rated "red" is around Information Asset Registers. He explained that the recommendation for 2021/22 has been addressed but some returns for 2022/23 have not yet been received and these had been due at the end of December.

8/24.3 Mr Clayton said that there was a target around the IGSG reviewing Data Privacy Impact Assessments (DPIAs) as part of health protection projects, and there had been a particular issue around capacity with a view to getting some external support. He added that IGSG members had wanted the issue of capacity to be highlighted to the Board. Mr Wilson advised that a mix of approaches is being looked at with a view to growing internal capacity, but he acknowledged that there are issues.

8/24.4 Members noted the update on the Information Governance Action Plan.

At this point Mr Clayton left the meeting.

9/24 **Item 9 – External Audit**

Report to those Charged with Governance (Final) [GAC/08/02/24]

9/24.1 Mr McCance advised that this was the final version of the Report to those Charged with Governance which members have already seen.

9/24.2 Members noted the Report to those Charged with Governance.

External Audit Strategy [GAC/09/02/24]

9/24.3 Mr McCance said that the Audit Strategy for 2023/24 has been prepared. He reminded members that this work is sub-contracted by the Northern Ireland Audit Office (NIAO) and that Cavanagh Kelly will be undertaking this work. He invited Mr Ryan Falls to present the Strategy.

9/24.4 Mr Falls advised that Cavanagh Kelly has previously worked with NIAO and there is no significant change to the Strategy based on that of previous years. He thanked Ms Crockett for her help to date.

9/24.5 Mr Falls highlighted the key messages for the Committee and explained that the level of materiality is similar to that of previous years. He advised that one risk has been identified, and that relates to management override of controls. He added that a risk around fraud has been rebutted. He outlined the proposed timetable for the audit which is draft and also the membership of the audit team.

9/24.6 Mr Stewart asked why the override of management controls has been included, but he noted that this is included for all organisations. He added that the Committee is not aware of any material misstatements.

9/24.7 Members noted the External Audit Strategy.

10/24 **Item 10 – Joint PHA/SPPG/BSO Annual Report on Emergency Preparedness 2022/2023 [GAC/10/02/24]**

At this point Ms Mary Carey joined the meeting

10/24.1 Ms Carey advised that this Report is being presented retrospectively as it was due to be submitted to the Department in November. She said that there had been a delay in finalising the report, but that the report the standard template and is set out against a series of themes.

10/24.2 Ms Carey outlined that one of the key issues identified relates to the capacity of the Northern Ireland Ambulance Service (NIAS) to carry out specialised training, but she advised that following discussions with the Department some funding has been provided. Mr Stewart asked who delivers the training, and if this is NIAS or another organisation on its

behalf. Ms Carey advised that it is arranged through the National Ambulance Service which is linking with the Department of Health.

10/24.3 Ms Carey reported that the regional emergency planning training budget of £30k will not be increased and therefore Trusts will have to carry out their own training needs analysis, find additional funding for training and contribute to a 3-year rolling programme. She said that further discussions are required around that.

10/24.4 Mr Stewart expressed concern about the multiplicity of groups and organisations focused on emergency planning which he said appears to be resource intensive thus making it difficult for people to support them. He suggested that there should be more joined up thinking. Ms Carey said that, within health, there is a streamlined approach and there is an Emergency Planning Forum which meets on an annual basis. She acknowledged that there is a challenge in terms of the number of multi-agency meetings, but said that PHA has no control over that. She added that this is going to be reviewed and she, along with Dr McClean and Ms Lisa McWilliams will be attending a meeting to look at this. Mr Stewart asked if there is an overarching forum set up through the Executive Office and could all the different groups not be corralled through that Office and this would be in the interests of all parties. Ms Carey replied that there is the Civil Contingencies Framework which is used for incidents such as strikes or severe weather, and there is a clear process for when matters need to be dealt with at a strategic level, albeit it may need refined.

10/24.5 Mr Wilson commented that in terms of the training budget, there were queries about the level of training available as part of Module 1 of the COVID Inquiry.

10/24.6 Members noted the Joint PHA/SPPG/BSO Annual Report on Emergency Preparedness 2022/2023.

11/24 Item 11 – Any Other Business

11/24.1 Ms Devine delivered a presentation giving an update to members on the migration of the Finance team from SPPG to PHA. She explained that once the new PHA Director of Finance, Ms Leah Scott, takes up post, there are a number of specific tasks that SPPG will continue to assist with, and an MOU will be developed for this. She gave an overview of the proposed team structure and explained that staff who wish to move across will do so from 1 April and where there are vacancies, some of these posts are currently out for recruitment. She outlined what will happen over the months of March and April and the areas that will be covered by the MOU.

11/24.2 Ms McCaig advised that she would be content to have a separate meeting to discuss the transfer. She advised that when Ms Scott takes up post, there are some elements of work that will move across

immediately, but for others the two organisations will work together to ensure a successful transition.

11/24.3 Mr Stewart said that it was clear that there was a very methodical process in place and he was confident about the handover. He expressed his thanks, on behalf of the Committee, to Ms McCaig for her support and said that it has been a pleasure to work with her. Ms McCaig thanked Mr Stewart for his words and said that she has enjoyed working with PHA and has not yet had the opportunity to reflect what it will mean for her personally when the transition is complete.

12/24 Item 12 – Details of Next Meeting

Monday 15 April 2024 at 10am

Fifth Floor Meeting Room

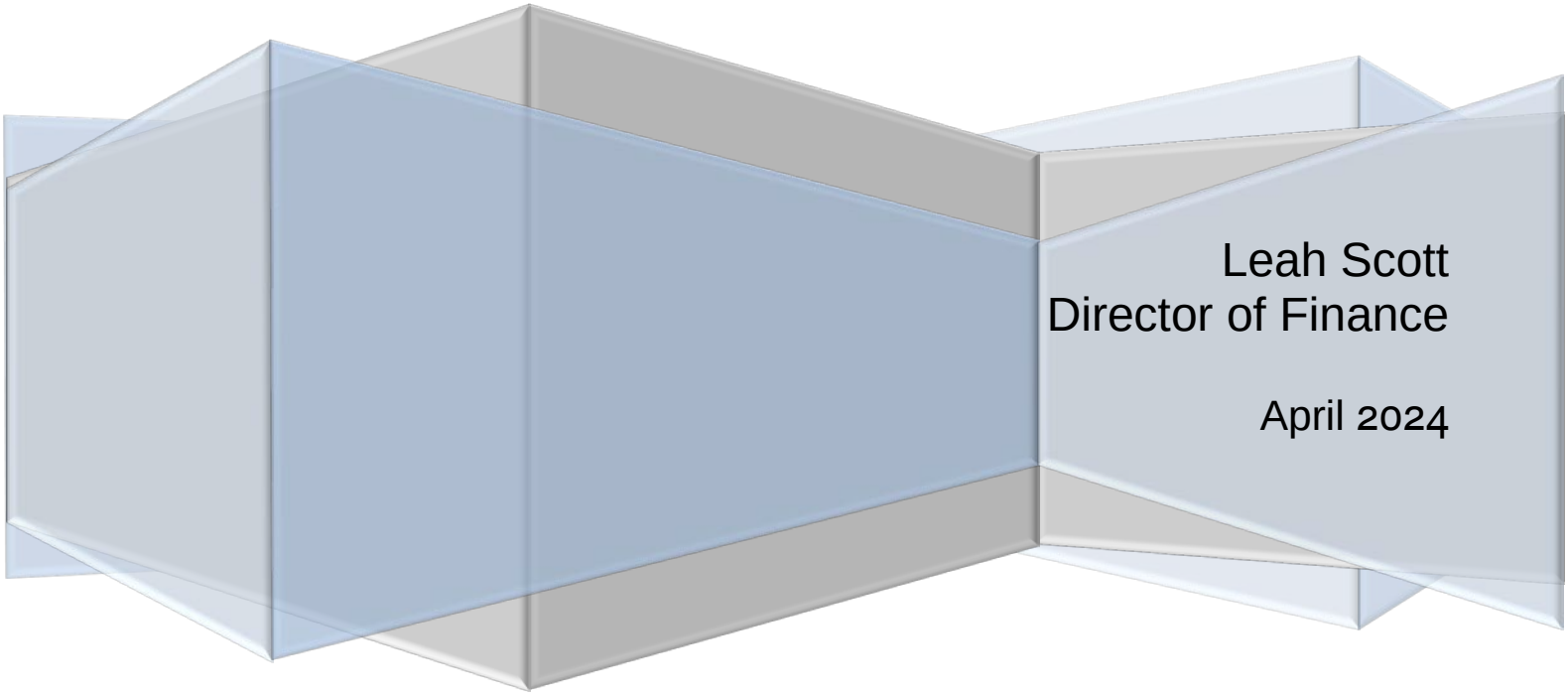
12/22 Linenhall Street, Belfast, BT2 8BS

Signed by Chair:

Joseph Stewart

Date: 15 April 2024

Finance Report
February 2024



Leah Scott
Director of Finance

April 2024

Section A: Introduction/Background

1. The PHA Financial Plan for 2023/24 has set out the funds notified as available, risks and uncertainties for the financial year and summarised the opening budgets against the high level reporting areas. It also outlined how the PHA would manage the overall funding available, in the context of cash releasing savings targets applied to the organisation. It received formal approval by the PHA Board in the June 2023 meeting.

2. The Financial Plan detailed the quantum of cash releasing savings targets (£5.3m, plus an additional £3.2m in respect of the area of Research and Development), the plans in place in year to address the target applied and the resultant opening forecast deficit of £0.65m. A focus on reducing and closing this gap is continuing as plans are required to meet the target both in-year and recurrently.

3. This executive summary report reflects the draft year-end position as at the end of February 2024 (month 11). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

4. The Financial Plan indicated an opening position for the Agency of a £650k deficit for the year. This is summarised in Table 1.

Table 1: Opening financial position 2023/24

	R&D £m	Other £m	Total £m
Savings targets applied	3.20[1]	5.30	8.50
Actions (2023/24):			
R&D budget reduced pending DoH decision on expenditure (UK wider NIHR)[1]	3.20[1]		3.20
Programme: budget / expenditure reductions		3.60	3.60
Management & Administration: anticipated net slippage		1.10	1.10
Subtotal deficit	**-**	**0.60**	**0.60**
HSCQI budget provision (unfunded pressure)		0.05	0.05
Opening deficit position	**-**	**0.65**	**0.65**

[1] Assumes funding in respect of R&D will be provided in line with DoH decision.

5. The PHA has reported a surplus position of £0.3m at February 2024 (January 2024, surplus of £0.8m) against the year to date budget position for 2023/24. The forecast year-end position is reported as breakeven (December 2023 forecast, breakeven).

6. The month 11 position is summarised in Table 2 below.

Table 2: PHA Summary Financial Position – February 2024

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Projected year end surplus / (deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	13,442	12,322	12,322	0	
Health Protection	9,757	8,944	8,944	0	
Service Development & Screening	14,979	13,731	13,731	0	
Nursing & AHP	8,000	7,333	7,333	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	24	22	22	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**46,202**	**42,352**	**42,352**	**0**	**0**
Health Improvement	29,613	26,859	27,347	(488)	
Health Protection	16,765	16,339	16,790	(450)	
Service Development & Screening	3,632	2,503	2,360	143	
Research & Development	3,282	3,210	3,210	(0)	
Campaigns	394	389	393	(4)	
Nursing & AHP	784	541	333	208	
Quality Improvement	143	82	66	16	
Other	(1,309)	(1,191)	(322)	(869)	
Programme expenditure - PHA	**53,305**	**48,733**	**50,202**	**(1,469)**	**(1,945)**
Subtotal Programme expenditure	**99,507**	**91,085**	**92,554**	**(1,469)**	**(1,945)**
Public Health	16,749	15,269	14,340	929	
Nursing & AHP	5,197	4,760	4,369	391	
Operations	5,368	4,919	4,783	136	
Quality Improvement	717	648	594	54	
PHA Board	456	350	255	95	
Centre for Connected Health	468	427	380	46	
SBNI	840	762	684	78	
Subtotal Management & Admin	**29,795**	**27,136**	**25,406**	**1,729**	**1,945**
Trusts	272	200	200	0	
PHA Direct	0	0	0	0	
Subtotal Transformation	**272**	**200**	**200**	**0**	**0**
Trusts	167	0	0	0	
PHA Direct	4,889	3,132	3,133	(1)	
Other ringfenced	**5,056**	**3,132**	**3,133**	**(1)**	**0**
TOTAL	**134,629**	**121,553**	**121,294**	**259**	**0**

Note: Table may be subject to minor roundings

7. In respect of the reported position:

   - **Programme – Trusts**: A total of £46.2m has been allocated to Trusts at this point, with full spend against budget shown.

   - **Programme – PHA**: The remaining annual programme budget is currently £53.3m.

- A cumulative overspend of £1.7m is shown to date (month 10, £0.9m) against the Programme budgets listed. This reflects some areas of spend ahead of current budget.
- In line with the Financial Plan, the anticipated overspend for the year is c£1.9m with the overspend being met in 2023/24 by a forecast underspend in Administration budgets. A mid-year review of the financial plan reported that £4.1m of recurrent budget reductions have been identified in year. Work is ongoing to fully identify the remaining savings measures to meet the full financial target applied to PHA in 2023/24 recurrently, pending the out-workings of refreshed Directorate structures and any resultant impacts on baselines.
- Savings plans will continue to be closely monitored throughout the year and will be regularly reported to the AMT and PPR Committee.

- **Management & Administration**: Annual budget of £29.8m.
  - An underspend of £1.7m is reported to date (month 10, £1.7m), reflecting underspends in Public Health, Nursing & AHPs and Operations. The primary surplus to date relates to the area of Public Health where staff costs have reduced due to role vacancies. Expenditure against funded budgets are reviewed with Directorate budget holders to understand any ongoing trends and incorporate these into the year-end forecast position.
  - The forecast full year underspend is £1.9m (month 10, £2.1m). The level of anticipated underspend will be subject to further refinement based on ongoing updates from Directorate budget managers and the review of assumptions made in the Financial plan in respect of anticipated cost pressures. Information has been received on the reduction of senior medical posts, however some assumptions have been made regarding the timing of the replacement or recruitment of these posts, which may have to be updated to increase expenditure forecasts if necessary.
  - The anticipated underspend will offset, in-year, cash releasing savings applied fully to Programme budgets. The favourable movement has

therefore enabled a reduction in the Agency's forecast deficit to report breakeven.

- **Ringfenced**: There is annual budget of c£5.1m in ringfenced budgets, the largest element of which relates to a Covid funding allocation for the Vaccine Management System (£2.7m), along with other funding allocations such as Safe Staffing (£0.3m) and Suicide Prevention (£0.3m) and smaller allocations for NI Protocol and for SBNI. A breakeven position is assumed against these budgets for the year, however they will be closely monitored for any risk to breakeven.

8. As noted above, the projected year end position is breakeven (month 10, breakeven) and work will continue to identify measures to maintain this breakeven position.

Section C: Risks

9. The following significant assumptions, risks or uncertainties facing the organisation were outlined in the Financial Plan.

10. **Recurrent impact of savings made non-recurrently in-year**: The opening allocation letter has indicated that, whilst 2023/24 savings measures may be non-recurrent in nature, the funding reductions are recurrent and therefore PHA is expected to work to ensure savings are made recurrently going forward into 2024/25 where necessary. While PHA has identified a significant element of the £5.3m savings target applied, there remain challenges in delivering the full requirement recurrently. PHA colleagues have identified savings / budget reductions for £4.1m recurrently in-year following a mid-year review and are continuing to work on developing savings proposals to address the remaining gap pending costing of refreshed Directorate structures and any resulting impacts on baseline. Savings targets will continue to be monitored throughout the year with the identification of further recurrent savings plans finalised for 2024/25.

11. **EY Reshape & Refresh review and Management and Administration budgets**: The PHA is currently undergoing a significant review of its structures and processes,

and the final report from EY will not be available until later in the year. There is a risk in implementing the outcomes of this review in a savings context, and careful management will be required at all stages of this process. In addition, there have been a number of material vacancies which are generating slippage and for which Directors are reviewing options for the remainder of the year.

12. **SEUPB / CHITIN income**: PHA receives income from EU partner organisations for the CHITIN R&D project. Claims are made on a quarterly basis, however PHA have not been receiving payments on a regular basis. At 31 March 2023, the value of funding due was c£4.3m however, PHA had an equal and opposite creditor listed for monies due to other organisations. Since year end a total of now c£2.6m has been received. R&D staff are continuing to work closely with colleagues in partner organisations and the relevant funding body to ensure the expected full reimbursement of all claims.

13. **Demand led services:** There are a number of demand led budgetary areas which are more difficult to predict funding requirements for, presenting challenges for the financial management of the Agency's budget. For example, smoking cessation / Nicotine Replacement Therapy (NRT) and Vaccines. The financial position of these budgets are being carefully tracked. Previous receipt of some information on Shingles vaccine showed a potential stock carry-forward level in the VMS system – further investigation has confirmed that these inventory levels are expected to reduce by year end as GPs have increased ordering and therefore no substantial slippage is now expected for this budget.

14. **Annual Leave:** PHA staff are still carrying a significant amount of annual leave, due to the demands of responding to the Covid-19 pandemic over the last two years. This balance of leave is being managed to a more normal level, and the assumption that this is expected to be at pre-pandemic levels by the end of 2023/24 has been included in financial planning and is kept under close review.

15. **Funding not yet allocated**: At the start of the financial year there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include Pay awards for the 2023/24 financial year which is expected in M12. No

expenditure will be progressed for any pay award payments to staff until such pay awards are approved by DoH and funding identified and secured.

16. Due to the complex nature of Health & Social Care, there will undoubtedly be further challenges with financial impacts which will be presented going forward into the future. PHA will continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

17. The PHA has a capital allocation (CRL) of £5.6m. This all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at February 2024, is reflected in Table 3, being a forecast breakeven position on capital funding.

18. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

19. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. Further information on delays experienced in the reimbursement of costs is provided in Section C, above.

Table 3: PHA Summary capital position – February 2024

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	4,000	3,096	4,000	0
R&D - Trusts	0	0	0	0
R&D - Capital Receipts	(369)	(163)	(369)	0
R&D - Other	456	445	456	0
Subtotal HSC R&D	**4,087**	**3,378**	**4,087**	**0**
CHITIN Project:				
CHITIN - Other Bodies	181	0	181	0
CHITIN - Trusts	0	0	0	0
CHITIN - Capital Receipts	(181)	0	(181)	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	363	170	363	0
iReach Project	405	0	405	0
R&D - NICOLA	731	0	731	0
ICT - VMS	51	0	51	0
Subtotal Other	**1,550**	**170**	**1,550**	**0**
Total PHA Capital position	**5,637**	**3,548**	**5,637**	**0**

20. PHA has also received four other smaller capital allocations for the Congenital Heart Disease (CHD) Network (£0.4m), iReach Project (£0.4m), NICOLA (£0.7m) and ICT VMS (£0.1m). With the exception of the ICT VMS these allocation are managed through the PHA R&D team.

21. The capital position will continue to be kept under close review throughout the financial year.

Recommendation

22. The PHA Board are asked to note the PHA financial update as at February 2024.

Public Health Agency

Annex 1 - Finance Report

2023/24

Month 11 - February 2024

PHA Financial Report - Executive Summary

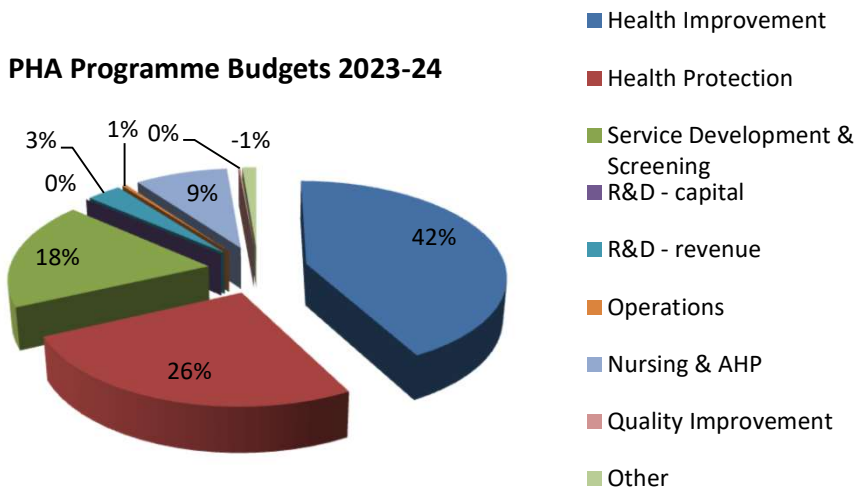
Year to Date Financial Position (page 2)

At the end of month 11, PHA is reporting an underspend of £0.3m against its profiled budget. This position is a result of PHA Direct programme budgets projected overspend for the financial year offset by underspends within Adminstration budgets (page 6).

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

Programme Budgets (pages 3&4)

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

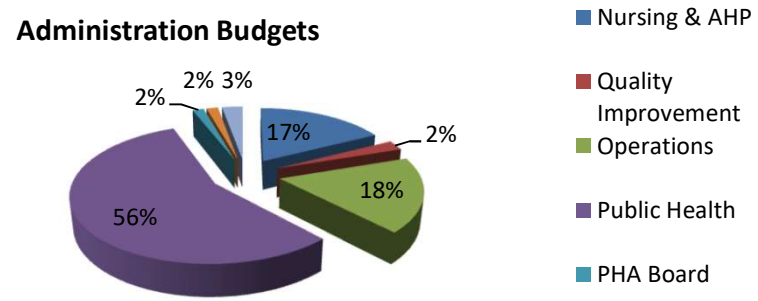


Administration Budgets (page 5)

The breakdown of the Administration budget by Directorate is shown in the chart below. Over half of the budget relates to the Directorate of Public Health.

A number of vacant posts remain within PHA, and this is creating slippage on the Administration budget which is offset by expenditure on the PHA Reshape and Refresh programme and other pressures noted in the Financial Plan.

Management will review the need for the recruitment of vacant posts to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year.

This reflects the continued requirement to fully identify savings measures to meet the full cash releasing savings funding reductions applied to PHA in 2023/24.

