Meeting agenda

PHA Board Meeting

Date and time	Venue
26 February 2026 at 1.30pm	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Item	Topic and details	Presenter
1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 22 January 2026	Chair
4 1.35	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reports of New or Emerging Risks • Corporate Risk Register as at 31 December 2025 **[PHA/01/02/26]**	Chief Executive
6 1.50	Raising Concerns	Chief Executive
7 1.55	Updates from Committees: • Governance and Audit Committee **[PHA/02/02/26]** • Remuneration Committee • Planning, Performance and Resources Committee **[PHA/03/02/26]** • Screening Programme Board • Procurement Board • Information Governance Steering Group	Committee Chairs
8 2.15	Performance Management Report **[PHA/04/02/26]**	Mrs Scott

9 2.30	Reports on Screening Programmes **[PHA/05/02/26]** • NI Breast Screening Programme Annual Reports: 2018-21, 2021-23 and 2023-24 • NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Reports: 2019-23 and 2023-24	Dr McClean
10 3.00	Chief Executive and Directors' Report	Chief Executive
11 3.10	Finance Report **[PHA/06/02/26] (For noting)**	Mrs Scott
12 3.20	Complaints, Compliments and Claims Quarterly Report **[PHA/07/02/26] (For noting)**	Mr Wilson
13 3.25	Items for Noting: • Workforce Information Report **[PHA/08/02/26]**	 Mrs Scott
14 3.30	Chair's Remarks	Chair
15 3.35	Any Other Business	Chair
16	Details of next meeting: *Thursday 26 March 2026 at 1.30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	Chair

PHA Board Meeting Minutes

Date and Time	Venue
22 January 2026 at 3.00pm	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Member	Title	Attendance status
Mr Colin Coffey	Chair	Present
Mr Aidan Dawson	Chief Executive	Present
Dr Joanne McClean	Director of Public Health	Present
Ms Emily Roberts	Interim Director of Nursing, Midwifery and Allied Health Professionals	Present
Mrs Leah Scott	Director of Finance and Corporate Services	Present
Mr Craig Blaney	Non-Executive Director	Present
Ms Anne Henderson	Non-Executive Director	Present
Mr Robert Irvine	Non-Executive Director	Present
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Ms Meadhbha Monaghan	Chief Executive, Patient Client Council	In attendance
Mr Robert Graham	Secretariat	In attendance
Mr John Patrick Clayton	Non-Executive Director	Present

1/26 - Item 1 – Welcome and Apologies

1/26.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr John Patrick Clayton.

2/26 - Item 2 – Declaration of Interests

2/26.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

3/26 - Item 10 – Personal and Public Involvement Board Report April 2024 – March 2025 [PHA/02/01/26]

Mr Martin Quinn joined the meeting for this item

3/26.1 Mr Quinn said that in line with governance arrangements, he has brought this annual Personal and Public Involvement (PPI) Report to the Board, but this will be the last one in this format as the PPI team has merged with the Patient and Client Experience (PCE) team which looks at areas such as Care Opinion and 10,000 Voices, so next year's report will cover those areas as well.

3/26.2 Mr Quinn outlined how involvement and partnership work as integral building blocks for all elements of public health. He gave an overview of the key priority areas the team has been working on advising that the number of requests for guidance has increased year on year. He explained that PHA does not take responsibility for decisions that Trusts made, and PHA only gets involved if issues are strategic or politically sensitive.

3/26.3 Mr Quinn said that involvement is something that organisations should be doing all the time, and not something that is commenced during a process. He added that his team consistently encourages people to get into this culture and practice. He highlighted the number of projects where there has been involvement and noted that the number for PHA has increased.

3/26.4 Mr Quinn advised that the PPI team is a small one, but it undertakes face to face training and over 225 individuals have undertaken the leadership programme. He added that while there is the Engage website, he hoped that Trusts are carrying out training consistently. He said that while there are tools on the website, people still wish to have a conversation and tell their stories so there are "human libraries". However, he said that there needs to be a better collation of the information.

3/26.5 Mr Quinn finished by outlining the challenges going forward. He said that there is a need to integrate PPI into the day to day work of PHA and to work with the wider HSC system to how PPI can support the joint planning and commissioning teams.

3/26.6 Ms Roberts said that the Report is comprehensive and she commended the work of the team.

3/26.7 The Chair advised that he had attended an event in Riddel Hall which was excellent. He asked how about how the PPI team has been integrated into the Reshape and Refresh programme as he felt the team sat outside this. Mr Quinn replied that Reshape and Refresh was seen as an opportunity for the team and that they are now represented in all of the public health planning teams. The Chair asked if there should be a separate PPI team. Mr Quinn said that PPI is everyone's business and within the planning teams his team are there to provide leadership, advice and guidance, and there is now a more collective approach.

3/26.8 The Chief Executive commented that PPI was perhaps "semi-autonomous", but there is a need for it to be "front and centre" and integrated within the new PHA. He noted that Mr Quinn is a member of the Senior Leaders Forum and is working more closely with other teams. He acknowledged that there is still work to do.

3/26.9 Ms Roberts noted that PHA has an Engagement Strategy and that is the main building block for work in this area.

3/26.10 The Board noted the Personal and Public Involvement Report for 2024/25.

4/26 - Item 12 – Update on "This Is Our Health"

Ms Denise Hampson joined the meeting for this item

4/26.1 Ms Hampson began by outlining the purpose of This Is Our Health stating that it is about changing the relationship between people and the healthcare system and encouraging people to stay well. She said that to in order to do that, it is necessary to have conversations with the public and encourage them to have conversations with each other. She advised that the aim is to broaden people's perspective when they think of health.

4/26.2 Ms Hampson said that starting with in-person engagement, the aim is to create something that people find interesting and gets buy-in. She added that she wants to create something that is propagated from person to person and will be discussed through media channels, TV, digital and a social media strategy.

4/26.3 Ms Hampson explained that she is a behavioural designer and outlined the approach to her work. She said that the "alpha" phase began in October last year and between December and January there was the "beta" phase where some of the tools were created and tested with real people in Healthy Living Centres. She said all the data was collected anonymously, but some demographic data was asked for. Following this testing period, work is ongoing for full engagement, but there will be one further round of testing with the aim being to spend one full day in each Trust area and hopefully collect up to 1,500 insights.

4/26.4 Ms Hampson advised that there will be an audio/visual "experience" as part of this work and this will be brought over to Northern Ireland soon. She said that she hopes that staff encourage others to engage with the idea.

4/26.5 The Chair asked what feedback Ms Hampson has received to date. Ms Hampson said that when people are asked about what helps them to stay well, responses were around meeting with family, men's sheds and staying healthy, but when asked a second question around what guarantees the health system can make to ensure that people stay healthy, up to 40% of responses were around the need to be able to see a GP. She added that there were also references to dementia care and good community care and also responses saying that it was up to health experts to figure it out. She advised that a final question asked around what people can do themselves to stay well, responses were around staying on medication and not cancelling medical appointments. She said that once the data has been collated the aim is to report back to the public on the things they can do to support themselves to stay well.

4/26.6 Dr McClean advised that a representative from primary care within the Department had wished to reach out to Ms Hampson and Ms Hampson confirmed that she had spoken to the individual. Ms Hampson added that Mr Peter Toogood had also spoken to them. She commented that it would be helpful if communities were able to help with reaching the public. The Chair asked whether Ms Hampson had spoken to Local Councils, but Ms Hampson replied that she had not as she is currently finalising a communications plan. She added that she envisaged that Local Councils would be involved, but they may not have yet heard of This Is Our Health.

4/26.7 Ms Henderson asked if there will be a campaign budget. Mr Wilson replied that there is not at present. Ms Henderson said that while it is possible to engage with a large number of people in places like shopping centres, this is only a representative sample and a campaign is needed. Ms Hampson said that the intention is to work with partners to facilitate smaller groups, for example within pharmacies or libraries. She added that she is also linking with the communications team in the Department regarding the Citizen Space website. She said that the Department does intend to look at media engagement.

4/26.8 Mr Blaney asked if there is a possibility of working with the Department of Education so that there is reach into schools. Ms Hampson agreed that it would be great to speak to young people and that she had met with the Department of Education at the outset. She said some age appropriate materials may be needed, but it may be possible to work with schools.

4/26.9 The Chair suggested that Ms Hampson should attend a future meeting and there should be more time allocated for discussion. He thanked Ms Hampson for attending today's meeting.

5/26 - Item 11 – Presentation by Starting Well Planning Team

5/26.1 Ms Roberts began by thanking Ms Laura Armstrong and Mr Danny Wilson for their work in compiling the information relating to this presentation. She outlined the objectives of the team which she said were in line with the priorities in the 2025/26 Action Plan. The Chair noted that this work commenced before the development of the Corporate Plan and Business Plan and asked whether the actions link to what PHA wishes to achieve corporately. Ms Roberts said that there may be new actions for this year.

5/26.2 Ms Roberts explained that there were 24 actions as well as 4 actions from the PHA Business Plan, all of which were based around 6 themes. Of the 9 performance measure objectives, she said that 8 were either completed or on track, with an action relating to Child Health System functionality on Encompass being delayed.

5/26.3 Ms Roberts said that for 2025/26, there is an action plan which covers areas in the PHA Business Plan and other actions from the Obesity/Physical Activity workstream. She displayed a map showing how all the objectives link together. The Chair asked if there is anything that the team is working on that does not link to the Corporate Plan. Ms Roberts replied that the team is working within the confines of the Corporate Plan.

5/26.4 Ms Henderson commented that this shows that there is a better synergy is what PHA is doing and asked if there is a better sense of what is happening. Dr McClean said that this new approach will ensure that staff are not working is silos.

5/26.5 The Chair said that he was looking forward to seeing the 2026/27 Business Plan and the updated Implementation Plan. He added that the Corporate Plan is the golden thread.

5/26.6 Ms Roberts advised that the next section outlines how PHA is spending its funding in these areas. Ms Henderson commented that there is now a much better awareness of where funding is going.

5/26.7 Ms Roberts said that the last section gives detailed overviews of each of the main programmes of work.

5/26.8 The Chair stated that this presentation was exactly what the Board needed to see as it outlines the strategy and what is being achieved and that he is keen to see what the outcomes are.

5/26.9 Mr Blaney welcomed the presentation and said that it showcased a lot of good work. He said that the Take 5 programme is a good way of changing mindsets, but noted that its budget was small and that it does not look at areas such as fitness and eating well. He suggested that changing children's behaviour could see a reduction in areas such as smoking and obesity. Mr Irvine said that he has the opposite view and felt that it was the parents' responsibility to educate children.

6/26 - Item 3 – Minutes of previous meeting held on 18 December 2025

6/26.1 The minutes of the Board meeting held on 18 December 2025 were **APPROVED** as an accurate record of that meeting.

7/26 - Item 4 – Actions from Previous Meeting / Matters Arising

7/26.1 The Chair advised that an updated action log had been circulated to members and a number of actions were ongoing.

8/26 - Item 5 – Reports of New or Emerging Risks

8/26.1 The Chief Executive advised that no new risks have been added to the Corporate Risk Register. The Chair noted that the Corporate Risk Register is currently being reviewed as at 31 December 2025 and that an updated Register will be brought to the Governance and Audit Committee and PHA Board in February.

9/26 - Item 6 – Raising Concerns

9/26.1 The Chief Executive advised that there were no new concerns to report on.

10/26 - Item 7 – Updates from Board Committees

Governance and Audit Committee

10/26.1 The Chair noted that the Governance and Audit Committee had not met since the last Board meeting

Remuneration Committee

10/26.2 The Chair noted that the Remuneration Committee had not met since the last Board meeting.

Planning, Performance and Resources Committee

10/26.3 The Chair noted that the Planning, Performance and Resources Committee had not met since the last Board meeting.

Screening Programme Board

10/26.4 The Chief Executive said that the meeting of the Screening Programme Board which took place on 20 January was an excellent meeting. He reported that there was a discussion on cervical screening as well as a discussion about PHA's input into Encompass. He said that some services need to be moved from old systems and that PHA should maximise the use of Encompass.

10/26.5 The Chief Executive advised that Dr Bronagh Clarke had delivered an excellent presentation on inequalities in screening and that a piece of work is now being undertaken to address these.

10/26.6 The Chief Executive reported that there still remain issues with moving the Chid Health System onto Encompass, but that further work will be invested in this area.

10/26.7 Ms Henderson asked if the IT systems are at risk of collapse. Dr McClean replied that there have been some issues transitioning the systems to Encompass. The Chief Executive added that the systems need replaced and it is complex getting them moved across to Encompass as new issues are coming to light. He said that some providers are withdrawing their support for the current systems, but he hoped that there will be a smooth transition.

Procurement Board

10/26.8 The Chair noted that the Procurement Board had not met since the last Board meeting.

Information Governance Steering Group

10/26.9 The Chair noted that the Information Governance Streeting Group had not met since the last Board meeting.

Public Inquiries Programme Board

10/26.10 The Chair noted that the Public Inquiries Programme Board had not met since the last Board meeting.

11/26 - Item 8 – Chief Executive and Directors' Report

11/26.1 This item was not discussed.

12/26 - Item 9 – Finance Report [PHA/01/01/26]

12/26.1 Mrs Scott said that this Finance Report outlines the position at the end of November where PHA is projecting a surplus of £296k, but the year-end position will show an overspend, in line with pay, of £1.1m following confirmation from the Department of this new target. She added that any slippage in non-pay expenditure is to be returned to the Department.

12/26.2 Mrs Scott reported that her team is currently finalising the December position and there is likely to be slippage of around £1.5m relating to vaccinations. The Chair sought clarity as to whether the volume of wastage of flu vaccines is around £400k, but Mrs Scott said that it is likely to be higher due to the reduced uptake among children.

12/26.3 The Chair noted that the Northern Ireland Audit Office (NIAO) had previously commented about the cost of vaccines showing in PHA's accounts. Dr McClean explained that the order for childhood vaccines was made a number of years ago and the amount used was less than what was ordered so next year PHA will instruct the Department what to order. She added that in previous years, it was difficult to determine how much wastage there was, but there are now better systems in place to track this. The Chair said that having such systems in place now is a huge success

story for PHA and that the Department should be giving PHA more of a say in the ordering process.

12/26.4 The Chief Executive echoed that NIAO had suggested that PHA could handle this process better, but PHA does not have a say in what is ordered. He noted that this year the uptake in school children is between 50 and 60%, but if PHA were to suggest making an order on that uptake, the Department would push for an order of 90% uptake.

12/26.5 The Chair asked that the minutes reflect that while PHA acknowledges that there is a Ministerial direction to overspend by £1.1m on pay, the Board is not content with this approach.

12/26.6 The Chair asked about the costs of the Reshape and Refresh programme which are noted as a risk in the Report. He said that matter was due to have been resolved by January. Mrs Scott said that this Report is the November position and since then work has been ongoing. The Chief Executive said that this will be resolved by February. The Chair said that he is seeking an assurance as the Report is highlighting a risk, but the Chief Executive is stating that action is being taken. It was agreed that there would be a further update at the next meeting **(Action 1 – Mrs Scott)**.

12/26.7 The Board noted the Finance Report.

13/26 - Item 13 – Chair's Remarks

13/26.1 This item was not discussed.

14/26 - Item 14 – Any Other Business

14/26.1 There was no other business.

15/26 - Item 15 – Details of Next Meeting

Thursday 26 February 2026 at 1.30pm

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

Signed by Chair:

Colin Coffey

Date: 26 February 2026

item 6

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	26 February 2026
Title of paper	Corporate Risk Register as at 31 December 2025
Reference	PHA/01/02/26
Prepared by	Karen Braithwaite
Lead Director	Leah Scott

Recommendation For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to bring the Corporate Risk Register, as at 31 December 2025, to the Board for approval.

2 Background Information

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the corporate register is to provide assurances to the Chief Executive, AMT, the Governance and Audit Committee and the PHA board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The previous review was undertaken as at 30 September 2025 and the Corporate Risk Register was approved by AMT on 10 October 2025 and forwarded to the Governance and Audit Committee for approval at its meeting which took place on 17 October 2025.

The attached Corporate Risk Register reflects the review as at 31 December 2025 and has been carried out in conjunction with individual directorate register reviews for the same period.

The next review will be undertaken as at 31 March 2026.

The 2025/26 Risk Management Audit was completed in May 2025 with a satisfactory level of assurance and work continues in implementing the recommendations. A Board workshop was held on 18 November 2025 at which Board Members considered risk appetite of the organisation in relation to risk management.

The Corporate Risk Register was approved by the Agency Management Team at its meeting on 26 January 2026, and by the Governance and Audit Committee at its meeting on 12 February 2026, subject to one amendment – the escalation of the Safety and Quality risk from the Population Health and Wellbeing Directorate Risk Register to the Corporate Risk Register (as attached).

3 Outcome

- There has been one new risk added to the register this quarter:
    - Safety and Quality (escalated from the Population Health and Wellbeing Directorate Risk Register)
- There have been no risks removed from the register this quarter.
- There have been no risks with their rating altered this quarter:

4 Next Steps

The next review of the Corporate Risk Register will be undertaken after 31 March 2026.

PHA Corporate Risk Register

Date of Review:
31 December 2025

Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has a systematic and unified process in place to ensure a fully functioning risk register at both corporate and directorate levels as set out in the PHA Risk Management Srategy and Policy.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DoH guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
1 – Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Overview of Risk Register Review as at 31 December 2025

Number of new risks identified	1 – from PHWB RR
Number of risks removed from register	0
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

CONTENTS

Corporate Risk		Lead Officer/s	Risk Grade	Page
39	Cyber Security	Director of Finance and Corporate Services	→ **HIGH**	6
55	Shortage of Staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / organisational change	All Directors	→ **MEDIUM**	11
59	Quality Assurance and Commissioning of Screening	Director of Public Health	→ **HIGH**	18
64	Cyber Security (compromise of HSC network due to cyber-attack on a supplier or partner organisation)	Director of Finance and Corporate Services	→ **HIGH**	23
71	Public Inquiries – PHA ability to respond to requests from various Public Inquiries	Head of Chief Executive's Office	→ **MEDIUM**	27
73	Financial Planning Context 25/26 & 26/27	Director of Finance and Corporate Services	→ **HIGH**	29
74	Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA.	Chief Executive	→ **MEDIUM**	31
75	Pandemic Preparedness	Director of Public Health	→ **HIGH**	33
76	Delay with Child Health System Migrating to Encompass	Interim Director Population Health	→ **HIGH**	36

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Control Effectiveness RAG Rating:	
GREEN	High: Controls in place assessed as adequate/effective and in proportion to the risks
AMBER	Medium: Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
RED	Low: Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
WHITE (not identified)	Insufficient information at present to judge the adequacy/effectiveness of controls

Corporate Risk 39					
RISK AREA/CONTEXT: Cyber Security					
DESCRIPTION OF RISK: Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure (including those used by the PHA, as well as Trusts providing services for the PHA) may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in significant business disruption. It could also lead to unauthorised access to any of our systems or information, theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage. Whilst the BSO is primarily responsible for managing this system wide risk as IT lead for HSC, the Agency has a key responsibility to safeguard against any actions by its staff that could compromise IT security.				**DATE RISK ADDED:** June 2017 **REVISED:** June 2024 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objective: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target	Possible	Moderate		MEDIUM	
LEAD OFFICER: Director of Finance and Corporate Services					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**
Technical Infrastructure: • HSC security hardware (eg firewalls); • HSC security software (threat detection, antivirus, email & web filtering); • Server/client patching; • 3rd party Secure Remote Access;	1st and 2nd line Technical risks assessments and penetration tests; 1st and 2nd line Reports to GAC/PHA board on reported incidents as appropriate. 1st & 2nd line PHA represented on cyber programme board	Gaps in Assurance: • Level of corporate recognition and ownership of cyber security threat as a service delivery risk. • An HSC Cyber Gap analysis (ISO 27001) was carried out. (external carried out by DXC		BSO ITS provides PHA IT services. PHA will continue to work with BSO ITS, DHCNI and through the HSC Cyber Scurity Programme Board. Work has continued in a number of priority work streams including Incident response and third party management. Further cyber projects are being	~~Dec 2025~~ Mar 2026

• Data & system backups **Policy, Process:** • Regional & local ICT/information security policies; • Data protection policy; • Change Control Processes; • User Account Management processes; • Disaster Recovery Plans; • Emergency Planning & Service/Business Continuity Plans; • Corporate Risk Management Framework, processes & monitoring; • Regional & local incident management & reporting policies & procedures; **User Behaviours – influenced through:** • Induction/ Annual Appraisal • Mandatory Training; • HR Disciplinary Policy; • Contract of employment; • 3rd party contracts/data access agreements • Metacompliance monthly training now operational	1st & 2nd line External security review carried out by ANSEC (external security company) 3rd line Internal Audit/BSO ITS self-assessment against 10 Steps towards NCSC; 3rd line: An HSC Cyber Gap analysis (ISO 27001) was carried out (externally carried out by DXC)	Technology) -need to work through the recommendations • External security review carried out by ANSEC (ext security co) <u>Gap in Controls</u>: – • Cyber security programme not delivered yet. • Strategic outline Case sent to DoH for consideration which shows gaps: A SIEM (security incident and event management system) Privleged accounts management (PAM) • BSO led Cyber strategic plan developed for implementation over next 4 years to deliver outputs of the cyber secrutiy strategy, however funding via DHCNI not yet secured.	undertaken to enhance capabilities across the region, under 3 key work streams:. • Communications and culture which contains Cyber training for all staff, Senior Teams, ICT, Department specific • Strategy and Policy, the development and implementation of HSC wide Cyber Security policies, standards and processes and Supplier Management • Technical and Infrastructure including a HSC Network Security Review, Implementation of Network Discovery and vulnerability Management Tools and Incident Response management See below for update on key projects ongoing under these workstreams ~~Training programme for Board members will continue to be delivered in consultation with Regional Cyber Security Programme Board) Update from Cyber Security Progamme Board – revised training being planned for roll-out with ALB Board members and senior teams. Now re-commenced~~	

PHA member of the Regional HSC Cyber Security Business Continuity Group BSO cyber project manager co-ordinating regional cyber security work. Regional cyber security programme board (BSO representing PHA) taking forward actions arising from DXC Technology report and recommendations. Ongoing work being taken forward and overseen by the Regional Cyber Security Programme Board. A regional cyber Incident Response Plan has been developed to effectively manage a cyber incident within the HSC. Cyber Incident Response Action Plan finalised and launched. Reviewed Feb 25. A baseline audit against ISO27001 across all ICT Departments and Internal audits against NSCS Cyber Essentials 10 steps have been completed and recommendations accepted			~~May 2024 and ongoing roll-out planned.~~ ~~All PHA Board Members due to complete this training – date set for 6 November 25.~~ Targetted training and 'all users' training (Metacompliance) (monthly) to be provided. New schedule from April 2025 to run during year 25/26 (complementary to the mandatory elearing cyber security training).	

Several Business Cases have been approved and implemented re ongoing resource funding for Cyber staff across HSC this includes: (i) Cyber Resource for one year (ii) Tactical Business Case for resource to implement the tactical recommendations from the network security review. Full HSC-wide cyber incident response test - Incident response plan completed on 1 June 2023 and May 2025 (Dir Fin & Corp Serv attended) Targetted training and 'all users' training (Metacompliance) provided during years 2022/23 (May-Mar) and 2023/24 (Apr-Mar) and 2024/25. HSC cyber elearning material current review completed June 2024 including Management review of compliance. Review of Incident Response Plan finalised – being issued to Programme Board				

members 5/12/24- now approved and tested in May 25. Revised (in June 24) HSC cyber elearning material launched 2 Dec 24. Quarterly updates provided to IGSG on completion of mandatory training across PHA. PHA Business Continuity Plan test carried out 6 May 2025 with emphasis on cyber security. Training programme for Board members (3 attended training on 16/4/25). Business Case completed and submitted to DoH (Sept 25) for SOC/SIEM (Security Operation Centre / Security Incident and Event Management System) Training for PHA Board Members, facilitated by Regional Cyber Security Progamme Board, completed 6 November 25				

Corporate Risk 55	
RISK AREA/CONTEXT: Shortage of Staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / Organisational Change	
DESCRIPTION OF RISK: The Public Health Agency does not currently have the appropriate retained staffing capacity / skill mix in order to be able to safely and sustainably discharge all of its statutory responsibilities pertaining to protecting and improving the health of the population of Northern Ireland. In particular, it is currently unable to fill Public Health Consultant positions due to the unavailability of suitably qualified people in the labour market. Whilst this has been managed to date through use of Retire & Return and locum recruitment as well as some reprofiling of skill mix this is not sustainable in the medium to longer term. There is therefore a risk that the absence of core public health services in key areas such as Health Protection and preventing the transmission of communicable diseases could directly impact the health of the population. A number of specific staffing-related risks have been identified in the organisation including: • A number of consultant in public health posts are vacant. ~~Following recent retirements and leavers the position within the Health Protection service has become acute.~~ Recent recruitement exercises for both locum and permanent HP and PH consultants has had some success. The team have recruited ~~and~~ 3 permanent Public Health Consultants (2 Service Development/Screening and one Health Protection) and two locum consultants (1 Service Development/Screening and one Health Protection). since June 2025. • A draft Professional Governance Framework for Healthcare Registrants employed by the PHA is being finalised after being issued to all registrant PHA staff for comment. The framework will outline governance structures for all professional staff in relation to responsibilities for maintaining registration and supervision. ~~• A number of positions in the structure remain vacant, AD for Ageing Well and Strategic PH Team Leads.~~ ~~• Interim Director Population Health will be vacant from December 2025.~~ Reshape Refresh risk details removed for Population Health and Wellbeing, the programme is near completion and structures are in place.	**DATE RISK ADDED:** June 2020 **REVISED:** August 2020 - HSCQI Risk added. June 2022 - Merged. September 2023 - Updated to cover all Directorate risks. March 2024 - Updated to detail specifc high impact staffing risks at March 2024 June 2024 – Redrafted to reflect core risk. Updated December 2024 **CLOSED:** N/A

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension and Operational Performance and Service Improvement Dimension

LINK TO ANNUAL BUSINESS PLAN 25/26: O1 Develop a new HR Strategy 'Beyond the People Plan'

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Moderate	**MEDIUM**
Target	Possible	Moderate	**MEDIUM**

LEAD OFFICER: All Directors

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
Organisation structure at Tier 4 and below approved by AMT & Senior Leaders Forum (31 August 2025) **Public Health** Two operational Assistant Directors have been appointed to strengthen leadership arrangements to ensure a safe high quality service is being provided. 2 new operational and governance HOS appointed Dec 2025 to directorate through R&R. 3 Deputy Director posts appointed since April 23 to support DPH in providing	1st & 2nd line: • Reports to CEx and AMT. • Staff in post postion kept under regular review • Updates to GAC via Corporate Risk register • Briefings provided to PHA Board. 3rd line: • Vacancy updates provided to Sponsor Branch via Ground clearance process. • Link with DOH Safety and Quality Standards branch. ~~**Population Health Reshape Refresh**~~	**Gap in Controls** • Ability to recruit to consultant posts ~~and other key posts~~ is ~~very~~ constrained currently due to a number of external factors including availability of suitably qualified professionals pay and conditions and market forces. ~~and impact of Reshape and Refresh change management pooling process.~~ **Gaps in Assurance**: • Deficits in the PHA workforce across a range of functions compromising the performance of the		Reshape and Refresh – Management of Change: • Level 2 Job Descriptions (Director level) 2 have been finalised and have been submitted to DoH for evaluation. Review progress by December 2025. • Level 3 (AD level) recruitment programme substantively complete with one outstanding position to be filled in Q4. 2025/6. Public Health - Continued advertisement of Consultant Posts. ~~and upskilling nursing workforce (increase numbers undertaking masters in public health.~~	~~Dec 2025~~ Mar 2026

leadership across the directorate. These will focus on • Governance and standards • Training and workforce • Epidemiology and public health science Ongoing implementation of the workforce plan which includes: **Recruitment:** 3 permanent consultant posts recruited and 2 locum consultants recruited since June 2025. ~~Two Locum consultants in place to support health protection.~~ Consultants on retire and return are providing support to the service. Recruitment of 2 permanent and 1 temporary specialty doctor to support health protection and screening services. ~~Locum Consultant posts are advertised on a rolling basis. PH Directorate have developed a refreshed JD to which facilitated a wider campaign approach for permanent recruitment~~	~~1st - Directors meets Team regularly and 1:1s are held as required~~ ~~2nd Reshape and Refresh Programme Manager has met with directorates to provide support. Ongoing support and liaison between Directors and HR. Access to Mural. Staff engagement events.~~ ~~3rd EY information sessions were held earlier in the year. Union representation at engagement events.~~ ~~1st – Vacancy reports are shared monthly with Senior Team and Line Managers. Monthly meetings are held between Finance, Planning & Business Support Manager and Interim Director to discuss staffing budget and vacancies.~~ ~~2nd – Monthly meetings are held between Interim Director and HR to discuss vacancies and progression of recruitment. Scrutiny Meetings twice monthly.~~	organisation and ability to deliver statutory functions. ~~**Population Health Reshape Refresh**~~ ~~**Gaps in Control**~~ ~~**Gaps in Assurance**~~ ~~The Reshape and Refresh process takes time, concerns and anxiety are likely to continue until process is complete~~ ~~**Population Health Staffing**~~ ~~**Gaps in Control**~~ ~~**Gaps in Assurance**~~ ~~Result of vacant posts is impact on capacity, potential support issues to ICS and new commissioning structures)~~ ~~Temporary backfill posts for some senior positions has led to gaps in lower band capacity~~ ~~**Professional Governance –**~~ ~~**Gaps in Assurance**~~ ~~Framework being finalised.~~	Locum Consultant posts are advertised on a rolling basis. Plans to go out for permanent PH and HP consultant recruitment in early 2026. ~~Advertising at present for locum posts. Revisit December 2025.~~ ~~Develop action plan to ensure the recommendations from workforce plan are implemented – Establish strong consultant led multidisciplinary teams in health protection and across directorate to make best use of skills of all staff – ensuring specialised skills of consultants are used to best effect. Revisit December 2025.~~ Discussions have commenced with the Faculty of Public health about supporting experienced staff in PHA to receive additional training and support with a view to specialist registration in the future. Revisit ~~December 2025.~~ March 2026. ~~**Population Health Reshape and Refresh –**~~ ~~Developing progression of support for staff wishing to pursue registration of UKPHR's Portfolio route~~	

exercise for HP and PH consultants. **Strengthen Consultant led MDT in Health Protection** 3 permanent consultant posts recruited. Recruitment completed for 2 x specialty Doctor and Recruited 6 x programme managers posts established in Health Protection team. Informal MDTs established in areas of GI and Zoonosis, TB and Resp, Sexual Health, BBV, AMR with input from HP/PH consultant, prog manager, surveillance and HP nursing. Bank staff list created following the closure of contact tracing service. Staff from the bank have received are training and are able to provide support to acute health protection service both in hours and out of hours. Staff development Introduction of SpR rota for acute response (Delegated responsibility) to release Consultant capacity.	**Professional Governance** 1st - Professional Governance Framework being finalised. 3rd – Regular communication with trade union reps and professional leads in DoH.		1:1 meetings will be facilitated as required. AFC Banding for SPH Team Lead posts to be finalised. An updated job description has been submitted to HR for review Population Health Interim Director in conjunction with senior professional staff, is finalising PHA policy for professional governance, supervision and accountability. Progress recruitment of MHLD roles Plans in place with other directorates and HR to maintain and develop a regular recruitment drive for admin posts.	

Upskilling nursing workforce – 1 completed MSc in PH, 2 senior nurses undertaking MSc in PH to complete 2026/27. CEO Office Reshape and Refresh Management of change process designed (end of Mar 24) New operational structure and model has been approved by board. Interviews for Tier 2 and 3 positions are progressing. Director of Finance appointed. . First Tuesday events continue Regular staff meetings, job planning and review of work prioritisation.				

