agenda

Title of Meeting	156th Meeting of the Public Health Agency Board
Date	17 August 2023 at 1.00pm
Venue	Board Room, Tower Hill, Armagh

standing items

1 1.00	Welcome and apologies		Chair
2 1.00	Declaration of Interests		Chair
3 1.00	Minutes of Previous Meeting held on 22 June 2023		Chair
4 1.05	Matters Arising		Chair
5 1.10	Chair's Business		Chair
6 1.15	Updates from Non-Executive Directors		Chair
7 1.20	Chief Executive's Business		Chief Executive
8 1.35	Update on Refresh and Reshape Programme		Chief Executive
9 1.45	Finance Report	**PHA/01/08/23**	Director of Finance

committee updates

10 2.00	Update from Chair of Planning, Performance and Resources Committee		Chair

items for approval

11 2.10	Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order	**PHA/02/08/23**	Mr Wilson

12 2.30	Draft Substance Use Strategic Commissioning and Implementation Plan	**PHA/03/08/23**	Mr Wilson / Dr McClean

items for noting

13 2.45	Performance Management Report	**PHA/04/08/23**	Mr Wilson

closing items

14 Any Other Business
2.55

15 Details of next meeting:

Thursday 19 October 2023 at 1.30pm

Board Room, County Hall, Ballymena

HSC Public Health Agency

minutes

Title of Meeting	155th Meeting of the Public Health Agency Board
Date	22 June 2023 at 1.15pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Professor Nichola Rooney	-	Interim Chair
Mr Aidan Dawson	-	Chief Executive
Dr Joanne McClean	-	Director of Public Health
Ms Deirdre Webb	-	Assistant Director of Nursing, Midwifery and Allied Health Professionals (*on behalf of Ms Reid*)
Mr Stephen Wilson	-	Interim Director of Operations
Mr Craig Blaney	-	Non-Executive Director
Mr John Patrick Clayton	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Ms Tracey McCaig	-	Director of Finance and Corporate Governance, SPPG
Mr Brendan Whittle	-	Director of Community Care, SPPG
Mr Robert Graham	-	Secretariat

Apologies

Ms Heather Reid	-	Interim Director of Nursing, Midwifery and Allied Health Professionals
Dr Aideen Keaney	-	Director of Quality Improvement

79/23	**Item 1 – Welcome and Apologies**
79/23.1	The Chair welcomed everyone to the meeting. Apologies were noted from Ms Heather Reid and Dr Aideen Keaney.
79/23.2	The Chair congratulated Ms Webb on being runner up in the public health award at the Nurse of the Year Awards ceremony.
80/23	**Item 2 – Declaration of Interests**
80/23.1	The Chair asked if anyone had interests to declare relevant to any items

	on the agenda.
80/23.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.
80/23.3	Mr Irvine declared an interest in his role as a Local Council representative. He indicated that as his Local Council receives PHA funding, he would step out of the meeting if there were detailed discussions on this as part of the Financial Plan.
80/23.4	Mr Whittle declared an interest relating to Public Inquiries and said that he would recuse himself from the meeting if required as SPPG, through the Department of Health, is also participating in Inquiries.
81/23	**Item 3 – Minutes of previous meeting held on 18 May 2023**
81/23.1	The minutes of the Board meeting held on 18 May 2023 were **APPROVED** as an accurate record of that meeting.
82/23	**Item 4 – Matters Arising**
82/23.1	For action 1, the Chair noted that a workshop is taking place with EY today and the Chief Executive added that a workshop around screening will be organised for September.
82/23.2	For action 2, the Chair noted that the Chief Executive has asked the Organisation Workforce Development (OWD) group to take forward work on supporting staff who have to appear before Inquiries.
82/23.3	For action 3, Ms Webb advised that work on the development of a public health nursing framework has been paused while the Chief Nursing Officer carries out a review of the work carried out to date.
83/23	**Item 5 – Chair's Business**
83/23.1	The Chair reported that she had attended a meeting with NHS Confederation Chairs at which a paper was presented on healthcare spend. She advised that following that meeting there was a meeting with Chairs from Northern Ireland where she raised the issue of the Partnership Agreement with the Department of Health. She noted that only 2 organisations had received theirs so she has asked for this to be placed on the agenda of PHA's Accountability Review meeting with the Permanent Secretary.
83/23.2	The Chair advised that the HSC Chairs met with the Permanent Secretary and a range of areas was discussed. She reported that it is unlikely that the Assembly will be sitting by the autumn and that Northern Ireland will have to live within its budget, and that any pay deals cannot be approved without the Assembly. She said that during a discussion on efficiencies, it was asked whether consideration had been

given to the impact of efficiencies on health inequalities and future generations. She added that going forward, it will be about doing more with less and trying to roll out new ways of working.

At this point Mr Clayton left the meeting.

83/23.3 The Chair noted the amount of work required to prepare for Inquiries and said that PHA is going to have to pay for additional resources. The Chief Executive advised that PHA has extra resources, but noted that when this was raised with the Permanent Secretary, HSC bodies were told that no additional funding was available and that organisations have to find resources from within their own budgets.

89/23.4 The Chief Executive explained that the issue for PHA is that it has undergone a significant turnover of staff resulting in a loss of corporate memory. He added that PHA will be involved in this work for a considerable period of time and therefore individuals working on this now may in future move to other jobs. He said he wished to place on record his thanks to those former PHA staff who have come and given up their free time to help, but he noted that their good will can only be relied on for so long, and there may come a point when those individuals are called before an Inquiry themselves. The Chair asked if remuneration could be given for their time but the Chief Executive replied that this may only be possible in some cases. A member suggested that there should be a mechanism whereby these individuals register through the Leadership Centre. The member added that given the size of the COVID Inquiry, PHA will need to scale up. The Chair suggested that there should be a Board workshop to look at how PHA is preparing for the COVID Inquiry **(Action 1 – Chair)**.

89/23.5 A member asked if there is an HSC position in terms of compelling people to appear at Inquiries, but the Chief Executive said while the HSC cannot compel individuals, Inquiries can.

89/23.6 The Chair asked what approach SPPG is taking and Mr Whittle advised that it has not asked former staff to come back, but has instead prepared its submission based on records.

89/23.7 A member asked what provision PHA has for obtaining legal support. The Chief Executive outlined that PHA has access to Junior Counsel and a solicitor dedicated to PHA. He noted that if a situation arose where a former staff member had a view that was contrary to PHA's view, they would have separate legal support. The member asked if the PHA Board needs to authorise this expenditure, but the Chief Executive replied that it is within his delegated limits. Ms McCaig added that provision for this has been made in PHA's Financial Plan. The member said that how information is presented at Inquiries is important and that coaching is required, to which the Chief Executive said that PHA has received Counsel help with its preparations in terms of lines to take, and anticipating what questions may be asked.

89/23.8 Mr Whittle noted that for the Muckamore Inquiry, the Department of Health and SPPG are core participants whereas PHA is not, and being a core participant means that you can access the Witness Statements of other organisations. The Chief Executive said that PHA had received advice not to be a core participant.

89/23.9 The Chair said that there needs to be a review of resources. Mr Wilson advised that 2 Band 6 staff and a Band 8a member of staff are being transferred from other work to assist. Dr McClean added that a Band 8a member of staff has also been recruited from an agency as PHA aims to build up a team.

84/23 Item 7 – Chief Executive's Business

84/23.1 The Chief Executive reported that PHA has submitted a third Statement to the Muckamore Inquiry and he will appear at the Inquiry on 28 June. For the COVID Inquiry, he advised that he has been asked to appear on 5 July but PHA is liaising with the Inquiry around sending another member of staff. He noted that each Inquiry operates differently and that other HSC bodies are taking the same approach in terms of asking that the appropriate individuals attend, rather than the Chief Executive. A member commented that it may be helpful if the legal advisors could discuss this with the Inquiries upfront. Ms McCaig agreed, and added that it is also useful to speak to others who have attended.

At this point Mr Clayton re-joined the meeting.

84/23.2 The Chief Executive advised that PHA is having its Accountability Review meeting with the Permanent Secretary on 6 July.

84/23.3 The Chief Executive reported that PHA staff have been assisting with providing advice in relation to ongoing matters at Daisy Hill and South West Area Hospital (SWAH). The Chair asked if there are any issues to be brought to the attention of the Board, but the Chief Executive said that part of PHA's role is to provide support and advice to SPPG. A member asked if this advice could be recorded and documented so that there is a record of it.

84/23.4 The Chair asked if PHA is giving professional advice. Dr McClean explained that PHA has always had a role in providing professional advice into commissioning and while PHA will not get a request to provide this advice, it will work collaboratively with Trusts and bring an external perspective. She said that the relationship with SPPG is different now that it is part of the Department. Mr Whittle advised that there is guidance from 2007 which states that organisations must seek guidance from PHA and HSCB, but that guidance is currently being updated.

84/23.5 Dr McClean said that in addition to Daisy Hill and SWAH, there are also issues relating to Maternity Services at Causeway Hospital. Mr Whittle

noted that PHA has provided advice to the Permanent Secretary on that matter.

84/23.6 A member noted that in these areas there are widespread community concerns and asked that if PHA is giving advice, does this look at health inequalities as well as safety and quality. Dr McClean advised that it would and added that if a public consultation is carried out PHA would receive the reports on these and analyse them. The member said that there is an issue, particularly with Causeway Hospital, where people may not have access to a car so it would be useful to know if issues such as travel and distance are being looked at. Mr Whittle said that if an HSC organisation is undertaking a public consultation, it will have to also undertake an Equality Impact Assessment (EQIA) and a Rural Needs Assessment of any decisions and the findings of those will assist SPPG/PHA in coming to its final decision.

84/23.7 The Chief Executive advised that a graduate trainee, Mrs Suzanne Johnston, has taken up post and he would like her to attend a future Board meeting.

84/23.8 The Chief Executive reported that an EY workshop was held with Digital Health and Care (DHCNI) which was very useful. He advised that PHA will be looking to partner with DHCNI and NISRA on population health analytics in the future. With regard to the Refresh and Reshape work, he advised that this will slow down over the summer to allow for an opportunity to take stock.

84/23.9 The Chief Executive offered his congratulations to Ms Webb for coming runner up in the public health award at the Nurse of the Year Awards. He advised that the award went to Ms Jane Ferguson and Ms Tanya Zulian in the Northern Trust for their work with asylum seekers and refugees.

84/23.10 The Chief Executive said that the launch of Professor Ray Jones' Independent Review of Children's Social Care Services took place on Wednesday and PHA was represented at the event by Ms Hilary Johnston, Ms Deirdre Webb, Ms Siobhan Slavin and Ms Anita Rowe. He added that on Tuesday there was an event on Working Together for Healthcare in Criminal Justice at which Ms Siobhan Donald represented the PHA. He advised that he was unable to attend these events.

84/23.11 The Chief Executive advised that Dr Alison Little presented at the International Confederation of Midwives (ICM) Triennial Congress. He said that to present on the world stage was a credit to her work in the Agency and she was a great ambassador for the Agency and Northern Ireland.

84/23.12 The Chief Executive advised that there are no new risks on the Corporate Risk Register but that it is due to be reviewed.

84/23.13 The Chief Executive said that the first ICS pilot started in the Southern Trust at the beginning of June and Dr Diane Corrigan and Dr Diane Anderson are representing PHA on this. He added that a delegation of Trust and Council Chief Executives, led by PHA, is travelling to Wigan on 9/10 July to meet with senior leaders there and see the ICS in action.

84/23.14 A member asked if stories about staff success and awards are relayed to all PHA staff. Mr Wilson replied that they would be communicated to staff via Connect and the staff newsletter, inPHA. The member said that it is good to build up the PHA brand internally.

85/23 Item 6 – Updates from Non-Executive Directors

85/23.1 The Chair advised that she wished to receive updates from other Non-Executive Directors at each meeting about meetings or events that they have attended.

85/23.2 Ms Henderson advised that she had attended the last meeting of the Screening Programme Board where there was discussion on delays in the cervical screening programme. She said that this is a high risk area for PHA and there needs to be more scrutiny by the PHA Board.

86/23 Item 8 – Finance Update

Draft PHA Financial Plan 2023/24 (PHA/01/06/23)

86/23.1 Ms McCaig presented the draft Financial Plan. She explained that PHA is required to make savings of £5.3m in 2023/24. She noted that a decision has to be made regarding £3.2m relating to R&D which has also been withdrawn from PHA's budget.

86/23.2 Ms McCaig gave an overview of how PHA's funding is allocated across each of the main programme areas. She noted that the budget for management and administration does not take account of any pay awards.

86/23.3 Ms McCaig advised that PHA has a deficit of £650k. She noted that where £100k of savings has been listed against Service Development and Screening, this could potentially increase to £400k. She said that she will be including the £650k deficit on the monitoring return to the Department.