Public Health Agency
2023/24 Summary Position - February 2024

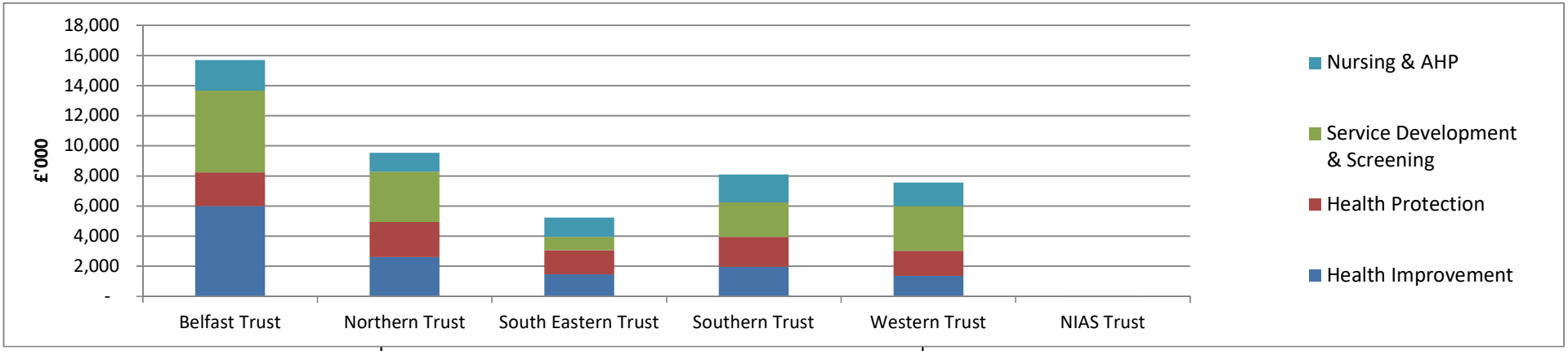
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	46,202	53,259	5,328	29,002	**133,789**	42,352	48,680	3,332	26,448	**120,813**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	46	-	794	**840**	-	53	-	687	**740**
Total Available Resources	46,202	53,304	5,328	29,796	**134,629**	42,352	48,733	3,332	27,136	**121,553**
Expenditure										
Trusts	46,202	-	379	-	**46,581**	42,352	-	367	-	**42,719**
PHA Direct Programme *	-	55,249	4,949	-	**60,198**	-	50,202	2,966	-	**53,168**
PHA Administration	-	-	-	27,850	**27,850**	-	-		25,406	**25,406**
Total Proposed Budgets	46,202	55,249	5,328	27,850	**134,629**	42,352	50,202	3,333	25,406	**121,294**
Surplus/(Deficit) - Revenue	-	(1,945)	-	1,945	**-**	-	(1,469)	(1)	1,729	**259**
Cumulative variance (%)						***0.00%***	***-3.01%***	***-0.03%***	***6.37%***	***0.21%***

Please note that a number of minor rounding's may appear throughout this report.
** PHA Direct Programme may include amounts which transfer to Trusts later in the year*

The year to date financial position for the PHA shows an underspend £0.3m, which is a result of an underspend on Management & Admin budgets being partially offset by a managed overspend on PHA Direct Programme expenditure.

The PHA is forecasting a breakeven position at year end, which includes the full absorption of the projected Management & Admin underspend.

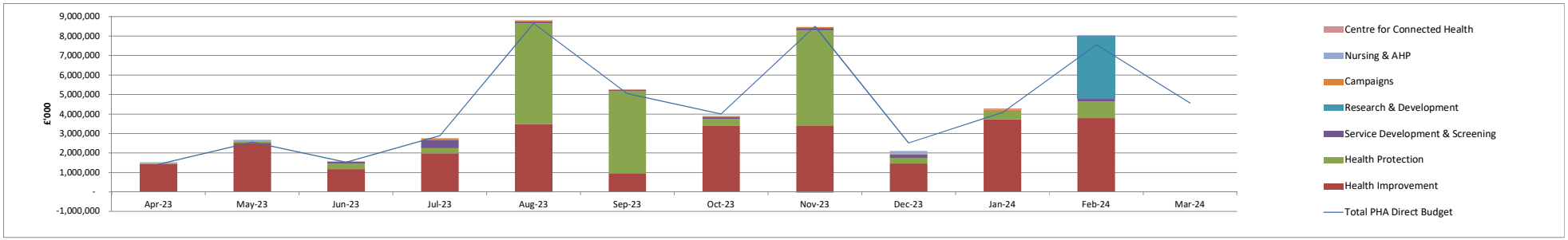
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,996	2,618	1,473	1,976	1,355	24	**13,442**	12,322	12,322	-
Health Protection	2,241	2,309	1,584	1,956	1,667	-	**9,757**	8,944	8,944	-
Service Development & Screening	5,430	3,356	896	2,311	2,985	-	**14,979**	13,731	13,731	-
Nursing & AHP	2,019	1,260	1,281	1,855	1,557	29	**8,000**	7,333	7,333	-
Quality Improvement	24	-	-	-	-	-	**24**	22	22	-
Total current RRLs	**15,711**	**9,542**	**5,234**	**8,098**	**7,564**	**52**	**46,202**	**42,352**	**42,352**	-
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date.

PHA Direct Programme Expenditure



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	YTD Budget	YTD Spend	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Profiled Budget																	
Health Improvement	1,318	2,228	1,356	1,920	3,482	975	2,912	4,172	1,493	3,472	3,531	2,754	**29,613**	26,859	27,346	(487)	*-1.8%*
Health Protection	42	204	184	122	5,143	4,030	1,192	4,131	525	632	134	426	**16,765**	16,339	16,789	(449)	*-2.7%*
Service Development & Screening	29	73	219	493	93	105	412	371	380	- 83	410	1,128	**3,632**	2,503	2,360	143	*5.7%*
Research & Development	-	-	-	-	-	-	-	-	-	-	3,210	72	**3,282**	3,210	3,210	- 0	*0.0%*
Campaigns	1	1	9	90	18	28	10	122	60	26	27	5	**394**	389	393	(4)	*-1.0%*
Nursing & AHP	32	53	- 33	21	26	26	55	37	30	- 26	321	243	**784**	541	333	208	*38.4%*
Centre for Connected Health	-	-	-	-	-	-	-	-	0	-	-	-	**-**	-	24	(24)	*0.0%*
Quality Improvement	-	-	-	-	18	-	-	16	23	-	25	61	**143**	82	66	16	*19.5%*
Other	-	-	(212)	245	(122)	(123)	(581)	(351)	0	54	(100)	(118)	**(1,309)**	(1,191)	(322)	(869)	*100.0%*
Total PHA Direct Budget	**1,421**	**2,558**	**1,522**	**2,890**	**8,658**	**5,041**	**4,000**	**8,498**	**2,511**	**4,075**	**7,558**	**4,572**	**53,305**	**48,733**	**50,200**	**(1,467)**	
Cumulative variance (%)																***-3.01%***	
Actual Expenditure	**1,608**	**2,765**	**1,643**	**2,898**	**8,801**	**5,414**	**3,867**	**8,533**	**2,177**	**4,335**	**8,159**	**-**	**50,200**				
Variance	**(187)**	**(207)**	**(121)**	**(7)**	**(143)**	**(373)**	**133**	**(35)**	**334**	**(259)**	**(601)**		**(1,467)**				

The year-to-date position shows an overspend of approximately £1.5m against profile. A year-end overspend of c£1.9m is anticipated, and this is being managed closely in order to offset a forecast underspend in Administration budgets.
Whilst work has completed to identify £4.1m of budget reductions in-year, the remaining £1.2m has been identified from Managment & Administration budgets to meet the full financial target applied to PHA in 2023/24 and recurrently.

Public Health Agency
2023/24 Ringfenced Position

	Annual Budget				Year to Date			
	Covid	NDNA	Other ringfenced	Total	Covid	NDNA	Other ringfenced	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
DoH Allocation	4,248	272	807	**5,328**	2,379	200	753	**3,332**
Assumed Allocation/(Retraction)	-	-	-	-	-	-	-	**-**
Total	4,248	272	807	**5,328**	2,379	200	753	**3,332**
Expenditure								
Trusts	-	212	167	**379**	-	200	167	**367**
PHA Direct	4,248	60	640	**4,949**	2,380	-	587	**2,966**
Total	4,248	272	807	**5,328**	2,380	200	754	**3,333**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**(0)**	**-**	**(1)**	**(1)**

PHA has now received COVID allocation of £4.2m for financial year 2023/24. (£2.7m for Vaccine Management System, £0.3m for Vaccinators and Covid Vaccine Storage, and £1.2m for vaccinations)

Transformation funding has been received for a Suicide Prevention project totalling £0.3m. This project is being monitored and reported on separately to DoH, and a breakeven position is anticipated for the year.

Other ringfenced areas include Farm Families (£0.2m), Safe Staffing (£0.3m), NI Protocol (£0.1m) and funding for SBNI relating to EITP (£0.1m). A breakeven position for each of these areas is expected for the year.

PHA Administration

2023/24 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	5,010	705	4,242	16,507	343	418	589	**27,814**
Goods & Services	186	12	1,126	242	113	50	251	**1,980**
Total Budget	**5,197**	**717**	**5,368**	**16,749**	**456**	**468**	**840**	**29,795**
Budget profiled to date								
Salaries	4,584	637	3,887	15,062	315	386	540	**25,410**
Goods & Services	176	11	1,032	207	36	41	222	**1,725**
Total	**4,760**	**648**	**4,919**	**15,269**	**350**	**427**	**762**	**27,135**
Actual expenditure to date								
Salaries	4,159	589	3,028	13,416	280	329	535	**22,336**
Goods & Services	210	4	1,755	925	- 24	51	150	**3,070**
Total	**4,369**	**594**	**4,783**	**14,340**	**255**	**380**	**684**	**25,406**
Surplus/(Deficit) to date								
Salaries	425	48	859	1,646	35	56	5	**3,074**
Goods & Services	(34)	6	(723)	(717)	60	- 10	73	**(1,345)**
Surplus/(Deficit)	**391**	**54**	**136**	**929**	**95**	**46**	**78**	**1,729**
Cumulative variance (%)	*8.21%*	*8.31%*	*2.76%*	*6.08%*	*27.14%*	*10.83%*	*10.22%*	***6.37%***

PHA's administration budget is showing a year-to-date surplus of £1.7m, which is being generated by a number of vacancies, particularly within the Public Health Directorate. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year.

The full year surplus is currently forecast to be c£1.9m, and this is being managed by PHA through a managed deficit in Programme expenditure in the financial year.

As part of the Mid Year Review £1.2m has been offered up from the Administration budgets to meet the £5.3m 23/24 savings target.

PHA Prompt Payment

Prompt Payment Statistics

	February 2024 Value	February 2024 Volume	Cumulative position as at February 2024 Value	Cumulative position as at February 2024 Volume
Total bills paid (relating to Prompt Payment target)	£8,868,532	509	£73,492,754	4,803
Total bills paid on time (within 30 days or under other agreed terms)	£8,806,671	501	£63,822,729	4,618
Percentage of bills paid on time	**99.3%**	**98.4%**	**86.8%**	**96.1%**

Prompt Payment performance for February shows that PHA met its prompt payment target on volume and value during the month. The year to date position shows that on volume, PHA is achieving its 30 day target of 95.0% but failing to achieve the 95% target on value, due to two large vaccines invoices (approx. £8m) which missed the payment deadline earlier in the year. Prompt payment targets will continue to be monitored closely over the 2023/24 financial year.

The 10 day prompt payment performance remains very strong at 82.5% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2023/24 of 70%.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	18 April 2024
Title of paper	Complaints Report
Reference	PHA/03/04/24
Prepared by	Alastair Ross / Catherine Collins
Lead Director	Leah Scott
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to present the latest quarterly Complaints Report to the Board for noting.

2 Background Information

In May 2023, BSO Internal Audit carried out an audit of Complaints and Claims Management within the PHA.

Recommendation 2.1 of the Audit recommended that,

'Regular reporting on complaints should be presented at both Executive and Non-Executive level. This reporting should provide number and age of open and closed complaints; types of complaints; performance reporting against KPIs etc'

By way of implementation of this recommendation, the Agency now produces a quarterly internal Complaints Report. The attached report is the second of its kind covering the period 1 October 2023 - 31 December 2023.

This report was approved by the Agency Management Team at its meeting on 10 April 2024 and was brought to the Governance and Audit Committee on 15 April 2024.

3 Key Issues

Between 1st March 2023 and 31st March 2024, PHA received eight complaints. Seven of these complaints have been closed while one remains open. Further information is contained within the Report.

4 Next Steps

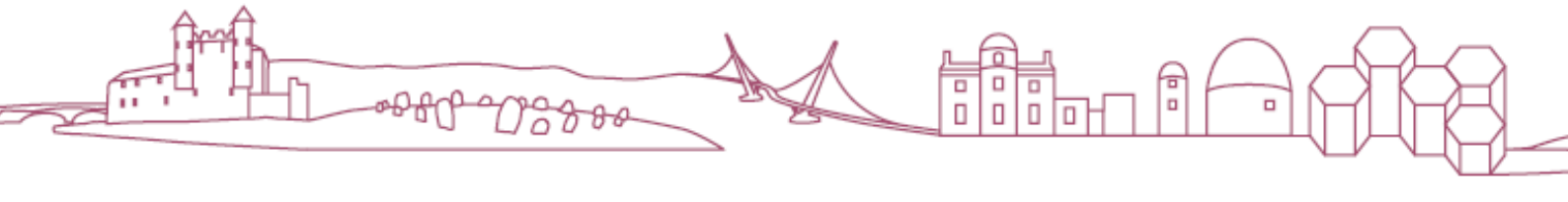
An annual Complaints Report will be prepared and brought to the Governance and Audit Committee and PHA Board.

2023/24

Quarterly Complaints Report

Position as at 31 March 2024

Report Prepared by PHA Complaints Office



1. Context

This report has been created as a mechanism to ensure that senior leaders within the PHA, at both Executive and Non-Executive level, receive regular and adequate information in respect of complaints made against the organisation.

2. Definition

In line with the guidance set out in the HSC Complaints Procedure, a complaint is '*an expression of dissatisfaction that requires a response*' in relation to the work undertaken by the PHA.

This is in contrast to the many general queries, public health concerns or complaints made against other organisations that make their way to the PHA - these being dealt with through alternate channels.

3. Key Performance Indicators

The management of complaints are monitored in line with the following key performance indicators (KPI):

1. A complaint should be acknowledged in writing within 2 working days of receipt;
2. A complaint should be responded to within 20 working days of receipt;
3. Where a full response within 20 days is not possible, a complainant should be updated every 20 working days on the progress of their complaint.

4. 2023/24 Overview

During the period, 1st April 2023 - 31 March 2024, the PHA received eight complaints*.

Table 1 Number of Complaints by month/quarter

	Q1			Q2			Q3			Q4			
	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	**23/24 TOTAL**
Complaints Received	1	1	1	2	0	0	1	0	0	0	1	1	**8**

*This number excludes two matters that were initially accepted as complaints but subsequently deemed not to be appropriate for consideration through the complaints process.

The following table sets out a breakdown of the number of complaints by Directorate during the period 1 April 2023 - 31 March 2024.

Table 2 Complaints by Directorate

	No of Complaints Received During 2023/24				
Responsible Directorate	Q1	Q2	Q3	Q4	**TOTAL**
Public Health	0	1	1	2	**4**
Nursing Midwifery & AHP	2	1	0	0	**3**
Operations	1	0	0	0	**1**
Quality Improvement	0	0	0	0	**0**
TOTAL	**3**	**2**	**1**	**2**	**8**

5. 2023/24 Closed Complaints

Seven of the eight complaints received during 2023/24 have been closed. The following tables provide information in respect of these closed complaints.

Table 3 Performance Against Key Performance Indicators for Closed Complaints

	KPI 1		**KPI 2**		**KPI 3**	
Number of Complaints Closed during 2023/24	Number of complaints acknowledged within 2 working days of receipt	Percentage of complaints acknowledged within 2 working days of receipt	Number of complaints responded to within 20 working days of receipt	Percentage of complaints responded to within 20 working days of receipt	Number of complainants updated every 20 days (where KPI 2 was not met)	Percentage of complainants updated every 20 days (where KPI 2 was not met)
7	6	86%	4	57%	1	33%

Table 4 Tenure of Closed Complaints

PHA Reference	Time taken to conclude Complaint (working days)
C05/2324	3
C02/2324	7
C03/2324	17
C07/2324	20
C04/2324	22
C01/2324	23
C06/2324	106
PHA AVERAGE	**28 Days**

Shortest To Longest

Table 5 Synopsis of Closed Complaints

PHA Ref	Responsible Directorate	Synopsis of Complaint and Response (listed with the most recently closed complaint to the top)
C07/2324	Public Health	Complaint - Dissatisfaction with the communication processes relating to the management of an Information Governance (IG) issue that had affected the complainant. Response - PHA to ensure that future correspondence in relation to IG issues (and wider concerns) include the details of a named contact within Agency.
C06/2324	Public Health	Complaint - Concern raised by complainant around the PHA response to an odour issue and the difficulties faced by the complainant contacting the PHA. Response - Clarification provided on the PHA's role in relation to the management of odours and the work undertaken by the Agency on the issue as described. Information also provided in respect of the Agency's updated complaint contact pathways.
C01/2324	Nursing Midwifery & AHP	Complaint - Ineligibility of complainant's son to receive a Covid-19 booster vaccination despite being able to arrange a vaccination appointment via the online booking platform. Response - Although the online platform had accepted the appointment, in line with JCVI advice, booster vaccinations were not available for young people as of March 2023.

C02/2324	Nursing Midwifery & AHP	Complaint - Accessibility of a Covid-19 vaccination clinic and difficulties experienced by Complainant contacting PHA in relation to this issue. Response - Complainant was contacted by a PHA service lead and arrangements were put in place for Complainant to receive required vaccination.
C03/2324	Operations	Complaint - Issues raised with the tone of PHA organ donation advertisements and perceived negativity towards individuals choosing to opt out. Response - PHA approach was based on audience feedback and was found to very clearly communicate the law change and the importance of informing others, so helping families to be certain of their loved one's decision.
C04/2324	Nursing Midwifery & AHP	Complaint - Difficulties faced by complainant trying to arrange a spring Covid-19 booster vaccination for her elderly mother. Response - Complainant was contacted by a PHA service lead and arrangements were put in place for her mother to receive required vaccination. Issue arose as the PHA did not receive any communication in relation to non-vaccination from the relevant GP Practice.
C05/2324	Public Health	Complaint - Timeliness of cervical screening results in which complainant had been waiting beyond the six-week period referred to within the invitation letter. Response - PHA to review and revise invitation letters to ensure they make clear to all those attending for screening that the wait for a result was expected to be longer.

6. 2023/24 Open Complaints

As at 31 March 2024, the PHA has one open complaint. Tables 6 and 7 provide further detail on this complaint.

Table 6 Synopsis of Open Complaints

PHA Ref	Responsible Directorate	Synopsis of Complaint and Current Position
C08/2324	Public Health	Complaint - Dissatisfaction with the approach taken by the PHA in relation to the management of an E Coli outbreak within a childcare setting. Position as at 31 March 2024 - A draft letter of response is under development within the Public Health Directorate.

Table 7 Performance Against Key Performance Indicators for Open Complaints

			KPI 1	KPI 2	KPI 3	
PHA Reference	Responsible Directorate	Date Received	Acknowledged within 2 working days of receipt	Responded to within 20 working days of receipt	Update Provided every 20 days	Duration of Complaint (working days)
C08/2324	Public Health	24/03/2024	Yes	Period not yet lapsed	n/a	4 (as at 31/03/2024)

7. Northern Ireland Public Services Ombudsman

Upon the completion of the PHA complaints process, each complainant is signposted to the Ombudsman should they be dissatisfied with the outcome they have received.

As at 31 March 2024, the Ombudsman is investigating one complaint in respect of the PHA. Table 8 provides further detail on this complaint.

Table 8 PHA Complaints with Ombudsman

PHA Ref	PHA Internal Record	NIPSO Position
O01/2324	Complaint - Received November 2022 - Perceived conduct of PHA staff member during a discussion with a service user regarding their experience of a training programme. Response - January 2023 - PHA staff member had acted compassionately and empathetically	This complaint remains under assessment by NIPSO

PHA Complaints Office
complaints.pha@hscni.net

END

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	18 April 2024
Title of paper	Substance Use Strategic Commissioning and Implementation Plan – Consultation Response
Reference	PHA/04/04/24
Prepared by	Stephen Murray / Kevin Bailey
Lead Director	Stephen Wilson / Joanne McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

The HSC Strategic Commissioning and Implementation Plan (the Plan) 2023-2027 has been developed as a direct response to recommendations made within the DOH Substance Use Strategy *'Making Life Better; Preventing Harm, Empowering Recovery'* 2021 (SUS).

The draft plan has previously been reviewed by AMT (May 2023), PPR Committee June 2023) and PHA Board (August 2023) prior to the commencement of a 12-week public consultation, which took place 1 September – 24 November 2024.

The attached paper; *Summary of responses to the public consultation on the substance use strategic commissioning and implementation plan* outlines the key findings from the public consultation.

34 online responses were received to the consultation via the Citizen Space portal, 20 responding on behalf of an organisation and 14 from members of the public. An additional 4 responses were submitted by mail on behalf of organisations.

Respondents were asked to indicate their level of agreement with the Plan including the proposed Strategic Priorities, actions and timescales.

Most of the 34 responses received online were strongly in favour of the Strategic Priorities and proposed Commissioning Actions, with a significant majority of respondents either agreeing or strongly agreeing with the priorities identified and the actions prioritised.

Based on feedback the substance use strategy core team (PHA/ SPPG /Doh Policy staff) are sense checking the plan for alignment to the SUS ensuring clarity on key elements of the plan including:

- Our commissioning intentions
- How we will fund services
- How we will implement our priorities
- Our timescales for implementation

Key feedback highlights, implications and considerations

A number of comments were received by community and voluntary sector services, many of whom PHA currently commission to deliver substance use services, requesting further clarity on PHA future commissioning intentions. The SUS and the Plan highlight a range of intentions for PHA commissioned services such as continuing to develop and expand the Needle & Syringe Exchange Service (NSES) and growing Low Threshold Services (LTS). Based on feedback and following the final approval of the Plan, the PHA will set out its commissioning intention and regional procurement process via the PHA website to ensure openness and transparency.

While a significant majority of respondents either agreed or strongly agreed with the priorities identified and the actions prioritised within the Plan a number of comments highlighted current and future funding challenges. The Plan highlights the financial context of implementing a 10-year strategy identifying the need to secure additional funding. The Plan highlights the PHA's and SPPG's intention to ensure the commissioning and delivery of high-quality services for the population within the limits of current and future resources available. Consequently, PHA Commissioning, based on revised priorities and limitations of resources, is likely to displace some existing services. The PHA Substance Use Team will bring forward a paper for AMT/Board and DoH consideration on future cost implications for existing service provision and consideration of how best to prioritise both existing and any new monies if received.

A comment received from one respondent stated: "*I have read this document, and I cannot find any reference to FASD (foetal alcohol spectrum disorder), which is a really glaring omission. A plan for substance abuse, without considering prenatal exposure to alcohol. Is a worrying and out of touch policy direction* "

The Plan does commit to engage early with families, including pregnant women identified with significant alcohol misuse (harmful/ dependent drinking) to ensure that Foetal Alcohol Syndrome Disorder (FASD) risk is assessed, with fast tracking into treatment and ongoing support, as appropriate, which is the outworking of action c8 of the SUS. Furthermore, action SP2-16 of the Plan commits PHA/SPPG to *Develop a strategy for the prevention of FASD similar to the HSE Position on Prevention of Foetal Alcohol Spectrum Disorders* within 3 – 5 years of implementation.

A key recurring theme emerging from feedback included the need to ensure a whole system approach particularly in relation to co-occurring issues such as mental health and substance use. The development of this Plan has provided a fuller understanding of population need relating to substance use and addiction, along with an understanding of systemic changes required in order to respond to such need. As we move towards implementation, it is important that this work is considered within the development of the Regional Mental Health Service (RMHS) and the Integrated Care System for NI (ICS). Both developments are required to balance consistency of service at a regional level with service provision that addresses local need. It is important therefore that in line with these requirements the substance use and addiction is recognised as having an impact on all programmes of care and requires prioritisation.

A number of comments received suggested that timeframes need to be clearer for implementation of the Plan. While each of the commissioning priorities detailed in the Plan has an associated indicative timeframe, it is envisaged that short term priorities will take one to two years, medium term priorities two to three years and long-term priorities three to five years. Based on this feedback we will update the Plan to ensure that all timeframes are clear for the reader.