~~Population Health Reshape and Refresh~~ ~~Reshape Refresh Programme Manager continues to support process~~ ~~Mural remains available online~~ ~~Staff engagement events~~ ~~Increase in staff meetings, augmented by 1:1s as required.~~ ~~New operational structure in place from September 1st.~~ ~~First Tuesday events continue increasing communication on R&R updates~~ ~~Successful admin recruitment exercise complete~~ ~~Recruitment process started for project support vacancies~~ ~~Vacancies within MH & LD team within MH & LD team are being progressed.~~ ~~Regular staff meetings, job planning and review of work prioritisation.~~				

~~Use of slippage to access external support~~ ~~Work is prioritised, to mitigate impact of current gaps in senior positions within Ageing Well team~~				

Corporate Risk 59	
RISK AREA/CONTEXT: Quality Assurance and Commissioning of Screening	
DESCRIPTION OF RISK: The commissioning and quality assurance of population screening programmes is a core PHA function. Screening programmes are delivered within complex systems, involve a number of organisations and are supported by a range of bespoke IT systems. The population demographics platform (NHAIS), used by a number of screening programmes including cervical, is being decommissioned and core functionality moved to NIDIS. As well as maintaining the core PHA functions associated with the programmes, the PHA is increasingly leading on complex change and development projects for the screening programmes in response to policy changes or the impact of wider HSC IT or service changes. Additonally the screening digital modernisation intent is to move all screening programmes onto a single digital platform which, during the design and implementation, will increase capacity demands requiring dedicated input and management from screening, service and digital leadership. There is a risk that PHA will not have the systems, capacity and digital expertise to manage and maintain comprehensive and robust provision of all of these functions for all screening programmes, especially during the transition phase to a new screening platform envisaged by the screening digital modernisation programme – whereby maintenance of the systems to be replaced and the introduction of the new systems will need be managed in parallel . This may result in a failure to deliver safe and effective screening programmes to the population, an inability to monitor, identify and respond to concerns regarding quality and performance, adversely impact public confidence in participating in screening programmes and negatively impact the reputation of the PHA.	**DATE RISK ADDED:** November 2020 **REVISED:** Dec 2023 - Risks revised (CR61 closed and integrated into CR 59) June 2024 **CLOSED:** N/A

LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension			
LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objectives 1 – 4			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Likely	Major	**HIGH**
Target	Possible	Major	**MEDIUM**
LEAD OFFICER: Director of Public Health			

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**
Screening Programme Board re-established to provide broader oversight (at CEx/Director level across regional organisations) **IT systems** • Project structure for implementation of Breast Screening Select has been established, business case approved and implementation ongoing. • Processes are in place within each programme to attempt to manage any identified current risk – manual processes / reporting /monitoring/failsafe systems.	**1st and 2 line assurance** • Reports to AMT and briefing/updates to PHA Board; • Report on screening internal audit follow-up to GAC. • Quality assurance site Quality assurance site visits re-established in breast and cervical • Desktop QA reviews in bowel screening • Ongoing meetings between the Encompass team and screening leads to ensure intregrity of interfaces is mainitained with Encompass going live. • PHA CEX represented on encompass Programme Board	Gaps in Controls: • Commissioning and delivery of screening programmes is a HSC wide system based approach (ie. a number of partners). PHA relies upon each part of the system having appropriate controls in place • Funding insufficient to meet delivery needs within some screening programmes • Funded staffing levels in PHA are insufficient to provide a robust and responsive QA infrastructure for all programmes • Limited technical and information governance expertise available to		**Southern Trust Cervical Cytology Review**: Continue to manage and respond to public and political interest relating to the cervical screening programme. ~~Publication of r~~Remaining reports published November ~~scheduled for October~~ 2025: Independent Expert Opinion of SHSCT review; NHS England report of PHA QA (review completed April 2025) of CSP and SHSCT SAI report • Ongoing funding pressures in Diabetic eye, and the call recall functions of bowel, and cervical screening programmes continue to be a feature.Need for additional recurrent funding continue to	~~Dec~~ March 2026

• Technical review of screening IT systems completed by BSO ITS • PHA has acquired strategic digital expertise from DHCNI • A screening digital modernisation programme board has been established with SRO representation from key regional digital programmes, as well as, clinical, digital and screening leadership. • £250K has been allocated to support digital resourcing until March 26 **Screening programmes –** Consultant screening group providing cross-programme oversight; regular updates provided to DoH Sponsorship branch. Ongoing monitoring of uptake, activity and capacity within each programme with escalation of risks and concerns as required. Baseline screening budget reviewed and recurrent inescalpable funding	• A programmed series of messaging to media/ public is ongoing to ensure that public confidence is maintained in the cervical screening programmes as a result of the Southern Trust Review. • Separate workstream established within the NIDIS project to extend the scope to replace the NHAIS functionality for cervical screening and business case submitted to DHCNI . • Regular communication with finance regarding budgetary pressures within programmes to ensure that the need for non-recurrent funding is flagged early in the year and can be considered as part of the wider financial planning process. **3rd line assurance:** • Regular updates provided to DoH through sponsorship arrangements	support the screening programmes Gaps in Assurances: • Limited resources (staffing, financial and technical) particularly to establish and support an enhanced QA structure for the newborn and antenatal screening programmes. • Limitations to core QA work as prioritisation given to responding to significant and urgent issues • Absence of cross organisation strategic approach to screening IT systems	to be raised as inescapable into 2026/27/ Mar 2026. **Staffing** Recruitment of ~~band 8B head of service and~~ Band 8B commissioning lead for screening in progress ~~under an ITM process as~~ part of Reshape and Reform.(ITM process unsuccessful) To explore options for recruitment of a quality manager across the screening programmes.	

needs have been highlighted. **Staffing** New post of AD for commissioning public health screening and immunisation recruited under Reshape and Refresh. Will provide additional expertise in PHA to support commissioning of screening programmes. Appointment of new post of Head of Service for screening (band 8B) from 1 December will support and provide additional oversight of operational functions across the screening programmes. **Programme specific issues:** • Cytology review completed - SHSCT review report and SHSCT cancer report published 11/12/24. • NHS England commissioned to undertake a review of QA process relating to cervical screening laboratories. ~~Draft a~~Action plan developed against recommendations	• Reporting to regular meetings of the DoH Cervical Screening Oversight and Assurance Group			

• Quarterly performance management meetings established with BSO for bowel and cervical screening delivery - with review of progress against audit action plan and SLA. • Final phase decommissioning of NHAIS and move to NIDIS is underway.				

Corporate Risk 64

RISK AREA/CONTEXT: Cyber Security - compromise of HSC network due to cyber-attack on a supplier or partner organisation

DESCRIPTION OF RISK: There is a risk to the HSC network and organisations in the event of a cyber-attack on a supplier or partner organisation resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. The risks and consequent impacts include the ability of the HSC to continue to deliver services to patients/service users/clients and therefore, potential harm to patients/service users/clients, compromise or loss of personal and organisational information, and loss of public confidence.	**DATE RISK ADDED:** September 2021 **REVISED:** June 2024 **CLOSED:** N/A

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension

LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objective: Our Organisation Works Effectively

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	**HIGH**
Target	Possible	Moderate	MEDIUM

LEAD OFFICER: Director of Finance and Corporate Services

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
BSO Cybersecurity Strategy, Programme & Workplan (via Regional Cyber Security Progamme Board) Information Governance Team support & advisory services	1st & 2nd line: Technical risks assessments and penetration tests; 1st & 2nd line: HSC SIRO Forum for shared learning and collaborative action planning and delivery;	Gaps in Control: • Business continuity plans to be up to date in relation to a cyber incident, implemented and regular testing • Develop and test an Information Governance		PHA Business Continuity Plan, BIAs and Directorate Business Continuity Plans kept under continual review (live documents) but next review scheduled for completion March 26. This work being taken forward by PHA	~~Dec 2025~~ Mar 2026

Info Gov Advisory Group (regional) Corporate Risk Management framework PHA BCP tested and updated February 2018 with a focus on cyber security PHA member of the Regional HSC Cyber Security Business Continuity Group Regional cyber security programme board led by programme manager – PHA representation on board Cyber Incident Response Action Plan finalised and launched Regional IT Security/cyber security training is now mandatory for all staff. Information Governance Team support & advisory services Info Gov Advisory Group (regional) available Cyber Incident Response Supplier on Retainer contract established to provide further cyber incident preparedness	1st & 2nd line: IGAG oversight 1st & 2nd line: Reports to GAC/PHA board on reported incidents as appropriate. 1st & 2nd line: HSC Supplier framework developed for contractors who provide any service to HSC (approved by SIRO as part of Programme Board). Worked with PALS, Legal & CPD. 3rd line: IA report on 3rd party suppliers undertaken 2022	emergency plan in response to a Cyber attack • ICT Security and data protection clauses in all contracts. Partner organisations to meet security and IG standards of the HSC being addressed via supplier framework for new contracts going forward • Legal binding agreements are in place where contracts not required • Lack of a PHA Incident Response Plan for IG Gaps in Assurance: • PHA does not have in-house ICT systems expertise and is reliant on BSO partner to provide expert analysis of cyber related issues with PHA contracted orgs.	Business Continuity Plan Project Team. With the QUB and other cyber incidents, HSC SIROs are commissioning, through the Information Governance Advisory Group, a Regional IG Task & Finish Group to address the risks/review data flows from HSC/Partner organisations and issues associated with data loss by a partner organisation. Proposal considered at IGAG 27/5/21. This action currently with DHCNI for decision/funding, etc. Ongoing – lack of funding is holding up progress. Review again Mar 2026 (as per below) Development and testing of IG emergency plan in response to cyber attack being led by IGAG. Currently with DHCNI to support financially. IGAG regularly seek input from DoH/DHCNI. – Currently not happening – no funding identified by DHCNI and no one identified to take it forward. Agreed to keep on risk register as an action and review in 6 months if there has been any change. (Review Mar 26). (but as ~~Sept~~ Dec 25 no update – sitting with IGAG and DHCNI).	

support in the event of an incident. HSC Supplier framework – to include Security and IG clauses, risk assessment and security management plans, approved by Cyber Security Programme Board in June 2022 now being implemented. ~~(note: currently under review (Sept 25) but existing framework still in place)~~ Amended Supplier Framework signed off by Cyber Security Programme Board 24 Oct 2025 (and BSO ELT Nov 2025.) Report to PHA IGSG at March 24 meeting re review of new and existing contracts in line with UK GDPR (working wih Cyber Security colleagues, PaLS and DLS as appropriate) and IG awareness raising re data sharing and other IG documentation to be considered/completed as required. Existing contracts reviewed for Security and Data Protection clauses – correspondence prepared & forwarded to H Imp for issue to contractors (June			Assistant IG Manager appointed to support Service Leads in a review of new and existing contracts in line with UK GDPR (working wih Cyber Security colleagues, PaLS and DLS as appropriate). Need for wider HSC discussion in independent sector social care contracts. IG awareness raising ongoing across PHA in relation to data sharing and other IG documentation to be considered/completed as required (ongoing) Standing item at PHA IGSG agenda – further update will be given at next meeting Jan 2026. ~~Oct 2025~~.	

2025). Standardized clauses documentation issued by PHA Health Improvement July 25 and signed contracts returned during July/August 25. PHA Business Continuity Plan, reviewed during 24/25. Business Impact Analysis undertaken and Directorate BCPs developed. BCP test in May 25. Report of test completed and circulated Sept 25.				

Corporate Risk 71			
RISK AREA/CONTEXT: Public Inquiries - Reputational damage to the PHA as a result of criticism received from any of the statutory public inquiries around the Agency's ability to respond to the requests made of it by each Public Inquiry.			
DESCRIPTION OF RISK: There is a risk that the PHA may suffer reputational damage and loss of professional credibility if the outcome of any public inquiry results in criticism of the PHA. The PHAs ability to adequately respond to Public Inquiries in a timely and complete manner is critically important. Factors such as loss of corporate memory with many key members of staff no longer in PHA employment, capacity of current staff to devote the time required to input into responses, and no corporate document retrieval system to readily locate relevant files are relevant. There is also the risk of adverse impacts on other significant PHA deliverables, if key staff are required to reallocate their time to input into the work of ongoing Public Inquiries. There has been no dedicated support / increase in core funding for staff from DoH. The PHA is actively involved in three open public inquiries alongside a requirement to review the work undertaken in respect of the now closed Hyponatraemia, Neurology and Infected Blood Inquiries			**DATE RISK ADDED:** 30 April 2023 **REVISED:** June 2024 Mar 2025 **CLOSED:** N/A
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objective: Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Possible	Moderate	MEDIUM
Target	Unlikely	Minor	LOW
LEAD OFFICER: Head of Chief Executive's Office and Strategic Engagement			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
When required, the Agency has the ability to stand up its PI Programme Management Board chaired by the CEXE.	1st & 2nd line: - Dedicated Inquiries team led by staff working at AfC Ba 8A level with access to a formal Programme Board ~~Steering~~	Gaps in Assurance:		~~In the immediate term (April 25 – March 26)~~ The Agency will continue to respond to the requests made of it from active	~~Dec 2025~~ March 2026

~~A formal governance structure has now been put in place in relation to PI work within the Agency:~~ ~~- A PI Programme Management Board chaired by the CEXE~~ ~~- A PI Steering Group chaired by the Director of Operations which meets as required.~~ On a day to day basis, the Agency's PI response is managed ~~These groups are supported~~ by a dedicated Inquiries team aligned to the Chief Executive's Office ~~Operations Directorate who co-ordinate the day to day response.~~ The Agency has dedicated legal support for its PI work through a named Solicitor Consultant financed by PHA. ~~Paper reviewing structure and support for Public Inquiry and Programme Governance drafted considered by AMT in Jan 25~~.	~~Group chaired by Head of Chief Executive's Office.~~ 1st & 2nd line - Dedicated input by DLS Solicitor Consultant - Escalation to a ~~Fortnightly reporting to~~ PI Programme Management Board chaired by CEXE and containing Director ~~and NED~~ representation. - Update reports and escalation pathway to PHA board as appropriate. ~~Approval from AMT and Board to take forward a new Working group reporting on the actions taken by the Agency to address recommendations relating to the PHA~~. 3rd line - None Identified	Gaps in Control: • No dedicated financial support from DoH (ie no increase in core funding) • Although the psychological impact of the Covid-19 response may have left an indelible mark upon staff, it is hoped that the tangible acts of recognition and engagement stemming from ODEF are helping to address this legacy of the pandemic.	inquiries ~~- primarily in relation to the UK Covid-19 Inquiry.~~ Update as at December 2025. Work is underway within the Agency to establish a formal framework in which the Agency can appropriately manage and progress learning in relation to inquiries, SAI, external audits, review etc. The proposed framework will be discussed at PHA AMT in January 2026 ~~Update as at 31 March 25.~~ ~~Following AMT and Board approval, an action plan is in place to establish new working group to monitor and report on Agency response to Inquiry recommendations and associated learning.~~ ~~Update as at 30 Sept 25~~ ~~Draft TOR developed and nominations for membership of new Internal working group sought from Directors. Pending clarification of interface between the Working Group and the work of the Quality, Safety and Innovation Directorate 1st meeting to take place in 3rd quarter 0f 2025/26.~~	~~Dec 2025~~ March 2026 ~~Dec 2025~~

Corporate Risk 73					
RISK AREA/CONTEXT: Financial Planning Context 25/26 & 26/27 Finance / Operational Performance and Service Improvement Dimensons					
DESCRIPTION OF RISK: In light of the current financial planning context, and the financial deficit facing the HSC sector in NI, there is a risk that PHA will be required to to deliver further savings against its current baseline budget. To achieve the savings, PHA will need to prioritise current investments which may risk the full implementation of the Reshape and Refresh programme . There is therefore a risk that PHA will be required to stop a significant number of existing contracts it has in place with Providers from March 2025. Without continued investment and growth it will not be possible to develop and deliver a Corporate Plan to deliver statutory requirements of Health Protection, Health improvement and tackle Health inequalities in NI.				**DATE RISK ADDED:** June 2024 **REVIEWED:** June 2025 **CLOSED:**	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objective: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target	~~Likely~~ Possible	Moderate		**MEDIUM**	
LEAD OFFICER: Director of Finance and Corporate Services					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**

PHA approach will be guided by AMT and PHA board direction Development of Financial plan in advance of agreement of budgets. Engagement at highest level with DOH officials including Perm Sec and Director of Health Engagement with Minister and SPAD on importance of PHA to the public health outcomes.	1st and 2nd line assurances AMT/ PHA board to be updated on budget position on a regular basis. Formal confirmation of allocation for 2025/2026 received from DOH. PHA staff to continue to engage with DoH Finance and Policy colleagues to ensure impact of achieving additional savings is understood.	<u>Gaps in Controls</u> <u>Gaps in Assurances</u> One year budget cycle	Based on the indicative opening allocation, the 25/26 financial plan has been approved by the the Board. The plan takes account of the agencies saving targets & in year pressures and is projecting breaking even at 31 March 2026. The DoH have, however, noted a significant funding gap across HSC and while steps are being taken to address the gap the DoH have indicated additional savings may be required in year. Mid year update: The DoH have confirmed that a review of funding and savings have resulted in the funding gap being reduced to 360M with a further 68M potential savings identified in year. The DoH have confirmed one third allocation towards the AFC 2526 pay award. HSC organisations are awaiting formal direction regarding the treatment of the remaining balance (circa £1.1M for PHA) in the year end accounts. PHA to continue to engage with DoH and monitor the financial	~~December 2025~~ Mar 2026

			position to ensure breakeven, excluding the AFC shortfall, is achieved at 31 March 2026.	

Corporate Risk 74			
RISK AREA/CONTEXT: ICS: Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA.			
DESCRIPTION OF RISK: A new system for the planning, delivery and performance management of health and social care is being designed and implemented in Northern Ireland. Integrated Care System (ICS) is the overall title for this. The primary risk is that the design and implementation of this new system and consequent legislation does not fully recognise the importance of public health in the role of planning and delivering better health for the population of Northern Ireland. The delay in the full programme of legislative instruments may mean that the PHA is at risk of operating 'ultra vires' in relation to accountability arrangements at an operational level with regard to joint planning and commissioning teams.			**DATE RISK ADDED:** June 2024 **REVIEWED:** **CLOSED:**
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension			
LINK TO ANNUAL BUSINESS PLAN 2025/26: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Possible	Moderate	**MEDIUM**
Target	Unlikely	Minor	**LOW**
LEAD OFFICER: Chief Executive			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date
The Agency Chair and Chief Executive sit on the group led by the permanent secretary tasked with the design elements of the new planning and governance approach. The Chief Executive sits on the regional project board for ICS and AIPBs The senior officers of the PHA are involved in the developing the SOPs for how the systems of governance of planning will run at SPPG and PHA level. PHA /SPPG workshop held on 23 June agreed actions on the following objectives relating to the new JPPTs: • Review the core functions, range and remit of the new teams. • Consider the governance and accountability arrangements	1st and 2nd lines - PHA Multi Disciplinary SPTs - Multi Disciplinary Planning and Commissioning teams - Regular reporting into JAM (PHA/SPPG joint assurance meetings) 3rd line - Internal Audit programme - Reporting to PTEB	Control gaps: - Clarity around PHA role and resourcing - PHA does not currently have the planning capacity to support the anticipated requirements of joint commissioning and Planning bodies. - This is being developed in parallel to the Reshape and Refresh programme. Assurance: - There is no legislative framework currently underpinning the Governance arrangements for the PHA - PHA ICS hub in place to oversee the exchange of information and development of appropriate actions - PHA CEO is engaged with SPPG interim Chief Operating Officer to develop a partnership approach to establishing and agreeing oversight arrangements for the new Planning and Commissioning Teams		SPT governance arrangements to be further developed within Reshape and Refresh programme Following the June 25 workshop next steps include: • SPPG and PHA to confirm Co charis and review JPPT membership • New timeline and plan template to be produced • Check in session to review progress planned for October 25 • Joint PPT development and governance arrangements to follow • SLT will work to ensure coherence and alignment between joint performance and planning teams and public health planning teams.	Dec 2025 Dec 2025

• Agree the structure, shape and support Joint PCT workshop held June 25				

Corporate Risk 75					
RISK AREA/CONTEXT: Pandemic Preparedness					
DESCRIPTION OF RISK: A key responsibility of the PHA is to provide the NI public health response to a pandemic. An emerging infectious disease including newly recognised infectious agents could result in large numbers of people falling ill and the next pandemic. The novel pathogen causing the epidemic could emerge abroad, with no effective treatment or vaccine. The immediate and critical public health response in NI will be focused on detection of the infection, surveillance, public health management of cases including testing, isolation, contact tracing, vaccination and treatments (if available). This needs to be scalable and will require co-ordination and implementation of national guidance and a supporting communications plan. ~~National Risk Register 2023.~~ UK National Risk Register. Key area of risk is the capacity of the organisation to deliver on its requirements for planning and response to a pandemic.				**DATE RISK ADDED:** June 2024 **REVIEWED:** **CLOSED:**	
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension					
LINK TO ANNUAL BUSINESS PLAN 2025/26: Corporate Objective: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target	Possible	Moderate		**MEDIUM**	
LEAD OFFICER: Director of Public Health					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating (RED)**	**Action Plan/Comments/ Timescale**	**Review Date**
Establishment of PHA; SPPG and BSO Joint Pandemic Planning Preparedness Group (June 2023) Completion table top exercises: (completed in 2023/24/25). Representation on the NI Regional Pandemic	Submission of draft plans to DoH assurance (Complete). The PHA / SPPG / BSO group is on hold after completing objective and will be re-convened to address outputs from Exercise Pegasus and deliver on long term	• Resources (capital and human) required to deliver a surge response for the required time period. • Joint planning with RoI and rest of UK in relation to border response for a pandemic including a 5 nations approach for the management of travel with respect to data sharing		• Meetings ongoing with convened by DoH from ~~in~~ January 2025 to review October 2024 Pandemic submissions. Currently on hold due to exercise Pegasus. • Opportunity re development of a UK wide Single Service Centre/ surge Response	~~Dec 2025~~ March 2026

Preparedness Planning Board – June 2024 Representation on the NI Regional Pandemic Preparedness Planning Board – June 2024. PHA representation on UKHSA 4 Nations planning groups as appropriate. PHA represented as observers on RoI National co-ordinating Group for HPAI. In light of upcoming exercise Pegasus, PHA are reviewed pandemic plans submitted to DOH in October 2024 and resubmitted in July 2025 with clear recommendations for urgent consideration including a request for a policy decision for NI sign up to UK wide Single Service Centre/ surge Response service. National Pandemic Exercise, exercise Pegasus commenced Sept 2025 and will run until 2026.	planning for Pandemic Preparedness Business impact analysis completed in August 2025. Next stage of staff mobilisation being progressed via Senior Leaders Forum. The Corporate business continuity plan review completed March 2025 and tested on 6th May 2025. There is regular liaison with UKHSA, other UK DA's and RoI on operational health protection matters. These can include cross border issus which are addressed on case by case basis while longer term solutions are worked through. The Common Framework is the statutory agreement which underpins co-operation and joint working across UK administrations. This agreement does support sharing of information across DA's.	around passenger locator forms. PHA input to this as appropriate but the work is led at government level and includes Home Office as well as health departments. • Review of data sharing agreements with respect to data sharing for pandemic response including border health security and travel (PLFS). • Ability to deliver a proportional contact tracing service to meet the requirements of the specific guidance with respect modelling assumptions as reflected in the UK National Risk register. • Identification and funding of a digital solution for contact tracing. • Development of business cases to be informed following further discussions with UKHSA re the proposed solution for a Single ServiceCentre/ Surge Response Service.	service now to be factored in to decision for NI.	

	The WHO international health regulations are implemented at UK level and these underpin working with RoI, EU and other countries. These strategic frameworks are not a substitute for DSAs which are the responsibility of the relevant services -			

Corporate Risk 76

RISK AREA/CONTEXT:

The Child Health System is used by all 5 HSC Trusts and is used to record and manage the information needed to plan, oversee and deliver Child Health services to the children and young adults. This includes;

Scheduling & Surveillance e.g. Healthy Child Healthy Future and immunisation programmes

Monitoring e.g. New born blood spot screening failsafe

Production of Quality and Performance Management Statistics~~:~~ including

- Births, breastfeeding data and infant mortalities

CHS is the driver for the Child Health Programme which is comprised of a number of complex processes and supporting algorithms that help ensure the right children are called for the right treatment / surveillance at the right time and that any significant results or outcomes are suitably followed up. Failure in any part of this has potential for serious adverse patient impact.

The Child Health System is not currently live on Encompass, Encompass intends to replace the Child Health System (CHS) regionally. The process of transitioning CHS workflows to Encompass, including engagement with relevant stakeholders, has commenced ~~with the majority work to commence in July 2025,~~ the proposed Go Live date has been proposed to be extended to a phased approach from August 2026

(Linked to Risk 59 Quality Assurance and Commissioning of Screening).

DESCRIPTION OF RISK:

- The complexity of the system build
- Confidence that it can be completed in the revised time scale
- Ability to replicate the full functionality of the current system
- Availability of an adequate resource: CHS staff to support professional staff to advise on build and capacity of PHA to maintain current CHS while managing implementation
- Rigorous testing and the time it will take to ensure
- Loss of data if it not migrated in respect of record retention schedule
- Litigation if children and young people are not scheduled for; screening or the provision of results following screening, immunisations and developmental reviews

DATE RISK ADDED: December 2024

REVISED:

CLOSED: N/A

• Lack of interface between Encompass and GP systems which may impact on scheduling and recording of childhood immunisations • Decision on what data is to be migrated from CHS will have a potential impact on resources available ~~currently~~ from Deadalus to BSO and this will incur additional costs ~~(updated 30.01.25)~~	

LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension

LINK TO ANNUAL BUSINESS PLAN 2025/26: Protecting Health / Starting Well; Drive and support the transfer of the NI Child Health system onto Encompass including supporting the build for the system with EPIC developers.

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	HIGH
Target	Unlikely	Major	HIGH

LEAD OFFICER: Interim Director Population Health

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date

Existing Controls – IT Programme Board for CHS and Encompass. Extension to CHS contract sought and granted Go Live Date extended to February 26 Working group aware of interface challenges between GP systems and Encompass and will seek solution. High profile projects /enhancements need to continue have been identified e.g. changes to child health vaccination programme starting early next year (Phase 1 changes to the vaccine schedule commenced Jul 25). CHS are progressing with changes in preparation for changes to the childhood vaccine schedule Phase 2 Jan 26. Encompass analyst resources were available from July 25, work is progressing but it has been proposed that the scheduling of preschool vaccinations will remain with CHS until EPIC are able to match this functionality. Escalated to Regional Encompass SRO and solutions are being actively sought to support Including applying trust encompass resources to the project to support the development.	1st– Early Years and Family Nurse Partnership Nurse Consultants, People AD SPH Starting Well and Interim Director from Population Health. 2nd – Subgroups include, Screening and Service Development Nurse Consultant and Senior Systems and Business Analysts and Operations Service Manager. 3rd – Encompass	**Gaps in Control:** Staged approach unconfirmed for Go Live CHS will be required to remain and run in parallel with the encompass sytem until all functionality and data flows have been tested and assurance has been sought that it replicates the CHS functionality. Gaps in interface between GP interface and Encompass, relating to Pre-Achool Vaccination Programme **Gaps in Assurance:**	Ongoing review of the work by all stakeholders will inform a Go Live date. At present it is proposed that it will be phased in from August 2026 ~~with the exception of Preschool Vaccination and Immunisation Scheduling.~~ The revision of the project carried out in spring will allow progress to be monitored. Encompass presented a new technical solution in December however CHS Managers would like to see the evidence used and have a number of questions before approval of this new solution as a replacement for CHS. Ongoing communication with encompass. The Vaccination & Immunisation Focus Design Group, Working Group and Steering Group will have to approve as this holds a high risk for children. An Options Review is planned for Monday 15th Dec where a decision will be made regarding whether Encompass will progress with	~~Dec 2025~~ Jan 26

Additional resource has been provided by Encompass to support CHS managers and BSO programme manager support. Dedicated Senior Project Manager now in place in PHA and as a result there is significant positive improvement Further GP representation has been secured A full revision of the project has been carried out (Spring 25) and detailed scoping documents provided to the Encompass. This informed the project plan and will allow progress to be monitored. Following the Risk Summit at end September'25 a proposal has been made to extend the go live date to August 2026 ~~with the exception of preschool vaccination scheduling.~~ A full review has taken place in relation to governance structures which have now been tightened up, with clear paths for escalation. ~~9~~ 8 focus design groups, a working and steering group who report through the delivery readiness group supporting the governance structure. The project is now a standing agenda item on Regional Delivery Readiness			the build of the pre school vaccination scheduling/ booking function. If this is agreed further discussion will take place around the most suitable / feasible go live date.	

Board which will provide oversight at senior level. Representation from five trusts to ~~to~~ inform and support the build across all ~~9~~ 8 FDGs and working group. Additional regional Encompass funding has been applied to this project. More will be requested if required. Encompass delivered a demonstration for the scheduling and booking of pre school vaccinations for GP clinics to the Focus Design Group on 8.12.25. It provided a much improved technical solution.				

APPENDIX 1

RISKS ADDED TO CORPORATE RISK REGISTER AS AT 31 December 2025

RISK TITLE: Safety and Quality – added from PHWB Directorate Risk Register
ADDED TO RISK REGISTER: March 2022
DOMAIN: Safety and Quality

LINK TO ANNUAL BUSINESS PLAN 25/26: Finalise a framework to support Quality and Safety corporate processes for PHA.

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Possible	Major	HIGH
Target	Unlikely	Major	High

Risk Ref	Description of Risk	Existing Controls	Treatment/ Action Plan & Timescale	Lead officer	Status	Review Date
SQ10	The 2011 Department of Health Framework document is out of date, specifically the section on Safety and Quality which outlines roles and responsibilities. Since the migration of HSCB to SPPG governance arrangements around Safety and Quality are unclear. PHA requires separate internal structures and policies to be identified in relation to the management of to Safety and Quality processes including but not limited to: SAI's, early alerts, CMRs, Child Deaths, development of clinical guidance.	Input from Safety and Quality team and escalation to AMT and JAM (on matters of joint working). DoH Quality Assurance framework 2011 outlines PHA roles and responsibilities – whist this remains extant guidance, content is significantly out of date. Requirement for PHA to provide assurance on safety and quality of Trust services for Population Health is undeliverable (governance of these services rests with HSC Trusts) The 2011 Framework has been issued by DoH for comments and these are for discussion at AMT	A joint PHA/SPPG Quality and Safety framework is under development and will be approved at the Joint Assurance Group this will incorporate the PHA plan. This is continuing to be discussed under the 4 pillars of - Information - Triangulation - Risk management - Escalation/ improvement A final version will be completed in early 2026 however will be subject to updates following publication of the revised 2011 Framework and release of the new PSI framework from DoH. PHA roles and responsibilities related to S&Q agenda will be discussed with Policy Sponsor Branch ADs for Systems Transformation and Learning will continue to work with other PHA Directorates to secure input to the PHA review of Safety and Quality, agree priorities to update existing processes for internal governance and link with partners on the safety and quality agenda. Regular monthly update review meetings are now established (Safety Brief).	D. Boulter / G. Cushley AD S&Q Systems Transformation and Learning	All PHA actions in progress. Continues to progress.	Mar 26

APPENDIX 2

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 31 December 2025

PHA Governance and Audit Committee Meeting Minutes

Date and Time	Venue
17 October 2025 at 2.00pm	Fifth Floor Meeting Room, 12/22 Linenhall Street

Member	Title	Attendance status
Mr Joseph Stewart	Non-Executive Director (Chair)	Present
Mr John Patrick Clayton	Non-Executive Director	Present
Mr Robert Irvine	Non-Executive Director	Present via Teams
Ms Anne Henderson	Non-Executive Director	Present
Ms Leah Scott	Director of Finance and Corporate Services	In attendance
Ms Helen O'Hare	Assistant Director of Finance and Corporate Services	In attendance
Mr Stephen Wilson	Head of the Chief Executive's Office	In attendance
Mr Stephen Murray	Assistant Director of Planning and Business Services	In attendance
Mrs Catherine McKeown	Head of Internal Audit, BSO	In attendance
Mr Ryan Falls	Cavanagh Kelly	In attendance Via Teams
Mr John Irwin	Northern Ireland Audit Office	In attendance
Mr Robert Graham	Chief Executive Office Manager	In attendance
Ms Aisling Smyth	Secretariat	In attendance

1/25 - Item 1 – Welcome and Apologies

1/25.1 Mr Stewart welcomed everyone to the meeting and noted that Mr Clayton will be joining the meeting slightly late and Mr Irvine will be leaving early.

2/25 - Item 2 – Declaration of Interests

2/25.1 No declaration of interests relevant to any items on the agenda were made with the exception of Mr Clayton's ongoing public inquiries work with Unison. Mr Stewart highlighted that the Audit Self-assessment would be deferred to a later time. He asked for a separate meeting to be arrange for the Committee Members.
(Action 1 – Ms Smyth).

3/25 - Item 3 – Minutes of previous meeting held on 14 August 2025

3/25.1 The minutes of the previous meeting, held on 12 June 2025, were **APPROVED** as an accurate record of that meeting.

4/25 - Item 4 – Matters Arising

4/25.1 Mr Stewart noted that an Action Log had been circulated in advance of the meeting and noted all matters arising were covered in the action log.

4/25.2 Mr Stewart noted two actions which are work in progress. The first was in relation to the Cyber Security paper where an update will be given at the Board meeting. The second was in relation to the electronic document management system and it was noted that SharePoint is now being used for some document management.

5/25 - Item 5 – Chair's Business

5/25.1 Mr Stewart advised that he had no business to update on. He advised that he and Ms Henderson attended the NICON conference on Thursday 16th October and both found it very worthwhile.

6/25 - Item 6 – Internal Audit

Internal Audit Progress Report [GAC/01/10/25]

6/25.1 Ms McKeown presented the Internal Audit Progress Report October 2025. She noted the KPI's and the Progress on the Audit Plan and highlighted two upcoming audits on Screening Programme and Governance and Assurance.

6/25.2 Ms McKeown advised that two audits had been carried out in this quarter. The first was Research & Development which received Satisfactory Assurance. She noted that funding, obtained via appropriately approved business cases, was in place for the sampled R&D projects. She noted that clear targets and objectives are in place. She

highlighted one exceptional finding and noted that there is evidence that PHA have been actively seeking the information.

6/25.3 Mr Stewart queried why the one exceptional finding needs to be written up, if it is being actively chased.

6/25.4 Ms McKeown explained that this is good practice and ensures completeness.

6/25.5 In relation to the 2nd audit, Financial Review, which received Satisfactory Assurance, Ms McKeown noted an improvement on last year's audit and advised that processes have been enhanced and there are no exceptional findings. She highlighted two key findings, (1) Staff Travel Claims and suggested that a reminder be sent out to approvers to check all claims and (2) PHA Contracts Register needs to be strengthened and updated in line with DOH requirements.

6/25.6 Ms Henderson noted that the Staff in Post (SiP) checks have settled and improved.