86/23.4 Ms McCaig explained that this Plan outlines how PHA could make savings in-year, but the savings are required to be found on a recurrent basis so PHA needs to start looking at all of its programmes to determine which of these are recurrent. She advised that she will be preparing correspondence for the Chief Executive to issue to all staff regarding the need to minimise discretionary spend. She added that financial governance and accountability training will be taking place for all budget holders. She stated that there will be no slippage for

	individual budget holders, but instead all slippage will be corporate slippage. She said that there are many risks which have to be managed in this Plan.
86/23.5	Ms McCaig gave an overview of the capital budget.
86/23.6	Ms McCaig said that she is asking for the Board to give consideration to, and approve, this draft Financial Plan.
86/23.7	A member said that while this Plan was developed based on what was available to PHA, they would find it hard to support as it contained areas of concern. The member noted that these savings have to be made recurrently and yet, when a review was carried out of PHA, the view was that public health was underfunded so this seems a backward step. The member asked if PHA has carried out an EQIA on the Plan as a whole and suggested that if this has not been done, it should be done urgently.
86/23.8	Ms McCaig said that PHA has a statutory duty to break even and the current Plan represents a challenge as there is a £650k deficit. She noted that PHA has had slippage in recent years and used it to fund other initiatives. She advised that the entire HSC is being contracted when PHA is working on its Refresh and Reshape programme. She said that this is the best Plan that PHA can up with under the circumstances.
86/23.9	The Chief Executive commented that in recent years PHA has found itself in a surplus, but the challenge now is to show good financial stewardship at a time when the whole system is under pressure. He added that there is a gap that PHA still needs to close.
86/23.10	A member said that this Financial Plan represents the best position at this time, but PHA now needs to spend time looking at how it is spending its money and how this relates to population need. Ms McCaig agreed that prioritisation is an area that the Board has struggled with, but now it will be the focus. With regard to the EQIA, she advised that an EQIA was carried out on the health budget as a whole, but PHA can carry out an EQIA if it is making a decision regarding a service. She explained that this Plan has derived from what was natural slippage and at the moment there is no solution for the £650k shortfall, and going forward it will become more challenging.
86/23.11	A member said that an EQIA should be carried out at the earliest possible stage and it is still worth doing. The member noted the duty of the Board to break even, but said that there is a conflict in that PHA also has duties with regard to Health Protection and Health Improvement and to reduce health inequalities.
86/23.12	A member said that the impact of the Plan will be felt by the PHA itself and it is for the Chief Executive and Directors to formulate a plan to mitigate that. The member added that there is a need to look at

outcomes given the reality now is that finances are limited and will be for the short to medium term. The member said that the Board needs to authorise the approach. The Chair commented that PHA is past the stage where it can use slippage from one area to support another area.

86/23.13 A member commented that the bigger risk is the recurrent nature of the savings. Ms McCaig agreed and said that PHA has until the end of March 2024 to develop a Plan to meet these savings and it should aim to have this completed by January.

86/23.14 The Board **APPROVED** the Financial Plan, but noted the dissent of one member.

87/23 Item 11 – Update from Chair of Planning, Performance and Resources Committee

87/23.1 The Chair advised that the main item for discussion at the recent Planning, Performance and Resources Committee meeting was the Financial Plan which had been discussed earlier in the meeting.

88/23 Item 9 – Health Protection Update

88/23.1 Dr McClean said that she had no specific matters to update on and proposed that going forward, there was no longer a need to have this standing item.

89/23 Item 10 – Update from Chair of Governance and Audit Committee (PHA/02/06/23)

89/23.1 Mr Stewart advised that the Committee had met on 8 June and he gave an overview of the issues discussed at that meeting.

89/23.2 Mr Stewart reported that the Committee had received the Annual Report from the Head of Internal Audit where a satisfactory level of assurance was given to PHA. However, he noted that PHA had received 2 audits with limited assurance during the year, one relating to screening programmes and one relating to recruitment.

89/23.3 Mr Stewart advised that the draft NIAO "Report to those Charged with Governance" gave PHA's accounts an unqualified audit opinion but it contained 3 Priority 1 recommendations. He said that the first of these related to a fraudulent payment which the Board has received updates on and that recommendations made following an Internal Audit review have been fully implemented. He said that the second related to an unlawful payment made by SBNI and advised that while the Chief Executive has put measures in place, the Committee raised with the auditors the inappropriateness of PHA hosting SBNI. He advised that the final matter related to a delay in PHA receiving outstanding payments owed by SEUPB (Special EU Programmes Body), which is due to a timing issue, but the payments will be made.

89/23.4 Mr Stewart said that NIAO raised an issue concerning how remuneration is recorded in the Annual Report, but this is a technical issue and he has spoken to Ms McCaig about it.

89/23.5 Mr Stewart reported that the Committee had considered the report of the Internal Audit on recruitment which consisted of 2 elements, those within the control of PHA and those outside PHA's control. He said that both he and the Chief Executive had expected this outcome and that management have accepted all of the recommendations. He hoped that Ms Karyn Patterson will help monitor the progress that needs to be made.

89/23.6 The Chief Executive informed members that he and Dr Janice Bailie had met with representatives from SEUPB and that further payments have been made in recent months. He added that SEUPB have appointed an external body to process the final payments.

89/23.7 A member noted that within the audit on Serious Adverse Incidents (SAIs), there was a reference to an MOU and that they would like to see this. The member added that information on complaints should be brought to the PHA Board.

89/23.8 The Board noted the update from the Chair of the Governance and Audit Committee.

90/23 Item 12 – PHA Annual Report and Accounts 2022/23 (PHA/03/06/23)

90/23.1 Ms McCaig advised that the Annual Report and Accounts were submitted to NIAO and that following the audit, there were some minor changes but no matters of materiality. She highlighted the issue regarding the Remuneration Report and how, because there is a delay in Senior Executive pay awards, the figures only reflect what has actually been paid.

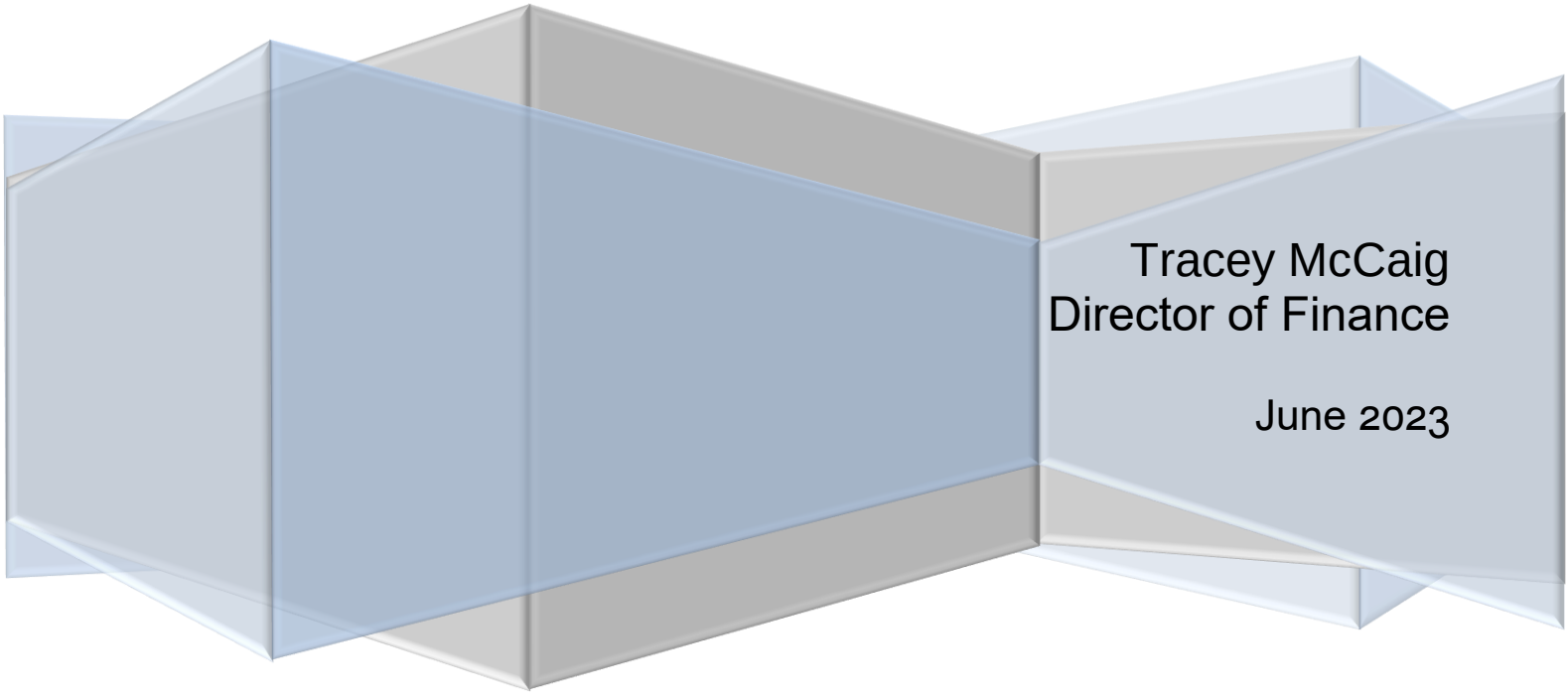
90/23.2 Ms McCaig said that there are no matters of significance within the accounts section, but she pointed out that there was a reduction in PHA's staff costs, mainly due to the closure of the Contact Tracing Centre.

90/23.3 Ms McCaig advised that once the Annual Report and Accounts are formally approved, they will be signed off by the Chair and Chief Executive and the Letter of Representation will be sent to the Comptroller and Auditor General. She added that once PHA receives the signed audit certificate it will be digitally inserted into the Report and the accounts will be formally laid.

90/23.4 A member commended the work undertaken to complete the Annual Report and Accounts, but asked if the matters highlighted in the Internal Audit report on screening programmes could be picked up as part of the Board workshop.

90/23.5	A member asked about the reference to optimising learning from Inquiries in the Chief Executive's Report and if this was an ambitious statement, but the Chief Executive said that PHA is always keen to ensure that learning is progressed.
90/23.6	The Board **APPROVED** the Annual Report and Accounts.
91/23	**Item 13 – Any Other Business**
91/23.1	There was no other business.
92/23	**Item 14 – Details of Next Meeting**
	Thursday 17 August 2023 at 1.30pm
	Board Room, Tower Hill, Armagh
	Signed by Chair:
	Date:

Finance Report
May 2023



Tracey McCaig
Director of Finance

June 2023

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 will continue in the coming months 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 May 2023 (month 2). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

4. The PHA has reported a deficit at May 2023 of £0.2m against the annual budget position for 2023/24. The month 2 position is summarised in Table 1, overleaf.

5. In respect of the reported position:
    - Programme – Trusts: A total of £41.3m has been allocated to Trusts at this point, with full spend against budget shown.
    - Programme – PHA: The remaining annual programme budget is currently £45.9m. The previously held budget for the Centre of Connect Health has been transferred to DoH for the central management of the Chief Digital Information Officer (CDIO). Engagement with DoH is also in train in respect of a required Programme budget for HSCQI, which PHA is no longer in a position to fund from internal resources. A cumulative overspend of £0.4m is shown to date against the Programme budgets listed, reflecting both some areas of spend ahead of current budget profiles, however this will also be impacted by an anticipated overspend due to the application of cash releasing

savings targets to Programme budgets, which are partially being met in 2023/24 by a forecast underspend in Administration budgets. At present there is work ongoing to fully identify savings measures to meet the full financial target applied to PHA. Savings plans will be closely monitored throughout the year and will be regularly reported to the AMT and PPRC.

Table 1: PHA Summary financial position - May 2023

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Projected year end surplus / (deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	12,582	2,097	2,097	0	
Health Protection	8,095	1,349	1,349	0	
Service Development & Screening	14,262	2,377	2,377	0	
Nursing & AHP	6,347	1,058	1,058	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	23	4	4	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**41,309**	**6,885**	**6,885**	**0**	**0**
Health Improvement	30,401	3,546	3,975	(430)	
Health Protection	10,696	246	116	130	
Service Development & Screening	3,046	102	165	(64)	
Research & Development	52	0	0	0	
Campaigns	824	2	1	0	
Nursing & AHP	1,192	84	115	(31)	
Quality Improvement	0	0	0	0	
Other	(300)	0	0	0	
Programme expenditure - PHA	**45,911**	**3,979**	**4,373**	**(394)**	**(1,750)**
Subtotal Programme expenditure	**87,220**	**10,864**	**11,258**	**(394)**	**(1,750)**
Public Health	16,757	2,536	2,351	185	
Nursing & AHP	5,011	750	699	51	
Operations	5,040	740	664	76	
Quality Improvement	676	110	117	(8)	
PHA Board	456	66	187	(121)	
Centre for Connected Health	341	56	60	(4)	
SBNI	757	126	112	15	
Subtotal Management & Admin	**29,037**	**4,384**	**4,190**	**194**	**1,100**
Trusts	272	35	35	0	
PHA Direct	0	10	10	0	
Subtotal Transformation	**272**	**45**	**45**	**0**	**0**
Trusts	0	0	0	0	
PHA Direct	555	122	122	0	
Other ringfenced	**555**	**122**	**122**	**0**	**0**
TOTAL	**117,083**	**15,415**	**15,615**	**(200)**	**(650)**

Note: Table may be subject to minor roundings.

Note: Centre for Connected Health - Programme budget transferred to Chief Digital Information Officer, DoH.