Following final approval and publication of the Plan, a number of Implementation Groups will be established to progress the recommendations. This activity will be co-facilitated by PHA and SPPG and will prioritise actions and recommendations with the aim of bringing service improvement to existing services in the absence of significant additional funding across five indicative workstreams including:

1. Prevention/Early Intervention
2. Pathways
3. Person-centred care
4. People
5. Performance & Improvement

It is important to note as the vast majority of the feedback received, agreed or strongly agreed with the priorities identified and the actions prioritised the Plan will receive minimal revision to the current content, with the following edits being agreed by the SUS core team:

- 2024-2028 to be added to the front cover
- Page 11 paragraph 2 (timescales) will be updated to table format to ensure clarity of short, medium, and long-term timescales
- The timeframe of each action of the strategic themes will be updated to reflect both narrative and numerical values i.e. short (1-2 years), medium (2-3 years, and long-term (3-5 years) in line with the SUS.

- 2021 drug and alcohol statistics, will be updated to reflect 2022 statistics were available

The Board is asked to approve the consultation response.

Next Steps

1. Complete final revisions to the Plan as noted above
2. Publish the Plan on PHA/SPPG websites
3. Hold a regional workshop with the substance use sector in May/June
4. Establish Regional Governance Structures and Implementation Groups in September
5. Prioritise and implement actions and recommendations of the SUS and the Plan

SUMMARY OF RESPONSES TO THE PUBLIC CONSULTATION ON THE SUBSTANCE USE STRATEGIC COMMISSIONING AND IMPLEMENTATION PLAN

FEBRUARY 2024

1. Introduction

In September 2023 The Public Health Agency (PHA) in partnership with The Strategic Planning & Performance Group (SPPG) DoH published a consultation seeking views on the **Substance Use Strategic Commissioning and Implementation Plan (the Plan)** which will deliver the vision outlined in the Department of Health's Substance Use Strategy **Making Life Better, Preventing Harm, Empowering Recovery (the Strategy)**

Specifically, views were sought on:

- the **Strategic Priority Areas** proposed in the Plan;
- the **Commissioning Actions** for each Strategic Priority Area and
- the **Timescales** identified for implementation

The proposals and decisions reached following consultation will help to finalise **the Plan** and refine the actions to be taken forward to address the issues of Substance Use in Northern Ireland.

2. Purpose of this document

This document:

- Describes how we carried out the consultation and who we consulted with;
- Summarises the responses received during the consultation
- Confirms next steps

3. Background

The harms caused by substance use across Northern Ireland are many and substantial. Societal issues including poverty, homelessness, employment, mental health, justice and education all influence the prevalence of alcohol and drug use across Northern Ireland. As the Strategy makes clear, the causes of, and harms arising from, substance use require a whole of Government response.

Whilst the entire Executive has a role to play in building and adapting services, health and social care has a pivotal contribution to make. **The Substance Use Strategic Commissioning and Implementation Plan (the Plan)** sets out an implementation framework for the health and social care commitments described in the Strategy, as well as confirming additional commissioning priorities and

other actions that will be taken forward by the PHA and SPPG over the next four years.

The Plan takes a whole system approach, identifying the importance of partnership working between the community, voluntary and statutory sectors. We recognise that many people who are struggling with the impact of alcohol or drugs, are also dealing with poor mental health and often physical health issues. That is why **the Plan** has a substantive focus on ensuring substance use, physical health and mental health services work more effectively together. It also sets out the need to consider substance use across all of our Health and Social Care (HSC) settings including primary and community care, general hospital services and emergency departments.

The Plan is informed by the voices of people from across Northern Ireland with living and lived experience of substance use and is underpinned by our belief in equality and fairness for all. **The Plan** offers a wide range of actions and commissioning priorities, each of which places the individual accessing our services at the centre of our response.

Over the next four years we will continue to deliver and build on what is working well, whilst also targeting resources across the identified Strategic Priority Areas detailed in **the Plan**.

4. How we carried out this consultation

We opened the consultation on 1 September 2023. It ran for 12 weeks until 24 November 2023 on the Citizen Space platform.

Consultees were able to respond online or by post and a contact number and address were provided for any queries. Consultation workshops for service users were also offered. Helpline information and signposting to available support was provided.

5. Overview of Responses

This section details the main themes raised during the consultation.

We received 34 online responses to the consultation, 20 responding on behalf of an organisation and 14 from members of the public. An additional 4 responses were submitted by mail on behalf of organisations.

The tables below provide information in relation to those who responded online including; gender identity, age range and place of residence. We note that just over half of the 34 respondents (59%) chose not to answer.

Respondents' gender identity

Option	Total	Percent
Woman/Girl	8	23.53%
Man/Boy	4	11.76%
Non-binary	0	0.00%
Other (Please specify in the box below)	0	0.00%
Prefer not to say	2	5.88%
Not Answered	20	58.82%

Respondents' age range.

Option	Total	Percent
16-17 years	0	0.00%
18-24 years	0	0.00%
25-34 years	0	0.00%
35-44 years	5	14.71%
45-54 years	5	14.71%
55-64 years	3	8.82%
65+ years	0	0.00%
Prefer not to say	1	2.94%
Not Answered	20	58.82%

Respondents' local council district as normal place of residence

Option	Total	Percent
Antrim and Newtownabbey Borough Council	1	2.94%
Ards and North Down Borough Council	2	5.88%
Armagh City, Banbridge and Craigavon Borough Council	3	8.82%
Belfast City Council	1	2.94%
Causeway Coast and Glens Borough Council	1	2.94%
Derry City and Strabane District Council	1	2.94%
Fermanagh and Omagh District Council	1	2.94%
Lisburn and Castlereagh City Council	1	2.94%
Mid and East Antrim Borough Council	0	0.00%
Mid Ulster District Council	0	0.00%

Newry, Mourne and Down District Council	1	2.94%
Prefer not to say	2	5.88%
Not Answered	20	58.82%

Urban/Rural split of respondents

Option	Total	Percent
Rural	6	17.65%
Urban	7	20.59%
Prefer not to say	1	2.94%
Not Answered	20	58.82%

Respondents were asked to indicate their level of agreement with **the Plan** including the proposed Strategic Priorities, actions and timescales.

Most of the 34 responses received online were strongly in favour of our Strategic Priorities and proposed Commissioning Actions, with a significant majority of respondents either agreeing or strongly agreeing with the priorities we have identified and the actions we have prioritised.

In relation to the appropriateness of timescales, 55% of all respondents agreed or strongly agreed, however we acknowledge that 44% of all respondents neither agreed nor disagreed, indicating that the timescales may need to be clearer.

Overall, while hugely supportive, the responses suggest that **the Plan** could be clearer in relation to the following:

- **Our commissioning intentions**
- **How we will fund services**
- **How we will implement our priorities**
- **Our timescales for implementation**

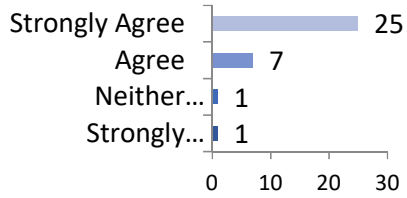
Responses to individual questions and the comments and key messages provided by respondents are detailed in the following section.

The additional responses received by mail have been included under comments and key messages.

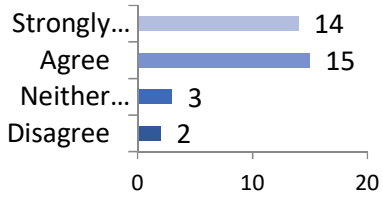
6. Summary of Responses by Strategic Priority Area

Summary of responses to Strategic Priority 1 - Prevention and Early Intervention

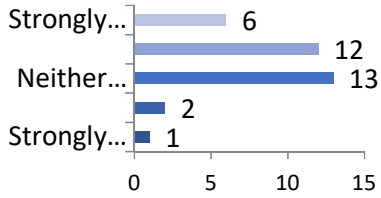
Do you agree with the inclusion of Prevention and Early Intervention as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 1 Prevention and Early Intervention?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 1 Prevention and Early Intervention?



- 94% of responses either agreed or strongly agreed with the inclusion of Prevention and Early Intervention as a Strategic Priority. 3% neither agreed nor disagreed with 3% strongly disagreeing.
- 85% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 15 with no responses in disagreement.
- 53% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 1 Prevention and Early Intervention. 38% neither agreed or disagreed

Comments received in relation to Strategic Priority 1 include:

"This is key – working upstream rather than firefighting"

"*PBNI strongly support a focus on prevention and early intervention within the plan. Research supports this as the best method to addressing substance misuse and the plan focuses positively on a whole-systems approach to incorporate the individual, their family and communities."*

"Prevention and early intervention are key to averting, reducing and delaying harms associated with substance use. We strongly support the inclusion of 'upstream' early intervention and prevention measures within this strategy which are community based and personalised to the needs of each individual"

"I have read this document, and I cannot find any reference to FASD (foetal alcohol spectrum disorder), which is a really glaring omission. A plan for substance abuse, without considering prenatal exposure to alcohol. Is a worrying and out of touch policy direction. To show the urgency of attending to FASD, please see what the Scottish govt have set out."

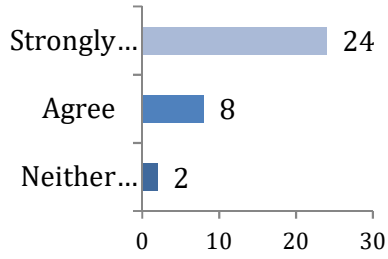
"Timescales may be challenging and flexibility may be required"

Key messages in relation to Strategic Priority 1

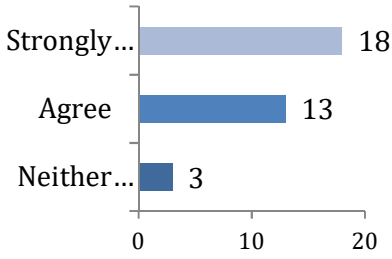
- Working upstream is key to success and provides a holistic approach to addressing substance use;
- Prevention and early intervention provision need to be offered by the right service at the time and in the right location;
- We need to recognise the benefits of a place-based approach to focus on the rurality of Northern Ireland;
- The plan is ambitious – however the finance resource needs to be made clear;
- Need to be clear on what services we intend to expand;
- We need to take account of the new planning structures such as ICS;
- The complex aetiology of harmful substance use requires a comprehensive whole system response;
- We need to ensure that we consider FASD (Foetal Alcohol Spectrum Disorder);
- Access to GP's creates a bottleneck in referral processes whereby problematic substance use can escalate to serious crisis situations;
- A health literacy approach should be applied to all services across the whole population;
- Nutritional support should be given greater prominence on www.drugsandalcoholni.info
- Community pharmacies can and do play a significant role in prevention and early intervention services, i.e. NSES, OST and Pharmacy First;
- There may be value in considering a wider public health campaign on substance use;
- There needs to be tighter monitoring of commissioned services and stronger criteria in relation to the qualifications and skills required by staff tasked with delivering services;
- Service provision should be mapped and shared with all providers;
- Services need to be joined up, i.e. prevention, co-occurring MH, trauma;
- We need to treat the whole person with a clear pathway for individuals in transition between custody – the community and resettlement;
- We need to understand that substance use is a significant risk factor in terms of vulnerability to the influence and harm of paramilitarism.

Summary of responses to Strategic Priority 2 - Pathways of Care and Models of Support

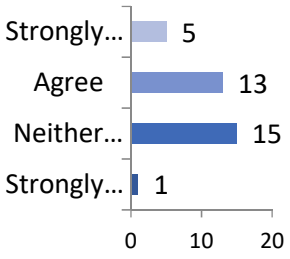
Do you agree with the inclusion of Pathways of Care and Models of Support as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 2 Pathways of Care and Models of Support?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 2 Pathways of Care and Models of Support?



- 94% of responses either agreed or strongly agreed with the inclusion of Pathways of Care/Models of Support as a Strategic Priority with none of the responses in disagreement.
- 94% of responses either agreed or strongly agreed with the commissioning actions for SP2 with no responses in disagreement.
- 53% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 2. 44% neither agreed or disagreed.

Comments received in relation to Strategic Priority 2 include:

"This looks to be the holistic, "no wrong door" approach that has been often discussed in the past but has struggled in execution. However, this looks like a firmer set of proposals and should they be acted upon and funded properly could have a dramatic positive impact."

"Yes, we agree and believe that Care Pathways need to be focussed and accessible. We have adapted the "not one cap fits all approach" they need to be well established, user friendly, service user lead, adapt steering groups made up by service users (we use this approach) and improve transition pathways as there is evidence to show a persistent reality of poor service user experience."

"When a person is in crisis regarding their mental health having to wait for months to see a shrink is unacceptable and lead to people turning to drugs for self-medicating."

"It may take longer than expected to see long-term change."

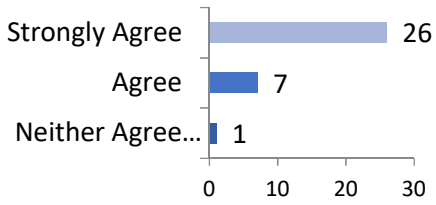
Key messages in relation to Strategic Priority 2

- The key role of the community and voluntary sector needs to be acknowledged and grown and funding needs to be at the appropriate level;

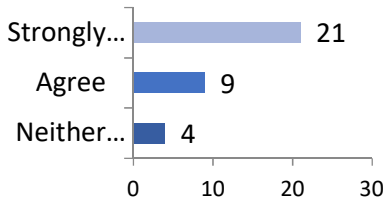
- Strong and effective community models in existence should be better supported, funded and developed;
- Strong support from other parts of the system including education and justice;
- Transition pathways are often poor and require improvement;
- Better pathways and models are needed for those in MH Crisis and with Co-occurring MH issues;
- Requires an integrated and holistic approach with right care, right time, right place(service) with the person's needs at the centre;
- Changing patterns of current need and demand within our population including poly-substance misuse, co-current mental health/ emotional well-being issues, chaotic users and those with offending behaviours;
- Community Pharmacy NI (CPNI) highlight the existing support available through Pharmacy First but also the challenge in dealing with the growing demand for community pharmacy OST provision;
- CPNI need to be supported in delivering Needle Exchange services;
- The Education Authority supports the concept of every contact counts. It is the idea of conversations with purpose for every service user;
- It's not just about improving pathways, staff, service users and families need to understand them and know how to access and navigate them successfully;
- Information sharing agreements are needed to improve communication and pathways;
- MDTs needed that span statutory and C&V sectors;
- The plan should have a stronger focus on co-occurring MH issues, this needs to be strengthened;
- Review of Drug and Alcohol Co-ordination Teams (DACTs) could be an opportunity for wider collaboration between local and regional stakeholders, leading to real integrated care partnerships;
- Consider developing a multi-agency protocol for rapid responses to non-fatal overdoses and develop accommodation support plans to support those relocated to the Western Trust.
- To address the ongoing tension between the theory behind the stepped-care/tiered approach and the reality on the ground, this plan should consider a fundamental review of those pathways, one which aligns with the requirements of the population and the reality of available services across the sectoral landscape;
- Psychiatrists in the Community Addictions Teams (CAT) should be allowed to make onward referrals without delay.

Summary of responses to Strategic Priority 3 - Trauma informed System

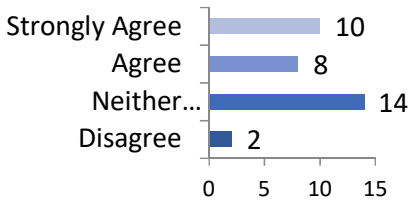
Do you agree with the inclusion of Trauma Informed System as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 3 Trauma Informed System?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 3 Trauma Informed System?



- 97% of responses either agreed or strongly agreed with the inclusion of Trauma Informed System as a Strategic Priority. 3% neither agreed nor disagreed.
- 88% of responses either agreed or strongly agreed with the commissioning actions for SP3 with no responses in disagreement. 12% neither agreed nor disagreed.
- 53% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 3. 41% neither agreed or disagreed.

Comments received in relation to Strategic Priority 3 include:

"Without the inclusion of Trauma informed system, we are at risk of further re-referrals into the system. Addressing the trauma will undoubtedly help with longer term wellbeing"

"Support community organisations and areas to become more trauma informed by investing in training but also invest in areas and buildings to make them more trauma sensitive. welcoming and open. Instil pride and pleasure in centres where these issues are being addressed to ensure the best possible chance of success for our most vulnerable"

"Fully agree- however it is important that organisations involved do not cherry pick items and ignore others- for example bodies should not simply use a list of ACEs as a checklist in response to forming their trauma informed systems"

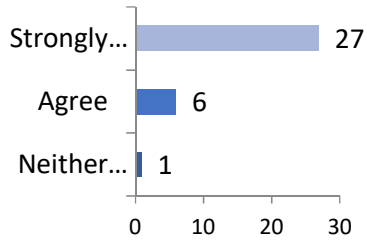
"A holistic and embedded approach to community care and rigorous information to the public about the dangers of prenatal, exposure to alcohol should inform any trauma approach"

Key messages in relation to Strategic Priority 3

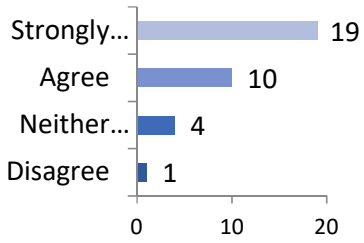
- Information and knowledge are key. Unresolved trauma needs to be understood and addressed for the people to reach long-term Recovery;
- Staff working in this area need to be supported to maintain resilience and positive coping mechanisms;
- The Strategy needs to recognise that trauma begins pre-birth and has may layers and therefore needs serious consideration and approaches;
- To truly embed a trauma informed system a more comprehensive investment is likely to be required alongside a greater strategic focus;
- All service models commissioned by this strategy need to have a of a trauma informed approach which will take time and investment to develop, deliver and embed;
- This priority is also very relevant to the actions under 'Pathways of Care and Models of Support' and recommend that the two priorities are developed in close relation to one another;
- A regional menu of Trauma Informed Training which is both universal and targeted and tailored to meet the specific needs of various groups should be commissioned;
- All trauma informed training should place a strong emphasis on recovery orientated practice and adopt a strengths-based approach to recovery;
- A greater focus could unlock real change and secure of additional, much-needed funding. It is regrettable that the actions in this section are not SMART. It is difficult, therefore, to assess their aims or value;
- A Trauma Informed System should be a separate process of implementation- it is relevant to all services and should be adopted unequivocally across the entire health service;
- Actions based on a trauma informed approach should be implemented immediately where possible, and continue perpetually to ensure this is embedded, sustained and developed according to the evidence base, and to service user and workforce satisfaction.

Summary of responses to Strategic Priority 4 – Family Support

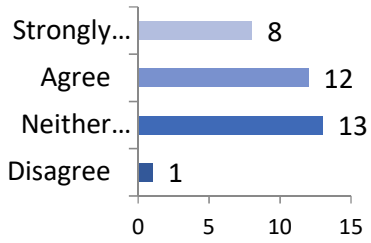
Do you agree with the inclusion of Family Support as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 4 Family Support?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 4 Family Support?



- 97% of responses either agreed or strongly agreed with the inclusion of Family Support as a Strategic Priority with none of the responses in disagreement.
- 85% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 4 Family Support.
- 59% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 4 Family Support, with 40% neither agreeing or disagreeing.

Comments received in relation to Strategic Priority 4 include:

"We support a family-inclusive approach to services and support. We particularly support the recognition that families can be impacted and traumatised by their loved one's substance use, often at the cost of their own health."

"This is an area which is long overdue reform, so we welcome the inclusion of family support in the Plan. We would advocate for a fully resourced service with tailored interventions delivered in an outreach basis to families in a pragmatic and responsive way."

"Links to the Mental Health Strategy and workforce planning are critical."

"Additionally, I think in the short term, CAT staff, especially psychiatrists, should be reminded that in many cases parents are working at the coalface, without payment, respect, gratitude or rest. It's a thankless job in many instances made worse by their aloofness and condescension."

"Families are key to Recovery, most often, their own recovery and well-being is often over looked as their focus is on the person in addiction/recovery."

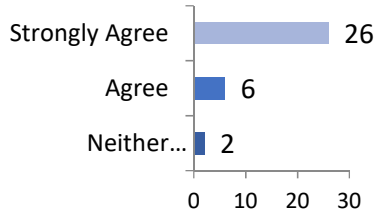
"Implementation timescales will be a challenge especially where whole system or cultural changes are required."

Key Messages in relation to Strategic Priority 4

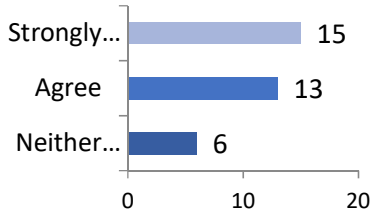
- Comments highlight the reality that carers and families are often hidden, stigmatised and traumatised and that they place their own physical and mental health needs behind the needs of the person using substances; Families will need encouragement and support to engage
- Family members often suffer from poor mental and physical health;
- Need for education for families and the wider community to increase engagement for isolated and stigmatised families;
- Family support should be broad and flexible and include family systemic practices, therapeutic approaches and crisis support;
- Families who do not live in the same area as the person using substances should not be excluded from accessing support;
- Support for Family inclusive training and the work of family support hubs;
- Need to include families who have lost ones to substance use, they need to be listened to and supported as individuals and as a group;
- Strong need for support for families from within their own communities, community support needed in relation to other determinants of health– poverty and deprivation and impact of the NI conflict;
- Strong support for co-production approach and involvement of those with lived experience, loved ones and families;
- Community Pharmacy N.I (CPNI) could provide vital outreach and services such as Living Well to family members and play a role in supporting carers and hidden carers who experience stigma;
- The links to Think Family are vital, as considering the whole system around a person can be key to assessment, support and intervention. This also supports the 'every contact counts' approach;
- Education around addiction, harm reduction, nutrition, withdrawal symptoms and trauma is a vital part of families' recovery;
- Family members can feel side-lined by service providers in relation to information on their loved one's treatment;
- Links to the mental health strategy and workforce planning is critical;
- Family support options need a core skills and knowledge base, the idea of a mental health/substance abuse worker is critical, to recognise and respond to the co-morbidity.

Summary of responses to Strategic Priority 5 - Stigma

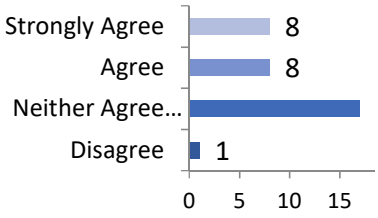
Do you agree with the inclusion of Stigma as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 5 Stigma?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 5 Stigma?



- 94% of responses either agreed or strongly agreed with the inclusion of Stigma as a Strategic Priority with none of the responses in disagreement.
- 82% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 5 with no responses in disagreement.
- 47% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 5 Stigma. 50% neither agreed or disagreed.

Comments received in relation to Strategic Priority 5 include:

"Reducing stigma needs to be a key focus moving forward as stigma prevents those in need from being honest about their situations as well as preventing access to services. Reducing stigma gives people permission to talk about their difficulties and issues and helps others understand addiction and the associated issues. This will require both investment and time."

"There needs to be recognition that problematic substance use is a medical issue and not a justice issue."

"We are strongly supportive of the inclusion of stigma as a strategic priority. This priority aligns in a complementary way to that of a trauma-informed system.""