6/25.7 Mr Stewart and Ms Henderson commented on the Travel Claims and agreed that a reminder should be sent out. **(Action 2 – Ms Scott**).

6/25.8 Ms Scott confirmed the Finance team are progressing work on updating the Contract Register and she will follow up with them on the travel claims recommendation.

6/25.9 Members Noted the Internal Audit Progress Report.

Mid-Year Follow up on Outstanding IA Recommendations 2024/25 [GAC/02/10/25]

6/25.10 Ms McKeown presented the Mid-Year follow up on Outstanding Internal Audit Recommendations. She advised that 72 (82%) of the outstanding 88 recommendations examined were fully implemented and a further 16 (18%) were partially implemented. From the 32 recommendations reviewed in this follow up, 19 (59%) related to significant findings which caused Limited/Unacceptable assurances to be provided. Of these 19 recommendations, 8 (42%) were implemented during this follow up period (April to September 2025. She noted that there has been a good implementation rate with the three oldest recommendations closed down. She advised that the oldest now is from 2022/2023 Screening. She advised that there are still 11 significant findings that are partially implemented, but she is reasonably content that good progress is being made. She drew members attention to the Trust Commissioned Services and advised that further evidence of progress is required.

6/25.11 Ms Henderson noted that it is a positive follow up and the Trust Commissioned Services (TCS) is a large area of work and asked if a presentation could be made on the progress for the next GAC meeting.

6/25.12 Ms Scott advised that there have been meetings between herself, Mr Murray and Mr Dawson on this area of work and they would bring forward an oversight on TCS. **(Action 3 – Ms Scott/Mr Murray**).

6/25.13 Ms Scott gave credit to Ms O'Hare and her team for the energy they have shown in driving these recommendations forward to completion. She advised that

progressing the TCS is more difficult but noted that progress is being made against an achievable action plan.

6/25.14 Mr Stewart noted his concern on the Management of Vaccinations and the controls are less than recommended and will not be in place before 2026.

6/25.15 Ms Scott advised that there has been progress with the Immunisation board but further input is needed from the DOH.

6/25.16 Mr Irvine thanked Ms Scott and her teams and noted that it is good to see the recommendations clearing and suggested logging the lessons learnt from the legacy audit recommendations after they had been closed.

6/25.17 Ms Scott noted it is good to reflect on lessons learnt on the legacy recommendations, such as agreeing more realistic timescales. She also noted that an increase in resources has helped progress actions more quickly. She advised that the learnings have been built into the Internal Audit process going forward.

6/25.18 Mr Stewart noted that he would have concerns with 'Implementation not passed' and is there confidence that progress is being made on these recommendations so that the dates will be met for Internal Audit (IA).

6/25.19 Ms Scott advised that follow up for progress being made on 'Implementation not passed' is reported on.

6/25.20 Ms Henderson noted that good progress is being made and would feel that the Trusts spending would not necessarily align with the PHA priorities. She also noted her concern about the Flu Vaccine levels and would be concerned that with the public uptake currently looking slow, that there will be a stock wastage this year.

6/25.21 There was a discussion around access to pharmacies to receive the vaccine and Ms O'Hare noted that there has been work between the PHA and pharmacies to raise awareness with the public.

6/25.22 Members Noted the Mid-Year follow up on Outstanding Internal Audit Recommendations.

Shared Services Audits 25 [GAC/03/10/25]

6/25.23 Ms McKeown presented the Shared Services Audits 2025. She advised that two audits have been conducted and finalised since the previous update, Accounts Payable Shared Services and Shared Services Accounts Receivable, both of which received Satisfactory Assurance. For both audits, the majority of the processes tested are working adequately and effectively as designed. This includes notable improvements regarding supplier creation /amendments by APSS.

6/25.24 Members Noted the Shared Services Audits 2025.

Mid-Year Assurance Statement to the Public Health Agency from the Head of Internal Audit 25 [GAC/04/10/25]

6/25.25 Ms McKeown presented the Mid-Year Assurance Statement to the Public Health Agency from the Head of Internal Audit 2025. Ms McKeown advised that there have been four IA assignments completed and reported on by mid-year. Health Protection Surveillance, Research & Development, Risk Management and Financial review. She noted that a summary is in the papers, but advised that it is important to note that the level of assurance provided by IA has been satisfactory.

6/25.26 Members noted the Mid-Year Assurance Statement to the Public Health Agency from the Head of Internal Audit 25

7/25 - Item 7 – Corporate Governance

Corporate Risk Register as at 30 September 2025 [GAC/05/10/25]

7/25.1 Ms Scott presented the Corporate Risk Register (CRR). She advised that it was an opportunity to refine and reflect on the current risk environment. She advised that no new risks had been added or removed and there were no changes to the overall rating. She welcomed any comments or feedback.

7/25.2 Mr Stewart noted that the risk on Pandemic Preparedness was wordy and asked for it to be tidied up. **(Action 4 – Ms Scott/Ms O'Hare**). He asked with Pegasus running at the minute, would there be any learnings and how would this impact the risk.

7/25.3 Ms Scott advised that there are considerable learnings from Pegasus and a review of the Pandemic Preparedness risk would be undertaken after the test exercise. She advised that the DoH is looking at the Public Health Bill with regards to roles and responsibilities.

7/25.4 Ms Henderson questioned whether Vaccines should be added as a risk as it is part of the agency core functions and the decline in uptake is a serious issue. Mr Wilson advised that it will be assessed at the end of the process and could be added then. Mr Stewart questioned whether a poor uptake and wastage would have a poor reflection on the Agency.

7/25.5 Mr Stewart questioned if the Financial planning risk was becoming any clearer. Ms Scott advised that the Agency is managing a balanced budget and the DoH has asked that any slippage be returned to contribute to staff pay rises. She advised that any slippage is being closely monitored.

7/25.6 Mr Stewart questioned the risk on Integrated Care Systems (ICS) and Ms Scott advised that the risk had been reviewed and is accurate within the current arrangements. Mr Stewart queried where ICS should sit. Mr Wilson advised on a joint PPT workshop and working on clarity around commissioning.

7/25.7 Members Approved Corporate Risk Register as at 30 September 2025

Finance and Corporate Services Directorate Risk Register as at 30 September 2025 [GAC/06/10/25]

7/25.8 Ms Scott presented the Finance and Corporate Services Directorate Risk Register. She advised that no new risks had been added or removed and it is a new directorate and are settling in. She noted that most risks appear in the Corporate risk register. She highlighted two risks. One with the resourcing of the Information Governance Team and advised that they are making progress to provide another Band 7 with the increased workload within the team and the other risk is the Procurement plan, which is currently under review with Mr Murray.

7/25.9 Ms Henderson asked for clarification with regards to the training of staff on the Procurement process and gave an example of an issue with Procurement and training within the process. Mr Murray explained that anyone who is currently active in procurement has been trained on the process and advised that it is a much bigger piece of training to train all those who potentially could use it in the future.

7/25.10 Ms Scott advised that they have the back up from PALS and there is an awareness around the Procurement Act and the policies and procedures within procurement.

7/25.11 Members noted the Finance and Corporate Services Directorate Risk Register as at 30 September 2025.

PHA Business Continuity Plan [GAC/07/10/25]

7/25.12 Ms Scott presented the Business Continuity Plan for approval. She advised that the plan has been reviewed and updated and asked for any comments or feedback.

7/25.13 Mr Henderson asked if those who have to implement the plan have a hard copy. Ms Scott advised that they do.

7/25.14 Ms O'Hare explained the process around the Business Continuity Plan and advised that it had been tested at a desk top exercise in May which featured a Cyber Security incident. Ms O'Hare advised that it is a framework to deal with a variety of issues and there are Directorate Business Continuity Plans which have much more detail on what to do during an incident for the individual directorates. She advised that it is a good assurance following ISO standards.

7/25.15 Mr Stewart questioned the R&D response times of 3 days and asked how it was picked. Mr Stewart asked for this to be checked out. **(Action 5 – Ms O'Hare**)

At this point Mr Clayton joined the meeting.

7/25.16 Mr Stewart welcomed Mr Clayton to the meeting.

7/25.17 Mr Irvine raised his concerns with regards to Cyber Security and the number of attacks over recent years. And asked if the PHA has a separate server if it was attacked.

7/25.18 Ms Scott advised that the agency works closely with BSO ITS and they have stringent business continuity processes in place. She also explained that with using

Sharepoint, this can be accessed from another laptop and allows for full replication and resilience. She advised that there will be more discussions at the upcoming Cyber Security workshop.

7/25.19 Mr Irvine noted that cloud systems are good but reminded members that there have been cases where goggle cloud has been infiltrated. He noted that it is a worry.

7/25.20 Members Approved PHA Business Continuity Plan

At this point Mr Robert Irvine left the meeting.

Contracts Assurance Process 2526 Report [GAC/08/10/25]

7/25.21 Mr Murray presented the report on the Contracts Assurance Process 25/26. He advised that an Information Governance checklist has been included as part of the Assurance Return and a database has been developed on Sharepoint to assist with the collation and assessment of the information and is available to the PEMS officers with Health Improvement. He advised that letters had been sent out requesting the necessary information to all Community and Voluntary sector organisations and the response rate of returns has been positive.

7/25.22 Ms Henderson noted that it is reassuring to see the response but questioned of those who have not returned their responses, what are the issues.

7/25.23 Mr Murray explained that follow ups go through the Contract Manager and outlined what processes are in place if the information is not returned. Ms Henderson noted that it was a good process.

7/25.24 Members Approved Contracts Assurance Process 2526 Report.

Summary of Contract Review in line with UK GDPR [GAC/09/10/25]

7/25.25 Mr Murray presented the Summary of Contract Review in line with UK GDPR. He gave a background to the reasons for the review and the actions taken. He highlighted that in March 2024 PHA initiated an exercise to review all existing roll-forward contracts, in line with UK GDPR. Mr Murray explained the process of the exercise undertaken and highlighted that whilst personal information is held that the risk to the Agency is relatively low. He advised that this has been a strong step forward with GDPR in contracts.

7/25.26 Ms Henderson noted that it was a very welcome step and it reassures the Agency and promotes awareness to those involved in the contracts.

7/25.27 Mr Clayton agreed that it has been good progress on a long-standing issue and the response rate is excellent.

7/25.28 Members Noted Summary of Contract Review in line with UK GDPR.

PHA Assurance Framework [GAC/10/10/25]

7/25.29 Ms Scott presented the PHA Assurance Framework. She advised of the background of the strategic context of the Programme for Government (PfG). She highlighted the primary functions of the PHA that fall under 3 broad headings and explained that the Agency's business plan is focused on five key outcomes as set out in the Corporate Plan. She advised that the layout of the PHA Assurance Framework is based on the four performance and assurance dimensions also known as the 'Four Dimensions of Governance'. Ms Scott noted that this provides members reassurance on the running of the organisation.

7/25.30 Mr Stewart noted that there had been a few changes to the document.

7/25.31 Ms Scott advised that Ms O'Hare and her team had reviewed the document and it reflects the current status. She highlighted to the members on the Operational Performance and Service Improvement that the Commissioning Plan arrangements from 2019/2020 remain in place.

7/25.32 Mr Stewart asked about RD expenditure and how it is accounted for and noted that it had not come to the board.

7/25.33 Ms Scott advised that the RD expenditure is not seen as one large business case. They are allocated a budget and they have smaller business cases. She advised that there are tight controls on expenditure.

7/25.34 Mr Clayton noted that he has not seen a report on how the RD budget is being used.

7/25.35 The members asked for a list on the funding of RD projects.
(Action 6 – Ms O'Hare/Ms Scott)

7/25.36 Mr Clayton questioned the Review of Standing Orders and asked what clarification was needed. Ms O'Hare explained that this was to do with legal responsibilities and commissioning.

7/25.37 Members asked for more clarity within the Assurance Framework on the Review of Standing Orders.

7/25.38 Mr Clayton noted that the IG risks may need updated, the IG Action Plan is considered but he has concerns that all information goes to GAC for noting – he suggests that this should be for approval. The Assurance Framework will be updated accordingly.

7/25.39 Members Approved PHA Assurance Framework subject to amendments.

Quarterly Complaints, Compliments and Claims Report 25/26 [GAC/11/10/25]

7/25.40 Mr Wilson presented the Quarterly Complaints, Compliments and Claims Report. He advised that from 1st April to 30th September there had been five formal complaints and in comparison, to this time last year there had been one complaint. He stressed that last year was exceptional. He advised that in 25/26 three complaints have been closed and noted that there are two still open but they will be closed shortly. Mr Wilson gave a summary of the complaints. He advised that during the same period in 25 there had been four compliments and he gave a summary of them.

7/25.41 Mr Wilson advised on one open and one closed claim and gave a summary of both cases.

7/25.42 Members noted the Quarterly Complaints, Compliments and Claims Report.

8/25 - Item 8 –Information Governance

Information Governance Action Plan [GAC/12/10/25]

8/25.1 Ms Scott presented the Information Governance Action Plan. She advised that it had been reviewed and continues to be scrutinised at the Information Governance Steering Group. She highlighted staff training and awareness and noted whilst it is an ongoing challenge, that all staff training should be completed. She advised on the Near Misses recorded and reported and noted that the Record Management Audit had been completed in 2024/25 and remains ongoing for 2025/26.

8/25.2 Ms Henderson noted that good progress had been made on the training levels and asks who coordinates it. Ms O'Hare explained that the induction process sits with the line managers through the eLearning systems and the Information Governance Team draw down the statistics and bring them to the attention of line managers.

8/25.3 Mr Wilson explained that there is no fixed one time a year for this training to be done. It is an ongoing cycle and the responsibility lies with line managers to make sure their staff are completing their training.

8/25.4 Mr Clayton accepted Mr Wilson's explanation about the ongoing cycle of staff and their training. He expressed his concerns on new starts training and having access to systems before their training is completed and noted that the induction process has not helped with this issue.

8/25.5 There was a discussion on the risk associated with training and if this was an issue that should be reported to the board on a monthly basis. Ms Scott highlighted that the numbers involved are very low, with one person not completing the Cyber Security and three not completing IG Awareness training.

8/25.6 Ms Stewart noted that these are issues and challenges facing the organisation and could cause reputational damage and advised that he would bring it to the board.

8/25.7 Members noted the Information Governance Action Plan.

9/25 - Item 9 – Finance

Fraud Liaison Officer Update Report [GAC/13/10/25]

9/25.1 Ms Scott presented the Fraud Liaison Officer Update Report. She advised that there had been no new cases of suspected fraud and the review of National Fraud Initiative (NFI) data matching by BSO Accounts Payable Shared Services and BSO Payroll Shared Service remains ongoing. At the date of writing the report 431 of the 479 matches (90%) had been processed and closed off with no issues noted. She highlighted that the details on the Fraud Action Plan were in the paper and noted there is continuing vigilance, test control and feedback provided. She advised that it is a positive position.

9/25.2 Mr Stewart asked for clarification on the records matching on Payroll. Ms Scott explained the process of matching the databases. Ms O'Hare advised that there are monthly payments and there are no issues of concern.

9/25.3 Members noted the Fraud Liaison Officer Update Report.

10/25 - Item 10 – PHA Mid-Year Assurance Statement

(for recommendation to PHA Board for approval) [GAC/14/10/25]

10/25.1 Ms Scott presented the PHA Mid-Year Assurance Statement (MYAS). She advised that the statement concerns the system of internal governance in the PHA as at 30 September 2025. She highlighted that Ms O'Hare's team had prepared the MYAS and had used the template provided by the Department.

10/25.2 Mr Stewart asked for an amendment made when referencing the Governance and Audit Committee rather than Audit Committee.

10/25.3 Ms Henderson questioned the level of detail used in the Management of Contracts section and should this be at a higher level and just show the big picture. Mr Murray explained that it was to show the progress that had been made.

10/25.4 Ms Henderson questioned the section on Cervical Screening, feeling that the current challenges faced in Cervical Screening are not reflected. She felt that the statement is showing a historical problem. Ms Scott advised that the end of the section does show next steps and there is a plan to take forward.

10/25.5 Ms Henderson asked for the Cervical Screening section to be updated to reflect the risks around screening, both historical and current. She noted that it is an important challenge faced and feels that the statement could reflect this more. Cervical Screening to be amended to reflect current challenges and risks and what mitigations are in place.

10/25.6 Mr Stewart noted that whilst there is the same Quality Assurance in England, the turnaround can be slower and this could potentially be a risk. Mr Clayton questioned the control issues on Screening and felt that more assurance is needed and asked if it was on the risk register.

10/25.7 Ms Scott advised that the team would revisit Screening arrangements.

10/25.8 Members Approved for recommendation to PHA Board subject to amendments. **(Action 7 – Ms O'Hare**)

11/25 - Item 11 – Draft Governance and Audit Committee Self-Assessment *[GAC/15/10/25]*

11/25.1 Mr Stewart advised that the members would meet separately in the next week or so to go through the Self-Assessment whether that be in person or remotely.

12/25 - Item 12 – SBNI Declaration of Assurance *[GAC/16/10/25]*

12/25.1 Mr Stewart asked Ms Scott if there were any concerns. Ms Scott advised that there are no concerns and all control and governance arrangements are in place. She said that the Memorandum of Understanding (MoU) is due finalisation and they are continuing moving forward to completion.

12/25.2 Members Noted SBNI Declaration of Assurance.

13/25 - Item 13 – Any Other Business

13/25.1 Mr Stewart asked if anyone had any other business. There was none to note. He thanked everyone for attending the meeting on the Friday afternoon.

14/25 - Item 14 – Details of Next Meeting

Thursday 12 February 2026 at 10am

Fifth Floor Meeting Room, 12/22 Linenhall Street

Anne Henderson

Signed by Chair:

Date: 12th February 2026

PHA Planning, Performance and Resources Committee Minutes

Date and Time	Venue
20th November 2025 at 10am	5th Floor Meeting Room, Linenhall Street

Member	Title	Attendance status
Mrs Anne Henderson	Non-Executive Director (Acting Chair)	Present
Mr Craig Blaney	Non-Executive Director	Present
Mr Aidan Dawson	Chief Executive	In attendance
Dr Joanne McClean	Director of Public Health	In attendance
Mrs Leah Scott	Director of Finance and Corporate Services	In attendance
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Mrs Helen O'Hare	Assistant Director of Finance	In attendance
Mr Stephen Murray	Assistant Director of Planning and Performance	In attendance
Mrs Karyn Patterson	Senior HR Business Partner, BSO	In attendance
Mr Robert Graham	Chief Executive Office Manager	In attendance
Ms Marie-Thérèse Higgins	Secretariat	In attendance
Mr Colin Coffey	Chair	Apologies
Mrs Heather Reid	Interim Director of Nursing, Midwifery and AHPs	Apologies

29/25 - Item 1 – Welcome and Apologies

29/25.1 The Chair welcomed members and acknowledged apologies.

30/25 - Item 2 – Declaration of Interests

30/25.1 No declarations of interest were made.

31/25 - Item 3 – Minutes of previous meeting

31/25.1 Members unanimously **APPROVED** the minutes of the previous meeting held on 21 August 2025.

32/25 - Item 4 – Matters Arising

32/25.1 There were no matters arising.

33/25 - Item 5 – Planning

Procurement Update

33/25.1 Mr Murray provided an update on procurement. The overall position remains positive, with good progress reported across the programme.

33/25.2 Updated regulations meant required revisions to contractual terms and conditions which have been subject to legal review. A final draft is now available, with minor queries outstanding. It is anticipated that a final draft of procurement terms and conditions will be signed off within the next 7–10 days.

Tenders ready for market:
- Two drug and alcohol service tenders are fully prepared but were delayed pending approval of terms and conditions. A decision will be taken on whether to proceed in December or defer until January due to the Christmas period and market capacity.

Other tenders progressing:
- Post-intervention Engagement tender
- Cognitive Behavioural Therapy (CBT) tender (longer timeline)

33/25.3 It was noted that the specialist bereavement services market in Northern Ireland is relatively small. Mr Blaney asked for clarification of the process for specialist services and Mr Murray provided detail on the approach taken.

33/25.4 Mr Murray advised progress on a priority one Internal Audit recommendation which has now been closed and noted continued focus is required to prevent slippage at pre-procurement stages.

33/25.5 The Chair asked for detail on specific tenders and Mr Murray responded to provide clarification.

Business Planning Processes 2026/27 (PPR/01/11/25)

33/25.6 Mr Murray outlined the proposed business planning process. He presented the paper which provided detail on how planning documents align within the corporate calendar. Mr Murray noted that particular emphasis is being placed on streamlining data collection to reduce duplication across the organisation and planning teams will assume a stronger coordinating role to improve efficiency.

33/25.7 The Chair asked Mr Murray for an update on the Implementation Plan.

33/25.8 Mr Murray advised the Implementation Plan will act as a forward-looking document identifying key priorities rather than detailed actions. The plan will support the annual business planning process and is expected to be brought to the Board alongside the Annual Business Plan, likely in March 2026.

33/25.9 The Chair and members welcomed the early commencement of planning activity and noted improvement compared to previous years.

34/25 – Item 6 Performance

Quarter Two Performance Report (PPR/02/11/25)

34/25.1 The Committee considered the Quarter Two Performance Report.

34/25.2 The Chair noted two KPIs recorded as red:

- **(I) KPI 8** - Drive and support the transfer of the NI Child Health system onto Encompass including supporting the build for the system with EPIC developers.
  'Full availability of CHS functionality on Encompass and go live.'

- **(II) KPI 22 -** New Operational Framework for Public Health Planning Teams and performance management framework, aligned to the new PHA operational model, to be developed and approved by PHA board.
  'PHPT Framework to be agreed'

34/25.3 Regarding KPI 8, Dr McClean advised progress had been impacted by delays in policy direction and GP contractual issues. Dr McClean explained GPs were recently

contacted and approximately 90% of GP practices responded positively enabling the child health system to proceed with appointments.

34/25.4 Dr McClean also noted the Department have been kept informed at every stage regarding delays associated with progress. The BRAG status is anticipated to change and improve by December 2025. The Board will be updated accordingly.

34/25.5 Mr Blaney expressed concerns regarding the Encompass system as the KPI status remains red.

34/25.6 Dr McClean provided an update explaining KPI 8 is red is because of timeline issues, however progress has been made. Ongoing risks associated with system transitions have been acknowledged and are being managed.

34/25.7 Dr McClean noted dedicated Encompass resources have been put in place to support systems. Key milestones include testing on 8th December and a decision workshop scheduled for 15th December. Members were reassured that risks are being actively managed and are content with progress.

34/25.8 The Chair asked for an update on the appraisal of the flu vaccine delivery process and questioned if the Board had been sent any information regarding this. Dr McClean advised an End of Programme assessment report was completed and could be shared.

ACTION Assessment report *End of Flu Vaccine Delivery Programme* to be shared with Board.

34/25.9 Mrs Scott noted change to KPI 22 and the financial position to break even, from Green (as of end of Sept) to Amber potentially Red (current status.

Finance Report (PPR/03/11/25)

34/25.10 Mrs O'Hare presented the Finance Report.

Key points noted:

- The organisation remains forecast to breakeven.
- Risks identified include:
  – Lower-than-expected uptake of flu vaccines, potentially resulting in financial losses. The Chair asked that an update be provided to the Board.
  – Uncertainty regarding funding for pay awards, with a potential overall pressure of approximately £2.9m, including £1.143m relating to unfunded element of PHA staff.

Financial Outlook 2026/27

34/25.11 Mrs Scott provided an overview of the emerging financial outlook. She noted the significant deficit expected in 2026/7 and noted plans by the Department to

introduce cost saving measures . Further updates will be brought forward as departmental guidance becomes clearer.

34/25.12 The Chair asked Mr Dawson, as Accounting Officer, for his assessment of the current financial position in 2025/6. Mr Dawson confirmed financial stewardship has significantly strengthened, with improved oversight and forecasting. The Chair agreed with Mr Dawson's comments.

35/25 Item 7 – Resources

Workforce Information Report (PPR/04/11/25)

35/25.1 Mrs Patterson presented the Workforce Information Report. She noted Staff turnover remains low at just over 3% and highlighted Sickness absence levels which are below the rest of the sector and are well managed. Workforce development indicators remain strong and progressing well.

35/25.2.

35/25.3 Mr Blaney asked how many cultural champions does PHA currently have. Mrs Patterson advised there are 6-7 cultural champions at present across all PHA main sites and also health champions, bringing the total count closer to 20. Mr Blaney suggested inviting the cultural and health champions to a '*meet and greet'* with the Board to acknowledge, support and recognise the work they do as volunteers.

ACTION Mrs Patterson will arrange a meet and greet with the Board for Culture and Health Champions.

35/25.4 The Chair remarked on the positive content of the Workforce Report and how well it reflects the organisation culture overall.

35/25.5 Mr Dawson added following a series of site visits to meet with staff, he feels the culture across the organisation is much more settled. Mr Dawson welcomes and notes the importance of site visits which provide a platform for staff to have open conversations to air issues and concerns.

PHA People Plan 2024 – 2025 Closure Report (PPR/05/11/25)

35/25.6 Mrs Scott thanked HR and Mrs Patterson for in year support with delivering the People Plan. Mrs Scott acknowledged it has been a great success and welcomes the direction of travel for the organisation.

35/25.7 Mrs Patterson presented the PHA People Plan 2024-5 closure report.

The report reflects the collective and combined support of everyone across the organisation and noted a significant contribution from sponsors and staff involved at different stages.

Key points noted:

• 93% of actions have been fully or substantially achieved.
• Small number of outstanding actions are largely due to external constraints.
• A key future consideration is workforce demographics, with over 50% of staff aged 50+.

35/25.8 The Chair asked the full report be summarised and presented to the Board.
ACTION People Plan Closure Report summary to be shared with the Board.

35/25.9 It was noted that a new People Strategy (2026–2030) is in development and will coincide with corporate plan timelines.

Update on Estates Issues

35/25.10 Mrs Scott provided the following update on estates and facilities;

- PHA have 8 locations throughout Northern Ireland and do not own any premises.
- Majority of estates are in various states of disrepair. Premises are leased which means having to compete with other HSC organisations and high-profile projects for capital funding. In absence of capital funding, PHA are working with landlords to carry out repair work addressing essential health and safety concerns to maximise use of resources.
- Significant works are underway at Linenhall Street, commencing 24 November for approximately 20 weeks. There are a number of shortfalls regarding windows, heating and electrics.
- Linum Chambers is second largest site and there is a lease in place for the 9th Floor until Sept 2026 – a business case has been submitted to the DoH to extend this. Feedback pending.
- Ballymena, County Hall office (67 desk, 63 staff, back-up duty room with additional 8 desks for business continuity and emergency planning response) closure anticipated around 2028–2029.
- Other sites remain stable.
- Working with partners in SPPG, BSO and DoH to secure other suitable premises.

35/25.11 The Chair asked if Ballymena staff were being kept informed of developments. Mrs Scott confirmed staff were being updated.

35/25.12 Mrs Scott provided an update on Climate Change regulation noting a climate mitigation report has been submitted to DEARA and an adaptation report is due March 2026. PHA is working with BSO to determine how sustainability services can be incorporated in their Service Level Agreement's and how PHA can be more environmentally conscious.

36/25 - Item 8 – Any Other Business

36/25.1 There was no other business.

37/25 - Item 9 – Details of Next Meeting

Thursday 19th February 2026 at 10am
Fifth Floor Meeting Room, 12/22 Linenhall Street

Signed by The Chair:
Colin Coffey

Date: 19 February 2026

item 8

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	26 February 2026
Title of paper	Performance Management Report
Reference	PHA/04/02/26
Prepared by	Stephen Murray / Marie Therese Higgins
Lead Director	Leah Scott

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2025/26.

2 Key Issues

The attached paper provides a summary of progress made, as at end of December 2025, on achieving the actions set out in the PHA Annual Business Plan 2025/26.

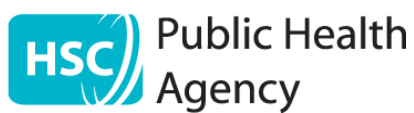
Of the **27** actions, **2** actions are rated Blue *(action completed)*, **17** are rated Green, **5** are rated Amber and **3** are rated Red.

This report provides the progress and BRAG status for each action with further details provided on those actions currently rated Amber or Red.

The Performance Management Report was considered by the Planning, Performance and Resources Committee at its meeting on 19 February 2026.

3 Next Steps

The next quarterly Performance Management Report update will be brought to the Board in May 2026.



PERFORMANCE MANAGEMENT REPORT

Q3 Monitoring of KPIs Identified in

The Annual Business Plan 2025 – 2026

Introduction

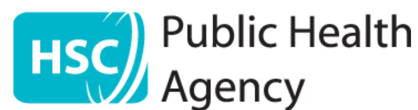
The Public Health Agency (PHA) Annual Business Plan outlines the key actions to be undertaken during 2025/26 to support Ministerial and Departmental priorities and demonstrate delivery against Corporate Plan objectives.

This report provides an update on the progress of actions identified in the PHA Annual Business Plan 2025-26. Progress updates for each action are to be provided by the designated Lead Officers. The Annual Business Plan identifies a total of **27** actions across 5 key priorities. Each action is assigned a BRAG status, as defined below:

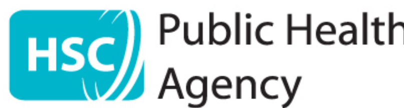
BRAG Status:

🔵	Action completed.
🟢	Action on track for completion by target date.
🟡	Significant risk of Action being delayed after target date.
🔴	Critical risk of Action being significantly delayed/unable to be completed.

At the end of December 2025, of the **27** actions, **02** are currently rated Blue, **17** are currently rated Green, **05** are currently rated Amber, and **03** are currently rated red. This report outlines the BRAG status of each action with a particular focus on those currently rated **Amber** or **Red**.



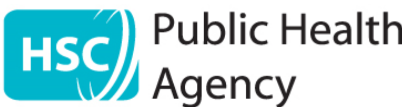
KPI	CP Priority	2025-26 Annual Business Plan Actions Summary	Target
PROTECTING HEALTH			
KPI 1	3,8	Universal indicator dashboard	Mar 26
KPI 2	6,12	Childhood vaccination schedule in line with JCVI advice.	Mar 26
KPI 3	1	Pandemic preparedness planning and national emergency planning testing.	Mar 26
KPI 4	5	Screening programmes digital needs - Option appraisal and business plan development.	Oct 25
KPI 5	5,32	Bowel screening age range business case and establish project structures.	May 25
STARTING WELL			
KPI 6	17	Work in collaboration to address the root causes of domestic abuse.	Mar 26
KPI 7	9, 11, 13, 15, 16, 17	Universal Child Health Promotion Programme Healthy Child Healthy Future	Jun 25
KPI 8	3, 5, 12, 14	Transfer of the NI Child Health system onto Encompass	Feb 26
KPI 9	1	Healthcare and therapeutic needs analysis of children with SEN's in special schools.	Mar 26
LIVING WELL			
KPI 10	21	PL2 Action Plan update and local Protect Life Implementation Groups	Dec 25
KPI 11a KPI 11b	18	Pharmacy based Stop Smoking Services across NI Trust based Stop Smoking services commissioned via PHA	Feb 26
KPI 12	19	Cancer Toolkit to facilitate cancer prehabilitation options	Mar 26
KPI 13	18,19,20	Physical activity referral scheme	Mar 26
KPI 14	18,19,24	Constipation campaign launch and establish a working group with the aim to co-produce a suite of resources / guidance.	Mar 26
AGEING WELL			
KPI 15	26	NI Regional Safer Mobility Model	Mar 26
KPI 16	27,31	Potential harms of deconditioning	Mar 26
KPI 17	27,31	Update and test MDT decision making pathway for care home residents to reduce unnecessary hospital admissions.	Dec 25
KPI 18	25	Evaluate the impact of the Age-Friendly Communities Initiatives across NI	Mar 26
OUR ORGANISATION AND PEOPLE			
KPI 19	O1	Develop a new HR Strategy 'Beyond the People Plan'	Nov 25
KPI 20	O3	Public Health Planning Teams operational and perf. Management frameworks	Nov 25
KPI 21	O3	PHA Procurement Plan	Jun 25
KPI 22	O3	Effectively manage the PHA financial position to achieve breakeven.	Mar 26
KPI 23	O2	Develop a Partnership Working Strategy and Action Plan	Feb 26
KPI 24	36	Finalise a framework to support Quality and Safety corporate processes for PHA	Aug 25
KPI 25	O1-O5	Conclude Agency Reshape & Refresh change management programme.	Dec 25
KPI 26	5	New PHA Corporate Website	Sep 25
KPI 27	35	Public Health Master Dataset development	Sep 25



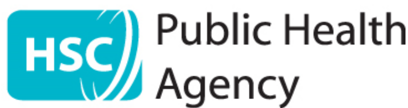
At the end of December 2025, 7 KPIs have been identified or partly identified with an Amber or Red BRAG status. Further details of these KPIs below.