- Management & Administration: An underspend of £0.2m is reported to date, with a forecasted full year underspend of £1.1m. This primarily reflects vacancy levels in budget areas and the anticipated expenditure relating to the PHA Reshape and Refresh programme. As noted above, the anticipated

underspend will offset, in-year, cash releasing savings applied to Programme budgets.

- Ringfenced: There is annual budget of c£0.8m in ringfenced budgets, the largest element of which relates to Safe Staffing (£0.3m) and Suicide Prevention (£0.3m). The balance of funding relates to small 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 throughout the year.

6. Currently, the projected year end position is an overall deficit of £650k and work will continue to identify measures to reduce this deficit position to a breakeven position.

Section C: Risks

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

8. **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 (excluding the £3.2m reduction relating to PHA R&D), there remain challenges in delivering the full requirement in year and recurrently. PHA colleagues are continuing to work on developing savings proposals which are to proceed against the different service areas. Savings targets will be monitored throughout the year with the identification of recurrent savings plans finalised well in advance of 2024/25.

9. **R&D revenue retraction:** A further £3.2m funding retraction has been applied in respect of the revenue Research & Development (R&D) budget, which eliminates this budget entirely. The formal allocation letter from DoH indicated that this funding is being held pending a decision to proceed with this expenditure. If this funding is not allocated, PHA will be unable to participate in the National Institute for Health

and Care Research scheme. This is a significant risk for Health & Social Care in Northern Ireland both now and in the future

10. **EY Reshape & Refresh review**: 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.

11. **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 c£1.7m 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.

12. **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. These will be kept under close review throughout the year, however the risk of significant slippage is mitigated given a significant amount of funding has been removed from the opening budget to address the savings requirements outline above.

13. **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.

14. **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. 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.

15. 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

16. The PHA has a current capital allocation (CRL) of £13.1m. This currently all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at May 2023, is reflected in the following table.

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	4,938	113	4,938	0
R&D - Trusts	8,136	0	8,136	0
R&D Capital Receipts	(1,074)	0	(1,074)	0
Subtotal HSC R&D	**12,000**	**113**	**12,000**	**0**
CHITIN Project:				
CHITIN - Other Bodies	1,040	0	1,040	0
CHITIN - Trusts	138	0	138	0
CHITIN - Capital Receipts	(1,178)	0	(1,178)	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	683	0	683	0
iReach Project	405	0	405	0
Subtotal Other	**1,088**	**0**	**1,088**	**0**
Total HSCB Capital position	**13,088**	**113**	**13,088**	**0**

17. 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.

18. 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.

19. PHA has also received two other smaller capital allocations for the Congenital Heart Disease (CHD) Network (£0.7m) and iReach Project (£0.4m), both of which are managed through the PHA R&D team.

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

Recommendation

21. The PHA Board are asked to note the PHA financial update as at May 2023.

Public Health Agency

Annex 1 - Finance Report

2023/24

Month 2 - May 2023

PHA Financial Report - Executive Summary

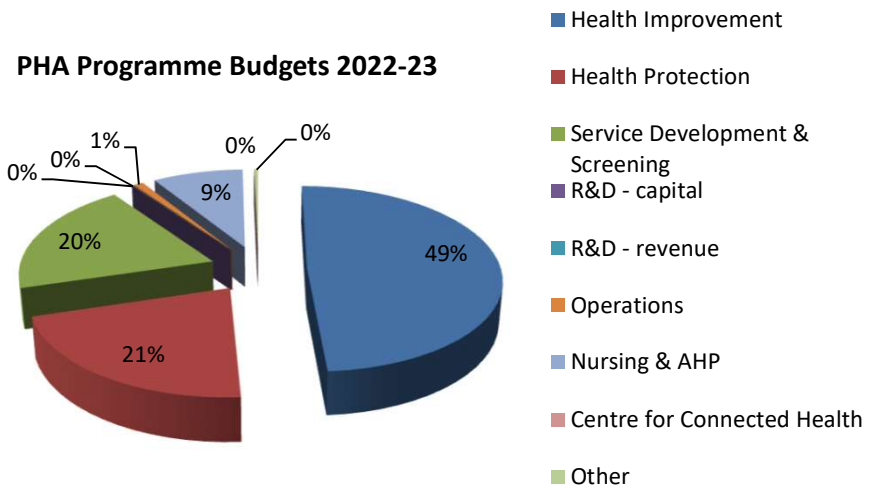
Year to Date Financial Position (page 2)

At the end of month 2, PHA is reporting an overspend of £0.2m against its profiled budget. This overspend is a result of PHA Direct programme budgets projected overspend for the finanical year. While Adminstration (page 6) budgets are recording a underspend to date and a projected to underspend at year end, this is contributing toward the savings requirement applied to PHA in 2023/24.

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.

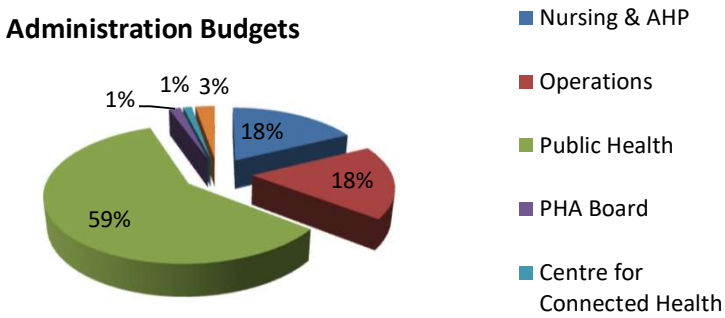


Administration Budgets (page 5)

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.

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 deficit of £0.65m 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 - May 2023

	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	41,309	45,911	827	28,360	**116,407**	6,885	3,979	167	4,384	**15,415**
Revenue Income from Other Sources	-	-	-	677	**677**	-	-	-	-	**-**
Total Available Resources	41,309	45,911	827	29,037	**117,084**	6,885	3,979	167	4,384	**15,415**
Expenditure										
Trusts	41,309	-	212	-	**41,521**	6,885	-	35	-	**6,920**
PHA Direct Programme *	-	47,661	615	-	**48,276**	-	4,373	132	-	**4,505**
PHA Administration	-	-	-	27,937	**27,937**	-	-		4,190	**4,190**
Total Proposed Budgets	41,309	47,661	827	27,937	**117,734**	6,885	4,373	167	4,190	**15,615**
Surplus/(Deficit) - Revenue	-	(1,750)	-	1,100	**(650)**	-	(394)	-	194	(200)
Cumulative variance (%)						***0.00%***	***-9.90%***	***0.00%***	***4.42%***	***-1.30%***

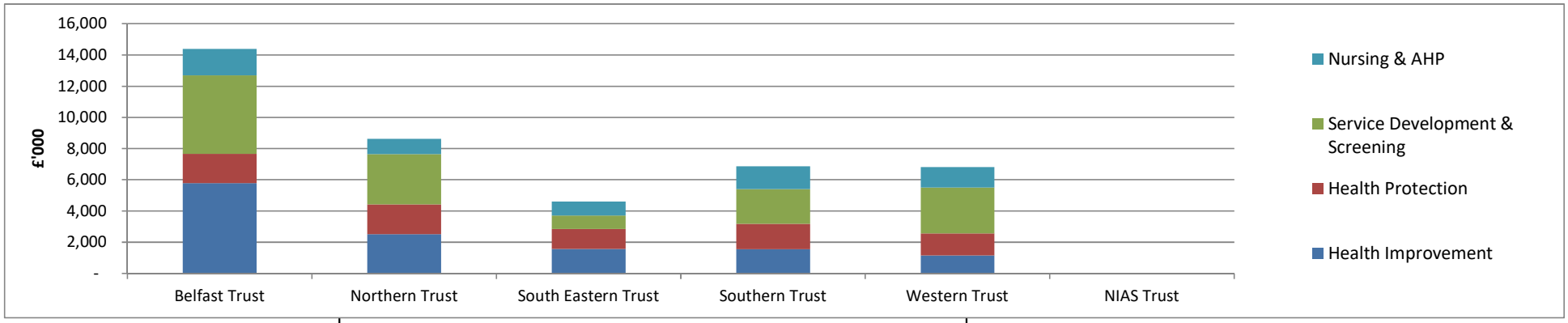
Please note that a number of minor rounding's may appear throughout this report.

** 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 overspend £0.2m, which is a result of PHA Direct Programme expenditure being overspent and fully absorbing the Management & Admin underspend.

The PHA is forecasting an overspend at year end of £0.65m which includes the full absorption of the projected Management & Admin underspend.

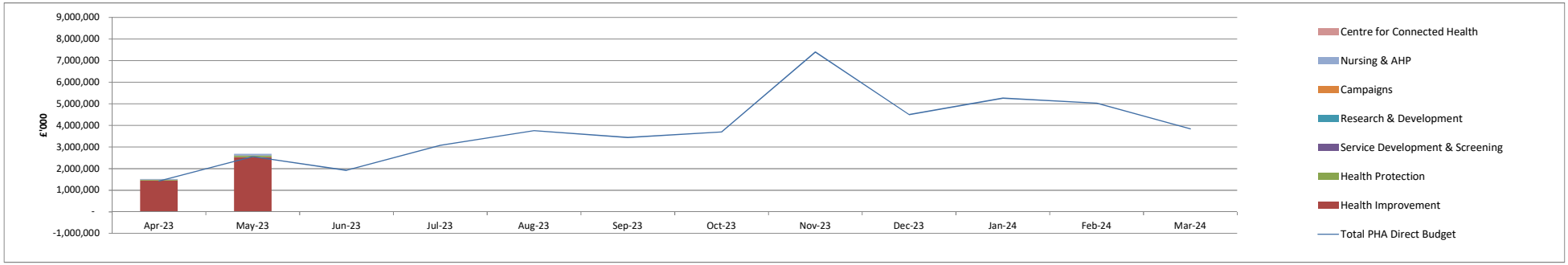
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS Trust	Total Planned Expenditure	YTD Budget	YTD Expenditure	YTD Surplus / (Deficit)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Health Improvement	5,788	2,524	1,569	1,548	1,153	-	**12,582**	2,097	2,097	-
Health Protection	1,880	1,905	1,284	1,620	1,407	-	**8,095**	1,349	1,349	-
Service Development & Screening	5,018	3,221	853	2,233	2,936	-	**14,262**	2,377	2,377	-
Nursing & AHP	1,708	966	894	1,456	1,322	-	**6,347**	1,058	1,058	-
Quality Improvement	23	-	-	-	-	-	**23**	4	4	-
Other								-		
Total current RRLs	**14,417**	**8,616**	**4,601**	**6,857**	**6,818**	**-**	**41,309**	**6,885**	**6,885**	**-**
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. A breakeven position is shown for the year to date as funds held against PHA Direct budget have been issued to Trusts in June 2023.

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	1,454	2,398	3,171	946	2,413	4,692	1,919	3,729	3,778	2,356	**30,401**	3,546	3,975	(430)	*-12.1%*
Health Protection	42	204	194	128	448	2,270	1,159	1,998	1,843	1,087	393	930	**10,696**	246	116	130	*52.7%*
Service Development & Screeni	29	73	223	489	53	106	22	574	523	272	399	283	**3,046**	102	165	(64)	*-62.4%*
Research & Development	-	-	-	-	-	-	-	-	-	-	-	52	**52**	-	-	-	*0.0%*
Campaigns	1	1	1	1	15	52	15	38	134	109	274	183	**824**	2	1	0	*30.7%*
Nursing & AHP	32	53	50	64	69	69	93	97	80	64	186	336	**1,192**	84	115	(31)	*-36.6%*
Quality Improvement	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	0	-	*#DIV/0!*
Other	-	-	-	-	-	-	-	-	0	0	0	(300)	**(300)**	-	0	0	*100.0%*
Total PHA Direct Budget	**1,421**	**2,558**	**1,922**	**3,080**	**3,757**	**3,443**	**3,701**	**7,399**	**4,499**	**5,261**	**5,029**	**3,840**	**45,911**	**3,979**	**4,373**	**(394)**	
Cumulative variance (%)																***-9.90%***	
Actual Expenditure	**1,608**	**2,765**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**4,373**				
Variance	**(187)**	**(207)**											**(394)**				

The year-to-date position shows an overspend of approximately £0.4m against profile. A year-end overspend of £1.7m is anticipated, reflecting work ongoing to fully meet savings requirements, which will be partially offset by anticipated underspends within Administration budgets, resulting in the overall projected year end overspend of £0.65m for PHA.

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	-	272	555	**827**	-	45	122	**167**
Total	-	272	555	**827**	-	45	122	**167**
Expenditure								
Trusts	-	212	-	**212**	-	35	-	**35**
PHA Direct	-	60	555	**615**	-	10	122	**132**
Total	-	272	555	**827**	-	45	122	**167**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

PHA has currently received no COVID allocation for financial year 2023-24.