"Reducing the stigma is key, as it is harmful. Too many people do not ask for help or support because of the stigma and shame around addiction. THEY SUFFER IN SILENCE."

"I've recently experienced a psychiatric nurse and team leader telling me that following a relapse, my son needed to undergo a period of reflection before he would be considered for reinstatement of his methadone prescription."

Key Messages in relation to Strategic Priority 5 include:

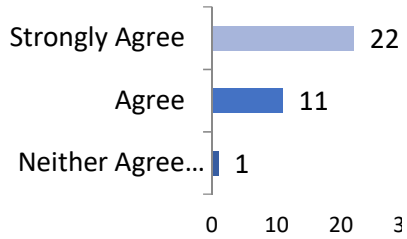
- Stigma is a barrier to seeking and accessing support and creates fear;

- Key messaging such as, “it is ok not to be ok”, needs to be central to all services;
- Suggest a campaign to highlight examples/stories of recovery with high profile figures used as examples, encouraging people to seek help;
- A gender-based approach to stigma is needed as men and women suffer from stigma in different ways and for different reasons – e.g. paramilitary involvement or fear of social services involvement in families;
- In order to reduce stigma, it would be important to consider what the research reports in relation to how stigma affects certain communities e.g. rural; urban; different ethnic groups as this may inform approach and enable better ways for the system to support 'help seeking' behaviour;
- Need to recognise the stigma experienced by families who have been bereaved by substance use and provide appropriate support;
- Reducing stigma should be central to this plan and be imbedded across all services, relevant strategic work streams and Northern Ireland Executive departments;
- Prioritising the reduction/removal of stigma is an essential characteristic of all services we provide, with the objective of promoting inclusion, service user involvement and engagement, and peer to peer support- all of which should assist in promoting the efficacy of the services offered across the province and ultimately have a part to play in reducing disengagement and crisis presentations to Health and Social Care services such as A&E;
- We have a considerable distance to travel in terms of our approach to challenging stigma including the views perpetuated by the media;
- Plan should include an action to challenge stigma where it exists;
- Support for a human rights-based approach;
- The actions could go further to precipitate change, including addressing attitudes between professionals across the health care sector which is prevalent from interactions in professional forums to referral pathways, appropriate information sharing, and ultimately service delivery;
- Core training on stigma should be included for the wider workforce as well as those who deal directly with those using substances;
- Campaign should include steps to raise public awareness and allay any fears or misconceptions which may exist in relation to the provision of community-based services such as OST and Needle Exchange;
- Charter of Rights should be balanced with responsibilities and supported by regulatory clarity for community pharmacy and other service in terms of withdrawal of services from violent or abusive patients;
- Support for people first language, it supports the person-centred inclusive approach of this strategy and is core to development of services, service user engagement and outcomes;

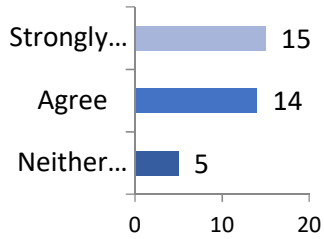
- Consider a regional approach to sudden deaths that covers substance use and suicide (this would be the preference of the Coroner's Office and more practical for frontline agencies);
- Any benchmarking exercise could also include a study of the other regions' provision of bereavement support;
- Suggestion that these actions should start immediately;
- Not just what people say but how they say it.

Summary of responses to Strategic Priority 6 – Workforce Development

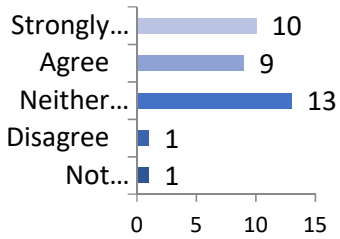
Do you agree with the inclusion of Workforce Development as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 6 Workforce Development?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 6 Workforce Development?



- 97% of responses either agreed or strongly agreed with the inclusion of Workforce Development as a Strategic Priority with none of the responses in disagreement.
- 85% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 6 with no responses in disagreement.
- 57% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 6 Workforce Development. 38% neither agreed or disagreed.

Comments received in relation to Strategic Priority 6 include:

"We recognise the challenges identified under this strategic priority and note again the skills and knowledge available in the community and voluntary sector to support a skilled and confident substance use workforce. The workforce represents a microcosm of society and substance misuse is often hidden within the workforce. In addition, workers in organisations right Northern Ireland are often dealing with family members who suffer from substance use disorders. Education of the workforce on SUD, Trauma Informed –Recovery Orientated practice is therefore a fundamental aspect of the Strategy. Such action could

expose the level of SUD within society, de-stigmatise the issue and provide different levels of support to individuals, families, employers and communities. Workplaces also offer opportunities for challenging the culture and attitudes towards harmful substances such as alcohol and drugs."

"Worryingly, the mental health workforce review included neither drugs and alcohol services nor the voluntary and community sector in its planning or scoping activities. Significant efforts are required inside systems to train staff. This would surely help deepen understanding, engender compassion and curb stigma."

"re GPs with specific training in the field. Sadly, not many of them around. Tier 2 is universally excellent with compassionate, empathetic staff who do their best to help and support addicts and their families. Tier 3 is mostly disappointing with staff who in some cases don't know what they're there to do, staff who appear overwhelmed, staff who are dismissive of families and their concerns, staff who shrug their shoulders when asked straight forward questions like when will my son see his psychiatrist? Tier 4 mostly good but little or no recognition that not all service users are the same."

Key Messages in relation to Strategic Priority 6

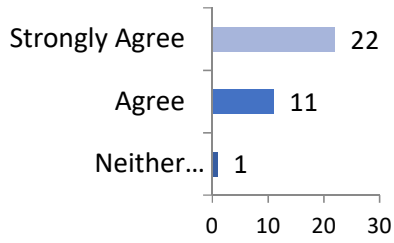
- Investment is essential to build, develop, and support the workforce who deliver substance use services, particularly those on the frontline;
- Workforce development underpins all other parts of this strategy;
- While it is encouraging that additional resourcing will be available for these actions, we know that significant resources are used to maintain the current workforce, where there are many vacancies and retaining staff is extremely difficult;
- There is a need to make funding and training available to the voluntary and community sector as key partners and ensure all Tiers are delivered to the same standard;
- Core training should include trauma informed practice, staff must feel confident to recognise and respond to trauma. Stressed people cannot regulate stressed people;
- Lots of examples of good practice across the sector, but some concerns that this was not universal, with examples given of some staff being seen as dismissive and uninterested, while some staff appear overwhelmed and are dismissive of families and their concerns;
- Stigma reduction and recovery orientated practice are a fundamental aspect of the strategy;
- Continue to witness a concerning lack of insight and knowledge of drugs and alcohol, throughout the mental health system;
- There is a lack of recognition for the challenges the workforce experience. Significant overhaul of the workforce is undoubtedly required, and this should

include aspects of the trauma informed priority and stigma, as this exists within the workforce between and across sectors;

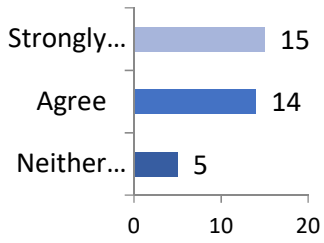
- Must factor in the funding and resourcing support which will be needed to ensure that service providers can give their teams protected time to participate in this training and development;
- Professional resilience needs to be enabled through peer support; supervision and working environments and processes;
- Workforce upskilling is needed in areas such as autism and substance use as it is currently seriously lacking;
- Need to include pathways for peers and people with lived experience; Upskilling for those who deliver addiction counselling therapy inside the voluntary and community, and statutory sectors;
- Equal partnership and collaboration between statutory and C&V workforce are critical into the future for this plan to be a success;
- The timescale of medium and long-term does not seem to match the ambition of the Plan - believe the focus on the workforce should be immediate given that the workforce will be delivering all actions across all priorities within the Plan.

Summary of responses to Strategic Priority 7 – Digital Innovation

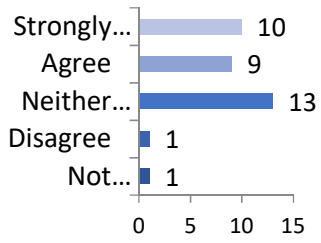
Do you agree with the inclusion of Digital Innovation as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 7 Digital Innovation?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 7 Digital Innovation?



- 88% of responses either agreed or strongly agreed with the inclusion of Digital Innovation as a Strategic Priority with none of the responses in disagreement.
- 79% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 7 with no responses in disagreement.
- 55% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 7 Digital Innovation; 44% neither agreed or disagreed.

Comments received in relation to Strategic Priority 7 include:

"Digital innovations should form part of the wider regional objective of addressing substance use issues. It is crucial that we use all of our many skills and experiences – as we did during the initial stages of the Covid-19 pandemic – in crafting fresh thinking around digital information and support."

"We are confident that this could be incorporated into the digital component of the mental health strategy implementation plan, removing multiple meetings and harmonising development across the mental health and addictions sectors."

"Local services should be consulted on what would work best / is most needed in their area as there may be differences across localities and population groups. There is potential for developing and trialling innovations though local services to meet needs."

"An on-line one stop shop would be very useful to avoid gaps in information available if multiple platforms are used as is currently the case. Systems at present are cumbersome and not user friendly and require time and knowledge to make the best use of resources available, which is just not realistic for many of our population, and particularly for those who don't have access and / or skillset to make use of digital technology."

Key Messages in relation to Strategic Priority 7

- Digital innovation is absolutely necessary but can be challenging. Information sharing needs to take form in a wide variety of ways;
- Must include connection to encompass via the epic care link;
- Ensure that any digital innovations reduce workload and administrative burden, and not add to it;
- The following elements are critical: service user involvement, accessibility depending on age and digital literacy;
- The HSC e-health directorate could lead the way on advising and providing expert guidance on the efficacy of digital innovation to support this vulnerable population;
- Access to the C&V sector to some HSC trust based digital platforms would be a positive development and may reduce the need for GP referrals;
- People need proportionate face to face interaction - we need to ensure there is balance to the digital approaches.
- Knowing and seeing the person and the system within which they live is crucial to building trust; reducing stigma and engagement with services;
- Consider the digital advancements made possible by knowledge transfer partnerships (KTPs) at Queen's University Belfast and Ulster University;
- Use of digital innovation is only one aspect of the improvements that need to be made to promote better service provision, and it may be difficult to measure outcomes;

- The use of digital innovation will not impact on some client groups who do not have access to technology, including family members and carers.
- Digital innovation is crucial, in particular when it is related to prevention and early intervention

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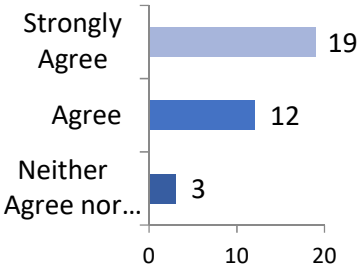
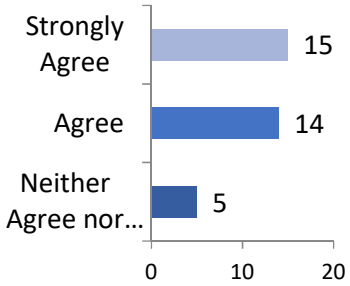
Summary of responses to Strategic Priority 8 – Data and Research

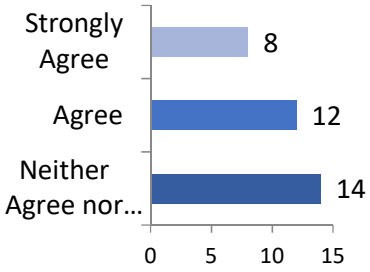
Do you agree with the inclusion of Data and Research as a Strategic Priority in this Plan?



Do you agree with the Commissioning Actions for Strategic Priority 8 Data and research?



Do you agree with the timescales for implementation of our Commissioning Actions for Strategic Priority 8 Data and Research?



- 91% of responses either agreed or strongly agreed with the inclusion of Data and Research as a Strategic Priority with none of the responses in disagreement.
- 85% of responses either agreed or strongly agreed with the commissioning actions for Strategic Priority 8 with no responses in disagreement.
- 59% of responses either agreed or strongly agreed with the timescales for implementation of our commissioning actions for Strategic Priority 8 Data and Research; 41% neither agreed or disagreed.

Comments received in relation to Strategic Priority 8 Data and Research include:

"The actions referenced are ambitious which is very encouraging and are appropriate if we aim to have a clear and on-going understanding of the needs of our client groups."

"We must have the right Data to measure outcomes, that need to be clear, with an evidence-based frame work that allows evidence to be the foundation for decision making. This needs to be comparable across trusts to measure performance and to determine what works."

"This is a welcome strategic focus as we know that NI specific data and research is not available for many of the client groups we support. Any improvement in this area will promote positive change and development in our

understanding of 'what works' and which evidence-based models can be translated into our services."

"I think It's unacceptable that services cannot provide sufficient, accurate information on outcomes for service users so that value for money and other metrics can be assessed. They seem preoccupied with footfall through the door. What other profession would get away with this? Service users and their families should be encouraged to provide feedback on the services provided, especially by Tier 3 services."

Key Messages in relation to Strategic Priority 8

- Support for inclusion of evidence-based prevention initiatives, such as the Icelandic model;
- Need to apply research into practice highlighted;
- We need to be clear on approaches shown not to be effective;
- Need to commission locally based research highlighted;
- Need for data to measure outcomes was a recurrent theme;
- Need for evidence for prevention in adults as well as young people;
- There will be a need to prioritise research to align with the delivery of wider priorities within the Plan;
- Need service user input to research and the prioritisation of research;
- Need to review the Impact Measurement Tool (IMT) and substance use data base in line with regional outcome measurement developments;
- Need to link data across providers and tiers;
- Query in relation to practitioner research as a priority at this phase of implementation and if it is something that the PHA will invest in;
- Need for SMART actions in this section;
- Budget and resourcing will be key to delivery – acknowledging that research can take time to deliver;
- Issue around clarity of the definition of short, medium and long term.

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7. Next Steps

- We would like to thank everyone who took time to respond to the Public Consultation on **the Substance Use Strategic Commissioning and Implementation Plan (the Plan)** and provided us with valuable feedback.

- All responses and comments have been reviewed and analysed by the Substance Use Strategy core team that includes PHA, SPPG, and DOH Policy staff.

- We will use this analysis to produce a final version of **the Plan** that incorporates the key messages we have received from the broad range of stakeholders who have been involved in developing **the Plan**.

- We will sense check the final version of **the Plan** for alignment with the **Department of Health's Substance Use Strategy** Making Life Better, Preventing Harm, Empowering Recovery and with other key pieces of work that are coming to fruition in the coming months, these include; the Review of Tier 4 Addiction In-Patient Detoxification Services and Residential Rehabilitation Services and the Needs Assessment for the Population of the Western Health and Social Care Trust Area relating to Substance Use.

- It is important that we also consider how **the Plan** will align with the work of the newly established Single Mental Health Service for Northern Ireland and the incoming Integrated Care System. Feedback throughout the development of the Plan has emphasised the importance of aligning activity on Substance Use with that in Mental Health and vice versa.

- We will ensure that any developments around issues such as preventative and crisis services include how people with substance use issues access these services.

- An analysis of our work to date on **the Plan** will be presented to the Substance Use Strategy Programme Board. This will happen by March 2024.

- An agreed final version of **the Plan** will be published by April 2024.

- Governance Structures and Implementation Groups will be established to take forward priority actions in **the Plan** with effect from April 2024.

HSC Public Health Agency

HSC Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

SUBSTANCE USE STRATEGIC COMMISSIONING AND IMPLEMENTATION PLAN

Working together to deliver change

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FOREWORD

We are delighted to introduce our **Substance Use Strategic Commissioning and Implementation Plan** (*Plan*), jointly produced by the *Public Health Agency (PHA)* and the Department of Health's *Strategic Planning and Performance Group (SPPG)*.

The harms caused by substance use across Northern Ireland are many and substantial. Societal issues including poverty, homelessness, employment, mental health, justice and education all influence the prevalence of alcohol and drug use across Northern Ireland. As the Department of Health's **Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31)** makes clear, the causes of, and harms arising from, substance use require a whole of Government response.

Whilst the entire Executive has a role to play in building and adapting services, health and social care has a pivotal contribution to make. This *Plan* sets out an implementation plan for the health and social care commitments described in the ***Preventing Harm, Empowering Recovery***, as well as confirming additional commissioning priorities and other actions that will be taken forward by the *PHA* and *SPPG* over the next four years.

This *Plan* takes a whole system approach, identifying the importance of partnership working between the community, voluntary and statutory sectors. We recognise that many people who are struggling with the impact of alcohol or drugs, are also dealing with poor mental health and often physical health issues. That is why this *Plan* has a substantive focus on ensuring substance use, physical health and mental health services work more effectively together. It also sets out the need to consider substance use across all of our Health and Social Care *(HSC)* settings including primary and community care, general hospital services and emergency departments.

This *Plan* is informed by the voices of people from across Northern Ireland with living and lived experience of substance use and is underpinned by our belief in equality and fairness for all.

Too often the problematic use of alcohol and drugs is perceived as a lifestyle choice without a full understanding and appreciation of the complexity of reasons people are using alcohol and/ or drugs to challenging levels.

Our *Plan* acknowledges such complexities by offering a wide range of actions and commissioning priorities, each of which places the individual accessing our services at the centre of our response.

This *Plan* highlights the link between trauma and the use of substances and prioritises the need to address stigma across society, including within services we commission.

Over the next four years we will continue to deliver and build on what is working well, whilst also targeting resources across the following eight strategic priority areas:

1. Prevention and Early Intervention
2. Pathways Of Care and Models of Support
3. Trauma Informed System
4. Family Support
5. Stigma
6. Workforce Development
7. Digital Innovation
8. Data And Research

The strategic priorities identified in this *Plan* are firmly aligned to, and aim to deliver on, the five outcomes detailed in the ***Preventing Harm, Empowering Recovery*** strategy, as well as inform the services we commission and procure.

Given the ongoing pressures on public sector finances, we are focusing our finite resources where they are needed to address the most pressing challenges. Our Plan provides an ambitious springboard for the longer-term transformational change required to sustainably improve the health and wellbeing of our population.

We are committed to working ever more closely with partner agencies and the community and voluntary sectors to integrate our collective resources and provide people and families with seamless pathways of support. The ideas, creativity and commitment of our workforce, together with that of the individuals and families accessing support and recovery services will be central to our success.

This *Plan*, when successfully delivered, will:

- ensure more people get the right, high quality treatment and support, at the right time and in the right place;
- reduce the harm caused by substance use;
- remove the stigma surrounding substance use;
- empower more people to keep getting better; and
- embed multi-disciplinary partnership working across sectors

We recognise however 'warm words' mean nothing without holding ourselves to account for delivering on our ambitions. That is why we will also establish strong and transparent governance mechanisms to monitor the implementation of our actions and demonstrate improving outcomes for individuals, families and communities.

We would like to thank everyone involved in the development of this *Plan*, particularly the people with lived and living experience who have provided invaluable insight into the challenges they face, the families who have shared their pain and frustration including those who have lost loved ones due to substance use. Thank you also to the HSC Substance Use Strategic Advisory Board and the expansive and collaborative outcome groups that worked with such commitment and vigour to co-produce the *Plan*.

Aidan Dawson
Chief Executive, PHA

Sharon Gallagher
Deputy Secretary, SPPG, DoH

INTRODUCTION

According to the Northern Ireland Audit Office (NIAO) report **Addiction Services in Northern Ireland** published in 2020, the cost of alcohol misuse alone to Northern Ireland is £900 million per annum. If the costs of the harms related to other drugs are added, this would almost certainly take this figure to approximately £1.5 billion per annum. The NIAO estimate that, on average, 200 hospital beds per day are occupied by patients with substance use listed as a contributing factor.

Northern Ireland experiences a higher rate of trauma and mental illness when compared to other parts of the United Kingdom (UK). Research clearly tells us that people who experience harm from substance use often have a history of trauma. Studies have also consistently shown a high prevalence of co-occurring mental disorders in people who have problems with alcohol and drugs. These trends confirm the need for this Plan to have an indelible and coherent linkage with the **Mental Health Strategy 2021 -2031**.

Alcohol

Alcohol related harm remains the most prevalent substance issue in Northern Ireland. In 2021, the Northern Ireland Statistics and Research Agency (NISRA) **statistics** confirm that there were 350 alcohol-specific deaths - the second highest on record and 53.9% higher than the number recorded 10 years ago.

Looking at the most recent five years together (2017 to 2021), there were almost four times as many alcohol-specific deaths in the most deprived areas compared to the least deprived areas. The most common underlying cause of alcohol-specific death is liver disease.

In 2021, **64.3%** of alcohol-specific deaths were males. The majority of those who died with alcohol-specific underlying causes each year since 2011 have been in the 45-54 and 55-64 age groups, together accounting for between **59.2%** and **68.0%** of all alcohol-specific deaths each year.

In 2019/20, **17%** of respondents reported drinking above recommended weekly limits, with males around three times more likely to do so than females. The most recent figures show that around **31%** of adults binge drink.

Drugs

The NISRA **statistics** on drug-related and drug-misuse deaths registered in Northern Ireland confirm there were 213 drug-related deaths in 2021, more than double recorded in 2011.

Males accounted for **73.7%** of the drug-related deaths registered in 2021. Of the 213 drug-related deaths in 2021, **31.1%** were in the 25-34 age group with a further **24.1%** in the 35-44 age group.

Over two-thirds of drug-related deaths in 2021 involved two or more drugs, with over half of drug-related deaths involving an opioid. Heroin and morphine were the most frequently mentioned opioids in 2021, involved in 18.3% of drug related deaths. The second most commonly mentioned drugs on death certificates were benzodiazepines.

The NISRA drug statistics also confirm that there were five times the number of drug related deaths registered in the 20% most deprived areas in Northern Ireland in 2021 compared with the number of drug-related deaths in the 20% least deprived areas.

Patterns of drug use are changing with the misuse of prescription drugs and polydrug misuse being significant factors. The NIAO noted in their report into **Addiction Services in Northern Ireland** that Northern Ireland prescribes more diazepam, strong opioids and pregabalin than anywhere else in the UK. There are also further issues related to the use and misuse of over the counter medicines.

Preventing Harm, Empowering Recovery

The Department of Health sets out how we respond to substance use harms across Northern Ireland in the recent strategy '**Making Life Better, Preventing Harm, Empowering Recovery**'. The clear vision in this strategy is that:

People in Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery.

We commit to actioning the recommendations for HSC services contained in the ***Preventing Harm, Empowering Recovery strategy.*** These recommendations are detailed in Appendix 2. The *HSC* system, comprising community, voluntary and statutory services, is pivotal to achieving the above vision.

Plan Development

The *Plan* has been developed following extensive work by ten, connected, collaborative outcome groups comprising of people with lived and living experience of substance use and wide representation from people working across the community, voluntary and statutory sectors. Each outcome group was led by one member from a statutory sector service, and one member from a community and voluntary sector service, in line with our 'whole system' approach to development.