A copy of the full Annual Business Plan can be found here:
PHA Annual Business Plan 2025_

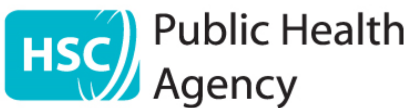
PROTECTING HEALTH									
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
1	Develop a public facing, universal indicator dashboard covering communicable diseases and related special health matters.								Joanne McClean Declan Bradley
	Dashboard launched	~~Dec 2025~~ Mar 2026	A project plan has been developed and commenced for this dashboard. Work includes scoping UK wide dashboards and identifying service priority areas across surveillance. Development includes setting up a structure and designing a dashboard using Shiny app on a public-facing Posit Connect server. Further phased development is in progress to use respiratory and genomics data initially. Progress has been delayed due to competing work priorities					Work to resume in Q4.	
	Review and further development	Mar 2026	This work has been paused due to competing work priorities.					Work to resume subject to staffing capacity.	
2	Implement Phase 1 and Phase 2 changes to the childhood vaccination schedule in line with JCVI advice.								Joanne McClean Louise Herron
	Phase 1	Jul 2025	The first phase of the changes to the childhood schedule was implemented on 1st July 2025. In preparation for the change, the team carried out a number of training sessions with primary care staff, public health nursing staff, community pharmacies and administrative staff. Associated changes have been made to the Child Health System to schedule appropriate						



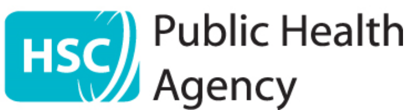
PROTECTING HEALTH						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			appointments. A patient information flyer has been developed to explain the changes in the interim prior to Phase 2 of implementation (where new appointment flyers will be created). NIDirect has been updated with relevant information. Associated PGDs for Phase 1 have also been reviewed and updated.			
	Phase 2	Jan 2026	Planning is underway for the second phase of changes (the introduction of a new 18-month appointment for MMR and hexavalent vaccine), with potential introduction of varicella component (policy decision awaited). Progress is being made with relation to the planning of training sessions with the clinical education centre. Conversations are underway with the Child Health System to implement the schedule change by January. A new 18-month appointment leaflet is in development for parents. The second phase of changes (introduction of new 18-month appointment for MMRV and hexavalent vaccine) was implemented on 1st January 2026. In preparation for the change Child Health System, updated training sessions were provided to clinical staff and updated information leaflets were developed and distributed for parents / carers.			



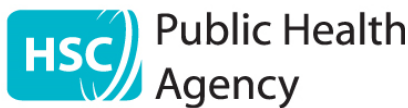
PROTECTING HEALTH						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
3	Pandemic preparedness planning					Joanne McClean Louise Herron
	Participation in the national emergency planning exercise	**Stage 1** Monday 15th- Wed 24th Sept; **Stage 2-** Monday 6th to Wed 15th Oct; **Stage 3-** Monday 27th to Wed 5th Nov	The PHA has confirmed their participation in Exercise Pegasus. This is a national exercise being delivered in three stages between September and early November 2026. The PHA are represented on the HSC Exercise Co-ordination Group (co-chaired by TEO and DoH) In addition, the PHA have convened a PHA planning group to prepare for participation in Exercise Pegasus. Following discussions with the DoH and SPPG on the 21st of May, it was agreed to resubmit an updated version of the PHA pandemic preparedness plans reflecting funding requirements and options appraisals as necessary.			
	Learning from exercise reflected in updated emergency plans	Mar 2026	Learning from exercise Pegasus will be incorporated into organisational pandemic preparedness plans. Following completion of the organisational debrief for exercise Pegasus, the PHA; SPPG; BSO Pandemic Preparedness Planning Group will be reconvened to take forward identified actions.			
4	Complete option appraisal and commence the development of a business plan that addresses the digital needs of all screening programmes.					Joanne McClean Gary Loughran
	Option appraisal	Aug 2025	Options appraised with NIDIS, encompass and the Screening Digital Modernisation Programme Board. The preferred option is to use encompass.			



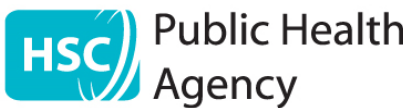
	KPI and Milestones	Date	Progress (100 Words max)	Q1-Q4	Mitigating Actions	Lead Director
PROTECTING HEALTH						
			A workshop was held to walk through options and encompass with PHA and Service screening leads which also endorsed the option. A formal request to inform capability, resources and planned timescales is being submitted to encompass which advise the Business Plan.			
	Business Plan	Oct 2025	The experience of CHS and encompass has varied the approach to developing screening programmes in encompass. Given the external developments by NIDIS and NHSE it is important to be fully assured end-to-end screening can work effectively in encompass. Resources have been secured by encompass to develop a Proof of Concept system for screening programmes. There will be a cost to PHA for this work, however, it is deemed essential to ensure the decision to forego NIDIS/NHSE developments and move to encompass is sound. The Business Plan is on track to be in place by the end of October and will reflect the changing circumstance of the Proof of Concept build. Should this prove successful then a plan to get to go live will follow.			



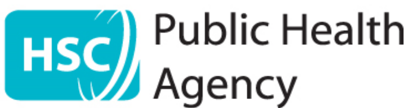
PROTECTING HEALTH									
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
5	Produce a business case for extension of the age range for bowel screening and establish project implementation structures.								Joanne McClean
	Project structures established	May 2025	Established June 2025						
	Business Case submitted	Jan 2026	Business case submitted to DOH Dec 2025						Cara Anderson



	KPI and Milestones	Date	Progress (100 Words max)	Q1	Q2	Q3	Q4	Mitigating Actions	Lead Director
STARTING WELL									
6	Address the root causes of domestic abuse.								Heather Reid Emily Roberts
	Recommendations from the Review of Routine Enquiry (RE)	Mar 2026	The recommendation is that the Regional HSC Routine Enquiry Policy is extended to other service groups. This action is complete.	Green	Green	Blue		The next stage in the process is for the DoH to approve the development of a Regional HSC Routine Enquiry Policy to extend to other service groups including; ED, Gynae, Radiology, mental health, breast/cervical screening services, Sexual Health, Abortion and Primary Care. Discussions have commenced with DOH and the steering group membership and TOR will be reviewed. This will be a new action for the 2026-27 ABP.	
	Final Model of Routine Enquiry for Midwifery and SCPHN	Dec 2026	The final draft of the Routine Enquiry Guidance document for midwifery and SCPHN has been approved and will be launched on March 9th to coincide with International Women's Day. A series of awareness raising webinars are currently in development in partnership with Women's Aid and will be delivered during February and March and the guidance will be implemented from April 1st. Education course content is currently being revised to reflect changes.	Green	Green	Green			



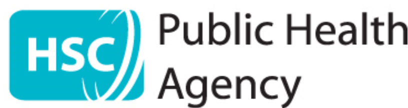
	KPI and Milestones	Date	Progress (100 Words max)	Q1-Q4	Mitigating Actions	Lead Director
STARTING WELL						
7	Universal Child Health Promotion Programme Healthy Child Healthy Future (HCHF) - strengthen reach and impact to enhance early intervention and developmental support from universal services and AHPs to meet the specific and developmental needs of children.					~~Heather Reid~~ Emily Roberts Deirdre Ward
	Refreshed HCHF Programme completed	Jun 2025	The programme has been reviewed and framework refreshed. Launch initially planned for May delayed until 25th Sept 25 to allow for the potential development of a business case. The HCHF Framework was formally launched on 25th September 2025. The DOH have advised there is no additional resource for implementation of framework and therefore no business case required.			
	Establishment of NI Implementation Group	Jun 2025	The Programme Implementation Board has not been stood up to date as a policy lead needs to be agreed		. PHA have requested that the additional /amended reviews within the refreshed HCHF are built in the Encompass system in preparation for the implementation of the refreshed programme.	
8	Drive and support the transfer of the NI Child Health system onto Encompass including supporting the build for the system with EPIC developers.					~~Heather Reid~~ Emily Roberts / Joanne McClean
	Establish project support and arrangements for escalation of issues	May 2025	Senior Project Manager (1WTE) in post from April. Project has been fully reviewed and restructured with significantly improved governance structures and escalation processes established.			



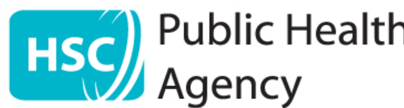
STARTING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Full availability of CHS functionality on Encompass and go live.	Feb 2026	Detailed review of project undertaken and detailed scoping document developed and shared with senior Encompass team. Although work has progressed there has been no firm commitment from Encompass or a timeframe on their capacity to meet the reporting functionality. Cogito, the reporting team within Epic will take this work forward. Following the Risk Summit at end September a proposal has been made to extend the go live date to August 2026 with the exception of preschool vaccination scheduling. Options Review held on 15th Dec – Presented with Aug 26 or Jan 27 as go live for full system functionality. No decision made on date. Agreement to work towards Aug 26 and take stock in March to see if this is achievable		Decisions being made to assist completion of build by end Feb 26. Escalation of risks / issues to Steering Group. Stocktake March 26 re go live date	Deirdre Ward / Gillian Weir
9	Analysis of the healthcare and therapeutic needs of children with Special Educational Needs (SEN) in Special Schools including capturing presenting co-morbidities and the level of complexities of need to help plan and support children's access to the education curriculum.					Heather Reid Geraldine Teague / Eilidh McGregor
	Nursing needs assessment	Jun 2025	Final report submitted to DoH August 2025. Awaiting implementation plan from DoH for work going forward into 2026/27.			

STARTING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Therapeutic needs assessment	Mar 2026	Working with relevant stakeholders, PHA leads have developed a scoping tool to capture relevant data in support of an assessment of therapeutic needs with an initial focus on CYP in Special Schools and Special Provision Schools. The tool is in initial stages of testing. Scope commenced on therapeutic needs commencing with CYP identified with nursing needs in special schools. Scoping tool has been implemented with the first phases of data being returned for analysis.			
	Develop updated pathways to support children with SEN	Mar 2026	Engagement with Epic/Encompass colleagues is ongoing to ensure guidance and templates for health care professionals supporting CYP with SEN in the initial stage of the EA Statutory Assessment process will be compatible with Encompass. A digital platform has been developed to house Regional Guidance for Healthcare Professionals supporting CYP with SEND. Discussions underway with Encompass to embed resources to enhance continuity of care and support the reporting of key population health data sets. PHA are working with EA to develop and			

STARTING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			implement an Early Alert process. This enables HSCTs to notify EA of CYP with SEN and Profound and Multiple Learning Difficulties prior to their -2 (nursery) school-year, current EA directive. This facilitates HSCTs to meet their statutory duties to support the identification, assessment and provision of services for CYP with SEN/D (Article 14 of the 1996 Order) Professional resource ready for dissemination across the region to HSCT SENCO services for appropriate distribution and use in-Trust. Professional templates currently included (five professional groups) at end stage of being available in Encompass.			

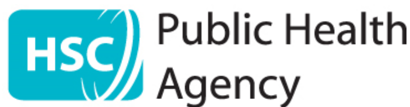


	KPI and Milestones	Date	Progress (100 Words max)	Q1-Q4				Mitigating Actions	Lead Director
LIVING WELL									
10	Review and update the Regional PL2 Action Plan and local Protect Life Implementation Groups (PLIGs) Action Plans to reflect updated PL2 Strategy priorities								Joanne McClean / Heather Reid Emily Roberts / Fiona Teague
	New regional PL2 action plan	Jun 2025	The new Protect Life Action and Implementation Plan have been approved by Minister and is due to be published on 1 July 2025. Launched 10th September	Blue	Blue	Blue	Blue		
	New PLIG Action Plans	Dec 2025	The new Local Protect Life Implementation Groups Action Plans are currently being developed through the 5 local partnerships. Action plans currently at development stage.	Green	Green	Amber		Work continues with the local PLIGs to update the action plans by March 26.	
	Review completed and if recommended update service specification with a plan to expand reach for the potential benefits of physical activity.	Mar 2026	On track to be completed.	Green	Green	Green			
11	Implement a review and revision of the service provision model of all Pharmacy based Stop Smoking Services across NI, considering refreshed NICE guidance and evidence base in re-commissioning of services. Implement a review of all Trust based Stop Smoking services commissioned via PHA, to ensure regionally consistent and comparable, measurable services are in place to meet population needs in each Trust.								Joanne McClean Colette Rogers
	Revised Pharmacy based Stop Smoking services rollout to begin across NI in partnership with SPPG	Feb 2026	A comprehensive quality assurance exercise is underway across all pharmacies in relation to the delivery and performance of existing Stop Smoking Services. Medicines Optimisation Innovation Centre (MOIC), has also been engaged to support an evaluation of current service with providers and service users. This review and evaluation	Green	Green	Green			

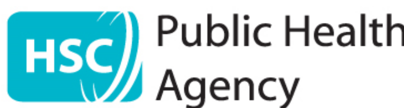


LIVING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			findings will inform the refreshed specification.			
	Review team established	May 2025	The Stop Smoking Services Review Team has been established. Membership will expand as required.			
	Development of a regional service specification	Feb 2026	Preliminary work underway including desktop reviews, workshops for provider input and engagement with Care Opinion. This is on track for February 2026 at present			
12	Develop a regional cancer toolkit as an option to facilitate cancer prehabilitation options.					Joanne McClean Lorna Nevin / Ceara Gallagher
	Establish in conjunction with NICaN and SPPG a proposed regional Model for Prehabilitation	Mar 2026	On target. NICaN Project Lead has lead Macmillan Northern Ireland Regional Cancer Prehabilitation Programme, a pioneering initiative designed to embed personalised, early-intervention support into cancer care pathways across all five trusts. The programme was delivered in partnership with 11 local councils and funded through the DoH's Cancer Charities Support Fund, part of a broader £10 million COVID-19 recovery initiative. The programme's overarching aim was to improve patient outcomes, reduce treatment-related complications and promote long-term health and wellbeing through multimodal prehabilitation—a proactive approach that includes physical activity, nutritional support and psychological care. Macmillan			

LIVING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			Evaluation has been completed. Summary paper regarding the components of a model for R Prehabilitation is being completed. Macmillan funded posts will be coming to the end of their temporary allocations during February and March 2026. Presentations have been made to Cancer Steering group to reflect contribution of model. Currently no recurrent funding allocation identified to sustain Trust programmes.			
	Establish opportunities to progress and embed targeted and universal prehabilitation through council, community and voluntary sector engagement	Mar 2026	On target. This collaborative model represents a significant step forward in transforming cancer care delivery in Northern Ireland, aligning with national health priorities and setting the foundation for sustainable, system-wide change. Integrating services across the health, leisure, and voluntary sectors. Engage with Health Improvement Team. Presentation to Cancer Programme Steering Group June 2025. Joanne McClean follow up meeting with CLOA pending. Information regarding the prehabilitation programme has been shared to inform PARS review.			



LIVING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
13	Undertake a review of PHA commissioned physical activity referral scheme (PARS) including consideration of expanding its role in helping people with serious illnesses manage their conditions, prehabilitation and rehabilitation					Joanne McClean Siobhan Donald
	Review completed and if recommended update service specification with a plan to expand reach for the potential benefits of physical activity.	Mar 2026	On track to be completed.			
14	Launch a constipation campaign, to include establishing an expert reference working group with the aim to co-produce a suite of resources / guidance to support people with learning disabilities, their families / carers and clinical staff to prevent, recognise and treat constipation across the lifespan.					~~Heather Reid~~ Emily Roberts Siobhan Rogan
	Identify specific needs and risk factors for prevalence of constipation in people with learning disabilities	Jun 2025	A high-level paper to consider specific needs and risk factors for prevalence of constipation in people with learning disabilities across the lifespan has been drafted for sign off. The paper has helped to establish how well services and systems are working across Northern Ireland to ensure people with learning disabilities get the right support to identify, manage and treat this preventable health condition. If constipation is not recognised and treated appropriately, it can have major adverse effects on an individual's health and wellbeing.			

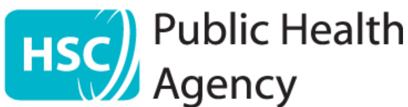


LIVING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Carry out a scope across the UK and Ireland to review the programmes of care in relation to constipation and people with learning disabilities.	Sept 2025	Scope has been undertaken across UK and Ireland providing a structure to make an informed decision on the best approach, avoid duplication and learn from practice.			
	Expert reference working group established.	Mar 2026	Scoping has been completed and consideration is now being given to progressing a Phase 1 of this campaign. Membership of the Expert Reference Group is currently under consideration. Upon confirmation, formal representation will be appointed to enable the group to commence work on Phase 1.			

AGEING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
15	Develop a NI Regional Safer Mobility Model and lead on the implementation, beginning with PHA commissioned services.					Heather Reid Sandra Aitcheson
	Creation of regional forum comprising of 6 trusts, and relevant stakeholders.	Sept 2025	A detailed project plan has been developed which outlines; governance structures, associated actions, timelines and stakeholders. New regional Safer Mobility SharePoint site developed. Model Design Task and Finish Group established and Regional Steering Group being established.	Green, Green, Blue		
	Scope SPPG commissioned services in relation to falls and working with the SPPG Joint commissioning team, agree NI Safer Mobility model.	Sept 2025	Comms have started to gather this data through Roisin Doyle in SPPG with coverage over the various areas that impact Safer Mobility. Key elements and deliverables of the NI Safer Mobility Model are in the process of being agreed with key stakeholders and SPPG.	Green, Green, Blue		
	Creation of implementation plan and evaluation framework.	Dec 2025	Implementation Plan developed. Service Users identified. Monitoring and evaluation framework progressing.	Green, Green, Amber	Evaluation framework being progressed. This work is dependent on understanding what data is available to inform indicators and Health Intelligence's capacity to provide this detail– hope to complete by end of March 2026. This is progressing more efficiently following meetings with Health Intelligence and Corporate Services to help expedite this work.	
	Begin implementation of Safer Mobility Model.	Mar 2026	Dependent on the above	Green, Green, Green		

AGEING WELL

	KPI and Milestones	Date	Progress (100 Words max)	Q1	Q2	Q3	Q4	Mitigating Actions	Lead Director
16	Adopt a regional approach to addressing the potential harms of deconditioning which older people may experience during an episode of care in hospital.								Heather Reid Sandra Aitcheson
	Agreement on key messages for older adults and their carers to improve awareness about the risk of deconditioning.	Mar 2026	Action complete	Green	Blue	Blue	Blue		
	The development of regionally agreed standards with associated KPIs for the identification of people at risk, prevention and management of deconditioning.	Mar 2026	The Frailty Care Bundle (FCB) agreed Sept 2025 incorporates the agreed Regional Standards which have associated KPI's. The standards cover the following 3 areas: Nutrition, Cognition& Mobility. Work to embed and standardise the use of the Clinical Frailty Score (CFS) for the identification of those at risk of Frailty, and subsequently deconditioning, over the age of 65 has been fully endorsed and implemented across HSC through the Big Discussion under the leadership of the PHA. Use of the CFS (Score > 5/6) across acute pathways will be the trigger to commence the use of the FCB. Local Implementation plans have been developed to pilot the FCB. Data subgroup being established to develop a regional Frailty Dashboard	Green	Green	Green			



AGEING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			which will support baselines and KPI development.			
17	Update and test MDT decision making pathway for care home residents to reduce unnecessary admission to hospital.					Heather Reid Sandra Aitcheson
	Analysis of regional NIAS and ED data to provide clarity on scale of problem and provide recommendations for improved access to data	Jun 2025	Analysis of Regional NIAS data in relation to ED attendance for care home residents complete. Work ongoing across Care Home sector, in partnership with Trusts and through Big Discussion to complete more detailed analysis of position in order to clarify scale of problem. Access to Data held by Trusts: MOU (SAPPHIRE Data Set) in place and awaiting Trust sign off. Awaiting Trust sign off of MOU, this is being actively pursued with Trusts.		New approach being co-ordinated under the Big Discussion workstream that has been established.	
	Working with staff and stakeholders to identify barriers and solutions for improvements	Aug 2025	SHSCT Project team have identified issues with escalation processes within Care Homes for residents requiring clinical support. Identified limited staff awareness of alternatives pathways to referral to NIAS e.g. District Nursing, Marie Curie. Work was delayed due to time required to get DPIA in place but is back on target now.			

	KPI and Milestones	Date	Progress (100 Words max)	Q1	Q2	Q3	Q4	Mitigating Actions	Lead Director
AGEING WELL									
	Test new decision-making pathway in SHSCT to refine approach	Sept – Dec 2025	The learning from this work was used to host an information session for all care homes in SHSCT in December 2025 re management of an unwell resident and the options/ services available. There is also a similar deep dive being conducted in a second home n SHSCT to assess if there are themes or threads across homes in Trust locality. Monitoring of impact ongoing	Green	Green	Green			
	Present findings and recommendations to relevant commissioning teams and PTEB	Feb 2026	Dependent on above	Green	Green	Green			
18	Evaluate the impact of the Age-Friendly Communities Initiative across NI (currently funded in each Local Council by PHA).								Heather Reid Diane McIntyre
	Evaluation report produced and analysed	Mar 2026	Final report due Jan 2026 New Age Friendly Business Plan being developed – supported by the evaluation.	Green	Green	Green			

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
19	Develop a new HR Strategy 'Beyond the People Plan'					Leah Scott / Karyn Patterson
	New HR Strategy agreed	Jan 2026	A workshop was held in April 2025 to inform this strategy document. During August 2025 an outline blueprint was presented to AMT and also to the Senior Leaders Forum. Following refinement in line with the principles of co-design staff engagement was planned and communicated during September with Town hall sessions held during October and Team / Individual engagement approaches also opened for input. Using the feedback received the full strategy document was developed and issued for consultation in Quarter 3 with consultation due to complete on Friday 23 January 2026 This remains on target	Green / Green / Green		
20	New Operational Framework for Public Health Planning Teams and performance management framework, aligned to the new PHA operational model, to be developed and approved by PHA board.					Leah Scott Stephen Murray
	PHPT Framework agreed	Jun 2025	Draft PHPT Governance and Accountability Framework document has been developed and reviewed by the Senior Leadership Forum. Finalisation of the framework has been delayed as there are on-going discussions to clarify accountability and reporting arrangements for PHA staff that have Chairing	Red / Red / Red	Workshop planned for Feb to discuss PHA accountability and reporting arrangements between PHPTs and JPPTs. Finalised Framework document will be submitted for approval to Board in March 2026.	

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			responsibilities for both PHPT's and JPPT's	Red, Red, Red		
	Performance Framework approved	Nov 2025	A draft performance framework has been developed and will be reviewed by PHPT Chairs and Senior Leadership Forum. Finalisation of the Performance Framework is linked to the finalisation of the PHPT Operational framework noted above.	Green, Green, Red	Performance management framework will be finalised and submitted for approval to PHA Board in March 2026.	
21	PHA Procurement Plan to be reviewed and updated and Procurement Plan priorities 2025/6 to be progressed in line with agreed timelines					All Directors (as per Leads for individual tenders)
	Organisational Procurement Plan setting out timelines for market testing all existing roll forward contracts	Jun 2025	A plan for completion of market testing of all existing roll forward contracts was submitted to PPR Committee in May 2025.	Green, Blue, Blue, Blue		
	Procurement Plan 2025/6 delivered in line with agreed timelines.	March 2026	Tenders planned for issue to the market in 2025/26 are progressing. However there has been a slight delay in getting tenders out to the market due to a regional review of T&Cs having to be undertaken by DLS to ensure they align with the new Legislation and Public Procurement Policy.	Green, Amber, Amber	As of 23 December 2025, DLS confirmed they will provide further advice on the revised T&Cs by mid-January 2026. This will impact the publication timelines for Postvention, PPSU and YT, and subsequently the T3 tenders.	
22	Effectively manage the PHA financial position to achieve a breakeven position at year-end.					Leah Scott
	The PHA will achieve a surplus position within the 0.25% tolerance level set by DoH on an annual basis.	Mar 2026	Based on the indicative opening allocation, the 25/26 financial plan was approved by the board. The plan takes account of the agencies saving targets & in year pressures and is	Green, Green, Green		

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			projecting breaking even at 31 March 2026. The DoH have however noted a significant funding gap across the HSC and while the funding gap has been reduced there remain significant challenges to DoH budget. The DoH have now confirmed one third allocation towards the cost of the AFC 2526 pay award. HSC organisations are awaiting formal direction regarding the treatment of the remaining balance (circa £1.1M for PHA) in the year end accounts. Based on our current allocation the PHA continue to forecast a break-even position for 25/26 excluding the AFC shortfall.			
23	Develop a Partnership Working Strategy and Action Plan, addressing PHA HSC wide Leadership responsibilities for PCE & PPI and which embeds these approaches into PHA culture & practice.					
	Draft Strategy and Indicative Action Plan	Jun 2025	AMT has approved and indictive action plan completed Action Plan to be finalised and published following public consultation (ended in Dec 2025). The action plan needs to reflect the comments from consultation			~~Heather Reid~~ Emily Roberts

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Public Consultation on Strategy Consultation on strategy only	Oct 2025	The AMT approved P&E strategy was out for public consultation until 19th December.			Martin Quinn
	Strategy Review & Finalisation	Dec 2025	Plans are underway in preparation for the review of the strategy consultation. Consultation period complete with learning to be summarised in Consultation report in advance of launch			
	Strategy, Launch & Implementation	Feb 2026	Plans are underway for the launch of the strategy.			
24	Finalise a framework to support Quality and Safety corporate processes for PHA.					~~Heather Reid~~ Emily Roberts/ Denise Boulter/ Grainne Cushley
	Framework will be finalised for AMT and Board	Aug 2025	A joint PHA/SPPG Quality and Safety framework is under development.		The framework to be submitted at December's Joint Assurance Group. This will incorporate the PHA plan. The framework is still under development given changes in SPPG this will be discussed with new lead Director for S&Q. a presentation to AMT re partnership working in S&Q was approved and a new operational structure diagram approved which will be the basis for the framework.	
25	Conclude Agency Reshape and Refresh change management programme.					Aidan Dawson (CEO) Grainne Cushley
	Reshape and refresh outcome measures delivered in line with Project plan timescales.	Dec 2025	A Reshape Refresh Closure Report was presented to the PHA Board in November 2025.			

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			This report will be shared with the Department and will be discussed at the Accountability Review meeting. An evaluation exercise based on the programme is being taken forward during Q4.			
26	Develop a new PHA Corporate Website providing greater functionality for engagement with target audiences.					Stephen Wilson
	Corporate website redevelopment project team in place	May 2025	Initial project work undertaken by Communications Mgt team. Project PID approved by AMT in June and revised project team being established. Discovery exercise commissioned and will report into Project Team.			
	Project plan agreed	Sept 2025	Draft project plan developed by Communications Mgt team. This will be further developed based on the Discovery exercise and input from wider project team. Discovery exercise includes: • PHA corporate site audit • UX baseline report • Competitive analysis report • Research methodology report • Google Search Console report • Public facing survey on PHA corporate site live • User behaviour survey		Initial Project plan drafted and a more comprehensive Discovery exercise agreed and commissioned with a resultant knock on impact on original timeline. Timeline revised and Project plan will still be developed for sign off by end of March 2026 in line with ABP commitment	

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			Internal and External stakeholders' workshops conducted and summary reports produced.			
27	Further develop the Public Health Master Dataset.					Paul McWilliams
	Dataset established, integrated with PHA systems, usage in analytics	Sept 2025	Access to PHMDS was opened to HSCNI network users in June 2025. This will enable wider reach for PHMDS and ensure HSC partners can make use of it. The most significant development has been the addition of geographic area-level profiles for District Electoral Areas and Trusts; Trust profiles are designed to support AIPBs. In addition, the Social Determinants of health section has been expanded. All changes have been co-developed with Health Intelligence.			

item 9

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	26 February 2026
Title of paper	NI Breast Screening Programme Annual Reports: 2018-21, 2021-23 and 2023-24 NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Reports: 2019-23 and 2023-24
Reference	PHA/05/02/26
Prepared by	Screening Team
Lead Director	Dr Joanne McClean

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to bring the annual reports on the Breast Screening and Abdominal Aortic Aneurysm (AAA) Screening Programme to the PHA Board for noting.

2 Key Issues

Breast Screening Programme

The Northern Ireland Breast Screening Programme aims to reduce the morbidity and mortality from breast cancer by identifying disease at an early stage when treatment is likely to be more successful.

These three reports provide an overview of the performance of the NI Breast Screening Programme between 2018-2024. The production of annual reports was paused during the COVID pandemic as the service focused on the critical delivery of the service during the recovery phase. Combined reports have been prepared to address this backlog in reporting.

The annual reports set out the performance of the programme against national standards. A summary of key statistics is provided at the beginning of each document for convenience.

Abdominal Aortic Aneurysm Screening Programme

The Northern Ireland Abdominal Aortic Aneurysm Screening Programme is offered to men aged 65 and aims to identify and offer treatment to those with an enlarged aneurysm to reduce deaths from rupture.

These two reports provide an overview of the performance of the NI Abdominal Aortic Aneurysm Screening Programme between 2019-2024. The production of annual reports was paused during the COVID pandemic as the service focused on the critical delivery of the service during the recovery phase. A combined report has been prepared to address this backlog in reporting.

The annual reports set out the performance of the programme against national standards. A summary and highlights during the reporting period is provided at the beginning of each document for convenience.

3 Next Steps

Following presentation to the PHA Board these reports will be published on the PHA website.

Breast Screening Programme

Consolidated Annual Report
2018-2021

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1. Introduction

The Public Health Agency (PHA) monitors and quality assures the Northern Ireland Breast Screening Programme (NI BSP) to ensure that women in Northern Ireland have access to a high-quality breast screening service that meets national standards. This consolidated annual report describes the performance of the NI BSP during the three-year period between 2018 and 2021, including the impact of the COVID-19 pandemic on the delivery of breast screening in Northern Ireland.

The statistics presented within this report cover activity in the NI BSP between 1st April 2018 and 31st March 2021, including invitations for breast screening, breast screening uptake, the breast screening pathway, outcomes of breast screening and the number and type of breast cancers detected. Local performance against each key indicator outlined in the NHS Breast Screening Programme Standards has been assessed to determine whether an appropriate level of performance which aligns with national standards has been achieved.[1] Data are presented for each of the four Breast Screening Units (BSUs) in Northern Ireland, in addition to data describing overall regional performance.

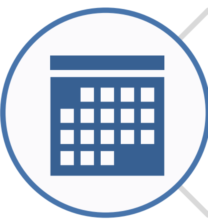
Given that this is a consolidated annual report spanning the time-period between 2018 and 2021, statistics have been calculated to describe performance during each individual year, as well as average performance throughout the time-period. The majority of statistics have been derived from data submitted by each BSU in the form of Korner returns using data from the National Breast Screening System (NBSS), the IT system supporting the NI BSP. This information is routinely collected by the NI BSP for operational purposes, including quality assurance. Data on the number and subtype of screen-detected breast cancers in Northern Ireland between 2018 and 2021 have been obtained from national NHS Breast Screening Programme and Association of Breast Surgery (NHS BSP ABS) audit data.[2]

A summary of key statistics in the NI BSP is included on Page 4. Page 6 includes a table showing performance of each Breast Screening Unit and Northern Ireland as a whole against the standards discussed in this report.

Summary of Key Statistics in the Northern Ireland Breast Screening Programme 2018-2021

Uptake

234,434 women aged between 50 and 70 years were invited for breast screening; 176,031 attended for screening, giving an average annual uptake rate of 75.1%.



Invitation

71.0% of women were offered an appointment for mammography screening that was within 36 months of their previous normal screen.*

Results

99.7% of women, who had a normal test result, received their results within two weeks of their screening appointment.

Assessment

99.2% of women who required further tests were offered an appointment within three weeks of their screening mammogram.

Cancer Detection

1527 breast cancers were detected through screening; 1,245 (81.5%) of these were invasive cancers, 7 (0.5%) were micro-invasive and 275 (18.0%) were non-invasive.

Treatment of Invasive Cancer

Of the 1,245 women diagnosed with screen-detected invasive cancer, 994 (79.8%) had breast conserving surgery, 226 (18.1%) had a mastectomy and 25 (2.0%) had no surgery.

*The NI BSP paused for a period of four months during 2020 due to the impact of the COVID-19 pandemic. This pause has affected the number of women reported as having been offered a mammography screening appointment within 36 months of their previous normal screen during 2018-2020. Figures for this indicator during each individual year of this time period are as follows: 96.4% during 2018-2019, 99.3% during 2019-2020 and 12.3% during 2020-2021.

Performance against key standards, 2018/19 – 2020/21

Table 1 outlines performance of the NI BSP against key standards in the year 2023/24, providing data at regional level and by BSU.

The data in this table are colour coded green if the achievable standard is met, amber if the acceptable standard is met and red if the acceptable standard is not met. A definition of the acceptable and achievable performance thresholds is included in section 6.2.2.