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 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	4,837	664	4,300	16,516	343	294	520	**27,475**
Goods & Services	174	12	740	241	113	47	237	**1,562**
Total Budget	**5,011**	**676**	**5,040**	**16,757**	**456**	**341**	**757**	**29,037**
Budget profiled to date								
Salaries	721	108	616	2,496	57	48	87	**4,133**
Goods & Services	29	2	123	40	9	8	40	**251**
Total	**750**	**110**	**740**	**2,536**	**66**	**56**	**126**	**4,384**
Actual expenditure to date								
Salaries	657	117	497	2,338	89	55	104	**3,856**
Goods & Services	42	1	168	13	98	5	8	**334**
Total	**699**	**117**	**664**	**2,351**	**187**	**60**	**112**	**4,190**
Surplus/(Deficit) to date								
Salaries	64	(9)	120	158	(32)	(7)	- 17	**277**
Goods & Services	(13)	1	(44)	27	(88)	2	32	**(83)**
Surplus/(Deficit)	**51**	**(8)**	**76**	**185**	**(121)**	**(4)**	**15**	**194**
Cumulative variance (%)	*6.79%*	*-6.91%*	*10.21%*	*7.30%*	*-181.78%*	*-7.46%*	*11.62%*	***4.42%***

PHA's administration budget is showing a year-to-date surplus of £0.2m, which is being generated by a number of vacancies, particularly within 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£1.1m, which is contributing toward PHA's savings requirements in the financial year.

PHA Prompt Payment

Prompt Payment Statistics

	May 2023 Value	May 2023 Volume	Cumulative position as at May 2023 Value	Cumulative position as at May 2023 Volume
Total bills paid (relating to Prompt Payment target)	£6,184,793	605	£10,866,446	1,194
Total bills paid on time (within 30 days or under other agreed terms)	£6,056,526	581	£10,730,895	1,166
Percentage of bills paid on time	**97.9%**	**96.0%**	**98.8%**	**97.7%**

Prompt Payment performance for May shows that PHA falling achieving the 95.0% target on both volume and value. The year to date position shows that on both value and volume, PHA is achieving its 30 day target of 95.0%. 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 84.8% 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 11

Title of Meeting	PHA Board Meeting
Date	17 August 2023
Title of paper	Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order
Reference	PHA/02/08/23
Prepared by	BSO Equality Unit
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

Purpose

The purpose of this paper is for the Board to note the contents of the PHA's Annual Progress Report and approve submission to the Equality Commission.

Summary

This report presents the statutory annual return to the Equality Commission for the period covering April 2022 to March 2023.

The report notes a number of outcomes demonstrating improvements in monitoring the impact on section 75 groups particularly around Health Improvement Progress Monitoring Returns, PPI monitoring, Health Intelligence evaluations and information gathering.

The report also highlights a range of examples where there has been further engagement with section 75 groups, for instance in relation to Care home Visiting and falls, Community Nursing, Investigating barriers to PPI and Tapestry programme.

Board members are asked to note the contents and approve onward submission to the Equality Commission in pursuance of our Equality commitments.

Public Authority Statutory Equality, Good Relations and Disability Duties - Annual Progress Report 2022-23

Contact:

• Section 75 of the NI Act 1998 and Equality Scheme	Name: Stephen Wilson Telephone: 03005550114 Email: Stephen.Wilson@hscni.net
• Section 49A of the Disability Discrimination Act 1995 and Disability Action Plan	As above

(ECNI Q28):
Documents published relating to our Equality Scheme, including our most recent Five-Year-Review of Equality Scheme, can be found at:
http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality
Our Equality Scheme is due to be reviewed again by 31st March 2026.

Signature:

This report has been prepared adapting a template circulated by the Equality Commission. It presents our progress in fulfilling our statutory equality, good relations and disability duties. This report reflects progress made between April 2022 and March 2023.

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Chapter	Page
1. Summary Quantitative Report	**3**
2. Section 75 Progress Report	**6**
Appendix – Further Explanatory Notes **(ECNI Q10,13,14,20)**	**21**
3. Equality and Disability Action Plan Progress Report **(ECNI Q2)**	**Chapter 3 (separate document)**
4. Equality and Human Rights Screening Report **(ECNI Q18)**	**Chapter 4 (separate document)**
5. Mitigation Report **(ECNI Q1,3,3a,3b)**	**Chapter 5 (separate document)**

Chapter 1: Summary Quantitative Report

(ECNI Q15,16,19)
Screening, EQIAs and Consultation

1. Number of policies screened (as recorded in screening reports). (see also Chapter 6) 5	**Screened in** 0	**Screened out with mitigation** 5	**Screened out without mitigation** 0	**Screening decision reviewed following concerns raised by consultees** No concerns raised by consultees on screenings published in 2022-23
2. Number of policies subjected to Equality Impact Assessment.	1			
3. Indicate the stage of progress of each EQIA.	Physical Activity Referral Scheme (PARS): A final draft version of the EQIA has been developed but further action has not been progressed due to staff capacity issues.			
4. Number of policy consultations conducted	0			
5. Number of policy consultations conducted with screening presented. (See also Chapter 2, Table 2)	0			

(ECNI Q24)
Training

6. Staff training undertaken during 2022-23. (See also Chapter 2, Q6)

Course	**No of Staff Trained**	**No of Board Members Trained**
Equality Screening Training	31	0
Equality Impact Assessment Training	15	0
Total	**46**	**0**

eLearning: 'Making a Difference' (mandatory equality awareness training)

Part 1 – All Staff	200
Part 2 – Line Managers	60

(ECNI Q27)
Complaints

7. **Number of complaints in relation to the Equality Scheme received during 2022-23**

0

Please provide detail of any complaints/grievances:

n/a

(ECNI Q7)
Equality Action Plan (see also Chapter 3)

8. **Within the 2022-23 reporting period, please indicate the number of:**

Actions completed:	1	Actions ongoing:	1	Actions to commence:	0

(ECNI Part B Q1)
Disability Action Plan (see also Chapter 3)

9. **Within the 2022-23 reporting period, please indicate the number of:**

Actions completed:	2	Actions ongoing:	0	Actions to commence:	3

Chapter 2: Section 75 Progress Report

(ECNI Q1,3,3a,3b,23)

1. **In 2022-23, please provide examples of key policy/service delivery developments made by the public authority in this reporting period to better promote equality of opportunity and good relations; and the outcomes and improvements achieved. Please relate these to the implementation of your statutory equality and good relations duties and Equality Scheme where appropriate.**

Table 1 below outlines examples of progress to better promote equality of opportunity and good relations[1].

In most cases, it is not possible to ascribe developments to one single factor of Equality Scheme implementation. New initiatives are not necessarily an outcome of any equality screenings or Equality Impacts Assessments. As mainstreaming progresses and the promotion of equality becomes part of the organisational culture and way of working, the more difficult it becomes to ascribe activities and outcomes to the application of a specific element of Equality Scheme implementation. From this point of view, staff training and engagement and consultation are arguably the most important factors. Changes resulting directly from equality screenings are reported in Chapter 5, the mitigation report. Those due to the implementation of Equality and Disability Action Plans are reported in Chapter 3.

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[1] This includes as a result of

- screening / Equality Impact Assessments (EQIAs)
- monitoring
- staff training
- engagement and consultation
- improvements in access to information and services
- implementation of Equality and Disability Action Plans.

Table 1:

	Outline new developments or changes in policies or practices and the difference they have made for specific equality groupings.
All Section 75 Groups	**Health Improvement and Section 75** PHA Health Improvement initiated a review of quarterly Progress Monitoring Returns from the majority of community and voluntary and statutory contract holders in 2021-2022. In order to deliver on our statutory duty as a public authority (ss referenced in the Terms and Conditions of contracts signed with the Public Health Agency; (11.9 p18)) Health Improvement asked the majority of contract holders to collect and record Section 75 data in their Quarter 4 return. (Commissioned services which are reported against DoH Impact Measuring tool already collect relevant S75 details). This year the mechanism for returns changed from an excel spreadsheet to the use of the Department of Finance, Citizen Space platform in response to requests from contract holders to move to an electronic format. The Citizen Space platform is secure and also facilitates detailed analysis of non-identifiable returns e.g. by S75 category.

	In 2022-23 S75 returns were requested from all 540 contracts that Health Improvement hold. 143 contracts have submitted returns. The Section 75 process of returns is developmental, some contract holders already gather such information and others do not. PHA Health Improvement division has communicated that we have a statutory duty to report on Section 75 and that this will be expected within future returns. Some service providers have indicated their service is not suitable to ask for S75 information e.g. Trust based client services. PHA HI have asked that whatever appropriate data is available should be collected and submitted e.g. gender, age, ethnicity. Of the 143 contracts analysed we have identified 128623 clients with 63892 S75 returns. This is equivalent to 49.7% response. From the information we receive we hope to identify the 'groups/communities of interest' we are and are not reaching and to use this information to target future services appropriately. As commissioning is rolled out across HI thematic areas over the forthcoming years, S75 returns will be made compulsory.

Persons of different religious belief	**Directorate of Nursing, Midwifery and Allied Health Professions** Personal and Public Involvement Monitoring We now collect the following information: 'Have you recorded any Section 75 data for this Involvement Project, Y/N'. We do this as a sense checker and a reminder of our responsibility under equality monitoring for Involvement based activity. The aim is to raise awareness of equality monitoring responsibilities amongst those undertaking Involvement projects. Response levels will be included as part of Involvement monitoring reports and is being integrated into our training programmes. This relates to all nine equality categories.
Persons of different political opinion	
Persons of different racial groups	
Persons of different age	**Directorate of Nursing, Midwifery and Allied Health Professions** **Older People Nursing** **Care Home Visiting** – The regional Normalising Visiting group with extensive stakeholder representation was stood down in November 2022 as the work was complete having brought the care home sector to a position of normalised visiting as prior to COVID-19. A further update to support visiting was issued to

	care homes in December 2022 removing restrictions to visiting during an outbreak except in exceptional circumstances. The PHA website was updated with information in relation to information and guidance on the management of COVID-19 in care homes, including information for staff, residents and families. Frequently Asked Questions regarding visiting were updated in September 2022 and further updates were issued in December 2022 to reflect new visiting guidance. PHA carried out a Snap Survey in May 2022 seeking views of residents, families and staff in care homes in relation to their experience of visiting. There were 935 responses to this survey regionally; responses indicated that 80% of respondents rated their experience of visiting as positive or strongly positive, 80% of respondents indicated the current measures supported residents and families to engage safely. Report was presented to AMT and was issued across HSC and Independent Sector in November 2022. **Care Home Falls** – When the co-designed Regional Post Falls Management Guidance and Falls Checklist and Review document were utilised, results indicated there has been an increase in people living in Care Homes and staff feeling confident about safer mobility. Early indications show a potential for a continued reduction in the falls rate and NI Ambulance Service call-outs although further work is planned to obtain more data and ensure integration of the pathway into all care homes. Key impact outcomes include: • 97% of residents no longer felt afraid of falling

	• 82% of residents reported that they knew how to move safely to reduce the risk of falls • 82% of residents reported that they felt safe and confident moving around the home • 93% of residents said they had all the equipment to help them move more safely • 91% of residents felt less worried about tripping and falling • 50% of staff felt confident in promoting safer mobility in their residents at the start of testing, this increased to 82% post testing • 68% of staff felt confidence in managing a resident fall at the start of testing, this increased to 82% post testing. As a result of these indicators a decision was taken to issue a suite of resources to support care home residents and staff in the promotion of safer mobility and the immediate management of a resident who has fallen in December 2022. This included guidance regarding a resident who experiences a long lie, Speech and Language Therapy guidance regarding oral intake and the Management of Falls guideline. A session to educate staff in the use of these documents was held following the launch in December 2022. Work continues to refine a Falls Risk Review and Checklist. This work was winner in the HSCQI Quality awards for the Care Home Category in November 2022. **Community Nursing** District Nursing (DN) teams deliver person and family-centered care in the person's home or in the community and assist people to make autonomous

	decisions about their care. Over 80% of people on the caseloads are over 65 years of age. It is important that anyone receiving District Nursing visits is aware of the service and why they are receiving it. In collaboration with service users, a new Patient Information leaflet (PIL) was designed to inform users of the various roles within the District Nursing Teams, what to expect and how to contact them for advice/support. This leaflet was delivered to all people in receipt of District Nursing Services in Northern Ireland in December 2022 and anecdotal feedback has been very positive to date citing improved communication for patients & staff and reduced anxiety. All Trusts received a hardcopy of this leaflet for further use. **Directorate of Operations** **Health Intelligence** A central function of Health Intelligence is to analyse data (eg from programme data and population-based surveys etc), evaluate programmes or interventions implemented by colleagues throughout the Agency, and report findings to colleagues internal and external to the Agency. In 2022/23 Health Intelligence commissioned the evaluation of campaigns such as FAST, Obesity and Winter vaccinations. As routine practice, analysis of data always includes gender, age, Socio Economic Group and marital status breakdowns. Findings are shared with colleagues who use the information to make decisions about the future of such interventions. Health Intelligence prepares the compendium - The Director of Public Health's Core Tables - which contain a range of demographic information such as