The outcome groups were formed around the five outcomes for Northern Ireland set out in the ***Preventing Harm, Empowering Recovery*** strategy to improve services for and tackle the harms around substance use:

OUTCOME A	Through Prevention and Reduced Availability of Substances, Fewer People are at Risk of Harm from the Use of Alcohol & Other Drugs across the Life Course
OUTCOME B	Reduction in the Harms Caused by Substance Use
OUTCOME C	People have Access to High Quality Treatment and Support Services
OUTCOME D	People Are Empowered & Supported on their Recovery Journey
OUTCOME E	Effective Implementation & Governance, Workforce Development, and Evaluation & Research Supports the Reduction of Substance Use Related Harm

The *HSC* Substance Use Strategic Advisory Board, co-chaired by the *PHA* and the *SPPG*, directed the programme of activity taken forward by the outcome groups, with the Advisory Board reporting to the Substance Use Programme Board, chaired by the Chief Medical Officer, Professor Sir Michael McBride.

This *Plan* provides an overview of the knowledge gained through the outcome groups and our ongoing engagement with both service providers and with individuals with lived and living experience of substance use, including their families and carers.

Compassion, hope and co-design sit at the very heart our *Plan*, alongside the acknowledgment of the fundamental connection between trauma and substance use and the human rights of every individual in the services we provide.

Our *Plan* outlines where we will focus effort and resource to improve current *HSC* provision, providing a clear direction to service providers on the range, scope and quality of services that will be commissioned over the next four years.

This *Plan* describes how the *HSC* system will focus on eight strategic priorities over the next four years to help reduce the harms to individuals, families and communities caused by substance use. The *Plan* also identifies the key actions we will take forward and sets the direction for the commissioning of services to 2027 and beyond.

The eight strategic priorities and associated actions described in this *Plan* have been created in the context of a whole system approach. The *Plan* has been significantly informed by the ***Preventing Harm, Empowering Recovery*** strategy, as well as influenced by other key strategies and policies, most notably the ***Mental Health Strategy.***

The link with mental health is recognised in our *Plan*, given the significant proportion of individuals who have co-occurring mental health and substance use issues. This *Plan* ensures that strong links are made between substance use and the developments around preventative, crisis, treatment and recovery services as detailed in the ***Mental Health Strategy***.

The *Plan* also acknowledges the physical health challenges associated with substance use, such as the impact of contracting hepatitis. This *Plan*, utilising both a universal and targeted approach, will support the goal of the **Northern Ireland Hepatitis C Elimination Plan** to eradicate hepatitis C as a public health threat in Northern Ireland by 2025, as well as the WHO goals for hepatitis B, hepatitis C and HIV elimination by 2030.

The *Plan* also recognises the current gaps in service provision including, for example, services tailored for people with Alcohol Related Brain Injury (*ARBI*) and commits to review the population need and where appropriate develop specific service models.

Success of this *Plan* will only be achieved by consistent, joined up working with our partners across the community, voluntary and statutory sectors. The *Plan* aims to strengthen collaboration and co-production between statutory services delivered by Health and Social Care Trusts (*HSCTs*) alongside those delivered by the other sectors. We must work in partnership - individuals accessing services, families, staff and politicians - in doing so we can co-produce lasting change that benefits us all.

This *Plan* is not in itself a destination, rather it is a living document on a much longer journey. Our *Plan* will be subject to transparent and regular review, as we listen to the voices of people accessing our services, monitor the performance of services, take account of the funding available and respond to emerging evidence based research.

Each of the commissioning priorities detailed in this *Plan* has an associated indicative timeframe. It is envisaged that short term priorities will take one to two years, medium term priorities two to three years and long term priorities three to five years.

As we look to the future, the *Plan* will be considered within the context of the developing **Integrated Care System** for Northern Ireland (*ICS*), which aims to balance regional consistency with local variation, based on population need.

This *Plan* is the continuation of our journey, a journey that Northern Ireland must take to ensure we reduce the harms from substance use being experienced by individuals, families and communities across the region and afford real hope and opportunity for people to take more positive control of their lives.

PRINCIPLES

This *Plan* and the subsequent delivery of the commitments made within the *Plan* is underpinned by a number of important Principles:

Human Rights

HSC Value Based Care

Partnership Working, Co-Production and Shared Responsibility

Inclusion Health

Research, Evidence and Evaluation

Quality Improvement

Human Rights

Human rights are the basic rights and freedoms that belong to every person, from birth until death. They apply regardless of where you are from, status, religious beliefs or how you choose to live your life. A human rights approach to substance use is particularly important due to the stigma associated with the use of drugs and alcohol in our society. A human rights approach is therefore integral to the planning and delivery of our *HSC* services to ensure that everyone using them has a positive and equitable experience.

Human rights go beyond the *HSC* services we deliver. It is important for us to foster a collaborative, whole system approach to working with partners responsible for issues such as homelessness, poverty, education and employment, to ensure that the human rights of individuals living with and those caring for people with substance use issues is also considered in these areas.

HSC Value Based Care

HSC services that are respectful, compassionate and non-discriminatory will continue to be our standard. We renew our commitment to providing safe, timely, person-centred, inclusive care that has a "no wrong door" approach. This means that people who use substances and their families can expect the right support, at the right time, in the right place, delivered by the right people.

This also means that we will seek to minimise any procedural or informational barriers to accessing *HSC* services, and that people will be empowered to taking "choice and control" over their care and treatment.

In most circumstances, unless requested otherwise by an individual, we will aim to provide care and support as close to an individual's home as possible. There will be times however that regional services will need to be accessed within another locality due to commissioning decisions based on demand and available resources.

Partnership Working, Co-Production and Shared Responsibility

"Nothing about us, without us" is a phrase that reminds us of the importance of ensuring that people with lived and living experience, their families and carers, are at the centre of the design, delivery and review of *HSC* services. We will build on the engagement processes we have used throughout the development of this *Plan* with people with lived and living experience and strengthen our network of individuals and communities as we move forward.

We refer to *HSC* services consistently throughout this *Plan*. We understand *HSC* services to mean services provided by both the statutory sector as delivered by *HSCTs* and services and support delivered by the community and voluntary sectors. The partnership between these sectors is critical to delivering the right support for our population. This *Plan* is built on the principle that all sectors are considered as equal partners in the planning and delivery of care.

We have adopted a public health, population based, approach to reducing the harms caused by substance use in Northern Ireland. This approach recognises that health and social care services alone cannot respond to the complex number of factors which are related to the problematic use of drugs and alcohol. It is essential that we continue to collaborate with our partners in education, housing, community planning and justice, to prevent and reduce substance related harms.

Inclusion Health

We know that the impact of substance use is not felt equally across society. Many of our population are socially excluded, and typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). People in these population groups often experience the poorest health outcomes including those related to substance use, and the greatest health inequalities.
People who belong to **inclusion** health groups face additional barriers to accessing and engaging with health services and require specific consideration of how their needs will be met when commissioning mainstream services. To address the inequalities that exist, we will get better at targeting more intensive interventions and increasing accessibility for those most at risk.

Research, Evidence and Evaluation

We will use high quality and up-to-date evidence to inform and evaluate the services we design and commission, including the use of best practice developed locally, nationally and internationally. All our alcohol treatment and support services will be taken forward in line with the UK-wide **Clinical Guidelines on Alcohol**, once these have been finalised, as well as relevant ***NICE*** guidelines and the **UK guidelines** on clinical management of Drug Misuse and Dependence.

Quality Improvement

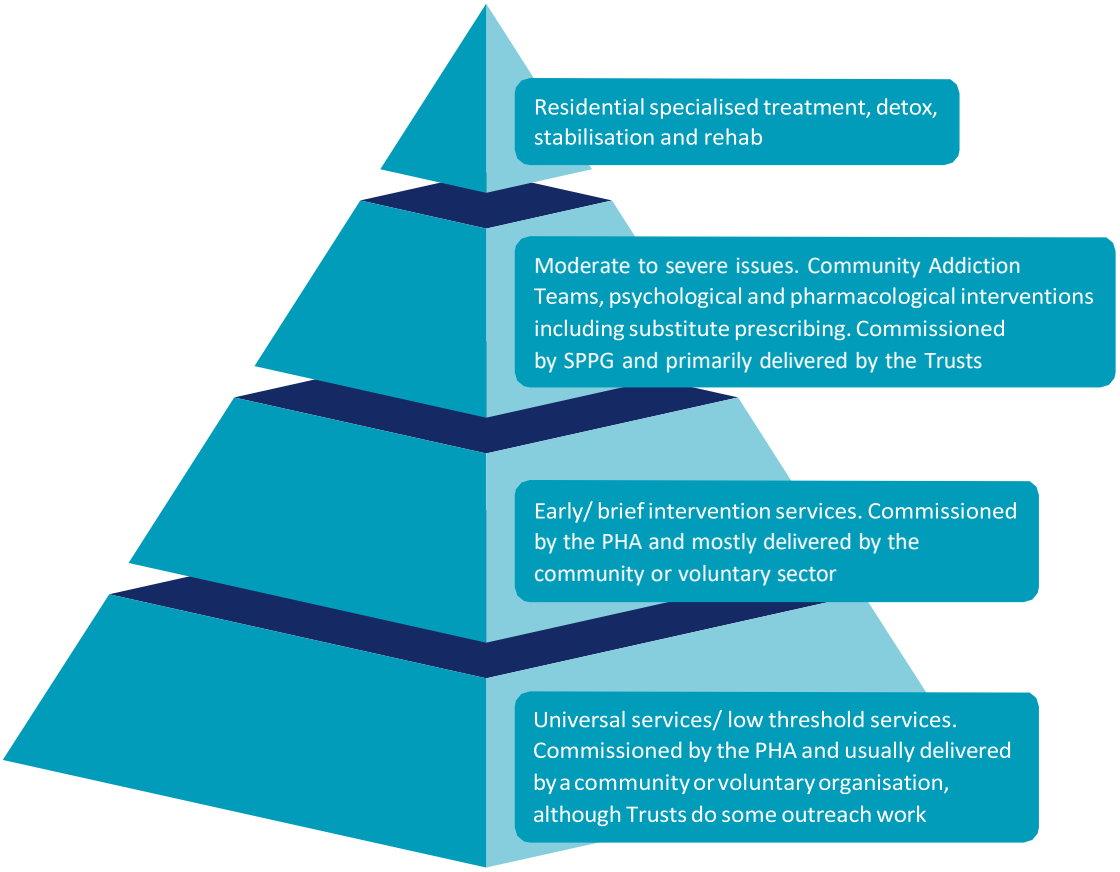
Utilising evidence, this *Plan* will actively promote innovation and quality improvement approaches to service transformation.

The use of quality improvement methodology will help us to map complex pathways, diagnose multifaceted problems and identify and test possible solutions. This will build on existing regional collaborative improvement projects and will link to the proposed **Regional Mental Health Service** and ***ICS***

CURRENT SERVICES

In 2021/ 2022, the *PHA*, *SPPG* and *HSCTs* spent circa £30 million on substance use related services. It is estimated that up to an additional £6.3 million per annum could be needed to fully support the implementation of the **Preventing Harm, Empowering Recovery** strategy, with any further investment subject to budgetary consideration.

In Northern Ireland, our substance use services and interventions are organised in the following tiered system:



Further details on the four tiers are provided in Appendix 1.

Children and Young People

Children and Young People can access services for substance use problems within Child and Adolescent Mental Health Services (CAMHS). Some HSC Trusts operate a Drug and Alcohol Mental Health Service (DAMHS), co-located within *CAMHS*.

The regional, 33-bed inpatient unit at Beechcroft is a general *CAMHS* inpatient service that admits children and young people with acute mental ill health. If a young person is also using alcohol and/ or drugs this does not exclude them from admission to the unit, however use of drugs and alcohol would not be on its own a reason for an inpatient admission. Admission is for 12-18-year-olds and younger children are more usually treated in the community, although if appropriate they can be admitted to Beechcroft.

Regionally Commissioned/ Funded Substance Misuse Services

The *PHA* commission a wide range of drug and alcohol services focused on meeting the drug and alcohol needs of children, young people, adults and families/carers.

Details on the range of services regionally commissioned are provided in Appendix 1.

COMMISSIONING CONTEXT

This *Plan* has been developed jointly between the PHA and SPPG to ensure it delivers a whole system approach to addressing substance use issues and that the commissioning priorities proposed will deliver the best outcomes possible for our population.

In taking forward the implementation of the *Plan*, the PHA and SPPG will continue to work in partnership to progress the actions and priorities agreed. However, it is important to note that organisationally, PHA and SPPG have different areas of responsibility where they will lead on the commissioning of services and prioritise how available funding is allocated and managed.

In delivering on this *Plan*, the PHA will continue to have lead responsibility for commissioning tier 1 and 2 provision and SPPG lead responsibility for commissioning tier 3 and 4 provision. Within the *Plan*, the responsibility for taking forward specific actions has been clearly identified.

In commissioning future services, it is recognised that support for people with substance use issues is provided by a 'mixed economy of care', which includes a wide range of services within the community, voluntary and statutory sectors. This *Plan* values this 'mixed economy' and is underpinned by a proactive, partnership approach to working with service providers across all sectors.

This *Plan* sets out our ambitions for a transformative program of evidence based, person-centred services for people who use substances and outlines our strategic focus for the next four years. As well as detailing our eight strategic priorities, the *Plan* delivers a clear statement of commissioning intent to current and potential service providers.

From a tier 1 and 2 perspective the PHA is clear that the existing commissioned services are evidenced based and provide a valuable service across the region. It is our intention to maintain and develop these services in line with population need and available resources. We recognise that there will be future opportunities to consider potential joint commissioning arrangements either with other PHA funding streams such as mental health and suicide prevention as well as external joint commissioning opportunities that may arise with other departments/public services such as justice and housing.

From a tier 3 and 4 perspective there are key areas of work emerging around a service transformation agenda including the independent review of tier 4 in-patient detoxification and residential rehabilitation services, the Western HSC Trust area Substance Use Needs Assessment, and the rapid review of treatment for addictions in healthcare in prison. Each of these areas will have a set of recommendations to support service transformation over the coming years and will need to be appropriately aligned with the development of the regional mental health service.

This *Plan* will help the PHA, SPPG and its key partners to drive and direct future commissioning while acknowledging the fact that some services may require more detailed review and potential change than others to ensure that their outcomes better align to our identified priorities for the benefit of service users and their families.

Subject to the outcome of a 12 week period of public consultation, the *Plan* will form the foundation for our ongoing dialogue with providers on the services that will be needed through to 2028 and beyond.

Financial Context

Whilst there is a recognition in the 10 year Strategy that there is a need to secure additional funding to deliver on the action proposed and achieve the outcomes set, it is recognised that the short term financial context is very challenging and opportunities to secure significant levels of new investment will be limited.

Given the challenging financial environment, combined with increasing service demand and an increasingly under pressure workforce, it is essential we work collaboratively with service providers to develop new pathways and models of care that achieve the best outcomes possible and deliver best value.

The commitment to make the best use of the finances available to us, will require a comprehensive consideration of current and potential future funding arrangements in line with the strategic priorities detailed in this *Plan*. While this may involve commissioning new services and disinvesting in others, our decisions will always be guided by achieving the best outcomes for Northern Ireland's population. This process will be supported by transparent contractual management and monitoring arrangements that promote fair employment practice, social considerations and environmental sustainability.

We have identified in this *Plan* that we need to balance support provision for all in our population with targeted support for the most vulnerable in our communities. We have also identified the need to shift resources 'upstream' to prevention and early intervention services, with the aim of delivering lasting harm reduction.

It is the PHA's and SPPG's intention to ensure the commissioning and delivery of high-quality services for our population, however we also recognise that within the finite resources available we are likely to be restricted in some areas of commissioning due to demand in others. For the purposes of existing services, we may need to make some hard decisions which could involve stopping some services to free up resourcing to commission others.

As part of the public consultation process members of the public will also have the opportunity to consider which strategic priorities should be prioritised to maximise impact and outcomes of the population within the existing financial climate. This will also include placing an emphasis on service improvement and reconfiguration of existing resources across all tiers.

STRATEGIC PRIORITY 1

PREVENTION AND EARLY INTERVENTION

OUR AMBITION

We will establish a process to build a Northern Ireland prevention approach that will enhance the protective factors and reduce risk factors for all, including children and young people across the region.

Through universal and targeted approaches, we will strengthen the advice, support and interventions available to people to enable them to take greater, more positive control of their lives and enhance their life opportunities by preventing the early initiation of substances.

The most effective way to lessen the long-term harms associated with substance use is to strengthen our approaches to prevention and early intervention. By working with individuals, families and communities earlier we will reduce the harms associated with the use of drugs and alcohol.

This requires our *HSC* services to be cognisant of significant life events that may precipitate or exacerbate substance use, such as loss of employment, illness of a loved one, bereavement, loneliness, and isolation, which can occur across the life course. Feedback from people who have used services highlights that when such life events occur they would prefer to be supported by the service and staff that they have existing relationships with, rather than having to be referred to another service.

There are opportunities to consider the prevention agenda across the *HSC* system. This *Plan* focuses on the following aspects of prevention:

Universal prevention	Selective prevention	Indicated prevention
Addresses a **whole population** irrespective of their risk or propensity for a certain behaviour	Targets **individuals or groups of people at risk/with a particular vulnerability** that is higher than average because the bio-psychological, behavioural or social risk factors they face are more pronounced than the general population	**Exclusively targets individuals who were identified/screened as being at increased risk** for poor health/ harmful patterns of use based on individual assessment (i.e., at risk of progressing to disorder).
It often tries to prevent or delay the initiation of substance use.	Its focus is to avoid escalation of substance use/ progression to harmful use.	Focus is to prevent harmful use and progression to disorder.

In designing prevention and early intervention services, we need to consider equality of access, individual choices and the rurality of Northern Ireland. Much of *HSC* provision exists within our large urban centres, however Northern Ireland is a predominately rural country. Therefore, to ensure that individuals, families and communities have access to the right service at the right time in the right place we must consider a place-based approach[1] to the commissioning and implementation of this *Plan*.

For us to realise our ambition of reducing harm through effective prevention and early intervention, we will map and evaluate current services to establish a 'Northern Ireland Prevention Approach'. An approach that recognises the cross sectoral interconnectedness of substance use services across the community, voluntary and statutory sectors, as well as other services such as mental health, housing, education, employment and justice.

1 Our Place define a placed based approach as "A place based approach is about understanding the issues, interconnections and relationships in a place and coordinating action and investment to improve the quality of life for that community." - https://www.ourplace.scot/about-place/place-based-approaches

In particular, given the many common risk and protective factors across substance use and mental health there is an opportunity to closely align early intervention and prevention approaches with those detailed in the ***Mental Health Strategy.***

Moving forward, our focus will be on commissioning prevention and early intervention services that have been evaluated and evidenced to work either universally or for specific targeted groups. Alongside building local evidence of what works, we will look beyond Northern Ireland to identify successful interventions that can be effectively deployed here.

We will build on existing universal services that provide advice, support and interventions, including **Making Every Contact Count** and the **Living Well** community based pharmacy service, which responds to risk factors contributing to poor health by providing healthy lifestyle advice and, where appropriate, signposting or referring individuals to other services. In addition to **Living Well**, building on existing trusted relations with individuals, community pharmacies will continue to have important role in other prevention and early intervention responses including mitigating against the misuse of over the counter medicines and providing Needle and Syringe Exchange Scheme and Opioid Substitution Treatment. We will also build on existing targeted support programmes such as **Steps to Cope**, **Think Family NI**, **Pharos** and **Voices**.

Our early intervention and prevention services will balance the requirement for equity and universal provision, with the needs of those most vulnerable in our communities. Our approach will be based on the principles of **inclusion health** to overcome the challenges that frequently lead to barriers in access to healthcare and extremely poor health and social outcomes. This will include broadening the reach of our services, by breaking down barriers of stigma to support people across their life course, particularly children and young people, who too often experience hidden harms from substance use.

With the voice of the child, young person and family central to the process, this *Plan* commits to establish a regional working group to update the **Hidden Harm Action Plan** and support its release with a comprehensive communication plan and workforce training package to inform everyone involved in supporting people and families dealing with substance use. We have already heard that the term Hidden Harm means different things to different people.

Ireland's **Seeing Through Hidden Harm to Brighter Futures** report states that "Hidden Harm encapsulates the two key features of that experience: those children are often not known to services; and that they suffer harm in a number of ways as a result of compromised parenting which can impede the child's social, physical, and emotional development."

This work is critical to develop a whole system, stepped care, trauma informed and responsive approach to parental substance use in Northern Ireland that realises, recognises and responds to the impacts of parental substance use.

It is key that children, young people and their families are supported and signposted to the right service at the right time to improve outcomes.

We need to consider the terminology and communication around Hidden Harm going forward, to ensure that all those involved in supporting children and young people are clear about the terminology, risks and supports available. For example, some have suggested using the term Parental Substance Use, with a sub definition of Problematic Parental Substance use or Harmful Parental Substance Use, this will be explored further.

We will engage early with families, including pregnant women identified with significant alcohol misuse (harmful/ dependent drinking) to ensure that Foetal Alcohol Syndrome Disorder (FASD) risk is assessed, with fast tracking into treatment and ongoing support, as appropriate.

Treating the whole person, we will enhance supports to people when they are both in prison and when they are released and ensure those experiencing homelessness, as well as those injecting drugs are included in our programmes.

The development of new planning structures such as the ***ICS*** and the maturing of approaches such as **Community Planning**, will enable us to inform the work of *HSC* and wider structures for improved whole system working and substance use outcomes.

We will continue to focus on services that promote self-care and self-help, including enhancing the tools and resources available on the **drugsandalcoholni.info** website. One resource that should be given greater prominence on the web site, is the importance and availability of nutritional support, for example, the Nutrition Workbook, **Nutrition for Substance Use | Extern: Transforming Lives Transforming Society**, produced by Extern and the *PHA.*

We will also engage more with specialist dieticians as we look to enhance prevention, early intervention and recovery services. Our *Plan* whilst grounded in evidence, also needs to be flexible and responsive to the voices of individuals, families and carers with lived and living experience of substance use. We will not be 'locked in' to our actions, instead adapting our prevention and early intervention services to the changing needs of the population across Northern Ireland. For example, designing services that consider and respond to the high prevalence of polydrug use and mitigate against the over prescribing and misuse of prescription medicines, including over the counter medicines.

The community and voluntary sectors provide essential and valuable prevention and early intervention services to individuals and families. We will strengthen this critical partnership, alongside our collaboration with other sectors, such as education, housing, community planning and justice (including those supervised by the Probation Board of Northern Ireland) to reduce substance related harms. A trauma informed and responsive system with strengthened staff substance use knowledge and skills across all service domains will truly make every contact count.

Prevention and early intervention activities have commonly been delivered as stand-alone interventions. Interventions that target multiple behaviours are likely to prove more effective in modifying risk taking behaviours than a stand-alone focus. Linking prevention and early intervention activities across *HSC* settings such as community pharmacy, general practice, maternity, children services and adult services takes account of our primary, secondary and tertiary prevention approach. This is further supported by links with other domains particularly mental health, where the ***Mental Health Strategy*** includes an action plan promoting mental health through early intervention and prevention, as well as education and justice.

ACTIONS

In addition to the HSC recommendations contained in the **Preventing Harm, Empowering Recovery** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities.