Table 1: Performance of NI BSUs against key standards, 2018/19 – 2020/21

STANDARD	Region			Eastern			Northern			Southern			Western			National Standards
	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	
Uptake Rate (%)	76.9	76.0	72.2	74.1	74.4	68.6	80.4	76.8	75.8	77.4	76.4	74.1	78.5	78.1	73.1	Acceptable > 70% Achievable > 80%
Screening Round Length (%)	96.4	99.3	12.3	92.8	99.6	7.7	97.3	98.9	12.9	99.7	99.9	5.7	98.5	98.7	24.9	Acceptable > 90.0% Achievable 100.0%
Technical Recall / Repeat Rate (%)	2.7	2.4	2.9	2.5	2.8	2.9	2.8	2.2	2.7	2.5	2.2	3.2	2.8	1.9	2.9	Acceptable < 3.0 % Achievable < 2.0 %
Screen to Routine Recall (%)	99.7	99.6	99.9	99.8	99.8	99.8	99.9	98.9	99.9	100.0	100.0	100.0	99.3	99.3	100.0	Acceptable > 95% Achievable 100 %
Referred to Assessment (%)																
Prevalent Screen	6.5	5.7	4.9	6.5	5.7	4.9	5.6	4.1	4.1	8.1	8.0	7.2	3.6	4.6	4.3	Acceptable < 10% Achievable < 7%

STANDARD	Region			Eastern			Northern			Southern			Western			National Standards
	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	
Incident Screen	2.5	2.5	2.3	2.0	2.1	1.7	2.2	1.9	1.9	4.0	4.0	3.9	2.4	2.7	2.0	Acceptable < 7% Achievable < 5%
Screen to Assessment (Date of First Offered Appt.)	99.0	99.2	99.4	98.5	98.0	98.2	98.2	100.0	100.0	99.9	100.0	100.0	99.1	99.7	99.7	Acceptable > 98.0% Achievable 100%
Short term recall rate (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	Acceptable < 0.25% Achievable < 0.12%
Non Operative Diagnosis Rate																
Invasive	100.0	98.7	99.7	100.0	99.3	99.2	100.0	95.2	100.0	100.0	100.0	100.0	100.0	100.0	100.0	Acceptable >95%
Non-Invasive	92.2	96.4	94.9	100.0	96.8	92.6	90.0	95.8	80.0	93.3	100.0	100.0	84.6	94.4	100.0	Acceptable > 95.0%
Non -Invasive Cancer Detection Rate per 1000																
Prevalent	2.5	1.6	2.0	2.1	0.3	1.7	3.8	2.5	0.5	1.3	2.2	1.6	3.1	2.3	**4.7**	Acceptable > 0.5/1000

STANDARD	Region			Eastern			Northern			Southern			Western			National Standards
	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	
Incident	1.1	1.3	1.3	0.9	1.5	1.1	1.7	1.4	0.9	0.8	0.9	1.7	1.5	1.2	**1.6**	Acceptable > 0.6/1000
Standardised Detection Rate (Invasive Cancer)																
Prevalent	1.3	1.2	1.7	1.4	1.1	1.2	1.5	1.1	1.5	1.2	1.4	2.7	1.0	1.3	2.0	Acceptable ≥1.0 Achievable ≥1.4
Incident	1.4	1.6	1.5	1.2	1.5	1.4	1.3	1.5	1.3	1.5	1.9	2.0	1.7	1.7	1.4	Acceptable ≥1.0 Achievable ≥1.4
Standardised Detection Rate (Small Invasive Cancer, Prevalent and Incident screens)	1.3	1.4	1.4	1.1	1.3	1.1	1.3	1.1	1.5	1.5	2.1	2.2	1.4	1.5	1.2	Acceptable ≥1.0 Achievable ≥1.4
Benign Biopsy Rate																

STANDARD	Region			Eastern			Northern			Southern			Western			National Standards
	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	2018 - 19	2019 - 20	2020 - 21	
Prevalent	1.0	0.7	0.3	Due to small numbers, data are not presented at unit level												Acceptable < 1.5/1000 Achievable < 1.0/1000
Incident	0.3	0.3	0.2	Due to small numbers, data are not presented at unit level												Acceptable < 1.0/1000 Achievable < 0.75/1000

2. Background

2.1 The Northern Ireland Breast Screening Programme

The NI BSP invites women between the ages of 50 and 70 to attend for regular breast screening every three years. The main aim of breast screening is to detect breast cancer at an early stage, when treatment is more likely to reduce the risk of death from the disease.

2.2 Benefits and Harms of Breast Screening

As with all screening programmes, breast screening results in both benefits and harms.[3] The main benefit is a reduction in breast cancer mortality. An independent review of the evidence on the benefits and harm of breast screening found a 20% reduced risk of death from breast cancer among women screened, compared to those not screened.[3] This equates to one breast cancer death prevented for every 235 women invited for screening, one breast cancer death prevented for every 180 women who attend screening and around 1300 breast cancer deaths prevented every year in the UK.[3]

The main harm of breast screening is overdiagnosis, which refers to the detection of low-risk or non-progressing breast cancers through screening that would not have been diagnosed without screening and would not have become life threatening.[3] For every breast cancer death prevented by screening in the UK, three women are diagnosed with and treated for a cancer that would never have been found without screening and would never have become life threatening.[3] Other harms include the need for unnecessary invasive investigations, as well the psychological distress and anxiety, which can arise from false positive screening results.[3] False negative results due to missed cancer detection or incorrect diagnoses can also provide unwarranted reassurance, potentially affecting a woman's perception of her risk of breast cancer and resulting in delayed presentation following the development of symptoms.[3,4]

3. Programme Overview

3.1 Eligibility

In Northern Ireland, eligible women aged between 50 and 70 are invited to attend for breast screening, by GP practice, every three years. Due to this three-yearly round of invites, about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53rd birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Everyone receives a total of seven invitations. Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every three years by phoning their local screening unit and requesting an appointment.

Women who have been identified as being at significantly increased risk of breast cancer (≥ 8 times the average risk) are invited to participate in more regular surveillance screening at an earlier age by the Very High-Risk (VHR) BSP, which commenced in 2013.

3.2 Screening Pathway

3.2.1 Invitation

- Invitations to attend for routine breast screening are sent to eligible women every three years based on their GP practice, along with information on breast screening, which describes the screening test and pathway involved.

- Approximately one third of the population eligible for breast cancer screening in Northern Ireland are invited to attend for screening every year.
- Each of the four Breast Screening Unit (BSUs) cover screening populations of varying sizes, with the number screened in each unit fluctuating on an annual basis, depending on the area being screened within the three-year round length.

3.2.2 Screening

- Women who accept the offer of screening attend their local BSU and undergo mammography, an imaging technique which involves low-dose radiation exposure to the breast tissue.
- The first time a woman enters the eligible age-range and attends for screening is referred to as a prevalent screen. The second and subsequent times a woman attends for screening are referred to as incident screens.
- Women should receive the results of the mammogram within two to three weeks of the screening appointment.
- A small number of women may be sent another screening appointment if their mammograms need to be repeated, for example, if the image was inadequate for diagnostic reporting.

3.2.3 Assessment

- If a potential abnormality is detected at initial screening, a woman may be asked to attend an assessment clinic for further investigations, including clinical examination, additional imaging or biopsy. A woman who receives a normal/benign result as the outcome of the assessment clinic should be returned to the routine screening programme for a further screen in three years.

3.2.4 Diagnosis

- If breast cancer is diagnosed, a woman should be referred for urgent treatment.
- If a definitive diagnosis cannot be made following the assessment process, a woman may be recalled for a further assessment at an interval shorter than the normal screening interval of three years.

3.3 Delivery

There are four BSUs in Northern Ireland; Eastern, Northern, Southern and Western. Table 2 outlines the locations and contact details of the headquarters of each unit.

Table 2: Breast Screening Units in Northern Ireland

Unit	Location	Contact Number
Eastern	12-22 Linenhall Street, Belfast	028 9033 3700
Northern	Antrim Area Hospital	028 9442 4425
Southern	Craigavon Area Hospital	028 3756 0820
Western	Altnagelvin Area Hospital	028 7161 1443

The Eastern Unit caters for the Belfast and South Eastern HSCT areas, while the Northern Unit covers most of the Northern HSCT, as well as providing surveillance screening for women at very high risk of breast cancer. The Southern Unit is responsible for delivering breast screening services in the Southern HSCT, while the Western Unit covers all of the Western HSCT areas and part of the Northern HSCT. The BSU in Linenhall Street provides mammography screening for women in the Belfast HSCT area. In other HSCT areas, most screening mammograms are carried out on mobile breast screening trailers, which rotate between a variety of locations across Northern Ireland.

4. Quality Assurance

Quality assurance (QA) is a fundamental part of all screening programmes. The aim of QA in the NI BSP is to maintain acceptable standards and continuously improve the performance of all aspects of breast screening in order to ensure that women have access to a high-quality service wherever they reside in Northern Ireland. QA helps to ensure that the benefits of breast screening outweigh the potential harms. It is a continuous process that is carried out externally by the PHA Breast Screening Team and internally by the BSUs and HSCTs.

4.1 Core QA Activities of the PHA

The core QA activities of the PHA Breast Screening Team include:

- Monitoring and review of programme management and delivery;
- Monitoring performance against agreed standards;
- Organising a rolling programme of formal QA Visits to BSUs;
- Review and monitoring of HSCT action plans to implement recommendations arising from QA visits;
- Adverse incident review and advice;
- Providing support and advice to HSCTs and BSUs.

4.2 QA Leads

The QA function is underpinned by an organised structure of public health and professional leads, supported by programme managers, information and administrative staff. There are seven QA Professional Leads in the NI BSP, covering each discipline involved in delivering the service. These include: radiology, radiography, surgery, pathology, breast care nursing, administrative and clerical and medical physics. QA Professional Leads assist with the coordination of QA activities for the NI BSP and provide professional advice to the PHA Breast Screening Team on issues relevant to the commissioning of the screening programme within their area of expertise. Each QA Professional Lead chairs a QA subgroup for their speciality. These groups play an important part in the QA Advisory Structure and work together to ensure that safe and effective breast

screening continues to be available to the eligible population. This includes working to ensure relevant national and local standards are met and that appropriate continuous quality improvement processes are in place.

4.3 QA Visits

A key component of the NI BSP QA Programme is the cycle of QA visits to each of the four BSUs in rotation. The process for these visits is based on national and local guidance

During the time-period covered by this report, public health measures implemented to control the COVID-19 pandemic impacted on the ability of the PHA Breast Screening Team to carry out in-person QA visits. To enable continuation of the QA visit cycle, in-person visits were replaced with alternative remote options, including desk-top reviews and virtual stakeholder meetings. In-person QA visits have now resumed.

5. The Impact of COVID-19

Along with the majority of routine healthcare services, breast screening in Northern Ireland was paused on the 24th March 2020, due to the emergence of the COVID-19 pandemic. The programme restarted on the 20th July 2020, the intervening period constituting a four-month interruption to the delivery of breast screening in Northern Ireland. Screening for women over 70 recommenced in September 2020. The VHR BSP continued without interruption throughout the COVID-19 pandemic. In addition to the temporary cessation of service delivery, the capacity of BSUs to perform routine breast screening during the time-period covered by this report has also been impacted by staff absences due to sickness or isolation, as well as social distancing requirements and enhanced infection control measures implemented to reduce transmission of COVID-19.

Breast screening round length is the interval between each offered invitation for screening mammography and is an important indicator of the efficiency with which a screening programme is managed. The pause in the delivery of routine breast screening in Northern Ireland resulted in an extension of the round length beyond the recommended 36 months in all BSUs, to a maximum of 40 months in October 2020. Given the importance of the breast screening round length in ensuring the long-term effectiveness of the programme, as well as the potential impact of delays in screening on individual patient outcomes, intensive efforts to recover the round length as quickly as possible were implemented by all BSUs, in collaboration with the PHA Breast Screening Team.

6. Programme Performance

This section of the report presents statistics to describe the performance of the NI BSP during 2018-2021, which have been collated and evaluated using the approach outlined below.

6.1 Programme Standards

The NI BSP uses the NHS Breast Screening Programme Standards, for the purposes of quality assurance and programme monitoring.[1] Local performance during 2018-2021 has been assessed against the programme standards valid for data collected between 1st April 2017 and 31st March 2021. These standards have since been updated for data collected from 1st April 2021 onwards.

6.2 Monitoring Performance

6.2.1 Data Returns

The PHA Breast Screening Team monitor the performance of each of the four BSUs and the NI BSP against national standards using data submitted through Körner returns:

KC62 – This is an annual return made by HSCTs on: outcome of initial screen, outcome of further assessment, cancers diagnosed (by size and type) and overall output and outcome measures. KC62 data are obtained from the National Breast Screening System (NBSS), the IT system that supports the NI BSP.

KC63 – This is an annual return made by HSCTs on: numbers of eligible women, invited and screened by age, numbers recalled, numbers self or GP referred, and time since most recent screen in 12-month blocks.

6.2.2 Performance Thresholds

Two performance thresholds are specified within the national standards; acceptable and achievable.

Acceptable Standards: This is the lowest level of performance which services are expected to attain in order to ensure patient safety and service effectiveness. Programmes not meeting the acceptable threshold are expected to implement recovery plans to ensure rapid and sustained improvement.

Achievable Standards: This represents the level at which the services are likely to be running optimally. Screening services should aspire to attain and maintain performance at this level.

This report provides information on both the individual performance of the four BSUs and the overall NI BSP. Information on the performance of individual staff is not provided.

6.2.3 Performance Indicators

Performance indicators have been reported according to the corresponding stage of the screening pathway; uptake, test, referral and diagnosis. Table 3 outlines the various indicators used in assessing performance of the NI BSP during 2018-2021.*

Table 3: Indicators Reported in Assessing Programme Performance

Stage	Indicator
Uptake	Screening Uptake
	Screening Round Length
Test	Technical Recall/Repeat
	Screen to Routine Recall
Referral	Referred for Assessment (Prevalent)
	Referred for Assessment (Incident)
	Screen to Assessment (First Offered Appointment)
Diagnosis	Number of Cancers Detected
	Early Recall
	Non-Operative Diagnosis (Invasive)
	Non-Operative Diagnosis (Non-Invasive)
	Non-Invasive Cancer Detection (Prevalent)
	Non-Invasive Cancer Detection (Incident)
	Standardised Detection Rate Invasive Cancer (Prevalent)
	Standardised Detection Rate Invasive Cancer (Incident)
	Standardised Detection Rate Small Invasive Cancer (Prevalent and Incident)
	Benign Biopsy (Prevalent)
	Benign Biopsy (Incident)

* Indicators are reported to either one or two decimal places, to align with performance thresholds specified for each standard. Figures for average performance over the three-year period are calculated based on cumulative numbers, rather than averages of the rounded individual year performances. In some instances, these figures may therefore differ slightly to those that would be obtained by averaging the figures displayed for the individual years. Percentages may not always total 100 due to rounding. Numbers less than five are reported as <5.

6.3 Uptake

6.3.1 Screening Uptake

Screening Uptake is the proportion of women who attend for breast screening each year, following an invitation.

- Acceptable standard: ≥ 70.0% of women invited accept the offer of breast screening.
- Achievable standard: ≥ 80.0% of women invited accept the offer of breast screening.

During 2018-2021, 75.1% of women invited (176,031 of 234,034) took up the offer to attend for breast screening in Northern Ireland.

On average, during the three-year period between 2018 and 2021, 75.1% of women invited for breast screening took up the offer to attend. Table 4 outlines the number of women who were invited and the number who attended for breast screening, as well as associated uptake figures, for each individual year and the overall three-year period. During the three-year period between 2018 and 2021, 234,434 women aged between 50 and 70 were invited for breast screening in Northern Ireland, of whom 176,031 attended.

Table 4: Breast Screening Uptake (%) in the NI BSP 2018-2021

	2018-2019	2019-2020	2020-2021	2018-2021
Invited	80,989	78,181	75,264	234,434
Attended	62,275	59,428	54,328	176,031
Uptake (%)	76.9	76.0	72.2	75.1

The acceptable level of uptake was maintained throughout the three-year period between 2018 and 2021. Table 5 shows uptake figures for each individual BSU and Northern Ireland overall during 2018 to 2021, as well as comparative figures for England to enable benchmarking of performance.[5,6]

Table 5: Breast Screening Uptake (%) by Breast Screening Unit 2018-2021				
	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	74.1	74.4	68.6	72.5
Northern	80.4	76.8	75.8	77.5
Southern	77.4	76.4	74.1	76.1
Western	78.5	78.1	73.1	76.6
Northern Ireland	76.9	76.0	72.2	75.1
England	71.1	69.1	61.8	67.3

The Eastern Unit fell marginally below the acceptable level of uptake during 2020-2021, achieving 68.6% uptake, although maintained an overall average uptake of 72.5% over the three-year period. All other BSUs maintained uptake levels above the acceptable level during each of the three years. Breast screening uptake in Northern Ireland has remained consistently above uptake levels in England. Figure 1 shows trends in breast screening uptake per BSU and Northern Ireland overall between 2015 and 2021.

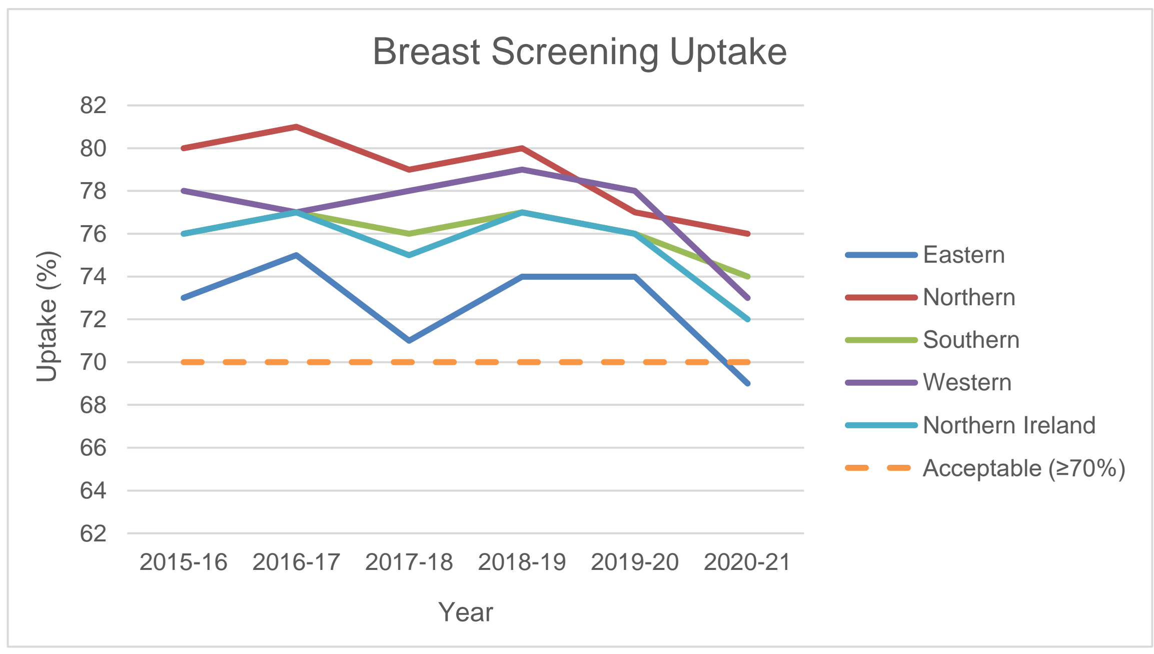


Figure 1: Breast Screening Uptake in Northern Ireland between 2015 and 2021

6.3.2 Screening Round Length

Screening Round Length is the interval between each offered invitation for screening mammography.

- Acceptable standard: ≥ 90.0% of women should be offered an appointment that is within 36 months of their previous screen.
- Achievable standard: ≥ 99.0% of women should be offered an appointment that is within 36 months of their previous screen.

On average during 2018-2021, 71.0% of women were offered an appointment that was within 36 months of their previous screen.

Measurement of the screening round length provides assurance that women with a previous invitation for screening have a subsequent invitation in a timescale that maximises the chance of cancer detection, whilst minimising harm to the woman. It also provides an indicator of the efficiency with which the screening programme is managed. The long-term effectiveness of the programme is dependent on women within the target age-group continuing to be screened at regular intervals.

On average during 2018 to 2021, only 71.0% of women were offered a screening appointment that was within 36 months of their previous screen. This falls below the acceptable standard of ≥90%, being largely attributable to the pause in the delivery of breast screening that occurred as a result of the COVID-19 pandemic. Table 6 outlines the proportion of women offered a screening appointment that was within 36 months of their previous screen for each BSU and Northern Ireland overall by year.

Table 6: Percentage of Women with a First Offered Appointment Within 36 Months of Their Previous Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	92.8	99.6	7.7	69.8
Northern	97.3	98.9	12.9	69.9
Southern	99.7	99.9	5.7	70.1
Western	98.5	98.7	24.9	74.9
Northern Ireland	96.4	99.3	12.3	71.0

The data in this table show that the proportion of eligible women in Northern Ireland offered a screening appointment that was within 36

months of their previous screen fell to just 12% in 2020-2021, during which the NI BSP was paused for a period of four months. This compares to the figure of 99.3% achieved during the previous year. As outlined previously, intensive efforts to recover the breast screening round length were implemented by each BSU, in collaboration with the PHA Breast Screening Team, following the resumption of screening services in July 2020. Close monitoring of this indicator continues to be undertaken to ensure that performance has recovered to an acceptable level in each BSU and the NI BSP overall.

Figure 2 shows trends in the proportion of women offered a screening appointment within 36 months of their previous screen in Northern Ireland between 2015 and 2021.

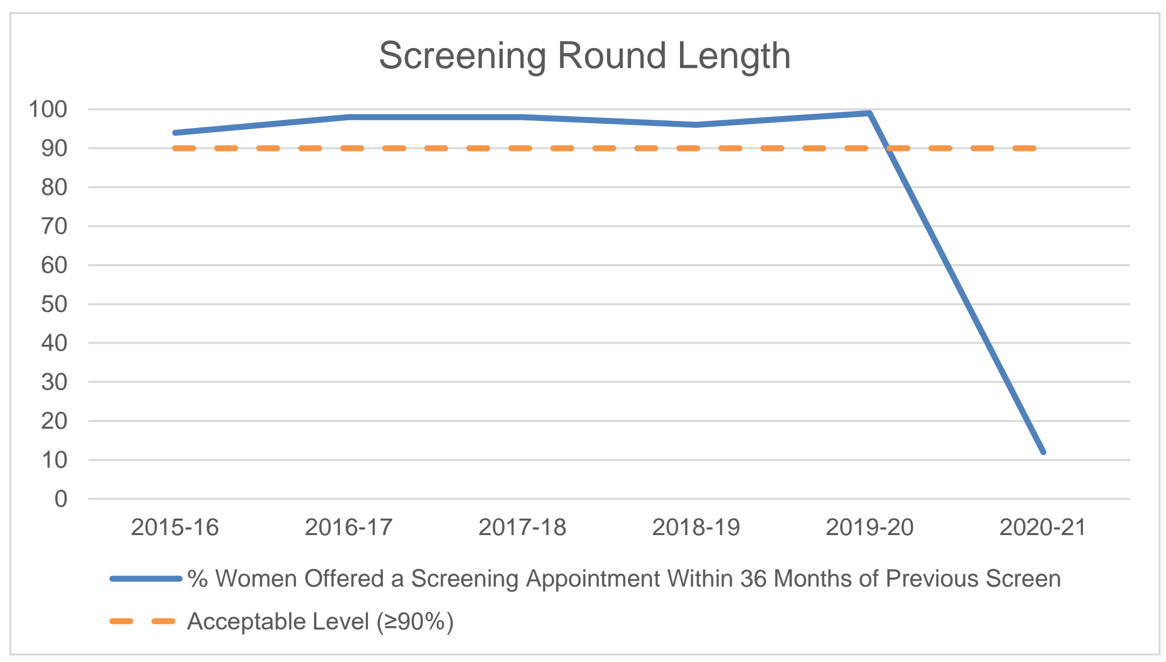


Figure 2: % of Women Offered a Screening Appointment within 36 Months of Previous Screen

6.4 Test

6.4.1 Technical Recall/Repeat

Technical Recall/Repeat measures the proportion of women who had additional mammograms due to technical recalls or technical repeats.

During 2018-2021, 2.7% of women screened in in Northern Ireland had a repeat examination, due to a technical recall or technical repeat.

- Acceptable standard: <3.0% of women undergoing a repeat examination due to technical recalls or technical repeats.
- Achievable standard: <2.0% of women undergoing a repeat examination due to technical recalls or technical repeats.

Mammograms may need to be repeated if the quality of the first image is not adequate for diagnostic reporting. Technical recall refers to when women are recalled for a further appointment for repeat images, while technical repeat refers to when women undergo repeat imaging during the initial screening appointment. BSUs should aim to deliver the optimum image quality with as low a radiation dose as possible to minimise anxiety for women, as well as their exposure to radiation. The number and type of repeat examinations undertaken are monitored to make sure good quality practice is provided. Table 7 shows the technical recall/repeat rate for each BSU and Northern Ireland overall between 2018 and 2021.

Table 7: Technical Recall/Repeat Rate (%) by BSU and Northern Ireland Overall

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	2.5	2.8	2.9	2.8
Northern	2.8	2.2	2.7	2.6
Southern	2.5	2.2	3.2	2.6
Western	2.8	1.9	2.9	2.6
Northern Ireland	2.7	2.4	2.9	2.7

The overall technical recall/repeat rate in Northern Ireland throughout the three-year period between 2018 and 2021 met the acceptable standard of <3.0%. Only the Southern Unit failed to meet the acceptable standard on one occasion in 2020-2021, when 3.2% of women underwent a repeat

examination. The Western Unit met the achievable standard of <2% in 2019-2020, with a technical recall/repeat rate of 1.9%.

6.4.2 Screen to Routine Recall

Screen to Routine Recall measures the proportion of women with a normal screening test who receive their results within two weeks of attendance for their screening mammogram.

During 2018-2021, 99.7% of women who had a normal screening test, received their results within two weeks of attendance for their screening mammogram.

- Acceptable standard: ≥ 95.0% women receiving their results within two weeks of attendance for their screening mammogram.
- Achievable standard: 100.0% women receiving their results within two weeks of attendance for their screening mammogram.

To minimise anxiety, it is essential that women receive the results of screening in a timely manner. The date a woman receives her result is not recorded, therefore the date her episode is closed on NBSS is taken as a proxy for this. This assumes the screening office has good administrative processes to minimise delays in posting the results letters. Table 8 shows the Screen to Routine Recall rate for each BSU and Northern Ireland overall, during each year between 2018 and 2021, as well as the average for the entire period.

Table 8: Screen to Routine Recall Rate (%) by BSU and Northern Ireland Overall

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	99.8	99.8	99.8	99.8
Northern	99.9	99.3	99.9	99.7
Southern	100.0	100.0	100.0	100.0
Western	99.3	99.3	100.0	99.5
Northern Ireland	99.7	99.6	99.9	99.7

The acceptable standard for Screen to Routine Recall was met consistently across all BSUs and Northern Ireland overall during 2018 to 2021, with an average of 99.7% of women with a normal screening test

receiving their results within two weeks of their screening appointment. The Southern Unit met the achievable standard of 100.0% during each year throughout this period. Figure 3 shows the trend in the proportion of women with a normal screening test receiving their results within two weeks of attendance for their screening mammogram in Northern Ireland between 2015 and 2021.

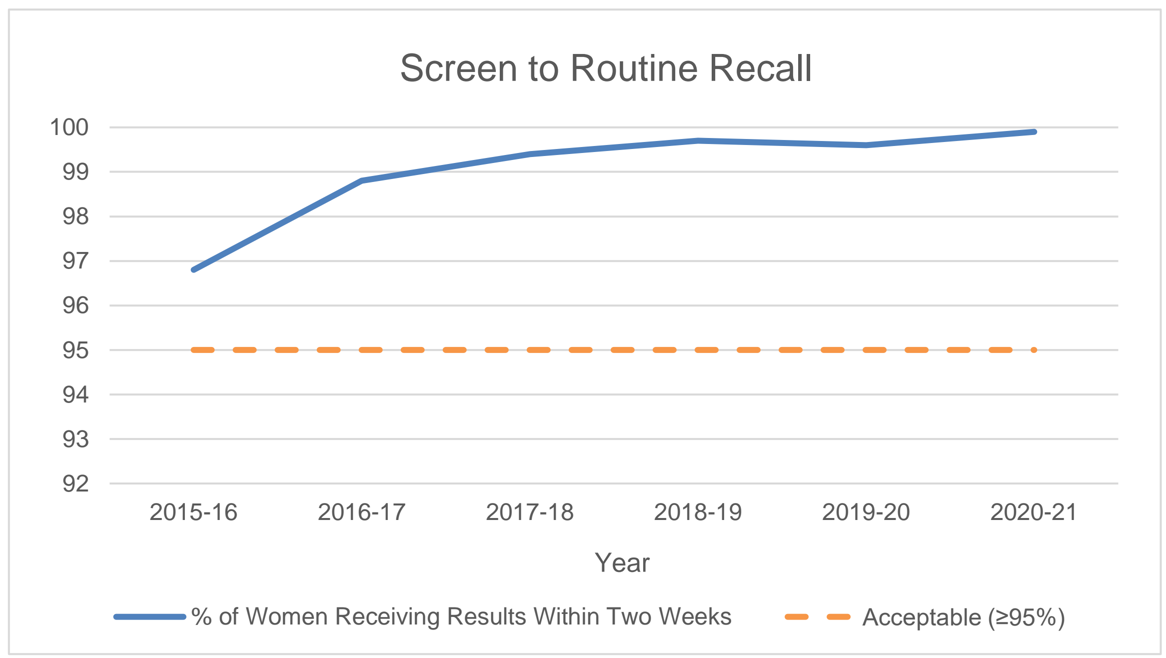


Figure 3: Percentage of Women with a Normal Screening Test Receiving Results within Two Weeks

6.5 Referral

About four in every one hundred women are asked to come back for more tests after screening as their mammogram looks abnormal. These women are invited to attend an assessment clinic for further tests (e.g. breast examination, ultrasound scan or biopsy) which will help confirm if the woman has breast cancer. On average, one in four women referred for assessment are found to have cancer. The three in four women confirmed as not having cancer are returned to the routine screening programme to be invited for screening again in three years (unless they will be over the age of 70, when they can self-refer).

6.5.1 Referred for Assessment

Referred for Assessment measures the proportion of women screened who are referred for further assessment.

The purpose of this standard is to provide assurance that women are not referred for further tests unnecessarily. Those responsible for interpreting the images from breast screening need to make sure that they are recalling women with areas of concern which require further investigation, whilst not recalling too many women where no abnormalities are subsequently found. The percentage of women who are recalled to an assessment clinic is normally higher in those attending their first screening mammogram (prevalent screens) than in those attending for subsequent screening mammography (incident screens).

Prevalent Screen

During 2018-2021, 5.5% of women screened during a prevalent screen were referred for assessment, while the equivalent figure for incident screens was 2.5%.

- Acceptable standard: <10.0% of women screened referred for further assessment.
- Achievable standard: <7.0% of women screening referred for further assessment.

During 2018 to 2021, 5.5% of women were referred for assessment from a prevalent (first screen), meeting the achievable standard of <7.0%. Table 9 outlines the proportion of women referred for assessment from a prevalent screen each year between 2018 and 2021 by BSU and Northern Ireland overall. All BSUs, apart from the Southern Unit, met the achievable standard of 7.0% in each year during the three-year period. The Southern Unit consistently met the acceptable standard of <10.0%.

Table 9: Percentage of women referred for assessment by BSU and Northern Ireland overall – prevalent screen				
	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	6.5	5.7	4.9	5.7
Northern	5.6	4.1	4.1	4.5
Southern	8.1	8.0	7.2	7.8
Western	3.6	4.6	4.3	4.1
Northern Ireland	6.5	5.7	4.9	5.7

Figure 4 shows trends in the proportion of women referred for assessment from a prevalent screen per BSU and Northern Ireland overall between 2015 and 2021.

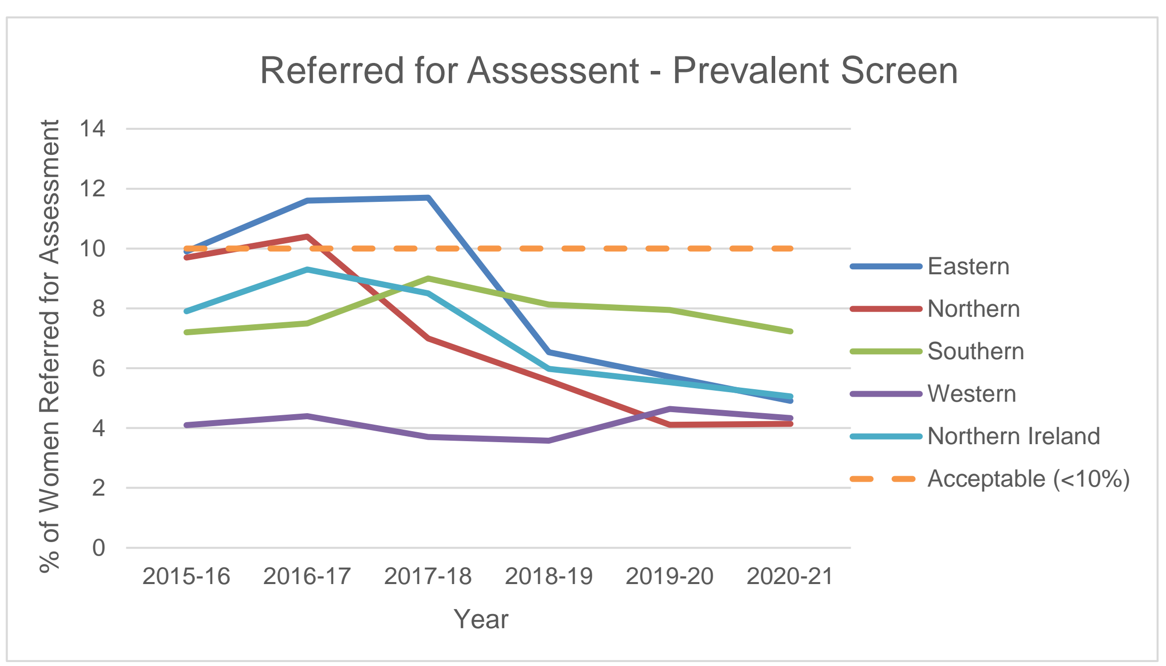


Figure 4: Percentage of Women Referred for Assessment from a Prevalent Screen

Incident Screen

- Acceptable standard: <7.0% of women screened referred for further assessment.
- Achievable standard: <5.0% of women screened referred for further assessment.