	estimated home population figures and projections, births information, fertility rates, death rates, information on life expectancy, immunisation rates, infectious diseases and screening uptake rates. These are presented also for gender (where applicable) and age group. https://www.publichealth.hscni.net/directorates/operations/statistics Family Nurse Partnership (FNP) is a licenced, intensive, home visiting programme provided to teenage parents by trained Family Nurses. In 2022 Health Intelligence produced the Family Nurse Partnership (FNP) International Annual Report 2022 Appendices: FNP Analysis of data to 31st December 2021 (Health Intelligence, 2022). The appendices are included in FNP Annual Reports including the Regional International Annual Report and each of the HSC Trust Annual Reviews for the FNP Family Advisory Boards. The collection of FNP data is a licensing requirement to help monitor and improve programme quality and replication of the original evidence-based programme model. The FNP data reports are used to review progress and outcomes with respect to FNP fidelity goals and FNP objectives concerning maternal and child outcomes. Health Intelligence commissioned qualitative research to explore the support needs of people affected by a relative's substance use. Participants were family members where the substance user was a young person (up to age 25 years) or an adult as intervention models can vary by life stage. These affected family members themselves comprised different age groups and life stages such as adolescent children of substance using parents, adult partners/spouses, parents and siblings of adolescent users, elderly parents of adult substance users, etc. The findings from this work will inform the PHA's further development and

	commissioning of family support services within the wider remit of the Substance Use Strategy in NI.
Persons with different marital status	**Directorate of Operations** **Health Intelligence** Please see entries above under ‘age’.
Persons of different sexual orientation	
Persons of different genders and gender identities	**Directorate of Operations** **Health Intelligence** Please see entries above (under ‘age’). Likewise, in December 2022 Health Intelligence published a compendium of monitoring data and statistics for the public and health professionals on breast feeding. This aims to support the development of strategies, programmes and action plans to promote the health and wellbeing of mothers and babies through breastfeeding.
Persons with and without a disability	**Directorate of Nursing, Midwifery and Allied Health Professions** The Dysphagia NI Partnership developed an easy read and audio version of a service user information booklet which is given to service users when they

	receive a diagnosis of Eating, Drinking and Swallowing Difficulties (dysphagia) PHA Swallow Aware Dysphagia Booklet (hscni.net)
Persons with and without dependants	**Directorate of Operations** **Health Intelligence** Please see entries above (under ‘age’ and ‘gender and gender identities’).

(ECNI Q4,5,6)

2. During the 2022-23 reporting period

(a) were the Section 75 statutory duties integrated within…?

	Yes/No	**Details**
Job descriptions	Yes	For all new posts, the Job Description now includes the following: "Assist the organisation in fulfilling its statutory duties under Section 75 of the Northern Ireland Act 1998 to promote equality of opportunity and good relations and under the Disability Discrimination (Northern Ireland) Order 2006. Staff are also required to support the organisation in complying with its obligations under Human Rights Legislation."
Performance objectives for staff	Yes	All PHA staff have a performance objective to complete the 'Equality, Good Relations and Human Rights: Making a Difference' training module which outlines the Section 75 statutory duties.

(b) were objectives and targets relating to Section 75 integrated into…?

	Yes/No	**Details**
Corporate/strategic plans	Yes	The PHA Corporate Plan 2017-2021, rolled over into 2022-23, includes five key outcomes. Two of these relate directly to Section 75 groups: 1. All children and young people have the best start in life 2. All older adults are enabled to live healthier and more fulfilling lives

Annual business plans	Yes	Against the Corporate Plan outcomes, a number of actions included in the Business Plan 2022-23 related to specific Section 75 groupings: “Lead the NMAHP public health support for children and young people including enhancing integrated working across the health and education sector.” “Develop a commissioning framework setting out PHA model for supporting Community-led approaches to addressing health inequalities.” “Use research funding programmes (CHITIN, NIHR, Opportunity Led, Research Fellowships) which have involved patients and public in their design to develop an evidence base to inform health and well-being at individual, community and regional levels by developing and securing the provision of programmes and initiatives which have been designed with patient and public involvement to secure the improvement of the health and social well-being of and reduce health inequalities between people in Northern Ireland.” “Through the NI Frailty Network we will improve outcomes for older people through: Coproduce, test and agree a Regional Frailty education programme for front line staff & Developing a regional falls pathway for care homes.”

(ECNI Q11,12,17)

3. **Please provide any details and examples of good practice in consultation during the 2022-23 reporting period, on matters relevant (e.g. the development of a policy that has been screened in) to the need to promote equality of opportunity and/or the desirability of promoting good relations:**

During 2022-23 the PHA undertook a consultation in relation to a Substance Use Needs Assessment for the WHSCT area.

Table 2

Policy publicly consulted on	**What equality document did you issue alongside the policy consultation document?**	**Which Section 75 groups did you consult with?**	**What consultation methods did you use?** **AND** **Which of these drew the greatest number of responses from consultees?**	**Do you have any comments on your experience of this consultation?**
Substance Use Needs Assessment for the Population of	**None**	**Opportunity for all groups to engage.** **Didn't seek out individually. Religious**	Fieldwork for the study took place between Nov22 – Mar23.	**None**

the Western Health and Social Care Trust		**belief, Political opinion, Men & women, older people, persons with dependants, sexual orientation**	Two initial Stakeholders Events were held at the front end of the research (23rd and 24th November 2022) to gather views and themes for consideration during the main fieldwork phase of the project. From these events the recruitment of two small working groups took place. The Working Groups each met twice to consider the key messages that arose from the initial Stakeholder Events. A final set of two Stakeholder Events were held	

			(15th and 16th February 2023) to consider early key messages from the evidence gathering phase and to identify a set of priorities for consideration in the study's conclusions. The purpose of these qualitative elements of the project was primarily to explore: • Views on current provision of interventions, help and support for those with a dual diagnosis; • Any gaps in current provision; • Views in relation to the nature and extent	

			of future requirements; and • Assets (groups, networks, individuals, etc.) across WHSCT. In order to capture the views and opinions of individuals with lived or living experience of problematic substance use and their families and loved ones, staff at Figure 8 facilitated a series of nine qualitative focus groups with 44 individuals recruited from the following services and organisations across the	

			Western HSCT area	
The proposed postvention service models for over and under-18s, to support those bereaved or affected by suicide	N/a	Participants at public consultation events were asked to complete section 75 data. Uptake of completion was 75%. Additionally a closed focus group was held with the • LGBTQIA+ community • Parents/carers of children and young people bereaved by suicide. Specific engagement was also held members of Traveller community and support organisations and with minority ethnic groups and support	Seven public consultation events were held as part of the consultation activity in accessible venues (1 per Trust area) across NI, alongside two regional online events. Closed focus groups were held with the Family Voices Forum, LGBTQIA+ community and Parents/Carers of children and young people bereaved by suicide.	The numbers of consultees involved in this public consultation have been low, however due to the nature of discussion and the small proportionate size of the population this service is aimed at we were still content with the level of engagement.

			The online survey was live for 12 weeks and closed on the 9th April 2023, which provided two weeks following the final stakeholder engagement for attendees or those who had been unable to attend events to add further comment. An Easy Read version was also made available. Consultation responses were also accepted via email or letter. The online drew the greatest number of	

			responses from consultees (78), this was closely followed by public consultation events (64)	

(ECNI Q21, 26)

4. In analysing monitoring information gathered, was any action taken to change/review any policies?

There is no information to evidence that PHA collected any equality monitoring information during 2022-23.

Table 3

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
-	-	-	-

(ECNI Q22)

5. **Please provide any details or examples of where the monitoring of policies, during the 2022-23 reporting period, has shown changes to differential/adverse impacts previously assessed:**

There is no information to evidence that PHA undertook the monitoring, during the 2022-23 reporting period, of policies previously screened or EQIAed.

Table 4

Policy previously screened or EQIAed	Did equality proofing show any additional needs/adverse impacts for any of the Section 75 groups?	Did you gather and analyse any equality monitoring information during 2022-23? (Please tick)	Did monitoring data show these adverse impacts had changed in 2022-23? Why do you think this is?
-	-	-	-

(ECNI Q25)

6. **Please provide any examples of relevant training shown to have worked well, in that participants have achieved the necessary skills and knowledge to achieve the stated objectives:**

The PHA avails of the joint Section 75 training programme that is coordinated and delivered by the BSO Equality Unit for staff across all 11 partner organisations. The following statistics thus relate to the evaluations undertaken by all participants for the training.

Screening Training Evaluations

The figures in bold below represent the percentage of participants who selected 'Very Well' or 'Well'. Participants were asked: "Overall how well do you think the course met its aims":

- To develop an understanding of the statutory requirements for screening: **94%**
- To develop an understanding of the benefits of screening: **95%**
- To develop an understanding of the screening process: **90%**
- To develop skills in practically carrying out screening: **85%**

EQIA Training Evaluations

Participants were asked: "Overall how well do you think you have achieved the following learning outcomes" (the figures in bold represent the percentage of participants who selected 'Very well' or 'Well'):

- To demonstrate an understanding of what the law says on EQIAs **97%**
- To demonstrate an understanding of the EQIA process **100%**
- To demonstrate an understanding of the benefits of EQIAs **97%**

- To develop skills in practically carrying out EQIAs **90%**

(ECNI Q29)

7. Are there areas of the Equality Scheme arrangements (screening/consultation/training) your organisation anticipates will be focused upon in the next reporting period?

During 2023-24 we will focus on:

- Consulting on our new Equality and Disability Action Plans, jointly with our partner organisations, and finalising the Plans following the consideration of what consultees have told us.
- Progressing the collection, analysis and use of equality monitoring information to inform our work and the decisions we take.

Appendix – Further Explanatory Notes

1 Consultation and Engagement

(ECNI Q10)
targeting – We did not undertake any public consultations or pre-consultation exercises during the year.

(ECNI Q13)
awareness raising for consultees on Equality Scheme commitments – During the year, in our quarterly screening reports we raised awareness as to our commitments relating to equality screenings and their publication.

(ECNI Q14)
consultation list – During the year, we reviewed our consultation list every quarter.

2 Audit of Information Systems

(ECNI Q20)
We completed an audit of information systems at an early stage of our Equality Scheme implementation, in line with our Scheme commitments.

Equality and Disability Action Plans 2022-23

What we did

If you need this document in another format please get in touch with us. Our contact details are at the back of this document. Our Equality and Disability Action Plan 2018-23 can be found on our website at: PHA Annual Progress Report to the Equality Commission 2021-22.pdf (hscni.net) (Chapter 5)

Equality Action Plan 2022-23: What we will do to promote equality and good relations

Action 1: Assistant Director HSC Research & Development – by end March 2023
What we will do: Investigate barriers to Personal and Public Involvement (PPI) and participation in HSC Research, especially for those who are less likely to take part in research and PPI, such as younger people, and those from ethnic minority groups.
What we are trying to achieve: Age and Ethnic Minorities - Increase the number of people including young people and those from ethnic minorities taking part in PPI activities and getting involved in research as participants.
Performance Indicators and Targets:

- Study to evaluate PPI in HSC R&D has been undertaken and reported.
- The PPI action plan developed as part of the NI Clinical Research, Recovery, Resilience and Growth Programme has been implemented in accordance with stated timeline.
- Recommendations for next phase of PPI in HSC Research have been provided.
- Numbers of people taking part in clinical trials and other research studies in Northern Ireland and in PPI activities including PIER, particularly from younger age groups and ethnic minorities where involvement is lower, have increased.
- Public Awareness Days for PPI including the launch of the NI CRRRG action plan, have been delivered in collaboration with partners including those agencies involved with BAME communities.
- The HSC R&D application for funding process will include questions on equality, inclusion and diversity.

What we did over the last year:
An evaluation of PPI in HSC R&D Division was undertaken in February 23 via a survey of our award holders using the UK Public Involvement Standards as a framework. The results can be accessed here.

The Building Research Partnership training we have delivered since 2012 was also evaluated as part of this work. Work is taking place to implement the recommendations from these evaluations through the development of a payment policy for public contributors and to make the course more accessible to a wider audience of health and social care professionals, service users and the public via the Engage website.

Efforts were made to advertise the training to BAME communities via several community groups. The online nature of the course also attracted people from elsewhere in the UK though numbers from the BAME community remained very small. Of 93 participants who attended the training in 2023, 6 were from a BAME background based on registration details, including researchers and service users.

A total of 2,500 participants were recruited to clinical trials via the NI Clinical Research Network in 2023 but it was not possible to extract demographic and ethnicity data. It is hoped that the public launch of the BePartofResearch website planned for September will help to highlight research opportunities more widely to NI participants. Permission has been obtained to approach those who signed up to the Vaccine Research Registry to encourage them to sign up to BePartofResearch website. This includes almost 10, 000 people from Northern Ireland.

The PPI action plan developed as part of the NI Clinical Research, Recovery, Resilience and Growth Programme has been implemented in accordance with stated timeline. A regional lead post for PPI in Research,

one of the actions, is currently in development. The group continues to be co-chaired by a member of PIER NI who also represents HSC R&D Division on UK wide working groups.

Questions to promote Equality, Diversity and Inclusion and promoting the UK Standards on Public Involvement have been added to HSC R&D funding scheme guidance in line with the National Institute for Health and Care Research recommendations for PPI. To date no equality monitoring data is collected from applicants to our funding schemes but discussions are taking place regarding the introduction of the collection of anonymised equality data. This would be in line with other funding bodies like the National Institute for Health and Care Research as trying to capture data around research participants and workforce.