Number	Action	Lead Organisation	Timeframe	Resourcing
SP1-1	Recommission and grow the provision of therapeutic services for children, young people and families affected by parental substance misuse based on recommendations from the regional	PHA	Short	Within Existing Resources
SP1-2	Review current resources from a *Health Literacy* perspective and develop new resources where required that support a reduction in the harm posed by the use of alcohol or drugs to the health of the general population.	PHA	Short	Within Existing Resources
SP1-3	Extend the making every contact count programme to ensure the workforce is skilled in brief interventions in respect of substance use.	SPPG PHA	Short	Within Existing Resources
SP1-4	Produce an evidence based, early intervention and prevention framework that maps and evaluates current provision and facilitates a responsive whole system approach across sectors.	PHA	Medium	Within Existing Resources
SP1-5	Commission evidence-based universal and targeted programmes for young people and adults that support healthy decision making and *Health Literacy*.	PHA	Medium	Additional Resourcing Required
SP1-6	Establish a Community Pharmacy brief intervention service to identify and support those at risk of misusing over the counter medicines such as analgesics and develop a pathway for onward referral by community pharmacists of at-risk patients to more specialist services.	SPPG	Medium	Within Existing Resources
SP1-7	Jointly develop and commission a health focused programme of prevention activities delivered in partnership with other agencies, including the community and voluntary sector, to ensure a whole system approach.	PHA	Long	Additional Resourcing Required

STRATEGIC PRIORITY 2

PATHWAYS OF CARE AND MODELS OF SUPPORT

OUR AMBITION

Adaptable care and support services are commissioned and delivered to reduce harm, adopting a whole system approach, to provide individuals and their families with access to the right service, at the right time, in the right place, to meet their individual needs and achieve their personal goals.

There are a range of key changes in the pattern of current need and demand within our population that are creating pressures within existing services. These include the:

- shifting levels of individual drug usage, including the increase of polydrug use;
- increasingly complex physical issues associated with the long-term use of substances for those in older age, particularly alcohol;
- prevalence of co-occurring mental illness and use of substances (including polydrug use);
- rise in the numbers of people being diagnosed with *ARBI* for whom current service provision is limited;
- needs of a transient and chaotic group of individuals who are subject to remand restrictions and frequently move in and out of custody; and
- needs of minority groups.

The actions we are taking forward in this *Plan* to enhance care and support services are in response to this prevailing need and demand, but we will always remain cognisant of future population changes and respond flexibly to reduce the potential for further inequities in access to services.

People with lived and living experience of substance use and their families and carers have shared with us that whilst the quality of support they have received is good, it can be difficult to access the necessary services at the right time and in the right place. They also tell us that the system of advice, support, treatment and recovery can feel disjointed and confusing, resulting in them having to move

between services and recount their personal stories on multiple occasions, too often exacerbating the trauma they may have already experienced in their lives. We are determined to reduce these adverse experiences.

The specific interface between mental health services, including psychiatry of old age, and addiction services, has been highlighted as an area where further work is required. This is particularly the case for individuals with *ARBI*. This *Plan* commits to better alignment between the ***Preventing Harm, Empowering Recovery*** and ***Mental Health Strategy*** strategies to identify and close service gaps ensuring individuals receive the right service, at the right time, in the right place.

Our *Plan* is underpinned by the clear principle that, at whatever age, people who use substances and their families and carers have the same right to health and social care support as anyone else. This means that our services must work together to ensure that every contact counts for the individual and their family.

Our ambition should mean that individuals with substance use issues and their families can, for example, access immediate crisis support, obtain a direct referral to the most relevant specialist service without experiencing unnecessary delay, or secure outreach support in rural areas. The right service will also mean ensuring that support is provided to respond to multiple challenges, including physical and mental health issues, offending behaviour, and social issues such as housing and finance.

Whilst there are a wide range of existing services and support across the region for people with substance use issues, we have heard from people who work within these services, and from those who use them, that the reach and remit of each service is not always known. We will address this knowledge gap in the *HSC* system to ensure people are signposted to the correct support.

We will prioritise a person-centred approach to connecting pathways of support and the models of care we provide across departments, agencies and sectors, adapting approaches and care models that change with demand and patterns of need. This includes prioritising consistency of service provision across our region.

There are several key strategies and transformational programmes in development across the *HSC* system, our *Plan* places substance use within the context of these developments, which include:

- ***ICS***;
- **Single Mental Health Service for Northern Ireland**;
- **Children's Social Care Services Northern Ireland – An Independent Review**;
- Treatment for Substance Use in Northern Ireland Prisons - Rapid Review and Consultation to Inform the Development of Services; and
- work of regional collaborative networks such as the Forensic Managed Care Network and Regional Trauma Network.

It is also important for us to build on existing models of support that already take a whole system, integrated approach, including:

- linking with multi-disciplinary teams (*MDT*s) established in some *GP* surgeries to provide support at a primary care level;
- strengthening the partnership working of local *DACTs*, which connect services across health, justice, local authority and communities; and
- reviewing the existing provision of liaison support for people with substance use issues who come into contact with acute general hospital services including emergency departments.

We will apply learning from several local approaches across Northern Ireland such as:

- the **Belfast Complex Lives** initiative, which supports vulnerable people with substance use, mental and physical health issues, and other risk factors such as offending behaviour and homelessness;
- the '**Good Lives**' model as piloted in the Southern Health and Social Care Trust, which takes a holistic therapeutic approach to those involved in the justice system;
- findings from the Regional Trauma Network Substance Use project, which has focussed on the interface between trauma and substance use services; and
- a number of key recommendations made within the Western Health Social Care Trust area Needs Assessment, which may be applicable to other areas.

Further areas we are prioritising within this *Plan* based on need and demand are pathways of support and models of care for:

Children and Young People

People who have both mental health and substance use issues

People who require Opioid Substitution Treatment (OST)

People who are entering and maintaining recovery

People who come into contact with the justice system

Children and Young People

The prioritisation of pathways of support is required across the life course, and we will pay specific attention to children and young people within the *HSC* system, including as they transition to adult services. This means that we will focus on coordination across services including *CAMHS, DAMHS,* Children and Family Social Work Services, Maternity Services, Adult Mental Health Services (including Peri-Natal Mental Health), Youth Justice Agency *(YJA),* Education and Support Services as provided by the community and voluntary sectors, including family systemic therapy and counselling for substance use issues.

Children and young people in residential care are known to be at heightened risk from substance use and we need to ensure our services are more effectively joined up to respond to the needs of this group. This includes prioritising developments underway in line with the **Children and Young People's Strategy**, **A Life Deserved Strategy**, **An Evaluation of how Safeguarding Board for Northern Ireland member agencies are effectively responding to and managing Child Sexual Exploitation within Northern Ireland** (Leonard Review) and **Northern Ireland Framework for Integrated Therapeutic Care for Care Experienced Children and Young People**.

Our *Plan* will also seek to expand drug and alcohol midwifery services to reduce the harms caused by substance use during pregnancy, with a particularly heightened focus on reducing the number of children exposed to high levels of parental alcohol intake in utero.

We understand that the stigma associated with substance use may make parents, particularly mothers, unwilling to seek support from family services including social work. Equally we understand that workers within these services may lack the specialist knowledge of substance use treatments and may make decisions in relation to family circumstances that focus on the risks associated with substance use, without fully understanding the capability of parents engaging in support during recovery. It is important therefore that we seek to enhance knowledge sharing between services to fully inform risk assessment and statutory decision-making processes.

People with Co-Occurring Mental Health and Substance Use Issues

Based on evidence, we know of significant overlap between mental ill health and substance use.

We also know that from the NIAO **Addiction Services in Northern Ireland** report that the number of bed days occupied where there was a primary diagnosis of mental and behavioural issues due to substance misuse has increased by over 35% in the last five years.

Despite the high incidence of co-occurring mental health and substance issues, individuals with lived experience and their families have told us that they cannot access mental health support until they have addressed their substance use issues. Individuals accessing services also tell us that there are 'silos' between services, leaving them unsure who is coordinating their care or how to access support. Workers have similarly recounted frustrations around the demarcation between services, and lack of appropriate training which can lead to people being moved between or excluded from services.

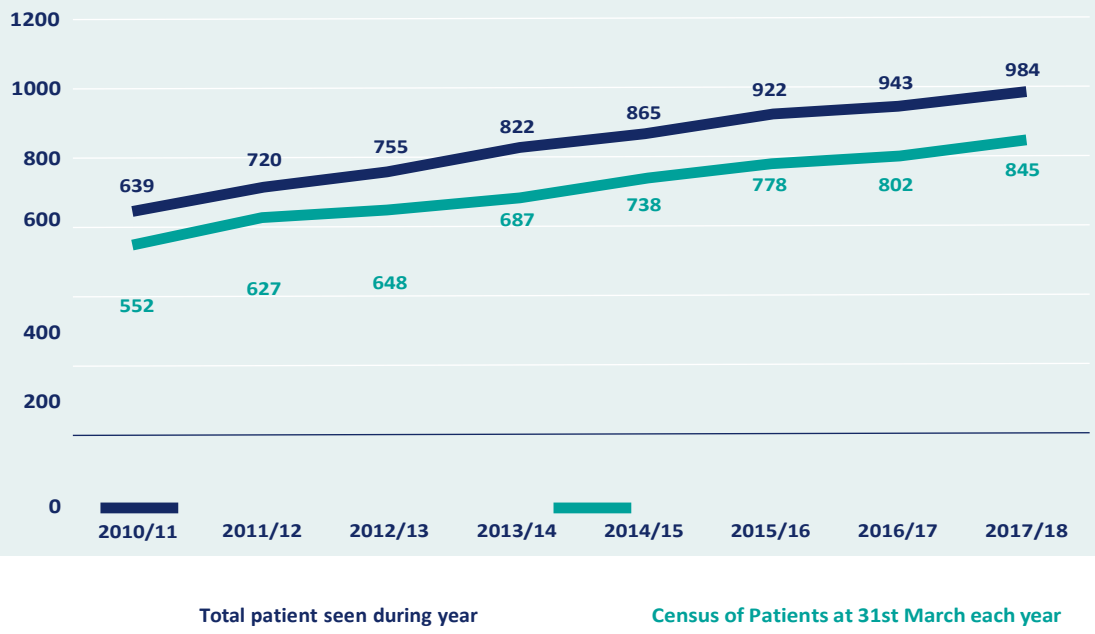
In response, the Northern and Southern Health and Social Care Trusts have both funded designated Co-Occurring Mental Health and Substance Use professionals to provide operational and strategic links between Trust provided mental health services and addiction services. These are reported to be beneficial to individuals using services and staff. The ***Mental Health Strategy*** and ***Preventing Harm, Empowering Recovery*** strategy both recommend the creation of a Regional Co-Occurring Mental Health and Substance Use Network. Our *Plan*, in the short-term, will focus on scoping the role and remit of this Network and identifying the current challenges between services.

The ***Mental Health Strategy*** includes a number of priority initiatives, including the development of a **Single Mental Health Service for Northern Ireland**, alongside preventative approaches to mental health and the development of crisis and recovery services. To deliver a holistic approach to support for the individual and their families, our priority will be to ensure that people with substance use issues have access to these services and that the pathways developed clearly recognise the needs of the whole person, which includes the use of substances.

Opioid Substitution Treatment

Demand for *OST* has been increasing year on year throughout the region:

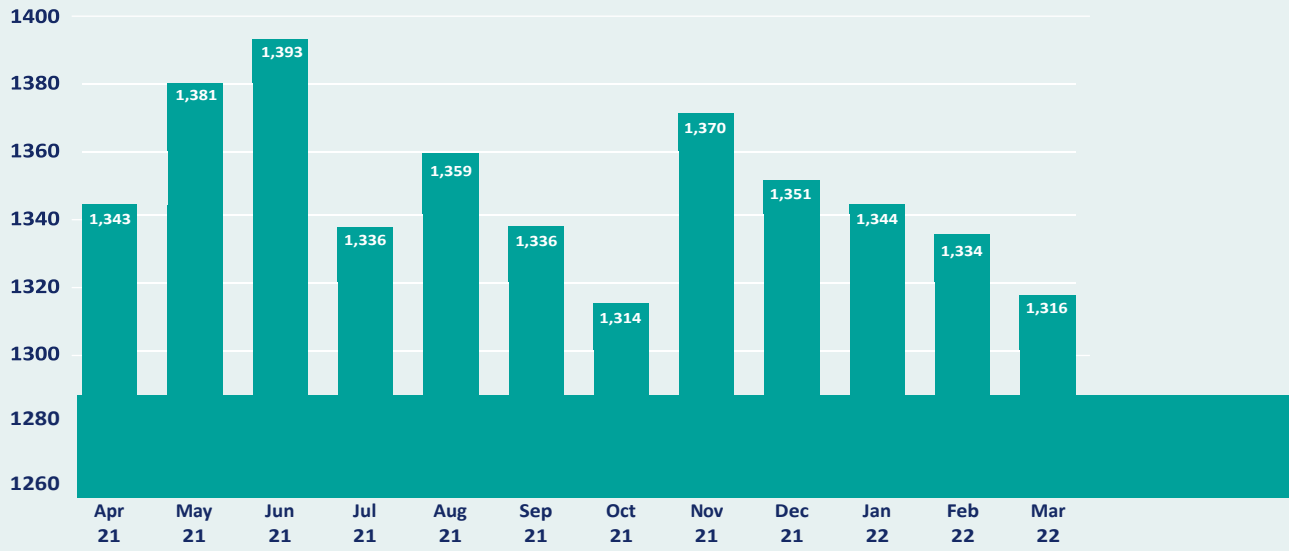
Figure 1: Total Number of Patients receiving Substitute Treatment during the years between 1/4/10 and 31/3/18 also showing Census of patients at 31st March each year



Source: Northern Ireland Substitute Prescribing Database Report, 31st March 2018

The most recent figures available since the publication of the 2018 report show that this trend has continued with over 1,300 individuals in treatment on average in 2021/22:

Figure 2: All Trusts Service Users on Prescription Medication on OST Caseload at month end in 2021/2002



Source: OST Dashboard, 2022

Continuing demand for *OST* is complicated by polysubstance use, particularly IV cocaine, benzodiazepine and gabapentin use, as well as misuse of over the counter medicines, particularly analgesics. Chaotic social circumstances can make engagement in treatment more challenging, particularly for individuals released from prison and those who move between Trust areas due to lack of housing provision in their locality. There are less supportive family networks (due to second and third generation substance users presenting) resulting in significant challenges to recovery.

There are also specific capacity and demand issues relating to provision of *OST* in prison. The recent Treatment for Substance Use in Northern Ireland Prisons - Rapid Review and Consultation to Inform the Development of Services notes the lack of facilities to detox away from the general prison population and limited clinical assistance or symptomatic relief to help with withdrawal. Furthermore, current waiting lists to see a *GP* and/or an Addictions Consultant in prison may also prevent people for entering treatment for recovery. We will focus on the recommendations made within the Review that target the specific prison related challenges.

The Regional Review of Tier 3 *OST* Services 2018 provided recommendations on the following areas:

A. Access Management
B. Initiation and Treatment
C. Capacity and Demand and Workforce Development
D. Outcomes Measurement

We will continue to prioritise implementation of these recommendations while acknowledging current challenges in our *HSC* system, which include:

- workforce and accommodation issues, particularly provision of services in prisons and to rural populations;
- service capacity, waiting lists and pressures given existing patient caseloads, with some areas not having access to shared care models or non-medical prescribers to allow flow through the service;
- increasing numbers of individuals who inject drugs requiring acute medical inpatient treatment for life and limb threatening conditions (such as sepsis, gangrene, bacterial infections);
- pressures on the regional toxicology lab due to lack of staffing and equipment issues leading to delays in urinary drug screening results, which can lead to delays in commencing treatment;
- increasing complexity of individuals presenting to services, with many presenting with polysubstance misuse such as the rise in comorbid dependence/ harmful use of cocaine, gabapentanoids and benzodiazepines;
- increase in oral opioid users requiring substitute prescribing, particularly those who use over-the-counter codeine products, which can result in significant physical health complications; and
- individuals presenting with complex mental and physical health needs (e.g., blood borne virus infection, significant history of trauma) as well as social needs such as homelessness, poverty, childcare concerns, domestic violence and lack of access to activities that promote recovery.

Recovery

As we recraft pathways of support, and models of care, we will be bold in responding to the multiplicity of needs of our population - this includes how we provide support for people who wish to enter or maintain recovery.

We have heard from people with lived experience and their families, that often it is difficult to access recovery support and treatment when the person is motivated to change.

We have also heard that even if the person is making a good recovery following treatment, other issues such as loneliness, boredom, the lack of appropriate housing, homelessness, meaningful employment opportunities, and ongoing proactive support can stop people making progress and sustaining recovery. This can be particularly difficult for people leaving prison and often includes those subject to probation supervision, as well as those who are homeless.

We have commissioned an independent review of Tier 4 substance use services, which will look at recovery services with a focus on Tier 4a In-Patient Detoxification, and Tier 4b Residential Rehabilitation services across the region. Given this Review will consider the relationship between Tier 4 services and other community services supporting recovery including referral pathways, it's findings will be important in setting the direction for future commissioning of services across the region.

We have heard of several other recovery initiatives benefiting individuals, including **Recovery Colleges** and the positive impact of advocacy services, peer mentors and the link between exercise and occupational therapy to support recovery. We will prioritise and embed what works in these areas based on evidence and how best to build or strengthen in our current system.

We will strengthen needle and syringe exchange services and the provision of naloxone to save lives.

We have heard that there is a need to prioritise services for people with *ARBI*. There is an increasing demand for these services particularly amongst women, older people and people who reside in Northern Ireland who may not have English as their first language. Currently there are no designated *ARBI* teams in the region or pathways to support people with the condition in the community. Individuals are currently supported via *HSCT* Physical Disability, Mental Health and Addiction services along with a regional residential facility run by the **Leonard Cheshire** organisation. We will prioritise how we improve age-appropriate pathways and services for people with *ARBI*, including consideration of *ARBI* teams, increased awareness amongst the workforce and earlier diagnosis of the condition and treatment that supports quality of life for the individual.

We will improve access to rapid treatment and support for individuals injecting drugs who are admitted to hospital with serious physical health conditions, including access to OST if required, to help them stay in hospital for the duration of their treatment.

Justice

People in contact with the justice system, include people who are in contact with the Police Service of Northern Ireland (including in custody), Court Services, medium secure mental health services, probation services and *YJA*, as well as people in prison. The population in contact with the justice system, as with the general population, have specific needs, including co-occurring mental health issues; polydrug usage and complex physical issues.

The Probation Board for Northern Ireland supervises approximately 4,000 individuals at any one time, subject to either community based sentences imposed by the Courts, or under license after being released from prison. Often these individuals have issues with substance use, and this will often have been a significant contributory factor in their offending. As a consequence, they will often have a legal 'additional requirement' to undertake interventions related to their substance use in the form of either a programme or services from a specialist provider under the auspices of this Plan. If such individuals do not undertake the interventions as directed they can be recalled back to prison or returned to court for re-sentencing. Given this context, we will explore ways to enhance information sharing between substance use services and Justice.

We are aware of the specific challenges relating to demand and capacity to provide support and treatment within Healthcare in Prison services. We also know of difficulties experienced by people moving from prison to the community in accessing support and treatment services to enable rehabilitation and recovery, as well as the increased numbers of women within or on the periphery of the justice system, along with a rising number of remand prisoners who are not accessing structured support.

Given our knowledge, we will prioritise consideration of several initiatives, :

- scoping the development of a new prison to community transition service, embedded across prisons and working with people up to six weeks prior to release and a further 6 to 12 months following release. This service will support transitions to suitable accommodation, linkage with *GPs, HSCTs* and community-based addiction services, education and training;
- strengthened *OST* services within prisons and improved pathways and transition support from prison to community, including continuation of in-prison treatment within the community with easier access for people returning to the community;

- scoping the development of a specialised service for children/ young people and females/ families of those in prison;
- scoping the development of a specialised service for those older females with chronic mental health issues in prison;
- improved support around substance use for younger people across all services whether in prison or the community;
- increased accessibility across Northern Ireland to **Substance Misuse Courts** to divert people with addiction issues from prison/the justice system and to provide a fast-track response to their addiction and treatment needs with a view to reducing the cost to the justice system and to reduce their likelihood to further re-offending;
- review of weekend prison releases, especially for individuals at risk of homelessness;
- encourage clear housing/accommodation pathways that are effective and safe with an emphasis on recovery and preventing relapse within a multi-disciplinary approach;
- development and expansion of the new THRIVE service (or similar) beyond 2024;
- ease of access for released prisoners to primary care on release – i.e., *GP* and Primary Care *MDT*s across all Trust areas;
- realignment of *PHA* and *SPPG* contracts to accommodate the needs of those from prison, including substance use treatments and mental health;
- realignment with Probation Board of Northern Ireland/ Department of Justice funded contracts to include those released from prison, but not under Probation Board of Northern Ireland orders; and
- align with Big Lottery funded projects to make better use of existing resources and support for people leaving prisons.

ACTIONS

In addition to the HSC recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Lead Organisation	Timeframe	Resourcing
SP2-1	Develop support for children and young people in residential care as they are known to be at heightened risk from substance use.	SPPG	Short	Additional Resourcing Required
SP2-2	Ensure drug and alcohol midwifery services are available across the Region to reduce the harms caused by substance use during pregnancy. Review screening and reporting services for substance drug use in pregnancy used to reduce the number of children exposed to high levels of parental alcohol intake in utero.	SPPG	Short	Additional Resourcing Required
SP2-3	Strengthen knowledge sharing between post-natal community services, peri-natal mental health services and substance use services.	SPPG	Short	Within Existing Resources
SP2-4	Review and reconfigure Substance Misuse Liaison Services available for people with substance use issues who come into contact with mental health in patient services and acute general hospital services including emergency departments.	SPPG	Short	Additional Resourcing Required
SP2-5	Building on the review of the role, function and membership of the *DACTs*, develop the role of the *DACTs* as a mechanism for wider collaboration between local/ regional stakeholders.	PHA	Short	Within Existing Resources
SP2-6	Strengthen the sustainability of services provided by the community and voluntary sector and review how the services are commissioned and procured through an ongoing review and assessment of models of intervention and evaluation of impact.	PHA BSO SPPG	Short	Additional Resourcing Required

Number	Action	Lead Organisation	Timeframe	Resourcing
SP2-7	Review tier 2 service provision ensuring enhanced community-based services for young people who are identified as having substance use difficulties and adults and family members affected by substance use are commissioned.	PHA	Short	Additional Resourcing Required
SP2-8	Develop person-centred pathways across services to ensure that people receive the right service at the right time. This includes *CAMHS, DAMHS*, *CAMHS* Substance Use Services, Children and Family Social Work Services, Maternity Services, Adult Mental Health Services (Including Perinatal Mental Health), *YJA*, Education and Support Services as provided by the community and voluntary sectors.	SPPG	Medium	Additional Resourcing Required
SP2-9	Ensure risk assessment, decision making and treatment option processes are informed by knowledge sharing between children and family, mental health and substance use services, as well as the community and voluntary sectors.	SPPG	Medium	Within Existing Resources
SP2-10	Implement the recommendations from the independent review of Tier 4 substance use services.	SPPG	Medium	Additional Resourcing Required
SP2-11	Implement the recommendations within the Review of Tier 3 *OST* Services with an emphasis on reducing waiting times and responding to challenges relating to *OST* in Prison and *OST* access in rural communities.	SPPG	Medium	Additional Resourcing Required
SP2-12	Enhance advocacy services and peer mentors in treatment and recovery services.	PHA	Medium	Additional Resourcing Required
SP2-13	Realign *PHA* and other contracts for substance use and mental health support, to ensure services are provided to those in, and on the periphery of, the justice system.	PHA	Medium	Within Existing Resources

Number	Action	Lead Organisation	Timeframe	Resourcing
SP2-14	Learning from 'Complex Lives' jointly commission a holistic rural service model with Health, Housing and Justice.	PHA NIHE PBNI	Medium	Additional Resourcing Required
SP2-15	Review substance misuse services for people who come into contact with Probation Board of Northern Ireland.	SPPG PHA PBNI	Medium	Additional Resourcing Required
SP2-16	Develop a strategy for the prevention of *FASD* similar to the **HSE Position on Prevention of Foetal Alcohol Spectrum Disorders**.	PHA	Long	Within Existing Resources
SP2-17	Review the provision of specialist community detox services to identify service gaps and make recommendations for service transformation and future commissioning priorities.	SPPG	Long	Additional Resourcing Required

STRATEGIC PRIORITY 3

TRAUMA INFORMED SYSTEM

OUR AMBITION

We will raise awareness of the prevalence of adversity and trauma in our society, including the impact on individuals, families and carers living with substance use.