During 2018 to 2021, 2.5% of women were referred for assessment from an incident (subsequent screen), meeting the achievable standard of

<5.0%. Table 10 outlines the proportion of women referred for assessment from an incident screen each year between 2018 and 2021 by BSU and Northern Ireland overall. All BSUs consistently met the achievable standard for the proportion of women referred for assessment from incident screens.

Table 10: Percentage of women referred for assessment by BSU and Northern Ireland overall – incident screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	2.0	2.1	1.7	2.0
Northern	2.2	1.9	1.9	2.0
Southern	4.0	4.0	3.9	4.0
Western	2.4	2.7	2.0	2.4
Northern Ireland	2.5	2.5	2.3	2.5

Figure 5 shows trends in the proportion of women referred for assessment from an incident screen per BSU and Northern Ireland overall between 2015 and 2021.

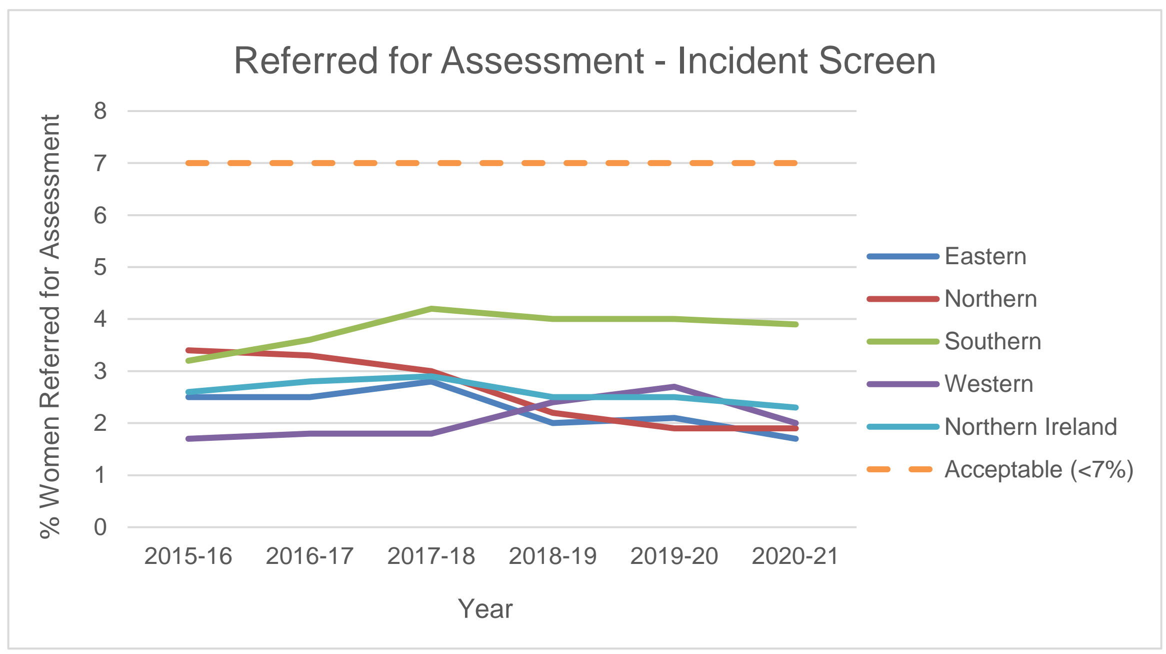


Figure 5: Percentage of Women Referred for Assessment from an Incident Screen

6.5.2 Screen to Assessment (First Offered Appointment)

Screen to Assessment measures the proportion of women who are offered an appointment at an assessment centre within three weeks of attendance for their screening mammogram.

During 2018-2021, 99.2% of women referred for assessment were offered an assessment appointment that was within three weeks of their screening mammogram.

- Acceptable standard: >98.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.
- Achievable standard: 100.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.

Monitoring this standard aims to minimise the time taken for women who need further investigations to obtain a definitive malignant, benign or normal diagnosis. Overall between 2018 and 2021, 99.2% of women who were referred for assessment in Northern Ireland were offered an assessment appointment that was within three weeks of their screening mammogram. Table 11 outlines the achievement of this standard by BSU and Northern Ireland overall for each individual year, as well as the three-year average. The acceptable standard was consistently met in all BSUs, with both the Southern and Western Units meeting the achievable standard of 100.0% in two of the three years.

Table 11: Screen to Assessment Rate (%) by BSU and Northern Ireland Overall

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	98.5	98.0	98.2	98.2
Northern	98.2	100.0	100.0	99.4
Southern	99.9	100.0	100.0	99.9
Western	99.1	99.7	99.7	99.5
Northern Ireland	99.0	99.2	99.4	99.2

Figure 6 shows trends in the proportion of women referred for assessment who are offered an assessment appointment within three weeks of their screening mammogram per BSU and Northern Ireland overall between 2015 and 2021.

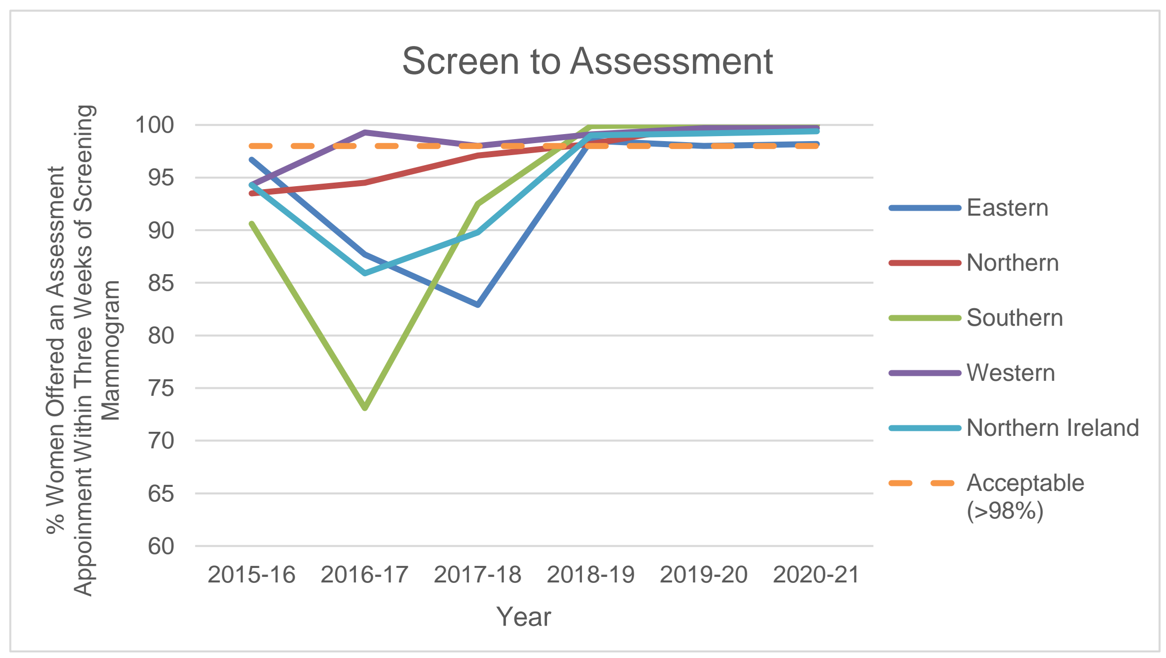


Figure 6: Percentage of Women Offered an Assessment Appointment within Three Weeks of Screening Mammogram

6.6 Diagnosis

6.6.1 Number of Cancers Detected

1,527 breast cancers were detected through screening in Northern Ireland between 2018-2021.

Between 2018 and 2021, 1,527 breast cancers were detected through screening in Northern Ireland. 1,245 (81.5%) of these were invasive cancers, 7 (0.5%) were micro-invasive cancers and 275 (18.0%) were non-invasive cancers. Table 12 outlines the number of screen-detected cancers overall and within each subcategory for each year during the period, as well as the cumulative total.

Table 12: Number of Screen-Detected Breast Cancers in Northern Ireland				
	2018-2019	2019-2020	2020-2021	2018-2021
Total cancers	527	520	480	1,527
Invasive	423	429	393	1,245
Micro-invasive	0	<5	6	7
Non-invasive	104	90	81	275
Unknown invasive status	0	0	0	0

6.6.2 Early Recall

Early Recall measures the proportion of women screened who are referred for further tests and invited back to assessment at an interval of at least one year (short-term recall).

During 2018-2021, 0.02% of women who were screened and referred for further tests were placed on short-term recall.

- Acceptable standard: <0.25% of women who are screened and referred for further tests should be placed on short-term recall.
- Achievable standard: <0.12% of women who are screened and referred for further tests should be placed on short-term recall.

Table 13 illustrates the proportion of women placed on short-term recall within each BSU and Northern Ireland overall during 2018 to 2021. Performance in each BSU and Northern Ireland overall consistently met the achievable threshold of <0.12%.

Table 13: Short-Term Recall Rate (%) by BSU and Northern Ireland Overall				
	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	0.02	0.00	0.01	0.01
Northern	0.05	0.01	0.03	0.03
Southern	0.00	0.01	0.00	0.00
Western	0.05	0.02	0.02	0.03
Northern Ireland	0.03	0.01	0.01	0.02

6.6.3 Non-Operative Diagnosis Rate

Non-Operative Diagnosis measures the proportion of women who have a non-operative diagnosis of cancer by needle histology or cytology after a maximum of two assessment clinic visits, as a proportion of all women screened diagnosed with breast cancer. This standard is reported separately for invasive and non-invasive cancers.

During 2018-2021, diagnosis was established prior to surgery for 99.5% of women with an invasive screen-detected cancer and 94.4% of women with a non-invasive screen-detected cancer.

It is important to minimise the number of operative procedures and to enable treatment planning in advance of surgery. To achieve this, the majority of women should receive a non-operative pathological diagnosis of cancer. However, some women may need to have a surgical biopsy i.e. a biopsy taken during surgery, if the diagnosis is difficult to establish beforehand.

Invasive Cancer

- Acceptable standard: ≥90.0% of invasive screen-detected cancers should be diagnosed before surgery.
- Achievable standard: ≥95.0% of invasive screen-detected cancers should be diagnosed before surgery.

Overall, 99.5% of invasive screen-detected cancers in Northern Ireland diagnosed between 2018 and 2021 had a non-operative pathological diagnosis of cancer, meeting the achievable standard of ≥95%. Table 14 shows non-operative diagnosis rates for invasive screen-detected cancers for each BSU and Northern Ireland overall during 2018 to 2021. The performance of all BSUs consistently exceeded the achievable standard of ≥95.0%, with 100.0% of women in both the Southern and Western Units receiving a non-operative diagnosis of invasive cancer throughout the three-year period.

Table 14: Non-Operative Diagnosis Rate (%) – Invasive Cancer				
	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	100.0	99.3	99.2	99.5
Northern	100.0	95.2	100.0	98.2
Southern	100.0	100.0	100.0	100.0
Western	100.0	100.0	100.0	100.0
Northern Ireland	100.0	98.7	99.7	99.5

Figure 7 shows trends in the proportion of invasive screen-detected cancers with a diagnosis established prior to surgery per BSU and Northern Ireland overall between 2015 and 2021.

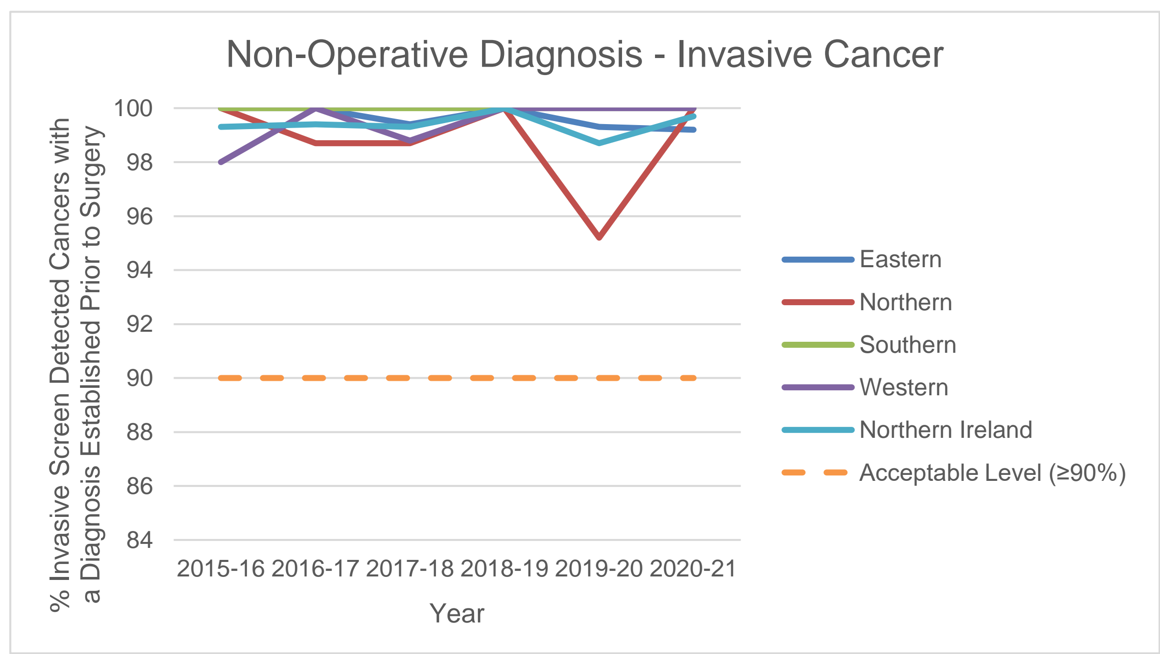


Figure 7: Percentage of Invasive Screen-Detected Cancers with a Diagnosis Established Prior to Surgery

Non-Invasive Cancer

- Acceptable standard: ≥85.0% of non-invasive screen-detected cancers should be diagnosed before surgery.
- Achievable standard: ≥90.0% of non-invasive screen-detected cancers should be diagnosed before surgery.

Overall, 94.4% of non-invasive screen-detected cancers in Northern Ireland diagnosed between 2018 and 2021 had a non-operative pathological diagnosis of cancer, meeting the achievable standard of

≥90.0%. Table 15 illustrates non-operative diagnosis rates for non-invasive screen-detected cancers for each BSU and Northern Ireland overall during 2018 to 2021. Performance dropped just below the acceptable level of ≥85.0% in the Western Unit in 2018-2019 (84.5%) and was 5.0% below the acceptable level in the Northern Unit in 2020-2021(80.0%). The three-year average for each BSU met the achievable standard.

Table 15: Non-Operative Diagnosis Rate (%) – Non-Invasive Cancer

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	100.0	96.8	92.6	96.6
Northern	90.0	95.8	80.0	90.7
Southern	93.3	100.0	100.0	97.7
Western	84.6	94.4	100.0	92.5
Northern Ireland	92.2	96.4	94.9	94.4

6.6.4 Non-Invasive Cancer Detection

Non-Invasive Cancer Detection measures the number of non-invasive carcinoma (in situ) cancers that are detected per 1,000 women screened.

Between 2018-2021, the average non-invasive cancer detection rate was 2.0 per 1,000 women screened during a prevalent screen and 1.2 per 1,000 women screened during an incident screen.

Detection of non-invasive cancer at screening, predominantly Ductal Carcinoma in Situ (DCIS), particularly high-grade disease, is assumed to be a factor contributing to long-term reduction in mortality. It is believed to be good practice to detect and treat DCIS.

Prevalent

- Acceptable standard: ≥0.5 non-invasive cancers detected per 1,000 women screened.

The average non-invasive cancer detection rate from a prevalent screen was 2.0 per 1,000 eligible women screened, meeting the acceptable standard. Table 16 outlines non-invasive cancer detection rates from a prevalent screen during each year between 2018 and 2021, as well as the

three-year average for each BSU and Northern Ireland overall. Each BSU achieved an overall average which met the acceptable standard, although the Eastern Unit did not meet the acceptable standard during 2019-2020, achieving a non-invasive cancer detection rate of 0.3 per 1,000 women screened.

Table 16: Non-Invasive Cancer Detection Rate (%) by BSU and Northern Ireland Overall – Prevalent Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	2.1	0.3	1.7	1.4
Northern	3.8	2.5	0.5	2.2
Southern	1.3	2.2	1.6	1.7
Western	3.1	2.3	4.7	3.4
Northern Ireland	2.5	1.6	2.0	2.0

Incident

- Acceptable standard: ≥0.6 non-invasive cancers detected per 1,000 women screened.

The average non-invasive cancer detection rate from an incident screen was 1.2 per 1,000 women screened, meeting the acceptable standard. Table 17 outlines non-invasive cancer detection rates from an incident screen during each year between 2018 and 2021, as well as the three-year average for each BSU and Northern Ireland overall. The performance of all individual BSUs consistently exceeded the acceptable standard throughout the three-year period.

Table 17: Non-Invasive Cancer Detection Rate (%) by BSU and Northern Ireland Overall – Incident Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	0.9	1.5	1.2	1.2
Northern	1.7	1.4	0.9	1.3
Southern	0.8	0.9	1.7	1.1
Western	1.5	1.2	1.6	1.4
Northern Ireland	1.1	1.3	1.3	1.2

6.6.5 Standardised Detection Ratio for Invasive Cancer

Standardised Detection Ratio is the ratio of the observed number of invasive cancers to the expected number in the eligible population invited and screened, given the age distribution of the population.

The SDR for invasive cancers in Northern Ireland between 2018-2021 was 1.41 for prevalent screens and 1.49 for incident screens.

It is important to compare cancer detection between screening services with differing mean ages of screening populations, as the age of women screened is a major determinant of cancer detection rates. This is corrected for by using a standard detection ratio (SDR). This allows the observed invasive cancers to be compared to the expected number of invasive cancers, given the age distribution of the population. The expected number of cancers is based on applying criteria from the Swedish Two Counties randomised control trial which is used as a comparator of performance.[1] An SDR of one indicates the observed number of invasive cancers is the same as that expected; greater than one indicates a higher detection rate, and less than one a lower detection rate.

Prevalent Screen

- Acceptable standard: SDR ≥1.00
- Achievable standard: SDR ≥1.40

The overall SDR for invasive cancers from a prevalent screen in Northern Ireland between 2018 and 2021 was 1.41, meeting the achievable standard. Table 18 shows the SDR for invasive cancers from a prevalent screen each year between 2018 and 2021, as well as the three-year average, for each BSU and Northern Ireland overall.

Table 18: Standardised Detection Ratio Invasive Cancer by BSU and Northern Ireland Overall – Prevalent Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	1.44	1.14	1.23	1.27
Northern	1.51	1.12	1.54	1.38
Southern	1.17	1.44	2.66	1.73
Western	0.97	1.31	1.97	1.39
Northern Ireland	1.28	1.23	1.73	1.41

Incident Screen

- Acceptable standard: SDR ≥1.00
- Achievable standard: SDR ≥1.40

The overall SDR for invasive cancers from an incident screen in Northern Ireland between 2018 and 2021 was 1.49, meeting the achievable standard. Table 19 shows the SDR for invasive cancers from an incident screen each year between 2018 and 2021, as well as the three-year average, for each BSU and Northern Ireland overall. The Northern Ireland average exceeded the achievable threshold during each year of the three-year period. All BSUs maintained at least an acceptable standard of performance throughout, while the Southern Unit consistently exceeded the achievable performance threshold.

Table 19: Standardised Detection Ratio Invasive Cancer by BSU and Northern Ireland Overall – Incident Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	1.19	1.48	1.38	1.35
Northern	1.34	1.46	1.30	1.37
Southern	1.47	1.85	2.04	1.76
Western	1.71	1.72	1.38	1.61
Northern Ireland	1.40	1.58	1.49	1.49

6.6.6 Standardised Detection Ratio for Small Invasive Cancer

Standardised Detection Ratio Small Invasive Cancer is the ratio of the observed number of small invasive cancers (<15mm) to the expected number in the eligible population invited and screened, given the age distribution of the screened population.

This standard is measured for both prevalent and incident screens combined.

The SDR for small invasive cancers in Northern Ireland between 2018-2021 was 1.38.

Prevalent and Incident Screen:

- Acceptable standard: SDR ≥1.00
- Achievable standard: SDR ≥1.40

The overall SDR for small invasive cancers in Northern Ireland between 2018 and 2021 was 1.38, meeting the acceptable standard. Table 20 shows the SDR for small invasive cancers each year between 2018 and 2021, as well as the three-year average, for each BSU and Northern Ireland overall. All BSUs maintained an acceptable standard of performance throughout this three-year period, with the Southern Unit consistently exceeding the achievable threshold.

Table 20: Standardised Detection Ratio Small Invasive Cancer by BSU and Northern Ireland Overall – Prevalent and Incident Screens

	2018-2019	2019-2020	2020-2021	2018-2021
Eastern	1.08	1.30	1.13	1.17
Northern	1.32	1.08	1.54	1.30
Southern	1.48	2.05	2.19	1.87
Western	1.40	1.49	1.20	1.37
Northern Ireland	1.28	1.41	1.44	1.38

6.6.7 Benign Biopsy Rates

Benign Biopsy Rate is a measure of the number of women per 1,000 women screened who had surgery for benign breast disease i.e. an open surgical biopsy with a benign or normal histological outcome.

0.7 women per 1,000 women screened during a prevalent screen had surgery for benign breast disease, while the equivalent figure for incident screens was 0.3 per 1,000 women screened.

The aim of this standard is to minimise harm to women due to unnecessary surgery. The number of open surgical biopsies performed because of screening that prove to be benign should be as low as possible.

Prevalent Screen

- Acceptable standard: <1.5 benign biopsies per 1,000 women screened.
- Achievable standard: <1.0 benign biopsies per 1,000 women screened.

The Northern Ireland average benign biopsy rate from prevalent screens between 2018 and 2021 was 0.7 per 1,000 women screened, meeting the achievable standard. Table 21 shows benign biopsy rates from prevalent screens for Northern Ireland overall during 2018 to 2021. Due to small numbers these data are not presented at BSU level.

Table 21: Benign Biopsy Rate (%) for Northern Ireland Overall – Prevalent Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Northern Ireland	1.0	0.7	0.3	0.7

Incident Screen

- Acceptable standard: <1.0 benign biopsies per 1,000 women screened.
- Achievable standard: <0.75 benign biopsies per 1,000 women screened.

The Northern Ireland average benign biopsy rate from incident screens between 2018 and 2021 was 0.3 per 1,000 women screened, meeting the achievable standard. Table 22 outlines benign biopsy rates from an incident screen for Northern Ireland overall during 2018 to 2021.

Table 22: Benign Biopsy Rate (%) for Northern Ireland Overall – Incident Screen

	2018-2019	2019-2020	2020-2021	2018-2021
Northern Ireland	0.3	0.3	0.2	0.3

7. Very High-Risk Breast Screening Programme

Surveillance screening for women at very high risk (VHR) of developing breast cancer was introduced in Northern Ireland in 2013. In September 2020, the programme title was changed from the 'Higher Risk Breast Surveillance Screening Programme' to the 'Very High-Risk Breast Screening Programme (VHR BSP)', to reflect national guidance. This title change does not indicate any increase in cancer risk for those enrolled in the programme.

Women at VHR are defined as those with more than or equal to eight times the relative risk of developing breast cancer compared to women in the general population. A woman may be at VHR of developing breast cancer due to a genetic mutation, most commonly in the BRCA gene, or a result of previous radiotherapy to the chest area. Women may be referred into the VHR BSP by a specialist in genetics, family history or oncology, where their family or medical history indicate a higher risk of developing breast cancer. The VHR BSP offers breast imaging at an earlier age and on a more regular basis than the routine BSP. Women enrolled in the programme are invited for annual Magnetic Resonance Imaging (MRI), mammography, or both depending on their age and reason for referral, up until their 50th birthday. After this, some women will remain within the VHR BSP, while others will enter routine breast screening. The protocols for each risk category determine screening frequency.

The VHR BSP is provided regionally at Antrim Area Hospital, in the Northern HSCT. The VHR BSU at Antrim Area Hospital is managed by a lead radiologist, with input from other radiologists, radiographers and administrative support. The programme is managed in line with the Northern HSCT VHR Breast Screening Operational Policy and overseen by a VHR BSP Coordinating Group, chaired by the PHA Consultant Lead for the NI BSP. The VHR BSP Coordinating Group meets twice per year (and by exception) and includes representation from all HSCTs and disciplines involved in the delivery of the VHR BSP. A representative from BRCA Link NI (a voluntary organisation helping people to access information and support about BRCA genetic mutations, who were involved in the establishment of the VHR BSP), also sits on the VHR BSP

Coordinating Group. The programme is included in the QA Visits to the Northern Unit and in internal QA activities undertaken by the Northern HSCT.

National standards for the VHR BSP came into effect for data collected from April 2021 and will be reported in future annual reports.

8. Promoting Informed Choice

Although the overall uptake of breast screening in Northern Ireland is high, uptake rates within certain geographical areas and subpopulations of women remain consistently lower than the general population. During 2018 to 2021, the PHA Breast Screening Team, in partnership with other stakeholders, continued to work to ensure that all eligible women in Northern Ireland can make an informed choice about attending for breast screening and that the service is as accessible as possible.

Key actions to promote informed choice during 2018 to 2021 included:

Regional Group on Promoting Informed Choice in Breast Screening.

This group is chaired by the PHA Consultant Lead for the NI BSP and has representation from all BSUs, as well as HSCT Health Promotion staff. The remit of the group is to identify opportunities to promote informed choice in the NI BSP, with a particular focus on women from disadvantaged communities, women who have learning/physical/sensory disabilities, women from minority ethnic groups, older women and other women considered to have additional needs. The group also aims to identify and share good practice in relation to promoting informed choice within breast screening and to advise on the provision of information to the public and health care professionals.

Inclusion of Promoting Informed Choice meetings in QA Visits to BSUs.

The PHA Breast Screening Team include standalone meetings related to promoting informed choice in breast screening in the QA Visits to BSUs. A dedicated chapter on promoting informed choice is included within each QA visit report.

Working with the Women's Resource and Development Agency (WRDA).[7]

In 2015, the PHA commissioned the WRDA, a local not-for-profit organisation, to raise awareness of the Breast, Cervical and Bowel Cancer Screening Programmes and to promote informed choice among individuals from communities and populations with historically lower

cancer screening uptake rates compared with the general population. The aim of the WRDA's programme of work is to provide individuals with sufficient information to enable them to make an informed decision about participating in cancer screening programmes. The WRDA recruit, train and support Peer Facilitators to deliver Educational Awareness Sessions to targeted service user groups, including; people from deprived areas, those from ethnic minorities, those from the LGBT+ community, homeless individuals and those with physical disabilities, learning disabilities or mental health issues. WRDA also carry out Bespoke Workshops for those latter groups with additional support needs.

Collaborating with HSCTs to ensure that comprehensive, up to date, information on screening is available on their website.

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Breast Screening Programme

Consolidated Annual Report 2021-2023

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1. Introduction

The Public Health Agency (PHA) monitors and quality assures the Northern Ireland Breast Screening Programme (NI BSP) to ensure that women in Northern Ireland have access to a high-quality breast screening service that meets national standards. This consolidated annual report describes the performance of the NI BSP during the two-year period between 2021 and 2023, including the impact of the COVID-19 pandemic on the delivery of breast screening in Northern Ireland.

The statistics presented within this report cover activity in the NI BSP between 1st April 2021 and 31st March 2023, including invitations for breast screening, breast screening uptake, the breast screening pathway, outcomes of breast screening and the number and type of breast cancers detected. Local performance against each key indicator outlined in the NHS Breast Screening Programme Standards has been assessed to determine whether an appropriate level of performance which aligns with national standards has been achieved.[1] Data are presented for each of the four Breast Screening Units (BSUs) in Northern Ireland, in addition to data describing overall regional performance.

Given that this is a consolidated annual report spanning the time-period between 2021 and 2023, statistics have been calculated to describe performance during each individual year, as well as average performance throughout the time-period. The majority of statistics have been derived from data submitted by each BSU in the form of Korner returns using data from the National Breast Screening System (NBSS), the IT system supporting the NI BSP. This information is routinely collected by the NI BSP for operational purposes, including quality assurance. Data on the number and subtype of screen-detected breast cancers in Northern Ireland between 2021 and 2023 have been obtained from bespoke NBSS reports.

A summary of key statistics in the NI BSP is included on Page 4. Page 5 includes a table showing performance of each Breast Screening Unit and Northern Ireland as a whole against the standards discussed in this report.

Summary of Key Statistics in the Northern Ireland Breast Screening Programme 2021-2023

Uptake

186,935 women aged between 50 and 70 years were invited for breast screening; 139,355 attended for screening, giving an average annual uptake rate of 74.5%.

Invitation

54.2% of women were offered an appointment for mammography screening that was within 36 months of their previous normal screen.*

Results

99.4% of women, who had a normal test result, received their results within two weeks of their screening appointment.

Assessment

98.3% of women who required further tests were offered an appointment within three weeks of their screening mammogram.

Cancer Detection

1,055 breast cancers were detected through screening; 861 (81.6%) of these were invasive cancers.

Treatment of Invasive Cancer

Of the 990 women diagnosed with screen-detected invasive cancer, 786 (79%) had breast conserving surgery, 170 (17%) had a mastectomy and 34 (3%) had no surgery.

*The NI BSP paused for a period of four months during 2020 due to the impact of the COVID-19 pandemic. This pause, and the infection control precautions put in place following the restart of the programme, meant that fewer were offered a mammography screening appointment within 36 months of their previous normal screen during 2021-23. Figures for this indicator during each individual year of this time period are as follows: 35.3% in 2021/22 and 75.3% in 2022/23.

Performance against key standards, 2021/22 – 2022/23

Table 1 outlines performance of the NI BSP against key standards in the years 2021/22 and 2022/23, providing data at regional level and by BSU.

The data in this table are colour coded green if the achievable standard is met, amber if the acceptable standard is met and red if the acceptable standard is not met. A definition of the acceptable and achievable performance thresholds is included in section 6.2.2.

Table 1: Performance of NI BSUs against key standards, 2021/22 – 2022/23

STANDARD	Region		Eastern		Northern		Southern		Western		National Standards
	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	
Uptake Rate (%)	74.8	74.3	72.2	72.3	77.2	77.6	76.1	75.1	76.5	74.6	Acceptable >70% Achievable >80%
Screening Round Length (%)	35.3	75.3	29.6	30.4	29.6	30.4	34.2	92.7	44.3	88.2	Acceptable >90.0% Achievable >99.0%
Technical Recall (%)	0.08	0.05	0.10	0.10	0.02	0.02	0.10	0.10	0.00	0.00	Acceptable <0.7% Achievable <0.2%
Technical Repeat (%)	2.2	1.8	2.5	1.5	2.0	2.0	1.4	1.9	2.8	1.9	Acceptable <2% Achievable <1.2%
Screen to Routine Recall (%)	99.8	98.9	99.8	98.4	99.9	99.4	100.0	100.0	99.9	98.4	Acceptable >95.0% Achievable >99.0%
Referred to Assessment (%)											
Prevalent Screen	5.0	4.7	5.1	4.8	5.6	4.2	5.6	5.1	3.3	4.8	Acceptable <9% Achievable <7%

STANDARD	Region		Eastern		Northern		Southern		Western		National Standards
	2021/22	**2022/23**	**2021/22**	**2022/23**	**2021/22**	**2022/23**	**2021/22**	**2022/23**	**2021/22**	**2022/23**	
Incident Screen	2.0	2.0	1.7	1.7	2.3	1.8	2.7	2.8	1.5	1.9	Acceptable <4% Achievable <3%
Screen to Assessment (Date of First Offered Appt.)	99.2	97.3	99.1	94.7	99.8	99.7	99.5	98.7	98.3	98.5	Acceptable >95.0% Achievable >99.0%
Short term recall rate (%)	0.00	0.02	0.00	0.03	0.07	0.01	0.00	0.00	0.01	0.02	Acceptable <0.25% Achievable <0.12%
Non Operative Diagnosis Rate											
Invasive	100.0	99.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	97.7	Acceptable >99%
Non-Invasive	94.3	93.0	92.3	100.0	95.2	93.8	100.0	100.0	90.9	73.7*	Acceptable >90.0% Achievable >95.0%
Non -Invasive Cancer Detection Rate per 1000											
Prevalent	1.6	1.8	0.9	2.6	3.0	0.9	1.0	0.5	2.4	2.6	Acceptable >0.5/1000

STANDARD	Region		Eastern		Northern		Southern		Western		National Standards
	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	
Incident	1.4	1.1	1.5	0.9	1.3	1.0	1.4	1.5	1.1	1.2	Acceptable >0.6/1000
Standardised Detection Rate (All Invasive Cancer)											
Prevalent	1.1	1.3	0.9	1.2	0.9	1.0	1.4	1.2	1.2	1.9	Acceptable ≥1.0 Achievable >1.2
Incident	1.1	1.2	1.2	1.4	1.1	0.8	1.3	1.4	1.0	1.2	Acceptable ≥1.0 Achievable >1.2
Standardised Detection Rate (Small Invasive Cancer)	1.1	1.0	1.0	1.0	1.0	0.7	1.5	1.3	1.0	1.2	Acceptable ≥1.0 Achievable ≥>1.2
Benign Biopsy Rate											
Prevalent	0.8	0.7	Due to small numbers, data are not presented at unit level								Acceptable <1.5/1000 Achievable <1.0/1000
Incident	0.2	0.2	Due to small numbers, data are not presented at unit level								Acceptable <1.0/1000 Achievable <0.75/1000

*Discussed with unit and related to data entry error (see section 6.6.3)

2. Background

2.1 The Northern Ireland Breast Screening Programme

The NI BSP invites women between the ages of 50 and 70 to attend for regular breast screening every three years. The main aim of breast screening is to detect breast cancer at an early stage, when treatment is more likely to reduce the risk of death from the disease.