We did some work on but didn't complete this action.

Action 2: Director of Human Resources (by end of March 2023)
What we will do: Identify and pilot training available from organisations in the gender identity sector and put arrangements in place to access such training for teams where a member of staff comes forward to disclose that they identify as transgender or non-binary.
What we are trying to achieve: Transgender and non-binary staff feel more supported in the workplace.
Performance Indicator and Target: Data collected from all staff who have drawn support through the policy indicates a positive experience.
What we did over the last year:
During the year, BSO (our provider of HR services) commissioned The Rainbow Project to deliver training on Gender Identity Awareness to a team for whom this specific training need was identified. The training was well

received by the team, with members reporting they found it really useful. This positive feedback means that The Rainbow Project's details can be held as a provider of Gender Identity Awareness Training, to ensure timely access to training when the need arises in future.

We did some work on and completed this action.

Equality Action Plan - Conclusions

- We did some work on but didn't complete 1 action (#1).
- We did some work on and completed 1 action (#2).
- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people in the Section 75 categories. We will tell the Equality Commission about any changes.

Disability Action Plan 2018-2023: What we will do to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life

Action 1 Assistant Director of Allied Health Professions, Personal and Public Involvement and Patient Experience - by end of March 2023
What we will do: Commission RNID (formerly Action on Hearing Loss) to deliver deaf awareness training to staff in the PHA.
What we are trying to achieve: Ensure that staff are aware of challenges faced by people who are deaf, and what they can do to support someone who is deaf. Promotion of positive attitudes towards people who are deaf.
Performance Indicator and Target: Training delivered for Nursing; Allied Health Professionals (AHP); Personal And Public Involvement (PPI); 10,000 Voices; and Patient Experience teams. Training sessions evaluated.
What we did over the last year: The relationship with voluntary bodies such as RNID and others, continues to be built upon. Whilst the originally envisaged training did not progress in 2022/23 as organisations emerged from the COVID pandemic and dealt with the consequences and impacts emanating from it, the Assistant Director of AHPs continued to work with RNID as previously advised. Options for progressing training such as this, to advance the Equality and Disability agenda remain under consideration.
We did not complete this action.

Action 2 Equality Unit - by end of March 2023
What we will do: Staff Awareness Days - Raise awareness of specific barriers faced by people with disabilities.

What we are trying to achieve: Staff are better equipped to identify and meet the needs of colleagues and service users with a disability.
Performance Indicator and Target: Two annual Awareness Days profiled in collaboration with voluntary sector groups. Features run on Connect (PHA intranet). >50% of staff participating in the evaluation indicate that they know more about people living with disabilities as a result of the awareness days.
What we did over the last year:
We ran a survey in which we asked staff which conditions we should feature. Based on its outcome, we held two days during the year, one on Autism (in February 2023) and one on Bowel Conditions (in March 2023). On both days we organised a live session with an expert in the field (from Autism NI for the first Awareness Day and a dietitian from the South Eastern Health and Social Care Trust for the second one). Following their presentation, staff had the opportunity to ask them questions during a Question and Answer session. The presentations were uploaded to the website of Tapestry (our disability staff network) for the benefit of staff and board members who were unable to attend on the day.

As a result, 38% of staff who attended a session on the day or accessed any of the materials felt they knew more about Autism. 42% thought they knew more about 42% Bowel Conditions. It is unclear why the other survey participants did not record an increase in knowledge. This could be either a reflection on the session or because they already had substantive specialist knowledge beforehand. One comment suggested that the focus of the session on Bowel Conditions (on Inflammatory Bowel Disease to the exclusion of Irritable Bowel Syndrome) may have played a role. In other words, the title of the Day may have been too broad and created expectations that then remained unmet.

We completed this action.

Action 3 Agency Management Team with support from Equality Unit - by end of March 2023
What we will do: Tapestry - Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its agreed priorities.
What we are trying to achieve: Staff with a disability feel more confident that their voice is heard in decision-making. Staff with a disability feel better supported.
Performance Indicator and Target: Increases in Tapestry membership or in participation at meeting.
What we did over the last year:
Tapestry is supported by the BSO Equality Unit on behalf of the PHA and our partners. For each Tapestry meeting, the Unit issued advance notices to all staff and reiterated the commitment by Chief Executives of the participating organisations that staff can attend in their worktime. On key issues the Unit also encouraged those members who were unable or not interested in attending the meetings to share their views and experiences by emailing them to a dedicated Tapestry email address.

There are currently 50 members on the mailing list for the Network. In comparison to the previous year, the number has remained the same. Over the year, a few members left the HSC and were removed from the list, however there have likewise been new members who joined.

During the year, the network elected Karen Hunter, BSO Director of Strategic Planning and Customer Engagement, as its new Chairperson. Four Tapestry members provided an input at one of the senior HSC Leadership Programmes during the year. They felt that their presentation was a great success and presenters received very positive feedback. Presentations included comments on recruitment and selection processes as well as a discussion on reasonable adjustments. Throughout the year, Tapestry members identified key issues and barriers for people with a disability and carers in relation to recruitment, employment, and training. These

include a lack of accessibility of recruitment processes, training, and IT systems as well as particular aspects of Hybrid Working. They likewise reported barriers for career progression of staff with a disability and those who are carers.

We completed this action.

Action 4 Agency Management Team with support from Equality Unit - by end of March 2023
What we will do: Disability Work Placements - Create and promote meaningful placement opportunities for people with disabilities.
What we are trying to achieve: People with a disability gain meaningful work experience. Staff are better equipped to identify and meet the needs of colleagues and service users with a disability.
Performance Indicator and Target: At least one placement offered by PHA for 2022-23 Scheme. Feedback through annual evaluation of scheme indicates that placement meets expectations.
What we did over the last year:
We did not offer any placements this year.
We did not progress this work.

Action 5 Agency Management Team - by end of March 2023
What we will do: Sign up to Mental Health Charter.
What we are trying to achieve: Staff with mental health conditions feel better supported in the workplace.
Performance Indicator and Target: Promotion of Charter Mark
What we did over the last year:

We did not progress this work.

(5) Additional Measures

- We always include Disability on our list of things to talk about at our quarterly Equality Forum with our partner organisations.
- We report on progress against our Disability Action Plan to our Board and Agency Management Team (the people at the top of our organisation) every year.

(6) Encourage Others

- We did not undertake any activities to encourage others.

(7) Monitoring

- We did not undertake any monitoring activities in addition to what is listed above.

(8) Revisions

- During the year we reviewed our Equality and Disability Action Plans 2018-23. We are currently consulting on our new Equality and Disability Action Plans 2023-28.

Disability Action Plan - Conclusions

- We completed 2 actions (#2,3).
- We didn't do any work on 3 actions (#1,4,5).
- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people with a disability. We will tell the Equality Commission about any changes.

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You can also email us through our website on:
http://www.publichealth.hscni.net/contact-us
August 2023

Equality and Human Rights Screening Report

April 2022 – March 2023

These screenings can be viewed on the BSO website under: https://hscbusiness.hscni.net/services/3307.htm

Policy / Procedure	Policy Aims	Date	Screening Decision
Bereaved by Suicide Development Project	The core objective of this service is to provide coordination, facilitation and development support to the Families Voices Forum to be a voice for individuals, families and communities who have been bereaved by suicide and to publicly promote the work of the Forum and highlight pathways for involvement.	Aug-22	Screened out with mitigation
Critical Care Nursing Career Pathway	The Project Steering Group will work with key stakeholders to develop a critical care nursing career pathway to support the development of registered and non-registered nursing staff.	Dec-22	Screened out with mitigation
Maintaining the integrity and functionality of the National Breast Screening system in Northern Ireland	To manage call, recall, cohort identification and recording of outcomes for screening subjects who are covered by the NI Breast Screening Programme and	Oct-22	Screened out with mitigation

	ensure National Breast Screening System (the IT system underpinning the programme) can continue to receive necessary updates.		
Procurement of a Shared Reading Service in the NI Criminal Justice Setting.	PHA will lead a competitive tendering process, to secure a formal contract with one provider to deliver a shared reading service across all NI adult prison sites.	Feb-23	Screened out with mitigation
Retendering of the Youth Engagement Service (formerly known as One Stop Shops)	The PHA is re-tendering for the provision of a Youth Engagement Service. This Service provides a wide range of interventions and acts as a hub where young people have opportunities to socialise in an alcohol and drug-free environment and avail of information, advice and support on a range of issues from relevant services both on-site and off-site, with the support of staff of the Youth Engagement Service.	Aug-22	Screened out with mitigation

No concerns were raised by consultees on any of the screenings published in 2022-23.

Chapter 5: Mitigation Report

Equality and Human Rights Mitigation Report

April 2022 – March 2023

Bereaved by Suicide Development Project

In developing the policy or decision what did you do or change to address the equality issues you identified?	*What do you intend to do in future to address the equality issues you identified?*
• PHA will provide information in alternative formats as requested. • Interpreting and signers will be made available on request. • Supporting documents will be made available in braille and large text if requested. • PHA will encourage participation through a blended approach to activity availing of a mix of face to face and online engagement and communication tools and through organisations and groups who promote individuals who have been bereaved through suicide. • All Forum Members will be required to adhere to the Code of Conduct and values which requires members to be treated with privacy, respect and dignity, have a respectful attitude and show non- offensive behaviour towards other members. **Gender** • Participation will be promoted through current networks that provide support to men. **Age** • Participation will be promoted through current networks that provide support to persons of different ages e.g. Youth Reference Group, Age Friendly Officers.	Monitor requests for alternative formats and / or language to inform the production of future involvement processes.

Religion • Participation will be promoted through the Flourish Churches suicide initiative. **Political Opinion** • Political parties will have the opportunity to input to involvement processes. **Marital Status** • The needs of single parents will be considered in relation to timing of involvement to take into account childcare arrangements. **Dependent Status** • The Forum will avail of a blended approach to activity availing of a mix of face to face and online engagement and communication tools. • Meetings will take place at different times, and various locations when face to face, to facilitate participation of those with caring responsibilities. **Disability** • Participation will be promoted through current networks that provide support to persons living with a disability • Where appropriate a video will be produced with subtitles to outline involvement. • Interpreters and/or signers will be available if required and supporting documents will be provided in braille or large text on request. • Accessibility will be taken into account in all forms of communication and information e.g. sign language, interpreting and all requests for alternative	

formats will be considered. • Participants will be signposted to support services if necessary. **Ethnicity** • Translation/Interpreting services will be provided on request. • Participation will be promoted through current networks that provide support to members of BAME and Traveller Communities. **Sexual Orientation** • Participation will be promoted through current networks that provide support to LGB people	

Critical Care Nursing Career Pathway

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
People with a disability, those whose first language is not English PHA and NIPEC's Accessible Formats Policy outlines how those developing information should consider alternative formats, and how information and publications can be requested in alternative formats, receipt of which is recorded and requests are monitored. **Children and Young People and Older People** PHA/NIPEC will provide alternative formats on request to meet the needs of older people who don't have computer skills or access to a computer/internet and will also	**People with a disability, those whose first language is not English** PHA/NIPEC will continue to monitor requests for alternative format and/or language to inform future production of electronic and written communication. **People with a disability, those whose first language is not English, Children and Young People and Older People, People with dependents** A checklist is available to assist those organising engagement events and meetings and developing information – this will cover the need to take account of specific needs of the nine groups.

consider the need to provide age-appropriate information to meet the needs of children and young people. **Those whose first language is not English** As part of HSCNI, PHA/NIPEC can access the regional contract for interpreting, translation and transcription services. **People with a disability** From the onset of the coronavirus pandemic, there had been a move to conducting most business online using advised virtual platforms. This move to virtual meetings highlighted the need for organisers to give consideration to any additional impact on Section 75 groups. However, in normal times, PHA/NIPEC's procedure for booking external venues requires those responsible for organising events and meetings ensure that venues and information are fully accessible. **People with dependents** During the current pandemic, there has been a move to conducting most business online using advised virtual platforms. This move to virtual meetings highlighted the need for organisers to give consideration to any additional impact on Section 75 groups. However, in normal times, when planning engagement events and meetings, PHA/ NIPEC will consider their timing and location. Where applicable, assistance with travel expenses will also be considered.	

Key activities of the project include: • Development of core competencies and education requirements for regionally agreed core roles in critical care nursing career pathway. • Development of regionally agreed job descriptions for the core critical care nursing roles. • Critical care nursing career pathway and resources submitted for inclusion on nursing and midwifery careers website.	Screening has identified that a number of Section 75 groups have particular needs and be more likely to require safeguarding. In developing the career pathway and any supporting documents, the specific needs of these Section 75 groups and their diversity across the groups will be considered, and where necessary, reflected within the pathway.