We will strengthen our services through an appreciative inquiry approach to fully integrate trauma knowledge into policies, procedures and practices.

"Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being."[2]

Our approach in *HSC* should be grounded in the understanding that trauma can impact an individual's neurological, biological, psychological, social and economic wellbeing. Our approach should be guided by the four key elements (4R's) of trauma informed practice:

1. **Realise** the impact of trauma on individuals, families, communities, organisations and systems
2. **Recognise** how trauma presents through signs, symptoms, behaviours and coping strategies
3. **Respond** by integrating knowledge about trauma into policies, procedures and practices
4. **Resist** and prevent re-traumatisation through the creation of safe physical and emotional environments for staff and service users.

2 https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

Trauma can overwhelm an individual's ability to cope and is a major risk factor in people using substances to problematic levels, in order to manage personal distress. This is why we have prioritised a trauma informed approach to the provision of support across the whole *HSC* system that aims to address the connection between trauma and substance use.

Our *Plan* recognises the inherent connections between adversity, trauma and substance use and we understand the need for *HSC* services to be delivered in such a way that acknowledges the impact of trauma individuals may have faced. This includes ensuring that accessing the *HSC* system avoids re-traumatisation and builds on the strengths of individuals and family/ carer network to help facilitate recovery.

Trauma informed practice can only happen in the context of trauma informed and trauma responsive environments, policies, systems and organisations.

We will take the learnings from the ongoing project as led by the Regional Trauma Network, which is scoping the challenges faced by people accessing support provision for trauma and substance use issues, along with evidence on how best to deliver integrated pathways and models of care.

Our responses will not only focus on the individuals that seek our support and, on the staff, and systems who provide that support, but also on identifying individuals who would benefit from support, but who are not yet actively engaged with services.

It is important for us to respond to the specific needs of children and young people dealing with trauma and substance use, including children and young people who have been within the care system. The provision of support to children and young people which identifies and addresses trauma can help reduce the harms caused by substance use. This includes the additional stigma experienced by families, and specifically mothers, who have had a child removed from the family unit due to substance use issues.

We also acknowledge the impact that substance use related bereavement has on individuals and families and their associated experience of trauma. We will prioritise strengthened support for those bereaved by substance use, by ensuring we have a skilled, experienced and compassionate workforce to best meet their needs.

We will listen and learn from those with lived and living experience of trauma and substance use, encouraging and nurturing a culture of peer support across our services. We will take forward initiatives to ensure our workforce is more fully trauma informed and responsive by building on what is already available, including the Safeguarding Board for Northern Ireland's **Adverse Childhood Experiences** and **Trauma Sensitive Approaches** training.

Focusing on a whole system approach we will work with partners to achieve the building blocks of trauma informed and responsive organisations learning from local, national and international examples such as **Trauma Informed Oregon.**

By making the connection between trauma and substance use explicit, we aim to help reduce the stigmas associated with substance use and encourage social dialogue. To this effect we will work with partners to develop appropriate information, tools and training packages, this will include a public awareness campaign.

System wide strain coupled with the challenge of recruiting and retaining staff has resulted in significant and rising pressures across addiction and mental health services including psychological therapies. We will seek to influence and secure strategic and operational integration of psychological therapies embedded within services, including supporting and enhancing the psychological therapy provision of the community and voluntary sectors.

The pandemic has undoubtedly impacted many of us personally and professionally, which at times has presented through staff sickness and burnout, therefore it will be important to consider how we prevent compassion fatigue and vicarious trauma in an ever-changing world. We will also consider how we respond to the trauma that is prevalent amongst new arrivals to Northern Ireland, including asylum seekers and people displaced from Ukraine and other countries due to war.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Lead Organisation	Timeframe	Resourcing
SP3-1	Create a training plan for the substance use workforce to enhance skills to recognise, understand and respond to trauma amongst people using substances.	PHA	Short	Within Existing Resources
SP3-2	Develop trauma informed commissioning processes to support the outworking of the ***Preventing Harm, Empowering Recovery*** strategy.	PHA	Short	Within Existing Resources
SP3-3	Support the development of trauma informed and responsive organisations across all tiers of addiction services that appropriately focus on the needs of the individuals that seek support and the staff that provide the support.	SPPG PHA	Short	Within Existing Resources
SP3-4	Commission research to explore the trauma experienced by asylum seekers, refugees and other at-risk groups and make recommendations to adapt services.	PHA	Medium	Additional Resourcing Required

STRATEGIC PRIORITY 4
FAMILY SUPPORT

OUR AMBITION

We will strengthen our services by taking a family inclusive approach to ensure we better understand the role of the family and carers in supporting individuals in their substance use journey.

We will further enable the positive contribution family members and carers can make to a person's recovery by helping families and carers build their own resilience.

The impact of substance use is not only felt by the person using drugs or alcohol, but it also has a significant impact on families, including children and young people, carers and wider communities. Taking a holistic, family inclusive approach to providing support for people affected by substance use is therefore fundamental to how we will approach service delivery.

As already described in our *Plan*, people often start using substances in an attempt to cope with current adversity, past trauma or experience of parental or sibling substance use . As well as adopting trauma-specific interventions to treatment and support, the services we commission equally need to work with families and carers to reduce the harms associated with the use of alcohol and other drugs, and to support recovery. Taking a holistic, family inclusive approach will require our combined ingenuity and innovation. This is particularly relevant when working with children and young people in response to parental substance use or when working with families to support adult loved ones who are using substances.

Holistic services that work not only with individuals, but the wider family unit should be the norm. Family members must be part of the solution. Sadly, many families are not receiving the necessary systemic support from our current service provision.

Equally, we recognise that not all families are supportive of a person's recovery and may have been instrumental in the adversity and trauma experienced by individuals who use substances. Therefore, a therapeutic approach that does

not add to the impact of family related trauma is essential. This approach should balance supporting the individual with substance use issues whilst encouraging the family to understand the impact family dynamics has in preventing or supporting the recovery process.

We will continue to build on established initiatives such as **Think Family NI**, which takes a whole family approach to the planning and delivery of services by supporting collaborative ways of working with individuals and their families living with substance use.

We will enhance existing family systemic therapy provision with increased funding to the community, voluntary and statutory sectors. This evidence-based approach supports families in group settings to help family members better understand each other and the impact of substance use across the family unit. Investment in this approach aims to change negative behaviours, resolve existing conflicts and empower families to create their own solutions.

It is also critical that families have access to meaningful support within their own right, whether their relative using substances is receiving *HSC* support or not. We are clear that, whenever appropriate, family members should be seen as carers eligible for HSC **Carer Assessment**.

We have learned from the reporting of serious adverse incidents of the importance of family contribution to providing information to inform the assessment of risk and the provision of support and treatment options. It is therefore imperative that the voices of families and carers are not only heard but listened to as part of risk assessment and subsequent care planning.

A strong, sustainable set of partnership arrangements will need to be in place at local and regional level with community and voluntary organisations who have the necessary skills, expertise and a proven track record in the delivery of whole family approaches. We need to commission services that tap into the strengths of service providers creating strong alignment between all substance use services.

This step change focus in embedding family support within models of care will be backed up with promotion of the services available to families and carers and additional workforce learning and development, as necessary.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Lead Organisation	Timeframe	Resourcing
SP4-1	Develop/ facilitate a network of family peer support groups that will provide support for families and carers not only as advocates for those using substances but also as individuals who have been impacted and traumatised by their loved one's substance use, often at the cost of their own health.	PHA	Short	Within Existing Resources
SP4-2	Embed family support options across a range of local services, platforms and networks, to ensure everyone knows what is available and how it can be accessed.	SPPG PHA	Medium	Within Existing Resources
SP4-3	Ensure the workforce is effectively trained in family inclusive practice and whole family approaches.	SPPG PHA	Medium	Additional Resourcing Required
SP4-4	Commission a range of evidence based therapeutic interventions for families with lived and living experience of substance use.	SPPG PHA	Long	Additional Resourcing Required

STRATEGIC PRIORITY 5
STIGMA

OUR AMBITION

Through education and leadership, our services will always be welcoming and respectful, free of judgement, encouraging people and their families to come forward for our support.

We will proactively contribute to developing a stigma free culture in Northern Ireland.

Many individuals struggling with substance use can feel shame or internalise their situation as a moral failing. Such feelings can often be attributed to a long-standing stigma associated with substance use.

Stigma is an attribute, behaviour, or condition that is usually socially discrediting. Evidence tells us that the use of negative language and attitudes can impact on a person's ability to seek help and support for their substance use, with prevailing stigma stopping people getting help due to feelings of being judged or being unworthy of support.

Whilst substance use stigma is universal, some groups experience heightened stigmatisation. Mothers tell us they feel judged and, in some cases, excluded from support when they come in to contact with maternity, mental health and other services.

Children and young people too often unfairly feel the weight of stigma of the impacts of parental substance use.

Stigma also affects the family and carers of people struggling with an alcohol or drug problem, limiting their ability to get help for their loved ones or themselves. Stigma experienced by families can also lead to feelings of shame and guilt. These feelings can be compounded when a family is bereaved through a substance use related death.

Stigma is also experienced by those involved with or on the periphery of the justice system.

We are in no doubt that stigma leaves people extremely isolated at the very time when they need our support. We recognise that by tackling stigma, we encourage more individuals to access *HSC* services and thereby contribute to a reduction in alcohol and drug related harms and deaths in Northern Ireland.

It is so important that we see each individual that seeks our support as a whole person that did not choose to become addicted to a substance, rather they have arrived at this point due to the many challenges experienced in life. We will do this by being trustworthy, respectful, competent and accountable and by treating individuals and families with compassion.

As detailed in the key principles section, our *Plan* takes a human rights-based approach that states that people with problematic alcohol or drug use are entitled to access the same quality of support and treatment as those without substance use issues. This support should be universally available without fear of judgment.

Words matter! Language sustains stigma surrounding substance use. It is important that we emphasis the impact words have on individuals and families effected by substance use and that the strengths of the individual are emphasised during recovery. Our services will seek to challenge prevalent stigmatising language used to describe people who use substances, in order to help remove barriers for people seeking support from *HSC* services.

We will develop an *HSC Service Charter*, which will address stigma. This will be co-produced with people with lived and living experience and implemented by *HSC* services across Northern Ireland to a set of guiding principles.

We will support our workforce with training and education on reducing stigma and harm. We will collate and share information resources to counter the use of inappropriate and stereotyping language and actions.

Creating a stigma-free Northern Ireland requires shared responsibility, commitment and action. Across health and social care, we can do this by having a kinder approach to those affected by substance use. One where we ask ourselves and our colleagues – if we needed help and support for substance use issues, how would we want to be treated.

Our services will be delivered with humility and understanding, meeting people where they are at, while offering people hope.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Lead Organisation	Timeframe	Resourcing
SP5-1	As part of a wider awareness campaign, co-produce a HSC Substance Use Services Charter with a set of guiding principles designed to support and encourage a stigma-free Northern Ireland.	SPPG PHA	Short	Within Existing Resources
SP5-2	De-stigmatise substance use and increase the visibility of those affected by creating a platform/forum where stories of individual and family experiences can be shared and heard.	PHA	Short	Additional Resourcing Required
SP5-3	Review the need for specific support information and/ or services for those bereaved by substance use , in line with Substance Use Strategy Outcome D Action 5	PHA	Short	Within Existing Resources
SP5-4	As part of a wider awareness campaign, produce a glossary of terms that encourage 'people first' language to combat against future stigmatisation of people using substances and their families.	PHA	Medium	Within Existing Resources
SP5-5	Commission a co-produced public information campaign tackling stigma.	PHA	Long	Additional Resourcing Required

STRATEGIC PRIORITY 6
WORKFORCE

OUR AMBITION

The substance use workforce is confident, compassionate and equipped to recognise the needs of the whole person. The workforce is supported to respond flexibly to the needs of people with substance use issues, with a trauma responsive and inclusive approach to deliver respectful support, care and treatment, free of stigma to individuals and their families.

The *HSC* workforce across the region is under significant pressure. This *Plan* recognises the importance of having a well-supported, trained and resourced workforce to meet the needs of individuals and their families living with substance use. This means developing a workforce in prevention and early intervention services through to intensive treatment and recovery.

This also means ensuring that the workforce in all of our *HSC* settings understands the impact and complexities surrounding substance use, not just staff within specialist drug and alcohol services. This is particularly important in community pharmacy, primary care and services supporting people with co-occurring issues such as mental and physical ill health.

It is important for us to map, review and evaluate current *HSC* workforce development programmes to fully understand how best to develop general and targeted training programmes around substance use.

We also aim to understand the training needs and core skills required from the substance use workforce and will build on a range of training packages funded by the *PHA* through the Workforce Development Services and provide a pathway for alcohol and drug workers from all sectors to engage in substance use training in line with national standards.

We will take forward a series of other priority workforce actions such as supporting and securing capacity for the substance use workforce to access training in evidence based psychological therapies. We will also provide any necessary naloxone training to support the expanding access of naloxone to save the lives of those at risk from an opioid overdose.

To effectively deliver on our ambition of developing a trauma informed *HSC* system, we will develop an approach making our workforce trauma informed and responsive.

Our *DACTs* Connections Service has a role in understanding the needs of the population in local communities alongside workforce and service requirements to address such needs. As such we will build on the positive contribution of the Connections Service and review their role and function in line with developments around the ***ICS***.

We will also connect the development of the substance use workforce with the comprehensive workforce review being undertaken as part of the ***Mental Health Strategy***.

Whilst multiple factors influence suicidal behaviours, substance use is a significant factor linked to a substantial number of suicides. Given the risk factors, we are determined to ensure our workforce is confident and informed in recognising and responding to suicidal behaviours in those living with substance use. We are committing therefore to provide suicide prevention training to all staff working in substance use related services. Our training will align and support Northern Ireland's **Protect Life 2 – A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024**, as well as the *DoH's* **Suicide Prevention Care Pathway**.

Technology will be a critical partner, as we look to strengthen our workforce. A training portal will provide the most effective method of connecting learning across people working in substance use in the community, voluntary and statutory sectors, as well as staff in other linked domains such as mental health, housing and justice.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Responsible Organisation	Timeframe	Resourcing
SP6-1	Commission a whole workforce training needs assessment for the substance use sector, that is strength based and client led, with flexibility to pick up emerging issues, and that includes the core skills and values that all staff in the sector should possess.	SPPG PHA	Medium	Additional Resourcing Required
SP6-2	Provide comprehensive naloxone training to support the expansion of access to naloxone to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose in line with Substance Use Strategy Outcome B Action 6	PHA	Medium	Additional Resourcing Required
SP6-3	Ensure the tools and resources developed to support prevention, intervention and recovery are promoted through any training delivered.	PHA	Medium	Additional Resourcing Required
SP6-4	Develop a strategic Northern Ireland Drug & Alcohol workforce framework that sets regional standards of training, competencies and pathways of development across all tiers of services.	SPPG PHA	Long	Additional Resourcing Required

STRATEGIC PRIORITY 7
DIGITAL INNOVATION

OUR AMBITION

We will adopt an approach to digital innovation, which will increase the numbers of people that can access our prevention, advice and support services and ensure that all information and tools are easily navigated and understood.

We will develop an accessible digital platform to provide a comprehensive substance use learning hub for the HSC workforce.

Digital technology is an important enabler to deliver on many of the commitments as detailed in this *Plan*. Technology can be transformative for people who are able to use it and is a vital tool in how we deliver our services.

During a period of sustained financial constraint, pursuing digitally innovative approaches holds real promise. Better use of technology is likely to prove cost effective by reaching greater numbers of people and offering less scope for divergence from policy and best practice guidance.

The ***Mental Health Strategy*** includes the opportunities from greater digital innovation and includes a number of actions to advance digital mental health. We will ensure we learn from digital initiatives being pursued under the auspices of the ***Mental Health Strategy*** and look for synergy of approaches where appropriate.

The regional rollout of the **Encompass** system across the statutory sector provides an exciting opportunity for integration of systems and improved connectivity and information sharing. It also presents a challenge to ensure that the needs of specialist substance use services are recognised in the development of the **Encompass** system.

COVID-19 presented an opportunity to evidence the use of technology when face to face contact was not permissible. We have learned from what can be achieved with the use of technology in areas such as psychological therapies and will build on this learning.

There are several Northern Ireland and UK web sites, tools and applications available to people seeking support and advice on substance use matters. Digital options are also available to all tiers of our workforce to strengthen their knowledge and skills, however the varying level of information across the community, voluntary and statutory sectors should be reviewed. It is clear, for example that signposting of what is currently available needs to be improved, as do the pathways and connections between the various sites and tools. We also need to revisit the content to ensure it is aligned with the latest research on what approaches, models and practices work, as well as targeting the strategic priorities set out in this *Plan*.

Our first action will be to undertake an audit of digital platforms and tools to baseline what is available across the community, voluntary and statutory sectors. The audit will validate content and user friendliness, as well as identifying the opportunities for further digital innovation. Digital innovation pursued will have a particular focus on connecting services across the whole system and supporting delivery of the strategic priorities set out in this *Plan*.

As part of this technology baselining, we will review, for example, **https://drugsandalcoholni.info/**, to ensure it provides a comprehensive entry point to appropriate resources, facilitating a 'no wrong door' philosophy to connect people to advice and support. We will also review workforce learning tools, ensuring they align with current practice and support the strategic direction for substance use advice and support.

We commit to an inclusive co-design process for digital innovation and developments, ensuring appropriate consideration is given to the issue of digital poverty as well as other accessibility issues to ensure people have ready access to information, advice and support regardless of the platform.

In line with this commitment, we will adopt a number of guiding principles in relation to technology:

- co-producing our developments with people with lived and living experience, families and carers;
- ensuring technology is easy to access and available for use in the person's home or community;
- using technology to improve outcomes for people and communities;
- ensuring equality in approach so access to technology is fair, consistent and free from discrimination; and
- promoting best practice in the use of technology and ensuring compliance with relevant standards.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Responsible Organisation	Timeframe	Resourcing
SP7-1	Review the effectiveness of existing digital tools in relation to their use in substance use advice and support, and workforce development; and develop a plan to optimise the use of existing and emerging digital technology.	SPPG PHA DOH	Short	Within Existing Resources
SP7-2	Review and commission a range of evidence based digital public health innovations, including self-help, to support a reduction in the harms associated with alcohol and drug use. These could include innovations such as remote monitoring, personal health apps and a web- based support portal.	PHA	Medium	Additional Resourcing Required

STRATEGIC PRIORITY 8
RESEARCH AND DATA

OUR AMBITION

We will collect, analyse and disseminate the right data to better understand substance use across Northern Ireland, how well our services are doing, whether they are making a difference, and what we need to commission to demonstrably reduce harms based on research and evidence.

Our research programme will deliver a powerful and expansive understanding of substance use which draws on both local and global evidence and supports the translation of evidence into policy and practice.

The provision and analysis of accurate, relevant, data, and evidence of what works, is vital to the good planning and commissioning of services. This includes data on population need, how services are used, waiting times for services, whether resources have been used effectively and whether outcomes have been achieved.

It is important for us to align work already underway on data and outcomes with that being undertaken around the ***Mental Health Strategy*** and **Single Mental Health Service for Northern Ireland**. The alignment of this work will allow us to balance a consistency of approach to data capture and analysis across wider statutory mental health system with the specific requirements around substance use services.

We will further review and develop existing data sources, including the **Drug & Alcohol Monitoring & Information System** and will explore the potential benefits from a standalone substance use survey to capture more granular information on the most at-risk groups of people, as well as new and emerging patterns of substance use. The collation of timely data from a new, bespoke substance use survey will better assist with forecasting service demand and shaping the requirements for future commissioning decision making. We will continue to use the extensive data produced via the annual UK wide **report of people who inject drugs**.

Community pharmacies are also a rich source of data. While the services provided by community pharmacy are known, a lot of the advice, signposting, interventions and referrals go largely unrecorded. We will look at opportunities to make better use of community pharmacy information.

As a member of the UK Government's **Advisory Council on the Misuse of Drugs**, Northern Ireland has long been a strong advocate and supporter of independent research to underpin policy and service design. As the ***Preventing Harm, Empowering Recovery*** substance use strategy acknowledges however, there is a pressing need to further improve our knowledge of what works in relation to substance use services work.

This *Plan* seeks to grow our use of evidence-based research and enhance our collection and dissemination of data to better determine the shape and size of services we commission in the future.

Given the dynamic nature of the service environment, the actions we pursue to improve our use of research and data will be subject to regular review and challenge.

We will be open, indeed welcoming, of research conducted outside of Northern Ireland, acknowledging that developing trends elsewhere may well be applicable to our local context.

The ***Preventing Harm, Empowering Recovery*** strategy articulates a need for us to develop and invest in a planned research programme for substance use. As well as being responsive to changing patterns of alcohol and drug use, the research programme should prioritise evaluation of prevention and early intervention programmes and include the review of locally collected data, including learning from serious adverse incident reporting, in order to inform research priorities. This programme will be underpinned by a commitment to work collaboratively with other research programmes and organisations with similar research interests including crossovers with research priorities on learning disability, forensic issues and domestic violence.

Given some of the current known trends and service gaps, it is expected that the research programme will include in its early work exploration into the misuse of prescribed medication and support requirements for people with *ARBI*.

It is important for us to link developments around data and research with that of digital technology. This includes using digital technology to spread knowledge across the HSC statutory, community and voluntary sectors.

ACTIONS

In addition to the *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy (refer Appendix 2), to deliver on our ambition for this strategic priority, this *Plan* commits to deliver the following commissioning priorities:

Number	Action	Responsible Organisation	Timeframe	Resourcing
SP8-1	Commission methodologically robust, rigorous, peer-reviewed, evidence reviews into what works for a 'Northern Ireland Prevention Approach' for young people.	PHA	Short	Within Existing Resources
SP8-2	Commission PhD studentships supporting the development of robust local evidence of what works across substance use services in line with Substance Use Strategy Outcome E Action 9	PHA	Short	Additional Resourcing Required
SP8-3	Scope the viability of developing a practitioner-researcher training programme encouraging the organic development of practitioner-researchers across each tier of substance use services.	PHA	Short	Within Existing Resources
SP8-4	Commission enabling infrastructure and systems to support the following: • data recording, analysis and outcomes • individual and service level data that supports real time capturing of risk and protective factors for individuals accessing services. • training and support programme to establish research practitioners across alcohol and drug services. • implementation of biopsychosocial assessments and evidence informed responses.	SPPG PHA	Medium	Additional Resourcing Required
SP8-5	Develop a robust research strategy to support the implementation of the substance use strategy.	SPPG PHA	Medium	Additional Resourcing Required

GOVERNANCE AND MONITORING

The development of this *Plan* has been underpinned by a collaborative governance structure, comprising ten outcome groups and associated sub groups (refer Appendix 3 for a project methodology statement).