2.2 Benefits and Harms of Breast Screening

As with all screening programmes, breast screening results in both benefits and harms.[2] The main benefit is a reduction in breast cancer mortality. An independent review of the evidence on the benefits and harm of breast screening found a 20% reduced risk of death from breast cancer among women screened, compared to those not screened.[2] This equates to one breast cancer death prevented for every 235 women invited for screening, one breast cancer death prevented for every 180 women who attend screening and around 1300 breast cancer deaths prevented every year in the UK.[2]

The main harm of breast screening is overdiagnosis, which refers to the detection of low-risk or non-progressing breast cancers through screening that would not have been diagnosed without screening, and would not have become life threatening.[2] For every breast cancer death prevented by screening in the UK, three women are diagnosed with and treated for a cancer that would never have been found without screening and would never have become life threatening.[2] Other harms include the need for unnecessary invasive investigations, as well the psychological distress and anxiety, which can arise from false positive screening results.[2] False negative results due to missed cancer detection or incorrect diagnoses can also provide unwarranted reassurance, potentially affecting a woman's perception of her risk of breast cancer and resulting in delayed presentation following the development of symptoms.[2,3]

3. Programme Overview

3.1 Eligibility

In Northern Ireland, eligible women aged between 50 and 70 are invited to attend for breast screening, by GP practice, every three years. Due to this three-yearly round of invites, about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53rd birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every three years by phoning their local screening unit and requesting an appointment.

Women who have been identified as being at significantly increased risk of breast cancer (≥ 8 times the average risk) are invited to participate in more regular surveillance screening at an earlier age by the Very High-Risk (VHR) BSP, which commenced in 2013.

3.2 Screening Pathway

3.2.1 Invitation

- Invitations to attend for routine breast screening are sent to eligible women every three years based on their GP practice, along with information on breast screening, which describes the screening test and pathway involved.

- Approximately one third of the population eligible for breast cancer screening in Northern Ireland are invited to attend for screening every year.
- Each of the four Breast Screening Unit (BSUs) cover screening populations of varying sizes, with the number screened in each unit fluctuating on an annual basis, depending on the area being screened within the three-year round length.

3.2.2 Screening

- Women who accept the offer of screening attend their local BSU and undergo mammography, an imaging technique which involves low-dose radiation exposure to the breast tissue.
- The first time a woman enters the eligible age-range and attends for screening is referred to as a prevalent screen, the second and subsequent times a woman attends for screening are referred to as incident screens.
- Women should receive the results of the mammogram within two to three weeks of the screening appointment.
- A small number of women may be sent another screening appointment if their mammograms need to be repeated, for example, if the image was inadequate for diagnostic reporting.

3.2.3 Assessment

- If a potential abnormality is detected at initial screening, a woman may be asked to attend an assessment clinic for further investigations, including clinical examination, additional imaging or biopsy. A woman who receives a normal/benign result as the outcome of the assessment clinic should be returned to the routine screening programme for a further screen in three years.

3.3.4 Diagnosis

- If breast cancer is diagnosed, a woman should be referred for urgent treatment.
- If a definitive diagnosis cannot be made following the assessment process, a woman may be recalled for a further assessment at an interval shorter than the normal screening interval of three years.

3.3 Delivery

There are four BSUs in Northern Ireland; Eastern, Northern, Southern and Western. Table 2 outlines the locations and contact details of the headquarters of each unit.

Table 2: Breast Screening Units (BSUs) in Northern Ireland

Unit	Location	Contact Number
Eastern	12-22 Linenhall Street, Belfast	028 9033 3700
Northern	Antrim Area Hospital	028 9442 4425
Southern	Craigavon Area Hospital	028 3756 0820
Western	Altnagelvin Area Hospital	028 7161 1443

The Eastern Unit caters for the Belfast and South Eastern HSCT areas, while the Northern Unit covers most of the Northern HSCT, as well as providing surveillance screening for women at very high risk of breast cancer. The Southern Unit is responsible for delivering breast screening services in the Southern HSCT, while the Western Unit covers all of the Western HSCT areas and part of the Northern HSCT. The BSU in Linenhall Street provides mammography screening for women in the Belfast HSCT area. In the time period covered by this report, in other HSCT areas, most screening mammograms were carried out on mobile breast screening trailers, which rotate between a variety of locations across Northern Ireland.

4. Quality Assurance

Quality assurance (QA) is a fundamental part of all screening programmes. The aim of QA in the NI BSP is to maintain acceptable standards and continuously improve the performance of all aspects of breast screening in order to ensure that women have access to a high-quality service wherever they reside in Northern Ireland. QA helps to ensure that the benefits of breast screening outweigh the potential harms. It is a continuous process that is carried out externally by the PHA Breast Screening Team and internally by the BSUs and HSCTs.

4.1 Core QA Activities of the PHA

The core QA activities of the PHA Breast Screening Team include:

- Monitoring and review of programme management and delivery;
- Monitoring performance against agreed standards;
- Organising a rolling programme of formal QA Visits to BSUs;
- Review and monitoring of HSCT action plans to implement recommendations arising from QA visits;
- Adverse incident review and advice;
- Providing support and advice to HSCTs and BSUs.

4.2 QA Leads

The QA function is underpinned by an organised structure of public health and professional leads, supported by programme managers, information and administrative staff. There are seven QA Professional Leads in the NI BSP, covering each discipline involved in delivering the service. These include radiology, radiography, surgery, pathology, breast care nursing, administrative and clerical and medical physics. QA Professional Leads assist with the coordination of QA activities for the NI BSP and provide professional advice to the PHA Breast Screening Team on issues relevant to the commissioning of the screening programme within their area of expertise. Each QA Professional Lead chairs a QA subgroup for their speciality. These groups play an important part in the QA Advisory Structure and work together to ensure that safe and effective breast

screening continues to be available to the eligible population. This includes working to ensure relevant national and local standards are met and that appropriate continuous quality improvement processes are in place.

4.3 QA Visits

A key component of the NI BSP QA Programme is the cycle of QA visits to each of the four BSUs in rotation. The process for these visits is based on national and local guidance. Every BSU in Northern Ireland will receive a QA visit once every four years.

5. The Impact of COVID-19

Along with the majority of routine healthcare services, breast screening in Northern Ireland was paused on the 24th March 2020, due to the emergence of the COVID-19 pandemic. The programme restarted on the 20th July 2020, the intervening period constituting a four-month interruption to the delivery of breast screening in Northern Ireland. Screening for women over 70 recommenced in September 2020. The VHR BSP continued without interruption throughout the COVID-19 pandemic.

In the time period 2021-23, the BSP continued in the process of recovery from the pandemic. The capacity of BSUs to perform routine breast screening was impacted by staff absences due to sickness or isolation, as well as social distancing requirements and enhanced infection control measures implemented to reduce transmission of COVID-19, which led to longer appointment times.

Breast screening round length is the interval between each offered invitation for screening mammography and is an important indicator of the efficiency with which a screening programme is managed. The pause in the delivery of routine breast screening in Northern Ireland in March 2020 resulted in an extension of the round length beyond the recommended 36 months in all BSUs, to a maximum of 40 months in October 2020. Given the importance of the breast screening round length in ensuring the long-term effectiveness of the programme, as well as the potential impact of delays in screening on individual patient outcomes, intensive efforts to recover the round length as quickly as possible were implemented by all BSUs, in collaboration with the PHA Breast Screening Team.

Actions to address the round length delay in 2021-23 included work by all BSUs to decrease the appointment time for mammography and by the provision of additional screening clinics, both in-hours and out-of-hours, within mobile and static sites. In addition, in 2021/22 the charity Action Cancer provided some mammography appointments on behalf of the NI BSP.

6. Programme Performance

This section of the report presents statistics to describe the performance of the NI BSP during 2021-2023, which have been collated and evaluated using the approach outlined below.

6.1 Programme Standards

The NI BSP uses the NHS Breast Screening Programme Standards, for the purposes of quality assurance and programme monitoring.[1] Local performance during 2021-2023 has been assessed against the programme standards valid for data collected from 1st April 2021.

6.2 Monitoring Performance

6.2.1 Data Returns

The PHA Breast Screening Team monitors the performance of each of the four BSUs and the NI BSP against national standards using data submitted through Körner returns:

KC62 – This is an annual return made by HSCTs on: outcome of initial screen, outcome of further assessment, cancers diagnosed (by size and type) and overall output and outcome measures. KC62 data are obtained from the National Breast Screening System (NBSS), the IT system that supports the NI BSP.

KC63 – This is an annual return made by HSCTs on: numbers of eligible women, invited and screened by age, numbers recalled, numbers self or GP referred, and time since most recent screen in 12-month blocks.

6.2.2 Performance Thresholds

Two performance thresholds are specified within the national standards; acceptable and achievable.

Acceptable Standards: This is the lowest level of performance which services are expected to attain in order to ensure patient safety and service effectiveness. All units are expected to exceed the acceptable threshold and to agree service improvement plans that develop performance towards an achievable level. Programmes not meeting the acceptable threshold are expected to implement recovery plans to ensure rapid and sustained improvement.

Achievable Standards: This represents the level at which the services are likely to be running optimally. Screening services should aspire to attain and maintain performance at this level.

This report provides information on both the individual performance of the four BSUs and the overall NI BSP. Information on the performance of individual staff is not provided.

6.2.3 Performance Indicators

Performance indicators have been reported according to the corresponding stage of the screening pathway: uptake, test, referral and diagnosis. Table 3 outlines the various indicators used in assessing performance of the NI BSP during 2021-2023.*

Table 3: Indicators reported in assessing programme performance

Stage	Indicator
Uptake	Screening Uptake
	Screening Round Length
Test	Technical Recall/Repeat
	Screen to Routine Recall
Referral	Referred for Assessment (Prevalent)
	Referred for Assessment (Incident)
	Screen to Assessment (First Offered Appointment)
Diagnosis	Number of Cancers Detected
	Early Recall
	Non-Operative Diagnosis (Invasive)
	Non-Operative Diagnosis (Non-Invasive)
	Non-Invasive Cancer Detection (Prevalent)
	Non-Invasive Cancer Detection (Incident)
	Standardised Detection Rate Invasive Cancer (Prevalent)
	Standardised Detection Rate Invasive Cancer (Incident)
	Standardised Detection Rate Small Invasive Cancer (Prevalent and Incident)
	Benign Biopsy (Prevalent)
	Benign Biopsy (Incident)

* Indicators are reported to either one or two decimal places, to align with performance thresholds specified for each standard. Figures for average performance over the two-year period are calculated based on cumulative numbers, rather than averages of the rounded individual year performances. In some instances, these figures may therefore differ slightly to those that would be obtained by averaging the figures displayed for the individual years. Percentages may not always total 100 due to rounding.

6.3 Uptake

6.3.1 Screening Uptake

Screening Uptake is the proportion of women who attend for breast screening each year, following an invitation.

- Acceptable standard: ≥ 70.0% of women invited accept the offer of breast screening.
- Achievable standard: ≥ 80.0% of women invited accept the offer of breast screening.

During 2021-2023, 74.5% of women invited (139,355 of 186,935) took up the offer to attend for breast screening in Northern Ireland.

On average, during the two-year period between 2021 and 2023, 74.5% of women invited for breast screening took up the offer to attend. Table 4 outlines the number of women who were invited and the number who attended for breast screening, as well as associated uptake figures, for each individual year and the overall two-year period. During the two-year period between 2021 and 2023, 186,935 women aged between 50 and 70 were invited for breast screening in Northern Ireland, of whom 139,355 attended.

Table 4: Breast screening uptake (%) in the NI BSP 2021-2023

	2021-2022	2022-2023	2021-2023
Invited	98,452	88,483	186,935
Attended	73,607	65,748	139,355
Uptake (%)	74.8	74.3	74.5

The acceptable level of uptake was maintained throughout the two-year period between 2021 and 2023. Table 5 shows uptake figures for each individual BSU and Northern Ireland overall during 2021 to 2023, as well as comparative figures for England to enable benchmarking of performance.[4,5]

Table 5: Breast screening uptake (%) by BSU, 2021-2023			
	2021-2022	2022-2023	2021-2023
Eastern	72.2	72.3	72.2
Northern	77.2	77.6	77.4
Southern	76.1	75.1	75.7
Western	76.5	74.6	75.7
Northern Ireland	74.8	74.3	74.5
England	62.3	64.6	63.5

Over the two-year period, all BSUs maintained uptake levels above the acceptable level. Figure 1 shows trends in breast screening uptake per BSU and Northern Ireland overall between 2017 and 2023.

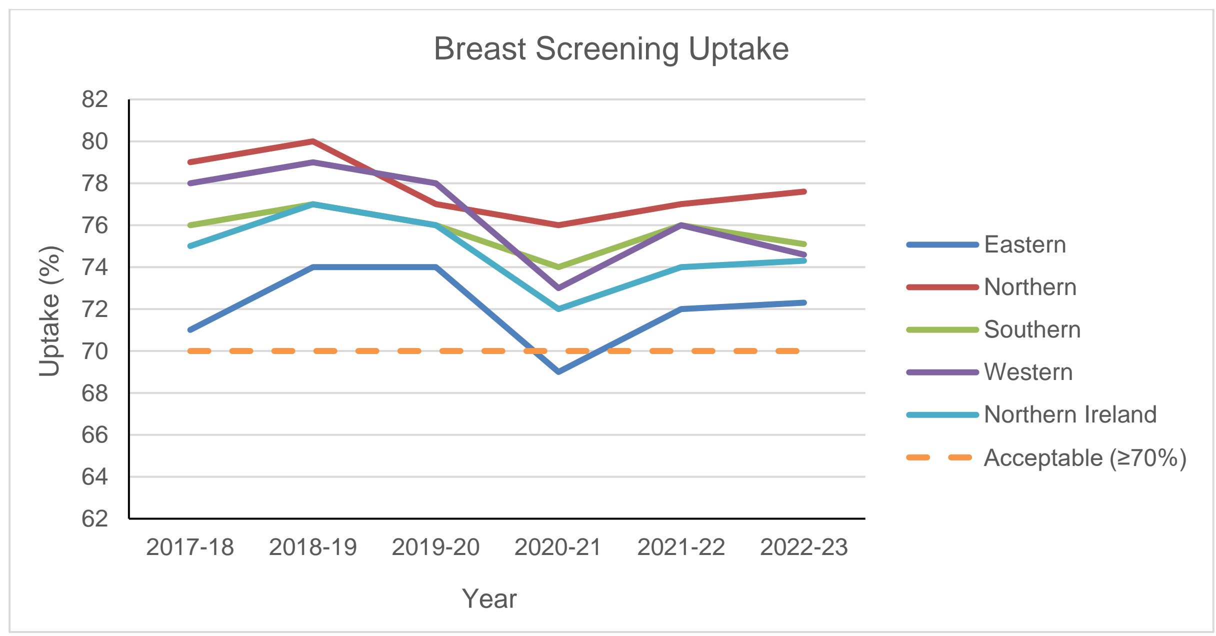

Figure 1: Breast screening uptake in Northern Ireland between 2017 and 2023

6.3.2 Screening Round Length

Screening Round Length is the interval between each offered invitation for screening mammography.

- Acceptable standard: ≥ 90.0% of women should be offered an appointment that is within 36 months of their previous screen.
- Achievable standard: ≥ 99.0% of women should be offered an appointment that is within 36 months of their previous screen.

On average during 2021-2023, 54.2% of women were offered an appointment that was within 36 months of their previous screen.

Measurement of the screening round length provides assurance that women with a previous invitation for screening have a subsequent invitation in a timescale that maximises the chance of cancer detection, whilst minimising harm to the woman. It also provides an indicator of the efficiency with which the screening programme is managed. The long-term effectiveness of the programme is dependent on women within the target age-group continuing to be screened at regular intervals.

On average during 2021 to 2023, 54.2% of women were offered a screening appointment that was within 36 months of their previous screen. This falls below the acceptable standard of ≥90%, being largely attributable to the pause in the delivery of breast screening that occurred as a result of the COVID-19 pandemic and the subsequent catch up phase. This is discussed further in Section 5 of this report.

Table 6 outlines the proportion of women offered a screening appointment that was within 36 months of their previous screen for each BSU and Northern Ireland overall by year.

Table 6: Percentage of women with a first offered appointment within 36 months of their previous screen

	2021-2022	2022-2023	2021-2023
Eastern	33.6	85.1	58.5
Northern	29.6	30.4	30.0
Southern	34.2	92.7	59.0
Western	44.3	88.2	63.6
Northern Ireland	35.3	75.3	54.2

The data in this table show that the proportion of eligible women in Northern Ireland offered a screening appointment that was within 36 months of their previous screen was 35.3% in 2021-2022, an improvement from the previous year (12.3% in 2020-2021, data not shown) during which the NI BSP was paused for a period of four months. As outlined previously, intensive efforts to recover the breast screening round length were implemented by each BSU, in collaboration with the PHA Breast Screening Team, following the resumption of screening services in July 2020. Close monitoring of this indicator during 2021-2022 onwards was undertaken to ensure that performance recovered to an acceptable level in each BSU and the NI BSP overall. In 2022-23, screening round length had increased to 75.3%.

Figure 2 shows trends in the proportion of women offered a screening appointment within 36 months of their previous screen in Northern Ireland between 2017 and 2023.

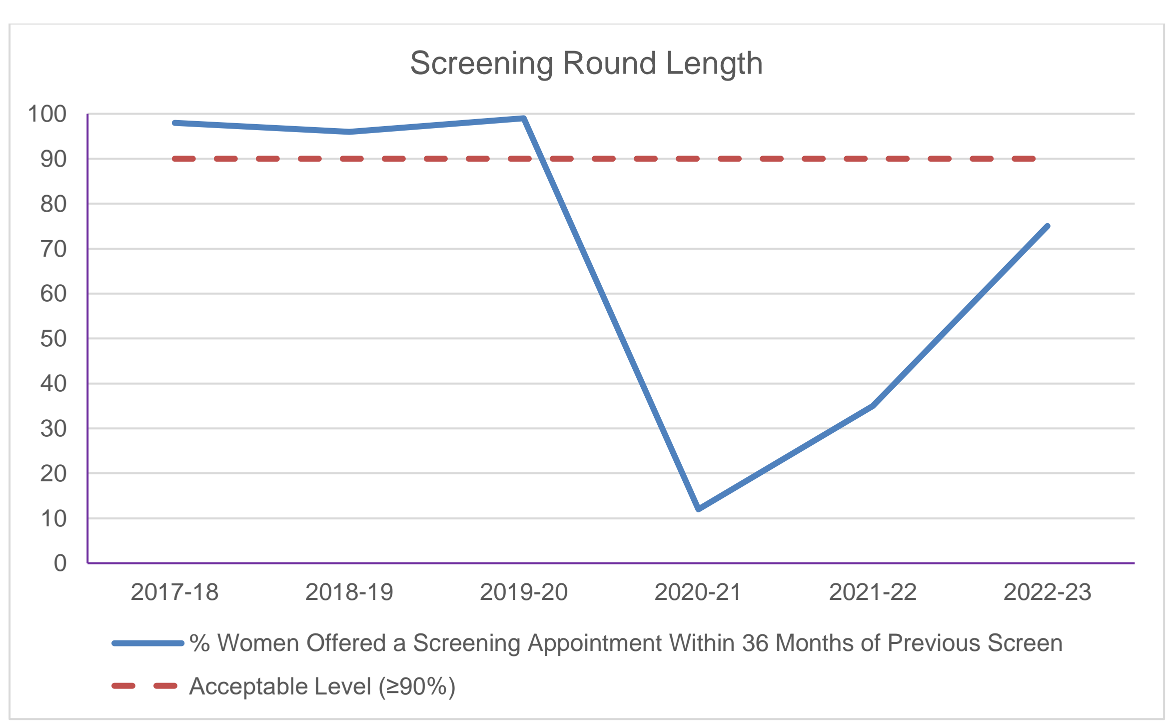

Figure 2: Percentage of women offered a screening appointment within 36 months of previous screen

6.4 Test

6.4.1 Technical Recall/ Repeat

Technical Recall/ Repeat measures the proportion of women who had additional mammograms due to technical recalls or technical repeats.

> During 2021-2023, 0.1% of women screened in Northern Ireland had a repeat examination due to a technical recall. 2.0% had a repeat examination due to a technical repeat.

Technical recall:

- Acceptable standard: less than 0.7%
- Achievable standard: less than 0.2%

Technical repeat:

- Acceptable standard: less than 2.0%
- Achievable standard: less than 1.2%.

Mammograms may need to be repeated if the quality of the first image is not adequate for diagnostic reporting. Technical recall refers to when women are recalled for a further appointment for repeat images, while technical repeat refers to when women undergo repeat imaging during the initial screening appointment. BSUs should aim to deliver the optimum image quality with as low a radiation dose as possible to minimise anxiety for women, as well as their exposure to radiation. The number and type of repeat examinations undertaken are monitored to make sure good quality practice is provided. Tables 7a and 7b show the technical recall and repeat rates for each BSU and Northern Ireland between 2021 and 2023.

Table 7a: Technical Recall rate (%) by BSU and Northern Ireland overall			
	2021-2022	2022-2023	2021-2023
Eastern	0.1	0.1	0.1
Northern	0.02	0.02	0.02
Southern	0.1	0.1	0.1
Western	0.0	0.0	0.0
Northern Ireland	0.08	0.05	0.07

Table 7b: Technical Repeat rate (%) by BSU and Northern Ireland overall			
	2021-2022	2022-2023	2021-2023
Eastern	2.5	1.5	2.0
Northern	2.0	2.0	2.0
Southern	1.4	1.9	1.6
Western	2.8	1.9	2.4
Northern Ireland	2.2	1.8	2.0

The technical recall rate in Northern Ireland for the two year period between 2021-23 met the achievable standard of <0.2%.

The technical repeat rate for Northern Ireland for the two years 2021-23 was 2.0% (acceptable standard <2.0%). In 2021/22 the NI rate was 2.2% and in 2022/23 the NI rate was 1.8%.

6.4.2 Screen to Routine Recall

Screen to Routine Recall measures the proportion of women with a normal screening test who receive their results within two weeks of attendance for their screening mammogram.

During 2021-2023, 99.4% of women who had a normal screening test received their results within two weeks of attendance for their screening mammogram.

- Acceptable standard: ≥ 95.0% women receiving their results within two weeks of attendance for their screening mammogram.
- Achievable standard: ≥ 99.0% women receiving their results within two weeks of attendance for their screening mammogram.

To minimise anxiety, it is essential that women receive the results of screening in a timely manner. The date a woman receives her result is not

recorded, therefore the date her episode is closed on NBSS is taken as a proxy for this. This assumes the screening office has good administrative processes to minimise delays in posting the results letters. Table 8 shows the Screen to Routine Recall rate for each BSU and Northern Ireland overall, during each year between 2021 and 2023, as well as the average for the entire period.

Table 8: Screen to routine recall rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2021-2023
Eastern	99.8	98.4	99.1
Northern	99.9	99.4	99.6
Southern	100.0	100.0	100.0
Western	99.9	98.4	99.2
Northern Ireland	99.8	98.9	99.4

The achievable standard for Screen to Routine Recall was met consistently across all BSUs and Northern Ireland overall during 2021-2023, with the exception of the Eastern and Western BSUs which met the acceptable level (i.e. ≥ 95.0%) in 2022-2023. During 2021-2023 an average of 99.4% of women with a normal screening test received their results within two weeks of their screening appointment. In the Southern Unit, 100.0% of women with a normal screening test received their results within two weeks of their screening appointment during each year throughout this period.

Figure 3 shows the trend in the proportion of women with a normal screening test receiving their results within two weeks of attendance for their screening mammogram in Northern Ireland between 2017 and 2023.

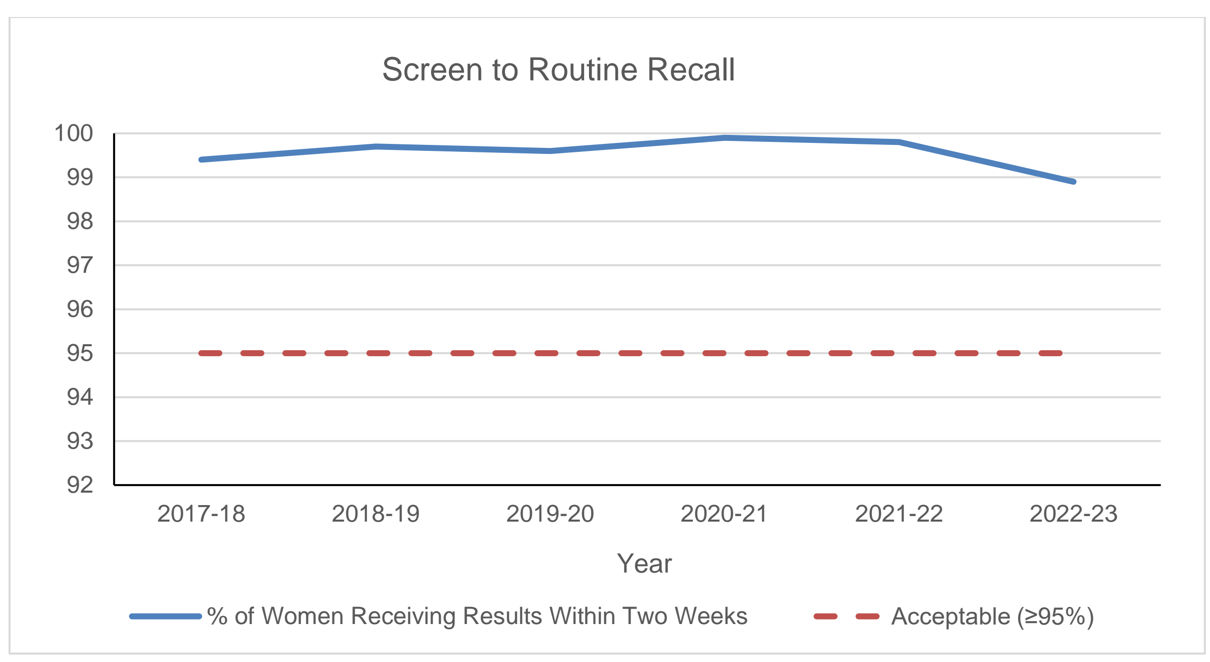

Figure 3: Percentage of women with a normal screening test receiving results within two weeks

6.5 Referral

About four in every one hundred women are asked to come back for more tests after screening as their mammogram looks abnormal. These women are invited to attend an assessment clinic for further tests (e.g. breast examination, ultrasound scan or biopsy) which will help confirm if the woman has breast cancer. On average, one in four women referred for assessment are found to have cancer. The three in four women confirmed as not having cancer are returned to the routine screening programme to be invited for screening again in three years (unless they will be over the age of 70, when they can self-refer).

6.5.1 Referred for Assessment

Referred for Assessment measures the proportion of women screened who are referred for further assessment.

The purpose of this standard is to provide assurance that women are not referred for further tests unnecessarily. Those responsible for interpreting the images from breast screening need to make sure that they are recalling women with areas of concern which require further investigation, whilst not recalling too many women where no abnormalities are subsequently found. The percentage of women who are recalled to an assessment clinic is normally higher in those attending their first screening mammogram (prevalent screens) than in those attending for subsequent screening mammography (incident screens).

Prevalent Screen

> During 2021-2023, 4.9% of women screened during a prevalent screen were referred for assessment, while the equivalent figure for incident screens was 2.0%.

- Acceptable standard: <9.0% of women screened referred for further assessment.
- Achievable standard: <7.0% of women screening referred for further assessment.

During 2021 to 2023, 4.9% of women were referred for assessment from a prevalent (first screen), meeting the achievable standard of <7.0%.

Table 9 outlines the proportion of women referred for assessment from a prevalent screen each year between 2021 and 2023 by BSU and Northern Ireland overall. All BSUs met the achievable standard of <7.0% in each year during the period.

Table 9: Percentage of women referred for assessment by BSU and Northern Ireland overall – prevalent screen			
	2021-2022	2022-2023	2021-2023
Eastern	5.1	4.8	5.0
Northern	5.6	4.2	4.9
Southern	5.6	5.1	5.4
Western	3.3	4.8	4.0
Northern Ireland	5.0	4.7	4.9

Figure 4 shows trends in the proportion of women referred for assessment from a prevalent screen per BSU and Northern Ireland overall between 2017 and 2023.

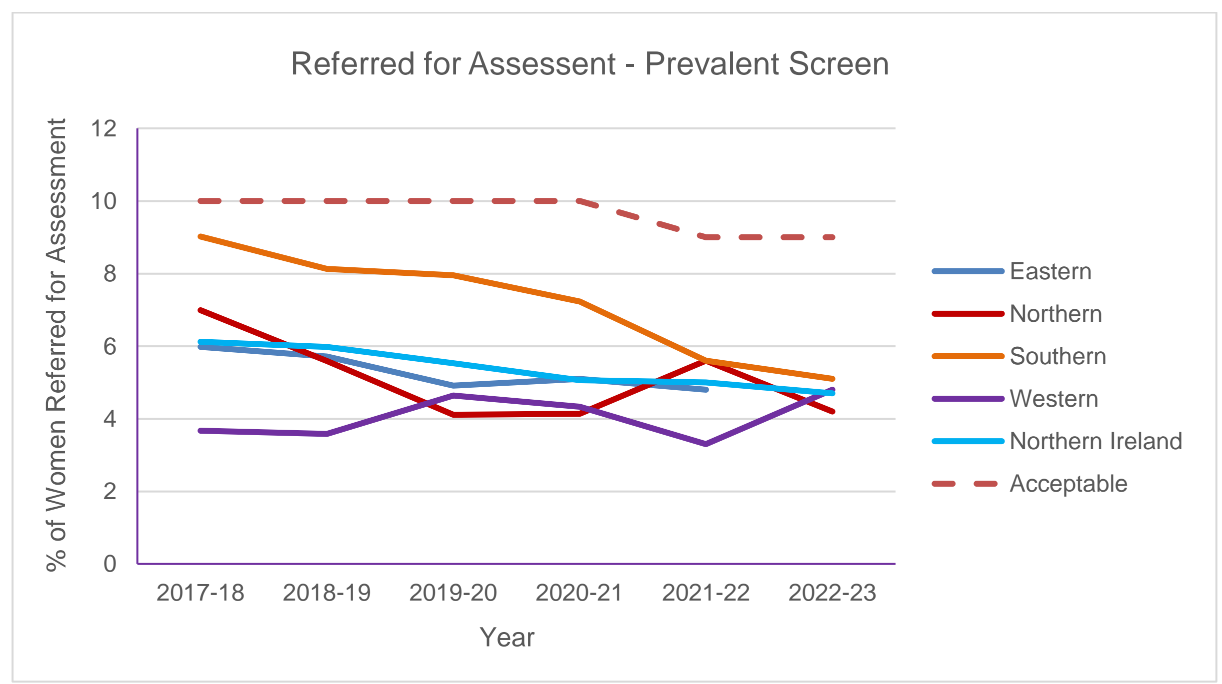

Figure 4: % of women referred for assessment from a prevalent screen

The acceptable standard changed in 2021, from less than 10.0% to less than 9.0%.

Incident Screen

- Acceptable standard: <4.0% of women screened referred for further assessment.

- Achievable standard: <3.0% of women screened referred for further assessment.

During 2021 to 2023, 2.0% of women were referred for assessment from an incident (subsequent screen), meeting the achievable standard of <3.0%. Table 10 outlines the proportion of women referred for assessment from an incident screen each year between 2021 and 2023 by BSU and Northern Ireland overall. All BSUs consistently met the achievable standard for the proportion of women referred for assessment from incident screens.

Table 10: Percentage of women referred for assessment by BSU and Northern Ireland overall – incident screen

	2021-2022	2022-2023	2021-2023
Eastern	1.7	1.7	1.7
Northern	2.3	1.8	2.0
Southern	2.7	2.8	2.7
Western	1.5	1.9	1.7
Northern Ireland	2.0	2.0	2.0

Figure 5 shows trends in the proportion of women referred for assessment from an incident screen per BSU and Northern Ireland overall between 2017 and 2023.