Maintaining the integrity and functionality of the National Breast Screening system in Northern Ireland

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
We have committed to ensuring that the system meets accessibility standards. As it was developed by NHS Digital, we asked if they could provide a statement on this. They have told us that while they do seek to incorporate accessibility standards, there is no formal assessment carried out for systems designed for internal NHS use (as opposed to web based systems for public use). The system has been used in Breast Screening offices across England for over 5 years with no outstanding accessibility issues. NHS Digital have given an undertaking that if any accessibility issues are discovered they will be added to the	Through the Business Change and Benefits Management group we will invite existing staff to take part in user testing of the new system. In recognition of the need to make IT systems accessible to staff, we will carry out user testing. We will particularly encourage staff with sight loss to take part in user testing. If that is not possible to arrange, then other HSC staff with sight loss will be asked to assist in user testing to help identify potential barriers. This approach has been discussed with RNIB NI who think it is sensible and proportionate. If any issues are discovered, then they will be reported back to NHS Digital for remediation

system development roadmap for urgent correction. We have set up a Business Change and Benefits Management group which has representation from all Breast Screening Units. Some of these staff have part-time working patterns. We have carried out a staff survey to measure awareness of the project and plan to maintain communication with the Breast Screening Units so that staff have a channel through which to raise any concerns.	and further advice will be sought from RNIB NI. As Equal Opportunities employers, Trusts and PHA will also be guided by their existing policies and the need for necessary reasonable adjustments. A training programme will be developed which will allow for initial training and on-going support in ways that best address any issues identified i.e. both face-to-face and e-learning; access to accessible training materials and manuals on-line after formal training; seeking feedback on training. Part-time working patterns will be considered when arranging the training schedule. The project will also ensure that business readiness for change is assessed and that there is early-life support after go-live to ease transition to new working practices.

Procurement of a Shared Reading Service in the NI Criminal Justice Setting.

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
A key feature of this SR offering is that participation/access is voluntary. The offering is one of a 'suite' of interventions aimed at improving the health and social well-being of participants.	PHA is working to re-build and deliver post COVID 19 public health improvement interventions. PHA is seeking to build upon the learning from COVID 19 and the emergence of alternative delivery models to respond

The commissioned evaluation reported in 2020 and has listed 6 Points of Consideration. Some aspects may apply to varying degrees to each prison and the JJC. These points also need to be viewed in conjunction with the identified facilitators, barriers and suggested improvements in the evaluation. The evaluation reported that shared reading service has embedded well in prisons/JJC; though, there is some variation between individual prisons. Some barriers to the implementation remain and present mainly around awareness/promotion, scheduling, and capacity. The most commonly made suggestion was to have more shared reading groups/sessions. Dependent status: All of the prison population who have dependent children are classified as an “absent parent”. The Shared Reading service can give prisoners the skills to change intergenerational effects when prisoners are released and return to the family, enabling them to participate more fully in their children’s lives. Disability: A number of vulnerable groups are over-represented in the prison population when compared with the national average, including those with mental ill health, personality disorder, learning disabilities, which can involve speech, language and communication difficulties. These individuals may	to emerging and changing need. PHA will work with the successful SDO to further promote equality of opportunity for the SR service and consider suggestions listed within the 6 Points of Consideration e.g. Point of Consideration 3 of 6. • Reassure a) prisoners with low literacy skills and/or low confidence and b) those with high literacy skills that the shared reading group is open to them too and they could very well benefit from it and enjoy it. • Explore the use of shared reading as a social prescribing option for those identified as having/seeking help for mental health problem Note: Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical wellbeing. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, people with complex needs, people who are socially isolated and those with multiple long-term conditions who frequently attend either primary or secondary health care.

experience particular difficulty in terms of communication, participation, access and welfare. Part of the contract management process includes reporting on accessibility and communication issues for those with different disabilities (i.e. hard of hearing, sight issues, learning disability, and physical disability). Staff are expected to have been trained in disability awareness, and this is included in the contract monitoring returns. Ethnicity: Foreign nationals may experience language and cultural barriers. Staff delivering the programme are expected to have been trained in cultural awareness, and this is reported in the contract monitoring returns. Accessibility issues such as the provision of reading material in foreign language or interpreters will be monitored and reported. Sexual orientation: Research suggests that issues affecting people from the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and/or Asexual) community within custody include isolation, harassment or physical abuse. One specific element of the service included in the specification is that the	

SR provides an engaging, respectful, non-judging, non-threatening, environment. One of the key findings from Gossrau-Breen's work (2020) was the positive impact of SR on social isolation and positive interact through the provision of a safe and relaxed space, respect and tolerance.	

Retendering of the Youth Engagement Service (formerly known as One Stop Shops)

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Gender: The needs of young people using the service are identified through the young people's committee/forum attached to each Youth Engagement Service. These groups identify both social and recreational activities to be provided within the service and the educational programmes to be provided. Usage of the services was around 60% male in 14/15; services are required to address this through consultation with young people to ensure that the services provided are attractive to both genders. In 2016/17 this had been effectively addressed with usage of the services having moved to 55% male and 45% female. A further sample taken in 21/22 continue the trend of 55% male and 45% female. Gender identity has been identified as an emerging issue for some young people. This is currently being	Uptake of services by gender will be monitored by PHA and any under-representation in service users will be addressed within each YES. Identify appropriate training for YES staff.

proactively considered by PHA how to best support staff and young people to ensure the service is accessible and safe for all young people to attend. Age: Advice needs to be available in places young people already go to such as youth drop-in centres offering co-located support services in accessible and safe locations. The needs of young people using the service are identified through the young people's committee/forum attached to each YES. These groups identify both social and recreational activities to be provided within the service and the educational programmes to be provided. Services provide activities and educational programmes that cater for the identified needs of all service users from 11-25. Religion/ political opinion: As part of the procurement process all YES applicants were asked how they would ensure equality of access and encourage good relations to all sections of the local community. Each YES apply their own approaches to this area to ensure mutual respect is paramount at all times. Dependent status: The needs of young people using the service are identified through the young people's committee/forum attached to each Youth Engagement Service. These groups identify both social and recreational activities to be provided within the service and the	Uptake of services in relation to age will continue to be monitored by PHA. Similar approach will be applied to upcoming procurement process.

educational programmes to be provided. Where there are young people with dependent children using the service their needs have been identified and, where appropriate, they have been proactively addressed, e.g. by the formation of a young mothers group or young fathers group. Disability: All YES Managers have received training on disability and accessibility issues. All services have also proactively contacted local organisations that provide services to young people with disabilities to promote the YES services Sexual orientation: All YES Managers received a training input from the Rainbow Project on LGBT accessibility issues. Most of the services have developed an ongoing relationship with either Rainbow or CaraFriend and the services continue to run LGBT groups or LGBT awareness sessions according to identified need. The specification for these services going forward includes a requirement for service providers to consult with young people and provide recreational services and educational programmes that attract equal numbers of service users of both genders. As with previous provision of these services under the name 'One Stop Shop', the YES Network will be used to ensure service providers have access to training around equality issues and obtain support from specialist	Training will be made available as and when required for YES staff.

organisations where appropriate.	Ethnicity: The 2017 evaluation of the OSS's found that staff identified young people for whom English was not their first language as an issue they were keen to address. However the evaluation only picked up one case where this had been a significant issue and in that case the OSS concerned had made a concerted and effective effort to support the service user in question. The evaluation did not pick up any other issues related to ethnicity. Post Pandemic in 2022 has seen some new trends which has been reported by three YES's. There has been an increase of ethnic minority and migrant young people accessing the recreational element of the service. This is a new development for the services which requires further consideration and PHA are actively exploring training and support options for these YES's. This will then be addressed within the development of the Specification in the re-tendering of the service.

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	17 August 2023
Title of paper	Draft Substance Use Strategic Commissioning and Implementation Plan
Reference	PHA/03/08/23
Prepared by	Stephen Murray / Kevin Bailey
Lead Director	Stephen Wilson / Joanne McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

Introduction

The HSC Strategic Commissioning and Implementation 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

The Strategy set a vision 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'.

To support the realisation of this vision, the PHA and SPPG were required to jointly produce a Substance Use Strategic Commissioning and Implementation Plan (the Plan) for alcohol and drug services.

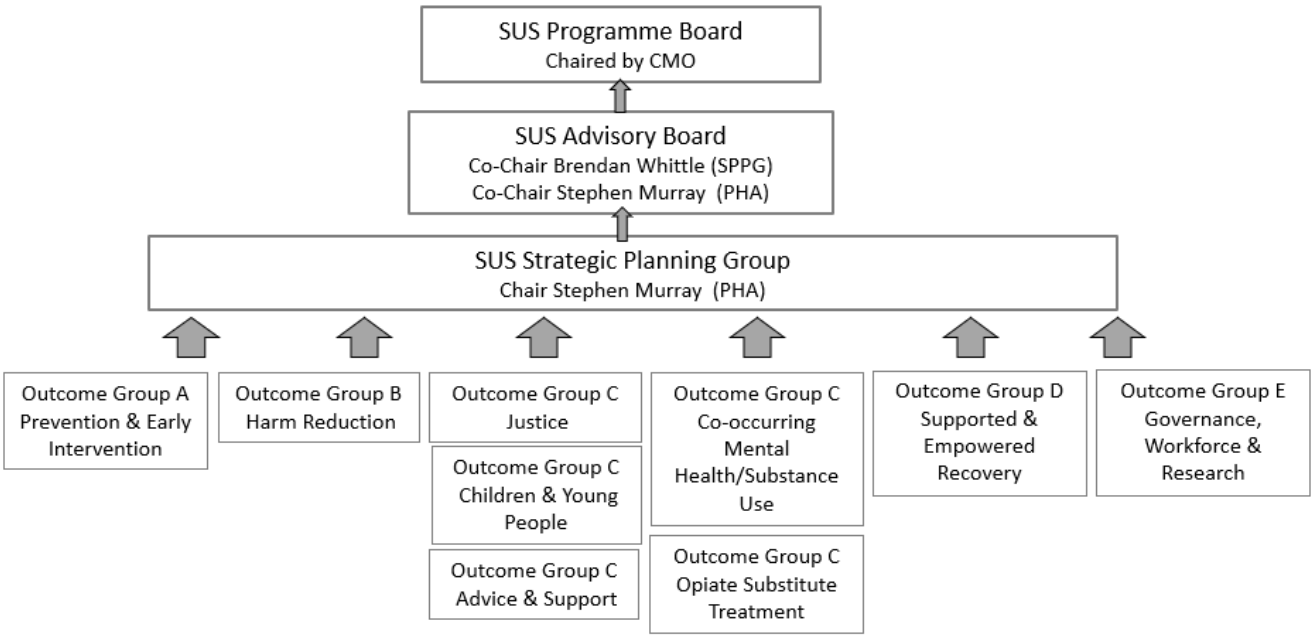
Process

The development of the Plan has been led and co-ordinated in partnership between the PHA and SPPG. This partnership is reflective of current commissioning arrangements for Substance Use/Addiction Services in which PHA commissions Tiers 1 and 2 Early Intervention and Prevention Services; and SPPG Tiers 3 and 4 Community Treatment, Hospital In-Patient and Residential Rehabilitation Services.

The process of developing the Plan involved over 150 representatives from Trusts and Community and Voluntary Services, people with lived and living experience and their families, and other agencies such as PSNI, and those with a focus on Housing, Education and Justice.

A comprehensive governance structure (*Figure 1*) was established to enable a number of Outcomes groups to focus on various aspects of substance use and addiction as determined by population need, current service provision and gaps in service provision.

Figure 1 SUS Governance Structure



Each of the Outcome group had a co-chairing arrangement with one representative from the statutory sector and one from the community and voluntary sector leading the Group. Each Group also had representatives with lived and living experience. This was in addition to a separate group for those who have experience of living with substance use to discuss and monitor the Outcome group outputs and two open invite meetings with members of the public who wished to contribute to the development of the Plan.

The planning programme was underpinned by strategic planning and commissioning methodology which allows the questions to be posed. '*Where are we now?' Where do we want to go? How do we get there?* and *How do we know we have made a difference?'*

The Plan therefore represents a response to these questions and identifies a number of principles, strategic priorities and associated action points for implementation over the planning period.

The Strategic Priority areas as identified in the Plan are;

- Prevention and Early Intervention
- Pathways of Care, Models of Support
- Trauma Informed System

- Family Support
- Stigma
- Workforce Development
- Digital Innovation
- Data and Research

Under each Priority area a number commissioning priorities have been proposed and a Lead organisation(s) identified to take it forward. An indicative timescale for implementation has also been set and an indication provided as the weather or not the action can be delivered within available resources or if additional funding will be required. Whilst it is recognised there is a need to secure additional investment from DoH to deliver fully on the Plan, the current challenging financial climate is highlighted to manage expectation on new monies being available in the short term, thereby placing an emphasis on service improvement and reusing existing resource.

The Plan will set the direction for the PHA led procurement of Community and Voluntary Sector services in relation to early intervention and preventative approaches within Tiers 1 and 2 which had been paused until completion of this work.

The Plan also sets direction for services commissioned by SPPG as delivered by HSCTs including the improvement of existing pathways of care (e.g. healthcare in prison and Community Addiction Teams, Community Mental Health Teams and Community Addiction Teams) and the development of additional services (e.g. supporting individuals with Alcohol Related Brain Injury (ARBI)).