This structure has worked well in the development phase of this *Plan*. However, as we move into the implementation phase, we will establish a new governance structure to monitor progress. One that remains underpinned by the principle of partnership working, co-production and shared responsibility.

We commit to developing a robust structure that will both drive and monitor implementation of the recommendations and commissioning priorities confirmed in this *Plan*. The governance will be developed in line with emerging arrangements for both the **Single Mental Health Service for Northern Ireland** and the ***ICS***. Our governance will build on the positive partnership working demonstrated in the development of this *Plan*, collaboration that involved the community and voluntary sectors, people, families and carers with lived and living experience of substance use, as well as a wide range of statutory services.

It is important that our new governance arrangements also measure the success of this *Plan*, by monitoring whether the desired outcomes have been achieved for individuals and our population as a whole. We will learn from the work being undertaken within the ***Mental Health Strategy*** on outcomes and ensure this includes people with substance use issues.

DACTs have had an important role in sharing information on services at a local level. In order to understand how we can best build on the current work of *DACTs*, we commit to reviewing current arrangements, alongside the locality planning arrangements as proposed by the ***ICS***.

APPENDIX 1 - CURRENT SERVICES

The four tiers of substance use services and interventions are:

Tier 1 - interventions include provision of alcohol and/ or drug-related information and advice, screening and referral to specialist substance use treatment services. Tier 1 interventions are provided in the context of general healthcare settings, or social care, education or criminal justice settings where the main focus is not substance use treatment.

Tier 2 - interventions include provision of alcohol and/ or drug-related information and advice, triage assessment, referral to structured alcohol and/ or drug treatment, brief psychosocial interventions, individual psychotherapeutic interventions, harm reduction interventions (including needle exchange) and aftercare. Tier 2 interventions may be delivered separately from Tier 3, but will often also be delivered in the same setting and by the same staff as Tier 3 interventions. Other typical settings to increase access are through outreach (general detached or street work, peripatetic work in generic services or domiciliary visits) and in primary care settings.

Tier 3 - interventions include provision of community-based specialised alcohol and/ or drug assessment and coordinated care planned treatment and alcohol and/ or drug specialist liaison. Tier 3 interventions are normally delivered in specialised alcohol and/ or drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.

Tier 4 - provides Tier 4a specialist stabilisation/ detoxification treatment services, which are 'medically managed' and Trust hospital based, and also Tier 4b rehabilitation services, which are community/ non-statutory sector based. **Tier 4a** are three wards providing treatment for adults who require detoxification under 24-hour medical supervision, based in South Eastern HSCT (Downshire Hospital), Northern HSCT (Holywell Hospital) and Western HSCT (Tyrone and Fermanagh Hospital). These services are available to people across the region. **Tier 4b** are three residential based rehabilitation services. These services have slightly different service specifications and contractual arrangements. Two of the services are referred to as Rehabilitation Services (Carlisle House, Northlands), and one (Cuan Mhuire) as Harm Reduction and Aftercare.

The *PHA* commission the following range of substance use services:

- Community Based Services for Young People who are identified as having Substance Misuse difficulties - This service provides Tier 2 treatment services including psychotherapeutic interventions for children and young people, aged 11-25 years including structured family support. The criteria for accessing this service for individuals aged 21-25 years are that the individual has been identified as vulnerable or has had difficulty integrating into the adult treatment system, for example, a history of disengagement and vulnerability.
- Drug and Alcohol Mental Health Service (*DAMHS*) - This service provides Tier 3 treatment services for children and young people with drug and/ or alcohol issues that are beyond the scope of community-based services due to complex co-morbid mental health issues. This includes the delivery of formal psychological therapies and drug therapies. The service is integrated within *CAMHS*.
- Adult Tier 2 Services - These services provide Tier 2 treatment services including extended brief interventions and psychotherapeutic interventions.
- Low Threshold Services - These are accessible services with minimum criteria for access that adopt a harm reduction approach. The services work to reduce drug and alcohol related harm amongst those with significant substance misuse problems, many of whom have complex needs. The services particularly target people who are currently not engaged with a treatment/ support service and /or have a history of disengagement and vulnerability.
- Therapeutic Services for Children, Young People and Families Affected by Parental Substance Misuse - This service provides therapeutic interventions and support to children affected by parental substance misuse as part of a multi-agency care plan through working directly with the young people and indirectly with non-substance misusing parents/ carers. The service also provides support for families, engages with other services who work with these children and families and provides specialist advice and support to front line workers working with families affected by Hidden Harm.
- Targeted Prevention Services for Young People - This service develops and delivers age-appropriate drug and alcohol life skills/ harm reduction programmes for young people in the age ranges of 11-13 years, 14-15 years and 16+ years across Northern Ireland. These programmes are delivered to young people identified as being at risk of substance misuse.

- Youth Engagement Services - Eight Youth Engagement Services for young people aged 11–25 years are available across Northern Ireland. The service provides up to date objective information about personal health and wellbeing issues (including drugs and alcohol), choices, where to find help/ advice and support to access services when they are needed. Youth Engagement Services also works with other providers to host peripatetic services for young people.
- Substance Misuse Liaison Services - This service is in place within admission wards and Emergency Departments across the five *HSCTs*. The service focuses on hazardous/ harmful substance use. Utilising a Screening, Brief Intervention and Referral to Treatment (SBIRT) model, the service provides a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk.
- Workforce Development Services - This regional service develops and delivers a range of training courses, ensuring there is a pathway for alcohol and drug workers from all sectors to achieve a recognised qualification in substance misuse. It provides mentoring and support to those staff that require additional support to undertake specific tasks following training.
- Drugs and Alcohol Coordination Teams' Connection Services - This Northern Ireland wide service seeks to build capacity for those working and volunteering in communities including provision of information, resources and signposting. The service also utilises local media in support of regional public information campaigns. The service also assists the *Drugs and Alcohol Co-ordination Teams (DACTs)* in each *HSCT* area to develop local action plans and support implementation of the **Drug and Alcohol Incident Protocol** when required. The service also supports and develops local information initiatives in partnership with key agencies, promotes the **Drug and Alcohol Monitoring and Information System** and advocates and promotes for legislation on addressing drug and alcohol issues.
- Needle & Syringe Exchange Scheme (NSES) - The ***NSES*** provides a free, confidential health service for people who inject drugs through the provision of sterile injecting equipment and safe disposal of used equipment. The service also puts clients in direct contact with a health professional who can help them engage with treatment services to address their drug misuse. There are currently 20 community pharmacies, four *HSCTs* and one community/ voluntary service that deliver the *NSES* across Northern Ireland.

- Take Home Naloxone programme - The programme provides naloxone to people at risk of opioid overdose. This medicine is available to anyone who uses opioids, through their local Trust Addiction Services, Prison Service, Low Threshold Services and the Belfast Inclusion Health Service.
- Drug and Alcohol Monitoring and Information System (DAMIS) - DAMIS is an "early warning system" designed to find out about emerging trends in drug and alcohol misuse, so that *PHA* and partners can act quickly and provide relevant information or advice to those who misuse drugs or alcohol. Much of the information sent out through DAMIS is practical advice aimed at reducing the harms to people from their drug use.

APPENDIX 2

Preventing Harm, Empowering Recovery Strategy – HSC Actions

In addition to the commissioning priorities for **Prevention and Early Intervention**, to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
A1	Targeted prevention and early interventions services will target those young people most at risk of substance use, including children and young people with lived experience of care and align with and support more generic local Youth Services.	Ongoing
A2	A 'Northern Ireland Prevention Approach', based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed and delivered in Northern Ireland and reviewed after 5 years.	Ongoing
A3	The Making Contacts Count programme in primary care will include brief interventions and advice in respect of substance use.	Ongoing
A5	The Hidden Harm Action Plan will be updated to ensure there is wide awareness i.e. "Everybody's business" and that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the **Joint Working Protocol on Hidden Harm** will be promoted and used across all services.	Medium

Number	Action	Timeframe
A6	The current community support mechanisms will be reviewed to ensure they support the local implementation of this strategy in the community, promote prevention, collaboration and access to services.	Ongoing
A13	Raise awareness of the harms associated with the illicit use of prescribed medicines and with polydrug use, including promoting awareness across primary and secondary care healthcare providers.	Short
A14	Update the **drugsandalcoholni.info** website with information on substance use, support materials and the services available in Northern Ireland and further develop engagement through social media and other channels.	Ongoing
A15	Promote and raise awareness of the **UK Chief Medical Officer low-risk drinking guidelines** and understanding of alcohol units.	Medium
A16	Substance use will be included as part of the new Mental Health Service model operating across general hospitals/ Emergency Departments, including as part of crisis response and services.	Medium

In addition to the commissioning priorities for **Pathways Of Care and Models of Support,** to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
B1	Work with partners to develop a joined up and integrated intensive outreach service to specifically identify and support those most at risk of alcohol and drug related deaths. The service will link with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services. This will learn from the whole system approach being trialled initially in Northern Ireland and other areas.	Medium
B3	Work with experts to develop an 'Overdose & Relapse Prevention Framework' to target those at most risk.	Medium
B4	Continue to develop and expand highly accessible Low Threshold Services to meet the growing needs of those who use alcohol and other drugs.	Ongoing
B5	Continue to develop and expand the **Needle & Syringe Exchange Scheme**, both within community pharmacies and within the community, to ensure adequacy of exchange services with the aim of ensuring that we meet the *WHO* target of 200-300 sterile needle and syringe sets distributed per client per year.	Short
B6	Expand the capacity of naloxone provision to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose (such as police officers). This will include providing access to nasal naloxone for carers and services on the periphery of substance use.	Short

Number	Action	Timeframe
B7	Increased screening and testing for blood borne viruses for those in treatment, with access to follow-up treatment and support, including peer-led services.	Short
B9	Produce an updated 'Prescription Drug Misuse Action Plan' which, building on the current processes, will include additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harms.	Medium
C2	Review services available for children and young people, particularly looking at the transition of young people from children to adult services.	Medium
C4	Create a managed care network, with experts in dual diagnosis supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full need of those with cooccurring issues. In addition, further review the support provided for those with co-occurring mental health and substance use issues.	Medium
C6	Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the South Eastern Health & Social Care Trust Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments.	Short
C8	Work to strengthen the link between maternity (including neo-natal) and substance use services, and that treatment services work to reduce barriers for women and those with childcare responsibilities.	Medium

Number	Action	Timeframe
C9	Alcohol treatment and support services will be taken forward in line with the new UK-wide **Clinical Guidelines on Alcohol**, once these have been finalised, and appropriate ***NICE*** guidelines.	Short
C10	Take forward the recommendations from the review of Opioid Substitution Therapy with a specific focus on reducing waiting times with the target that no-one waits more than 3 weeks, at most, from referral to assessment and treatment.	Short
C11	The 'COVID-19 Addiction Services Rebuilding Plan' will be implemented to ensure that substance use services are in place and that learning from how services operated during the pandemic is built into future delivery and planning for any future waves. This will include an emphasis on initiatives to tackle the increase in substance use waiting lists that have occurred since COVID-19 emerged, to ensure these are urgently reduced to pre-COVID levels.	Short
D5	Review the need in relation to *ARBI* and subsequently develop, as required, appropriate service models and pathways to support those impacted by *ARBI* to recover.	Medium
E4	Build on the regional structure in place to support the involvement of experts by experience, service users and their families at all levels of the implementation of this strategy, from policy development to local service design and delivery.	Ongoing

In addition to the commissioning priorities for **Trauma Informed System,** to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
C5	Building on the ongoing project in the Western Health & Social Care Trust area to design and develop an integrated model between all Tiers of Addiction Services and the Regional Trauma Network, the proposed model will be considered and rolled out across the region.	Medium
D6	Learning from support provided in relation to deaths by suicide, the *PHA* will develop material and services for those bereaved by substance use. Acknowledging the complexity of these issues, these should be built into existing bereavement supports and not stand-alone.	Short

In addition to the commissioning priorities for **Family Support,** to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
C3	Family support services will be reviewed by the *PHA* to ensure that evidence-based supports are available for all those who wish to avail of them, whether or not their family member is in treatment. Service models will also be updated to ensure the involvement of family members in treatment as appropriate.	Ongoing

In addition to the commissioning priorities for **Stigma**, to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
D1	Work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harms.	Short
D2	Work with service users and their families to support the development and commissioning of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.	Medium
D3	Develop appropriate information sources that focus on the reduction of stereotyping of drug users, use of inappropriate language, etc. These could then be offered to journalists, local politicians, community representatives, and other appropriate persons.	Medium

In addition to the commissioning priorities for **Workforce Development**, to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
E3	Review the role, function and membership of *Drug & Alcohol Coordination Teams* to ensure they are effective and strategically placed to inform, support and monitor the delivery of ***Preventing Harm, Empowering Recovery***.	Medium
E5	Continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as **DANOS**. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.	Ongoing
E6	Suicide prevention training will be provided to all staff working in substance use related services.	Short

In addition to the commissioning priorities for **Digital Innovation**, to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
C7	Ensure that self-care advice and support is available through a range of sources, including online and via apps. Consideration will also be given to expanding available helpline/ web chat services to cover substance use.	Medium

In addition to the commissioning priorities for **Data and Research**, to progress our ambition for this strategic priority, this *Plan* commits to deliver the following *HSC* recommendations contained in the ***Preventing Harm, Empowering Recovery*** strategy:

Number	Action	Timeframe
B8	Develop and implement a new harm reduction database to improve monitoring of these services.	Short
B10	Continue to grow and expand the **Drug & Alcohol Monitoring & Information System** to ensure that up-to-date information on current trends and harm reduction support is available to those at risk and shared with relevant key services and explore expansion of the system to include a drug poisoning database based on the Welsh model to gather specific information on overdoses and drug related deaths.	Short
E7	Publish regular update reports on the implementation of this strategy, evaluating progress against its outcomes, indicators and actions.	Ongoing
E8	Develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the *PHA* will continue to be required to complete the **Impact Measurement Tool** with a view to aligning to one outcome framework across all services in the longer term.	Medium
E9	A funded two-year rolling research programme will be developed to meet the needs of the development and implementation of this strategy. A new cross-sectoral sub-group will be established to support the development and oversight of this programme, as well as advise all stakeholders in relation to best practice, what works and outcome monitoring/ evaluation.	Short

Number	Action	Timeframe
E10	Consideration will be given to developing or amending current monitoring mechanisms (such as the health survey, the substance misuse database and the young people's behaviour and attitude survey) to ensure these are robust and fit for purpose.	Short

APPENDIX 3

Methodology - Strategic Planning

This *Plan* has been developed using strategic planning methodology[3] to analyse population need, identify current service provision and conduct gap analysis as well as focus on service development and outcome monitoring, all underpinned by co-production. This approach has allowed us to pose the questions:

Where are we now? Where do we want to go? How to we get there? And how do we know if we have made a difference?

To respond to these questions, it has been important to ensure strong **Leadership**, robust **Governance**, meaningful **Partnership Working** and comprehensive **Stakeholder Engagement.**

Leadership

The ***Preventing Harm, Empowering Recovery*** strategy sets out a vision and a comprehensive set of proposals for tackling the harms caused by substance use by 2031.

In order to achieve this vision, the *DoH*, *PHA* and *SPPG* have developed a collaborative leadership approach to the planning, commissioning, delivery and monitoring of quality, evidenced based *HSC* services for individuals and communities which are safe, person-centred, accessible, acceptable and effective.

The *PHA* and *SPPG* have led the collaborative process that determined the eight strategic priorities detailed in this *Plan*. Moving forward, the *PHA* and *SPPG* will coordinate the delivery of the commissioning priorities set out in this *Plan*, alongside the *HSC* recommendations detailed within the ***Preventing Harm, Empowering Recovery*** strategy.

Governance

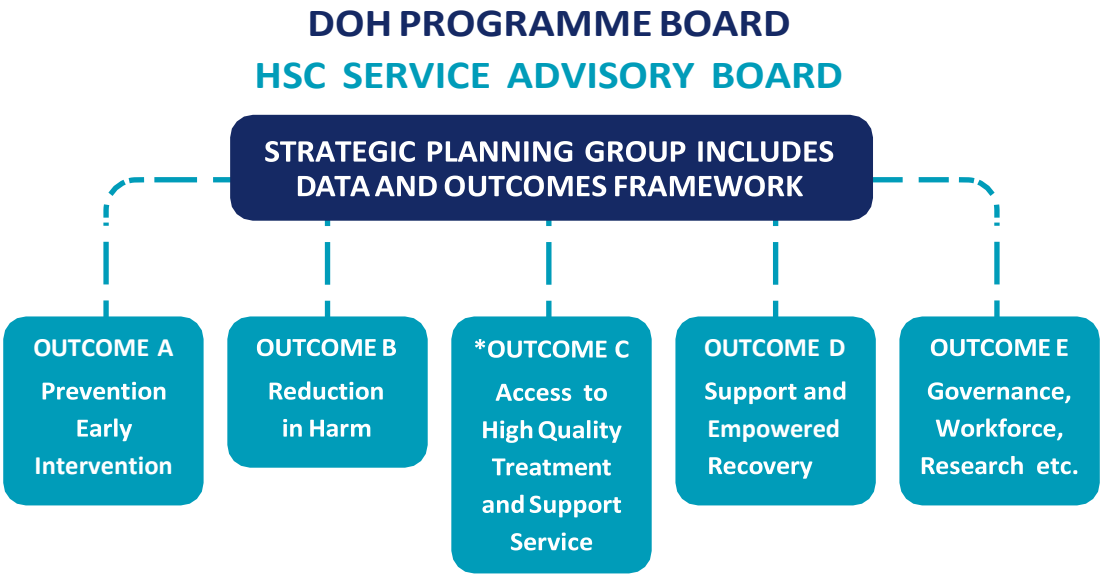
The *HSC* Substance Use Strategic Advisory Board oversaw the breadth of activity that culminated in the development of this *Plan* and it's eight strategic priorities.

3 https://ihub.scot/media/6879/good-practice-framework-for-strategic-planning.pdf

The Board is co-chaired by the *PHA* and *SPPG* and reports to the Substance Use Programme Board chaired by the Chief Medical Officer for Northern Ireland.

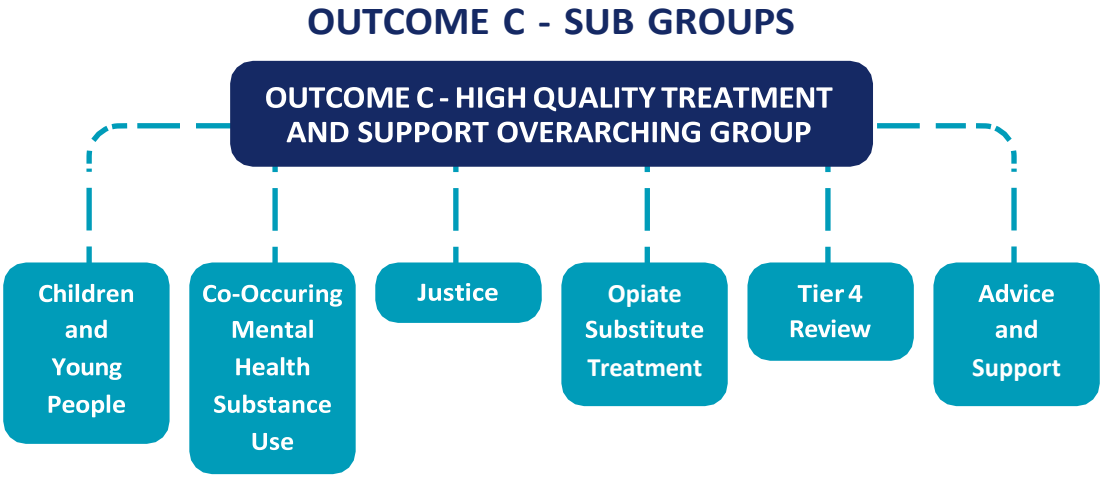
Outcome groups reported to the Substance Use Advisory Board as detailed below. The outcome groups were formed around the outcomes set out in the *Preventing Harm, Empowering Recovery* strategy. The governance also included a Strategic Planning Group, which connected outcome group activity and coordinated the development of this *Plan*.

Diagram 1. HSC Substance Use Strategic Planning, Commissioning and Implementation Governance Structure



* (6 sub-groups that report into this group)

Diagram 2. Outcome C - Access to High Quality Treatment and Support Services Sub Groups



Partnership Working

The development of this *Plan* has been underpinned by expansive and meaningful partnership working. The *PHA* and *SPPG* have adopted multi-faceted approaches to ensure a broad range of stakeholders have been involved in creating the *Plan*, including not only statutory, community and voluntary services, but also individuals with lived and living experience of substance use. This multi-faceted approach to ensure partnership working has involved the follow methods:

- Substance Use Programme Board meetings
- Substance Use Strategic Advisory Board meetings
- Statutory, community and voluntary sector led Outcome Group Co-Chair meetings
- Multi-stakeholder Outcome Group Member meetings
- Multi-stakeholder Outcome Group Task and Finish Group meetings
- On line workshops for individuals with lived and living experience of substance use, including families and carers
- Multi-stakeholder Planning Workshop event
- Strategic Workshop events
- Cross departmental meetings
- Multi-agency meetings
- Multi-stakeholder desktop review process

It is only with a continued focus on partnership working will delivery on the ambitions set out in the *Plan* be achieved.

Stakeholder Engagement

Stakeholders from a wide range of experiences were involved in the development of this *Plan*, including statutory, community and voluntary services, lived experience groups, as well as research and academic institutions. This Plan is the culmination of the invaluable contributions from many professionals and lay people.

ARBI	Alcohol Related Brain Injury
CAMHS	Child and Adolescent Mental Health Services
COVID	Coronavirus Infectious Disease
DACTs	Drugs and Alcohol Coordination Teams
DAMHS	Drug and Alcohol Mental Health Service
DAMIS	Drug and Alcohol Monitoring and Information System
DANOS	Drug and Alcohol National Occupational Standards
DoH	Department of Health
FASD	Foetal Alcohol Syndrome Disorder
GP	General Practitioner
Health Literacy	Health literacy describes the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.
HSC	Health and Social Care
HSCT	Health and Social Care Trust
ICS	Integrated Care System
Inclusion Health	Describes any population that are socially excluded, and who typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). People in these population groups often experience the poorest health outcomes including those related to substance misuse, and the greatest health inequalities. People who belong to inclusion health groups face additional barriers to accessing and engaging with health services and require specific consideration of how their needs will be met when commissioning mainstream services.

MDT	Multi-Disciplinary Teams
Mental Health Strategy	Mental Health Strategy 2021 – 2031
NIAO	Northern Ireland Audit Office
NICE	National Institute of Clinical Excellence
NISRA	Northern Ireland Statistics and Research Agency
NSES	Needle and Syringe Exchange Scheme
OST	Opioid Substitution Treatment
PHA	Public Health Agency
Plan	Substance Use Strategic Commissioning and Implementation Plan 2023 – 2027
Preventing Harm, Empowering Recovery	Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31) Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31)
SPPG	Strategic Planning and Performance Group
WHO	World Health Organisation
YJA	Youth Justice Agency


HSC
Public Health
Agency


HSC