The draft Plan has been presented at the DOH Substance Use Programme Board as chaired by Professor Sir Michael McBride. Comments received from Board Members are both welcoming and positive in relation to the content of the Plan. The draft Plan has also been reviewed and approved by the Planning, Performance and Resources Committee of PHA board.

PHA has undertaken an Equality Screening and Rural Needs Assessment of the draft Plan and no specific issues have been identifed.

Next Steps

The draft Plan will be issued in early September 2023 for a 12- week period of public consultation. Comments received under the consultation will be considered and an updated Plan will be presented to PHA board for final approval in January 2024.

PHA board is asked to endorse that the draft Plan sets out clear commissioning priorities for the PHA to deliver on its responsibilities in achieving the Outcomes set out in the Minister’s Regional Substance Use Strategy and approve that the document be issued for public consultation.

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

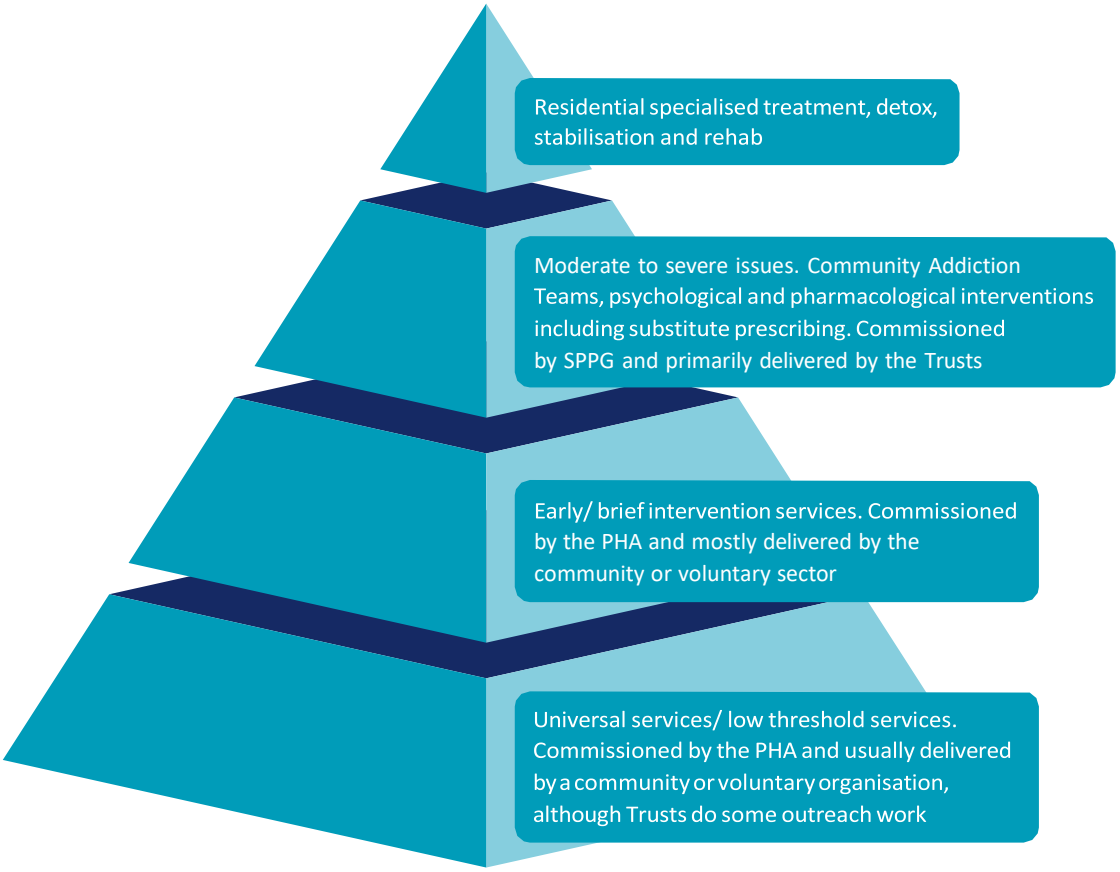
Utilising evidence, this *Plan* will actively promote innovation and quality improvement approaches to service transformation.

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.

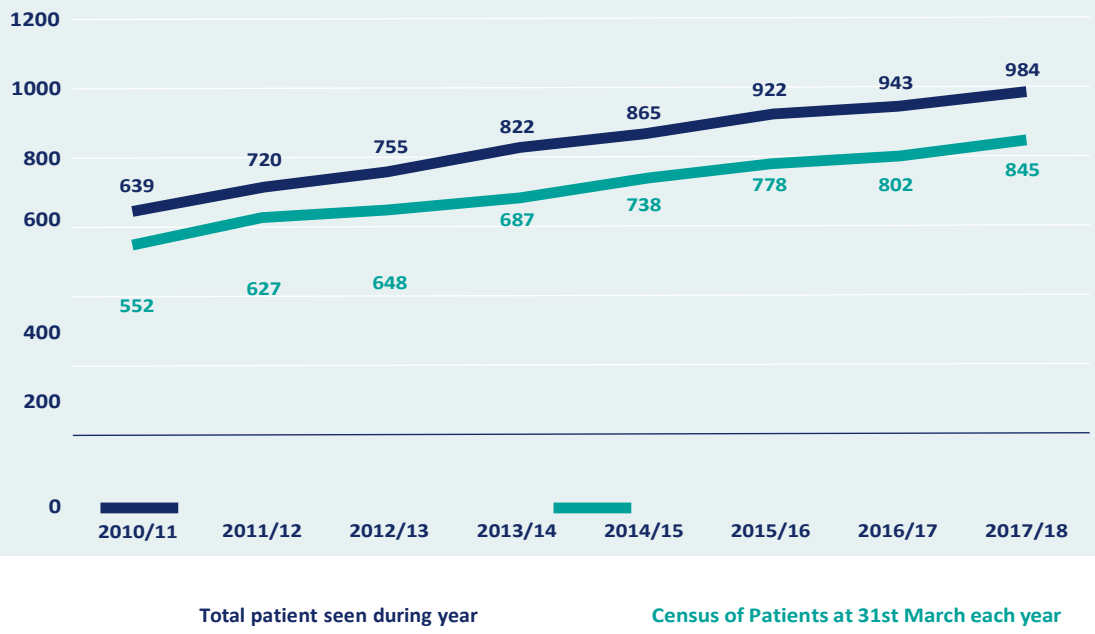
In response, the Northern and Southern Health and Social Care Trusts have both funded designated Co-Occurring Mental Health and Substance Use professionals to provide operational and strategic links between Trust provided mental health services and addiction services. These are reported to be beneficial 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:

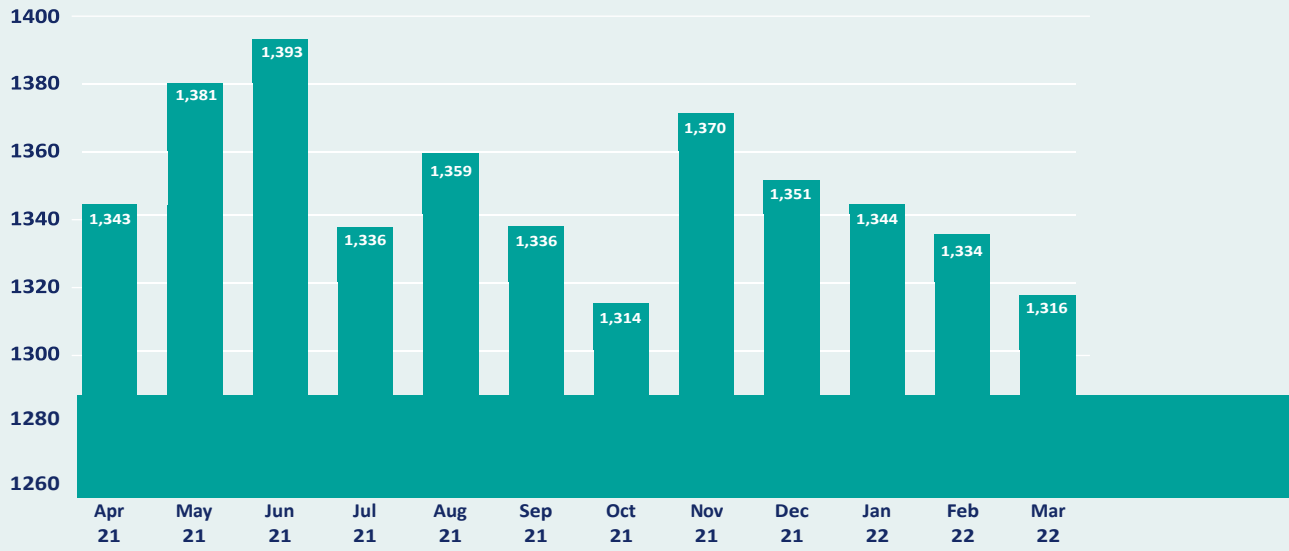
Figure 1: Total Number of Patients receiving Substitute Treatment during the years between 1/4/10 and 31/3/18 also showing Census of patients at 31st March each year



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

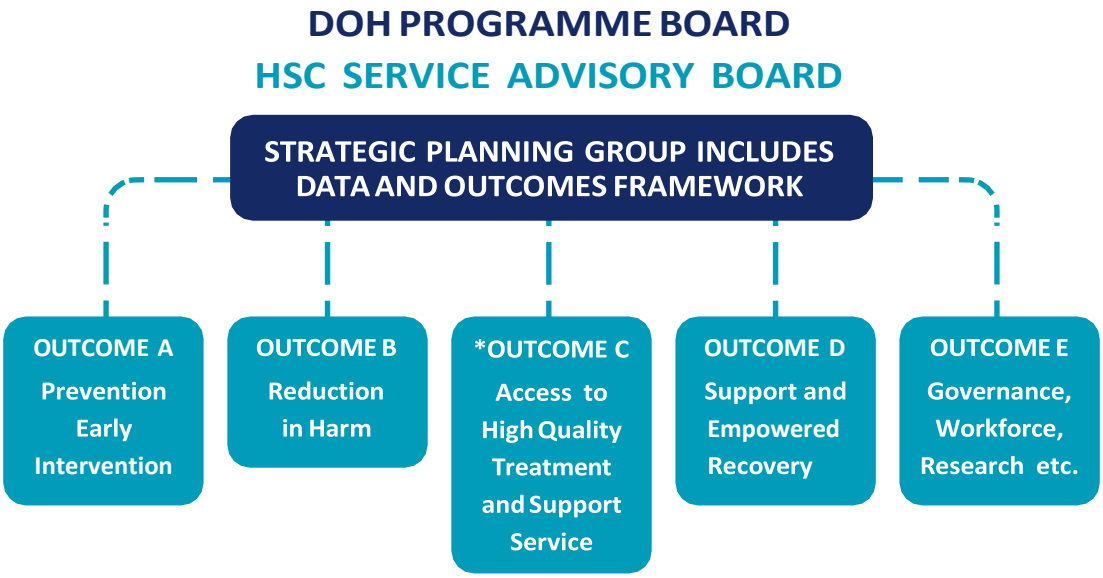
The *HSC* Substance Use Strategic Advisory Board oversaw the breadth of activity that culminated in the development of this *Plan* and it's eight strategic priorities.

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.

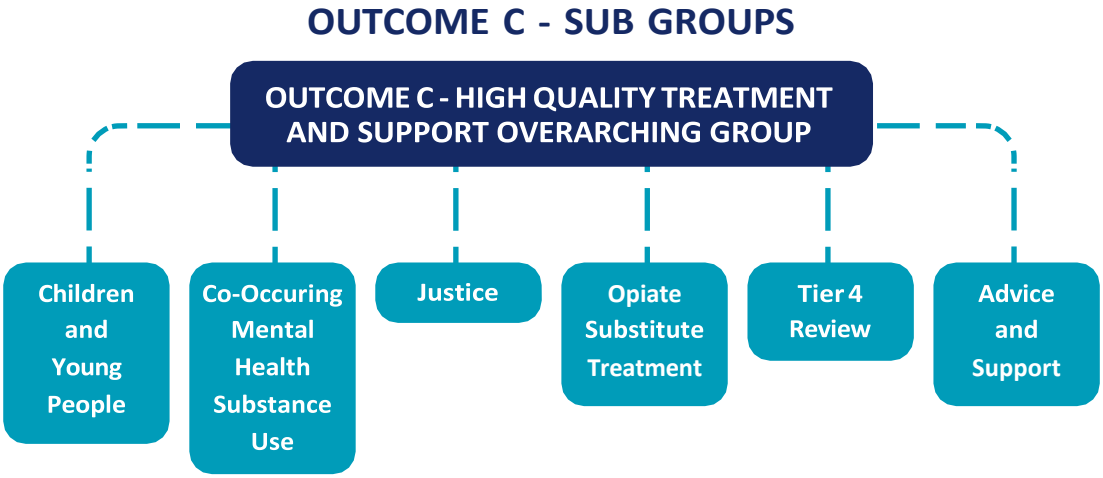
Outcome groups reported to the Substance Use Advisory Board as detailed below. The outcome groups were formed around the outcomes set out in the *Preventing Harm, Empowering Recovery* strategy. The governance also included a Strategic Planning Group, which connected outcome group activity and coordinated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