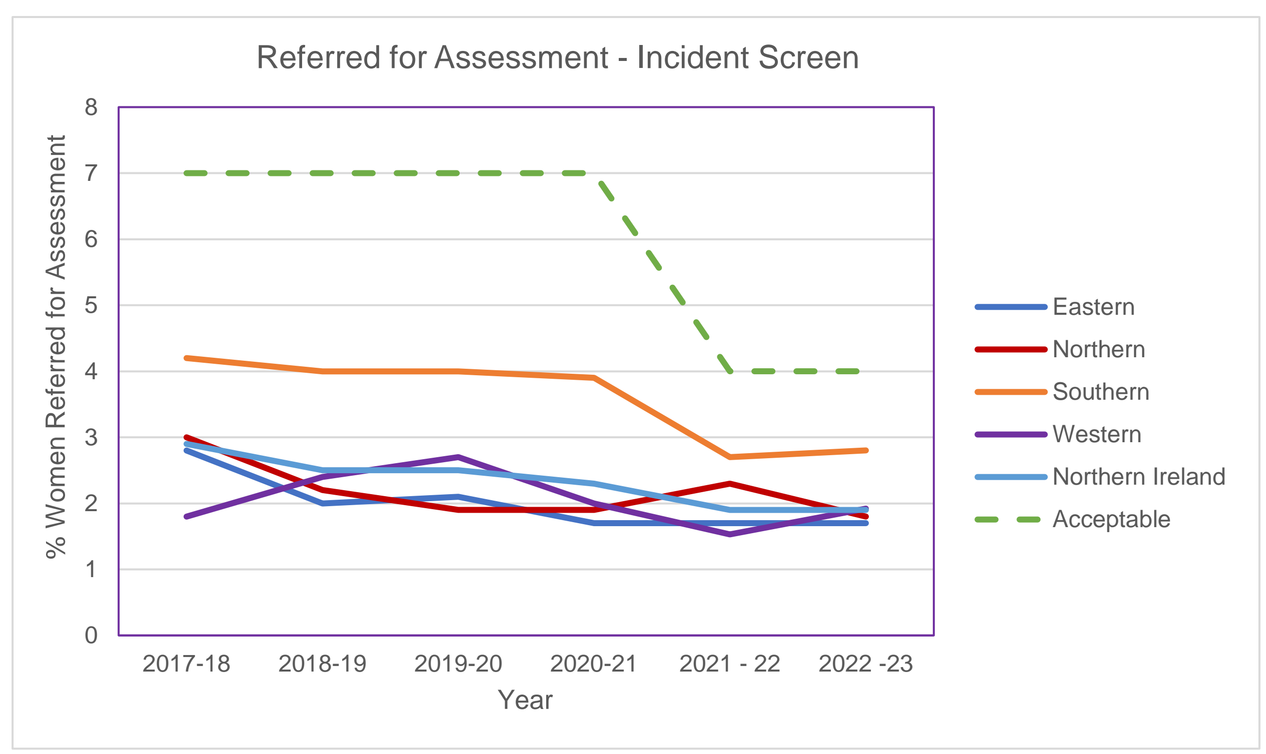

Figure 5: Percentage of women referred for assessment from an incident screen

The acceptable standard changed in 2021, from less than 7.0% to less than 4%.

6.5.2 Screen to Assessment (First Offered Appointment)

Screen to Assessment measures the proportion of women who are offered an appointment at an assessment centre within three weeks of attendance for their screening mammogram.

During 2021-2023, 98.3% of women referred for assessment were offered an assessment appointment that was within three weeks of their screening mammogram.

- Acceptable standard: ≥95.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.
- Achievable standard: ≥99.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.

Monitoring this standard aims to minimise the time taken for women who need further investigations to obtain a definitive malignant, benign or

normal diagnosis. Overall between 2021 and 2023, 98.3% of women who were referred for assessment in Northern Ireland were offered an assessment appointment that was within three weeks of their screening mammogram. Table 11 outlines the achievement of this standard by BSU and Northern Ireland overall for each individual year, as well as the two-year average.

The acceptable standard was consistently met in all BSUs, with the exception of the Eastern BSU during 2022-2023, in which 94.7% of women referred for assessment were offered an assessment appointment that was within three weeks of their screening mammogram (acceptable level ≥95%). The achievable level had been met by the Eastern BSU during the previous time period 2021-2022 i.e. 99.1%. The Northern and Southern BSUs met the achievable standard of ≥99.0% throughout 2021-2023.

Table 11: Screen to assessment rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2021-2023
Eastern	99.1	94.7	96.9
Northern	99.8	99.7	99.7
Southern	99.5	98.7	99.1
Western	98.3	98.5	98.4
Northern Ireland	99.2	97.3	98.3

Figure 6 shows trends in the proportion of women referred for assessment who are offered an assessment appointment within three weeks of their screening mammogram per BSU and Northern Ireland overall between 2017 and 2023.

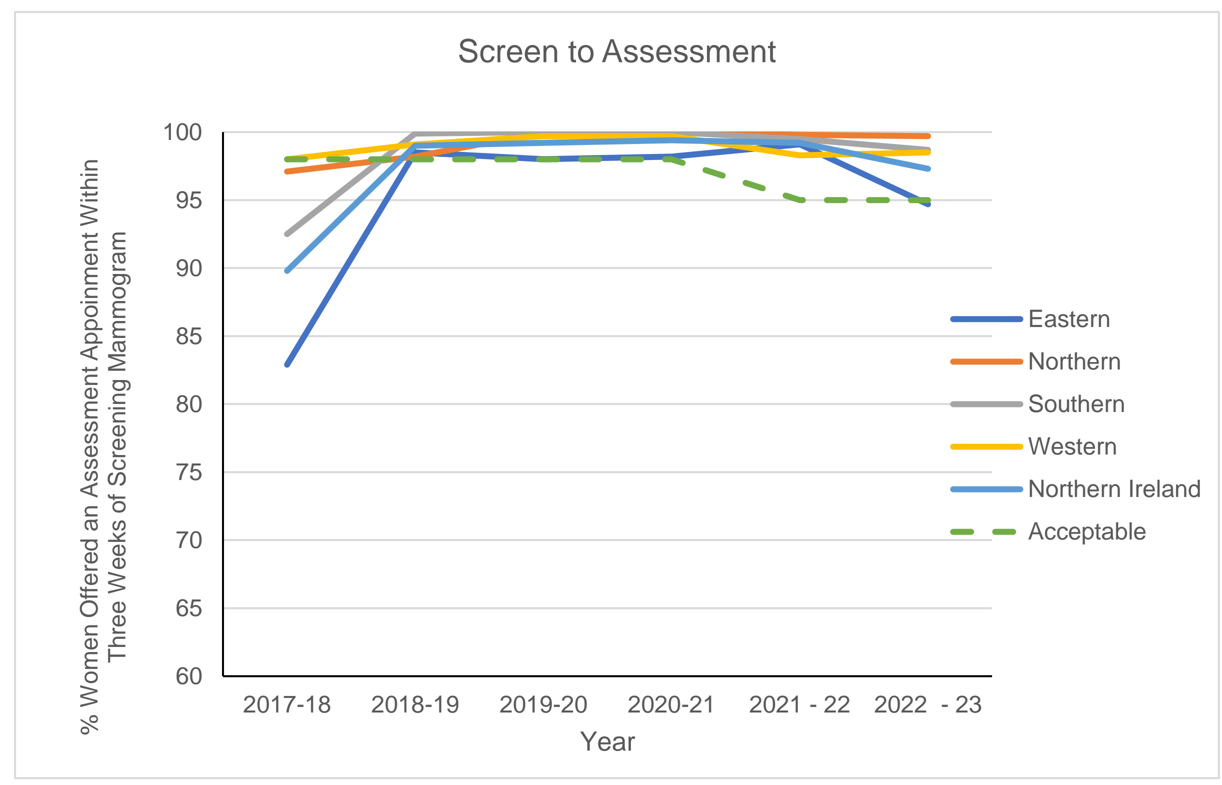

Figure 6: Percentage of women offered an assessment appointment within three weeks of screening mammogram

The acceptable standard changed in 2021, from 98.0% to 95.0%.

6.6 Diagnosis

6.6.1 Number of Cancers Detected

1055 breast cancers were detected through screening in Northern Ireland between 2021-2023.

Between 2021 and 2023, 1055 breast cancers were detected through screening in Northern Ireland, 601 in 2021/22 and 454 in 2023/23. 861 (81.6%) of these were invasive cancers. Of the remainder, the majority were micro-invasive and non-invasive cancers with a small number (<5) of cancers with unknown invasive status.

6.6.2 Early Recall

Early Recall measures the proportion of women screened who are referred for further tests and invited back to assessment at an interval of at least one year (short-term recall).

During 2021-2023, 0.02% of women who were screened and referred for further tests were placed on short-term recall.

- Acceptable standard: <0.25% of women who are screened and referred for further tests should be placed on short-term recall.
- Achievable standard: <0.12% of women who are screened and referred for further tests should be placed on short-term recall.

Table 12 illustrates the proportion of women placed on short-term recall within each BSU and Northern Ireland overall during 2021 to 2023. Performance in each BSU and Northern Ireland overall consistently met the achievable threshold of <0.12%.

Table 12: Short-term recall rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2021-2023
Eastern	0.00	0.03	0.05
Northern	0.07	0.01	0.03
Southern	0.00	0.00	0.00
Western	0.01	0.02	0.01
Northern Ireland	0.01	0.02	0.02

6.6.3 Non-Operative Diagnosis Rate

Non-Operative Diagnosis measures the proportion of women who have a non-operative diagnosis of cancer by needle histology or cytology after a maximum of two assessment clinic visits, as a proportion of all women screened diagnosed with breast cancer. This standard is reported separately for invasive and non-invasive cancers.

> During 2021-2023, diagnosis was established prior to surgery for 99.8% of women with an invasive screen-detected cancer and 93.7% of women with a non-invasive screen-detected cancer.

It is important to minimise the number of operative procedures and to enable treatment planning in advance of surgery. To achieve this, the majority of women should receive a non-operative pathological diagnosis of cancer. However, some women may need to have a surgical biopsy i.e. a biopsy taken during surgery, if the diagnosis is difficult to establish beforehand.

Invasive Cancer

- Acceptable standard: ≥99.0% of invasive screen-detected cancers should be diagnosed before surgery.

Overall, 99.8% of invasive screen-detected cancers in Northern Ireland diagnosed between 2021 and 2023 had a non-operative pathological diagnosis of cancer, meeting the acceptable standard of ≥99%.

Table 13 shows non-operative diagnosis rates for invasive screen-detected cancers for each BSU and Northern Ireland overall during 2021 to 2023. The performance of all BSUs, with the exception of the Western BSU, consistently exceeded the acceptable standard of ≥99.0%, with 100.0% of women receiving a non-operative diagnosis of invasive cancer throughout the period. During 2022-2023, the Western BSU did not meet the acceptable standard, at 97.7%.

Table 13: Non-operative diagnosis rate (%) – invasive cancer			
	2021-2022	2022-2023	2021-2023
Eastern	100.0	100.0	100.0
Northern	100.0	100.0	100.0
Southern	100.0	100.0	100.0
Western	100.0	97.7	98.8
Northern Ireland	100.0	99.5	99.8

Figure 7 shows trends in the proportion of invasive screen-detected cancers with a diagnosis established prior to surgery per BSU and Northern Ireland overall between 2017 and 2023.

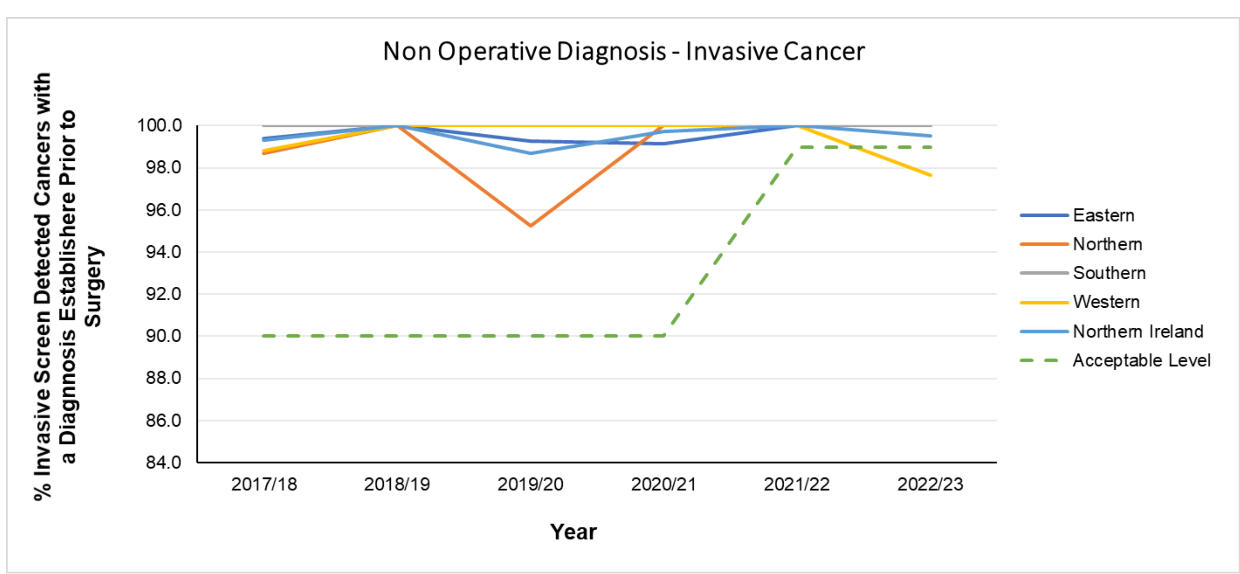

Figure 7: Percentage of invasive screen-detected cancers with a diagnosis established prior to surgery

The acceptable standard changed in 2021, from greater than or equal to 90% to greater than or equal to 99%.

Non-Invasive Cancer

- Acceptable standard: ≥90.0% of non-invasive screen-detected cancers should be diagnosed before surgery.
- Achievable standard: ≥95.0% of non-invasive screen-detected cancers should be diagnosed before surgery.

Overall, 93.7% of non-invasive screen-detected cancers in Northern Ireland diagnosed between 2021 and 2023 had a non-operative

pathological diagnosis of cancer, meeting the acceptable standard of ≥90.0%. Table 14 illustrates non-operative diagnosis rates for non-invasive screen-detected cancers for each BSU and Northern Ireland overall during 2021 to 2023. Performance dropped below the acceptable level of ≥90.0% in the Western Unit, from 90.0% in 2021-2022 (meeting the acceptable level) to 73.7% 2022-2023. This was explored with the unit and found to be due to a data entry error.

Table 14: Non-operative diagnosis rate (%) – non-invasive cancer			
	2021-2022	2022-2023	2021-2023
Eastern	92.3	100.0	95.9
Northern	95.2	93.8	94.5
Southern	100.0	100.0	100.0
Western	90.9	73.7*	82.9
Northern Ireland	94.3	3.0	93.7

*Discussed with unit – related to data entry error

6.6.4 Non-Invasive Cancer Detection

Non-Invasive Cancer Detection measures the number of non-invasive carcinoma (in situ) cancers that are detected per 1,000 women screened.

Between 2021-2023, the average non-invasive cancer detection rate was 1.7 per 1,000 women screened during a prevalent screen and 1.2 per 1,000 women screened during an incident screen.

Prevalent

- Acceptable standard: ≥0.5 non-invasive cancers detected per 1,000 women screened.

The average non-invasive cancer detection rate from a prevalent screen was 1.7 per 1,000 eligible women screened, meeting the acceptable standard. Table 15 outlines non-invasive cancer detection rates for the prevalent screen during each year between 2021 and 2023, as well as the two-year average for each BSU and Northern Ireland overall. Each BSU met the acceptable standard.

Table 15: Non-invasive cancer detection rate (%) by BSU and Northern Ireland overall – prevalent screen			
	2021-2022	2022-2023	2021-2023
Eastern	0.9	2.6	1.7
Northern	3.1	0.9	2.0
Southern	1.0	0.5	0.8
Western	2.4	2.6	2.5
Northern Ireland	1.6	1.8	1.7

Incident

- Acceptable standard: $\geq$0.6 non-invasive cancers detected per 1,000 women screened.

The average non-invasive cancer detection rate from an incident screen was 1.2 per 1,000 women screened, meeting the acceptable standard. Table 16 outlines non-invasive cancer detection rates from incident screens during each year between 2021 and 2023, as well as the two-year average for each BSU and Northern Ireland overall. The performance of all individual BSUs consistently exceeded the acceptable standard throughout the two-year period.

Table 16: Non-invasive cancer detection rate (%) by BSU and Northern Ireland overall – incident screen			
	2021-2022	2022-2023	2021-2023
Eastern	1.5	0.9	1.2
Northern	1.3	1.0	1.1
Southern	1.4	1.5	1.4
Western	1.1	1.3	1.2
Northern Ireland	1.4	1.1	1.2

6.6.5 Standardised Detection Ratio for Invasive Cancer

The Standardised Detection Ratio is the ratio of the observed number of invasive cancers to the expected number in the eligible population invited and screened, given the age distribution of the population.

> The SDR for invasive cancers in Northern Ireland between 2021-2023 was 1.2 for prevalent screens and 1.2 for incident screens.

It is important to be able to compare cancer detection between screening services with differing mean ages of screening populations. This is corrected for by using a standard detection ratio (SDR). This allows the observed invasive cancers to be compared to the expected number of invasive cancers, given the age distribution of the population. The expected number of cancers is based on applying criteria from the Swedish Two Counties randomised control trial which is used as a comparator of performance. A 20% increase on the original expected levels has been used since 2021 to account for the increase in background incidence in invasive breast cancer in the population since the previous rates were applied in 1993.[1] An SDR of one indicates the observed number of invasive cancers is the same as that expected; greater than one indicates a higher detection rate, and less than one a lower detection rate.

Prevalent Screen

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for invasive cancers from a prevalent screen in Northern Ireland between 2021 and 2023 was 1.2, meeting the achievable standard. Table 17 shows the SDR for invasive cancers from a prevalent screen each year between 2021 and 2023, as well as the two-year average, for each BSU and Northern Ireland overall.

Table 17: Standardised detection ratio invasive cancer by BSU and Northern Ireland overall – prevalent screen

	2021-2022	2022-2023	2021-2023
Eastern	0.9	1.2	1.0
Northern	0.9	1.0	1.0
Southern	1.4	1.2	1.4
Western	1.2	1.9	1.5
Northern Ireland	1.1	1.3	1.2

Incident Screen

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for invasive cancers from an incident screen in Northern Ireland between 2021 and 2023 was 1.2, meeting the achievable standard. Table 18 shows the SDR for invasive cancers from an incident screen each year from 2021 - 2023, as well as the two-year average, for each BSU and Northern Ireland overall.

Table 18: Standardised detection ratio invasive cancer by BSU and Northern Ireland overall – incident screen

	2021-2022	2022-2023	2021-2023
Eastern	1.2	1.4	1.3
Northern	1.1	0.8	1.0
Southern	1.3	1.4	1.4
Western	1.0	1.2	1.1
Northern Ireland	1.1	1.2	1.2

6.6.6 Standardised Detection Ratio for Small Invasive Cancer

Standardised Detection Ratio Small Invasive Cancer is the ratio of the observed number of small invasive cancers (<15mm) to the expected number in the eligible population invited and screened, given the age distribution of the screened population.

This standard is measured for both prevalent and incident screens combined.

The SDR for small invasive cancers in Northern Ireland between 2021-2023 was 1.1.

Prevalent and Incident Screen:

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for small invasive cancers in Northern Ireland between 2021 and 2023 was 1.1, meeting the acceptable standard. Table 19

shows the SDR for small invasive cancers from 2021 - 2023, as well as the two-year average, for each BSU and Northern Ireland overall.

Table 19: Standardised detection ratio small invasive cancer by BSU and Northern Ireland overall – prevalent and incident screens			
	2021-2022	2022-2023	2021-2023
Eastern	1.0	1.0	1.0
Northern	1.0	0.7	0.8
Southern	1.5	1.3	1.4
Western	1.0	1.2	1.1
Northern Ireland	1.1	1.0	1.1

6.6.7 Benign Biopsy Rates

Benign Biopsy Rate is a measure of the number of women per 1,000 women screened who had surgery for benign breast disease i.e. an open surgical biopsy with a benign or normal histological outcome.

0.7 women per 1,000 women screened during a prevalent screen had surgery for benign breast disease, while the equivalent figure for incident screens was 0.2 per 1,000 women screened.

The aim of this standard is to minimise harm to women due to unnecessary surgery. The number of open surgical biopsies performed because of screening that prove to be benign should be as low as possible.

Prevalent Screen

- Acceptable standard: <1.5 benign biopsies per 1,000 women screened.
- Achievable standard: <1.0 benign biopsies per 1,000 women screened.

The Northern Ireland average benign biopsy rate from prevalent screens between 2021 and 2022 was 0.7 per 1,000 women screened, meeting the achievable standard. Table 20 shows benign biopsy rates from prevalent

screens for Northern Ireland overall during 2021 to 2023. Due to small numbers these data are not presented at BSU level.

Table 20: Benign biopsy rate (%) for Northern Ireland overall – prevalent screen

	2021-2022	2022-2023	2021-2023
Northern Ireland	0.8	0.7	0.7

Incident Screen

- Acceptable standard: <1.0 benign biopsies per 1,000 women screened.
- Achievable standard: <0.75 benign biopsies per 1,000 women screened.

The Northern Ireland average benign biopsy rate from incident screens between 2021 and 2023 was 0.2 per 1,000 women screened, meeting the achievable standard. Table 21 outlines benign biopsy rates from incident screens for Northern Ireland overall during 2021 to 2023. The performance of all BSUs consistently exceeded the achievable standard throughout the two-year period. Due to small numbers these data are not presented at BSU level.

Table 21: Benign biopsy rate (%) for Northern Ireland overall – incident screen

	2021-2022	2022-2023	2021-2023
Northern Ireland	0.2	0.2	0.2

7. Very High-Risk Breast Screening Programme

Surveillance screening for women at very high risk (VHR) of developing breast cancer was introduced in Northern Ireland in 2013. In September 2020, the programme title was changed from the 'Higher Risk Breast Surveillance Screening Programme' to the 'Very High-Risk Breast Screening Programme (VHR BSP)', to reflect national guidance. This title change does not indicate any increase in cancer risk for those enrolled in the programme.

Women at VHR are defined as those with more than or equal to eight times the relative risk of developing breast cancer compared to women in the general population. A woman may be at VHR of developing breast cancer due to a genetic mutation, most commonly in the BRCA gene, or a result of previous radiotherapy to the chest area. Women may be referred into the VHR BSP by a specialist in genetics, family history or oncology, where their family or medical history indicate a higher risk of developing breast cancer. The VHR BSP offers breast imaging at an earlier age and on a more regular basis than the routine BSP. Women enrolled in the programme are invited for annual Magnetic Resonance Imaging (MRI), mammography, or both depending on their age and reason for referral, up until their 50th birthday. After this, some women will remain within the VHR BSP, while others will enter routine breast screening. The protocols for each risk category determine screening frequency.

The VHR BSP is provided regionally at Antrim Area Hospital, in the Northern HSCT. The VHR BSU at Antrim Area Hospital is managed by a lead radiologist, with input from other radiologists, radiographers and administrative support. The programme is managed in line with the Northern HSCT VHR Breast Screening Operational Policy and overseen by a VHR BSP Coordinating Group, chaired by the PHA Consultant Lead for the NI VHR BSP. The VHR BSP Coordinating Group meets twice per year (and by exception) and includes representation from all HSCTs and disciplines involved in the delivery of the VHR BSP. A representative from BRCA Link NI (a voluntary organisation helping people to access information and support about BRCA genetic mutations), who were involved in the establishment of the VHR BSP, also sits on the VHR BSP

Coordinating Group. The programme is included in the QA Visits to the Northern Unit and in internal QA activities undertaken by the Northern HSCT.

In line with the NI BSP (outlined in section 6), the VHR BSP uses the NHS Breast Screening Programme Standards, for the purposes of quality assurance and programme monitoring.[1]

National standards for the VHR BSP came into effect for data collected from April 2021. Table 22 below outlines those standards applicable for the VHR BSP.

Table 22: Very High Risk Standards, valid for data collected from 1st April '21.

Standard	Description	Acceptable level	Achievable level
Screening Uptake	The proportion of eligible women who have a technically adequate screen ≤ 6 months from date of first offered appointment.	≥ 85.0%	≥ 95.0%
Screening Round Length (shadow)	The proportion of eligible women whose date of first offered appointment is ≤ 12 months from their previous episode.	To be set	To be set
Screen to Routine Recall	The proportion of women who have a results letter with no referral for further testing produced on NBSS ≤ 2 weeks from a technically adequate screen.	≥ 95.0%	≥ 99.0%
Rate of Referral to Assessment	The proportion of eligible women with a technically adequate screen who are referred for assessment.	< 10.0%	< 7.0%
Time to First Offered Appointment for Assessment	The proportion of women referred for assessment whose date of first offered appointment at an assessment centre is ≤ 3 weeks (≤ 21 calendar days) from attendance for the screening mammogram.	≥ 95.0%	≥ 99.0%

* Round length for the VHR BSP remains in shadow format, as data continues to be evaluated in order to determine an acceptable and achievable level.

Once NI have implemented the new software system to support breast screening (see section 9.2), VHR activity data and standards will be available for presentation.

8. Promoting Informed Choice

Although the overall uptake of breast screening in Northern Ireland meets the acceptable standard, uptake rates within certain geographical areas and subpopulations of women remain consistently lower than the general population. During 2021 to 2023, the PHA Breast Screening Team, in partnership with other stakeholders, continued to work to ensure that all eligible women in Northern Ireland can make an informed choice about attending for breast screening and that the service is as accessible as possible.

Key actions to promote informed choice during 2021 to 2023 included:

Regional Group on Promoting Informed Choice in Breast Screening.

This group is chaired by a member of the PHA Breast Screening team and has representation from all BSUs, as well as HSCT Health Promotion staff. The remit of the group is to identify opportunities to promote informed choice in the NI BSP, with a particular focus on women from disadvantaged communities, women who have learning/physical/sensory disabilities, women from minority ethnic groups, older women and other women considered to have additional needs. The group also aims to identify and share good practice in relation to promoting informed choice within breast screening and to advise on the provision of information to the public and health care professionals.

Inclusion of Promoting Informed Choice meetings in QA Visits to BSUs.

The PHA Breast Screening Team includes standalone meetings related to promoting informed choice in breast screening in the four-yearly QA Visits to BSUs. A dedicated chapter on promoting informed choice is included within each QA visit report.

Working with the Women's Resource and Development Agency (WRDA).[6]

In 2015, the PHA commissioned the WRDA, a local not-for-profit organisation, to raise awareness of the Breast, Cervical and Bowel Cancer Screening Programmes and to promote informed choice among

individuals from communities and populations with historically lower cancer screening uptake rates compared with the general population. The aim of the WRDA's programme of work is to provide individuals with sufficient information to enable them to make an informed decision about participating in cancer screening programmes. The WRDA recruit, train and support Peer Facilitators to deliver Educational Awareness Sessions to targeted service user groups, including people from deprived areas, those from ethnic minorities, those from the LGBT+ community, homeless individuals and those with physical disabilities, learning disabilities or mental health issues. WRDA also carry out Bespoke Workshops for those latter groups with additional support needs.

Collaborating with HSCTs to ensure that comprehensive, up to date, information on screening is available on their website.

9. Other developments in the Breast Screening Programme

9.1 Digital mammography equipment and breast screening mobile unit replacement

In 2021 the PHA and the five HSC Trusts established a project to support the development of a regional business case to replace, and add to, the mammography equipment used by the screening and symptomatic breast services and the breast screening mobile trailers. This regional capital business case was led by the Belfast HSC Trust on behalf of the Northern Ireland Breast services. This was finalised in 2023.

9.2 Maintaining the integrity and functionality of NBSS in Northern Ireland

A project was established by the PHA in 2021 to obtain and implement a software solution to allow NBSS, the IT system underpinning the Breast Screening Programme, to continue to be updated and operate effectively. The project involves multiple stakeholders within Northern Ireland and the NHS in England.

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Breast Screening Programme

Annual Report
2023-2024

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1. Introduction

The Public Health Agency (PHA) monitors and quality assures the Northern Ireland Breast Screening Programme (NI BSP) to ensure that women in Northern Ireland have access to a high-quality breast screening service that meets national standards. This annual report describes the performance of the NI BSP during the year 2023/2024.

The statistics presented within this report cover activity in the NI BSP between 1st April 2023 and 31st March 2024, including invitations for breast screening, breast screening uptake, the breast screening pathway, outcomes of breast screening and the number and type of breast cancers detected. Local performance against each key indicator outlined in the NHS Breast Screening Programme Standards has been assessed to determine whether an appropriate level of performance which aligns with national standards has been achieved.[1] Data are presented for each of the four Breast Screening Units (BSUs) in Northern Ireland, in addition to data describing overall regional performance.

The majority of statistics have been derived from data submitted by each BSU in the form of Körner returns using data from the National Breast Screening System (NBSS), the IT system supporting the NI BSP. This information is routinely collected by the NI BSP for operational purposes, including quality assurance. Data on the number and subtype of screen-detected breast cancers in Northern Ireland between 2023 and 2024 have been obtained from bespoke NBSS reports.

A summary of key statistics in the NI BSP is included on Page 4. Page 5 includes a table showing performance of each Breast Screening Unit and Northern Ireland as a whole against the standards discussed in this report.

Summary of Key Statistics in the Northern Ireland Breast Screening Programme 2023-2024

Uptake

87,275 women aged between 50 and 70 years were invited for breast screening; 64,494 attended for screening, giving an uptake rate of 73.9%.

Invitation

96.7% of women were offered an appointment for mammography screening that was within 36 months of their previous normal screen.

Results

99.0% of women, who had a normal test result, received their results within two weeks of their screening appointment.

Assessment

98.7% of women who required further tests were offered an appointment within three weeks of their screening mammogram.

Cancer Detection

565 breast cancers were detected through screening; 468 (83%) of these were invasive cancers.

Treatment of Invasive Cancer

Of the 468 women diagnosed with screen-detected invasive cancer, 387 (83%) had breast conserving surgery, 61 (13%) had a mastectomy and 20 (4%) had no surgery.

Performance against key standards, 2023/24

Table 1 outlines performance of the NI BSP against key standards in the year 2023/24, providing data at regional level and by BSU.

The data in this table are colour coded green if the achievable standard is met, amber if the acceptable standard is met and red if the acceptable standard is not met. A definition of the acceptable and achievable performance thresholds is included in section 5.2.2.

Table 1: Performance of NI BSUs against key standards in 2023/24.

STANDARD	NI	Eastern	Northern	Southern	Western	National Standards
Uptake Rate (%)	73.9	72.2	77.4	75.7	75.7	Acceptable >70% Achievable >80%
Screening Round Length (%)	96.7	99.1	93.5	99.8	98.3	Acceptable >90.0% Achievable >99.0%
Technical Recall (%)	0.1	0.1	0.0	0.1	0.0	Acceptable <0.7% Achievable <0.2%
Technical Repeat (%)	1.8	2.2	1.7	1.1	1.9	Acceptable <2% Achievable <1.2%
Screen to Routine Recall (%)	99.0	99.4	98.5	100.0	97.9	Acceptable >95.0% Achievable >99.0%
Referred to Assessment (%)						
Prevalent Screen	5.1	6.3	4.4	6.3	3.7	Acceptable <9% Achievable <7%
Incident Screen	2.1	2.0	1.8	3.0	1.9	Acceptable <4% Achievable <3%
Screen to Assessment (Date of First Offered Appt.)	98.7	98.1	100.0	99.8	97.2	Acceptable >95.0% Achievable >99.0%
Short term recall rate (%)	0.02	0.02	0.02	0.00	0.01	Acceptable <0.25% Achievable <0.12%

STANDARD	NI	Eastern	Northern	Southern	Western	National Standards
Non Operative Diagnosis Rate						
Invasive	100.0	100.0	100.0	100.0	100.0	Acceptable >99%
Non-Invasive	92.9	87.0	90.5	95.0	100.0	Acceptable >90.0% Achievable >95.0%
Non -Invasive Cancer Detection Rate per 1000						
Prevalent	2.2	2.0	2.5	0.7	0.9	Acceptable >0.5/1000
Incident	1.2	0.8	1.1	1.7	1.5	Acceptable >0.6/1000
Standardised Detection Rate (All Invasive Cancer)						
Prevalent	1.2	1.3	1.1	1.3	1.1	Acceptable >1.0 Achievable >1.2
Incident	1.2	1.3	1.0	1.3	1.2	Acceptable >1.0 Achievable >1.2
Standardised Detection Rate (Small Invasive Cancer)	1.1	1.2	1.0	1.2	1.0	Acceptable >1.0 Achievable >1.2
Benign Biopsy Rate						
Prevalent	0.57	Due to small numbers, data are not presented at unit level				Acceptable <1.5/1000 Achievable <1.0/1000
Incident	0.16	Due to small numbers, data are not presented at unit level				Acceptable <1.0/1000 Achievable <0.75/1000

2. Background

2.1 The Northern Ireland Breast Screening Programme

The NI BSP invites women between the ages of 50 and 70 to attend for regular breast screening every three years. The main aim of breast screening is to detect breast cancer at an early stage, when treatment is more likely to reduce the risk of death from the disease.

2.2 Benefits and Harms of Breast Screening

As with all screening programmes, breast screening results in both benefits and harms.[2] The main benefit is a reduction in breast cancer mortality. An independent review of the evidence on the benefits and harm of breast screening found a 20% reduced risk of death from breast cancer among women screened, compared to those not screened.[2] This equates to one breast cancer death prevented for every 235 women invited for screening, one breast cancer death prevented for every 180 women who attend screening and around 1300 breast cancer deaths prevented every year in the UK.[2]

The main harm of breast screening is overdiagnosis, which refers to the detection of low-risk or non-progressing breast cancers through screening that would not have been diagnosed without screening, and would not have become life threatening.[2] For every breast cancer death prevented by screening in the UK, three women are diagnosed with and treated for a cancer that would never have been found without screening and would never have become life threatening.[2] Other harms include the need for unnecessary invasive investigations, as well the psychological distress and anxiety, which can arise from false positive screening results.[2] False negative results due to missed cancer detection or incorrect diagnoses can also provide unwarranted reassurance, potentially affecting a woman’s perception of her risk of breast cancer and resulting in delayed presentation following the development of symptoms.[2,3]

3. Programme Overview

3.1 Eligibility

In Northern Ireland, eligible women aged between 50 and 70 are invited to attend for breast screening, by GP practice, every three years. Due to this three-yearly round of invites, about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53rd birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every three years by phoning their local screening unit and requesting an appointment.

Women who have been identified as being at significantly increased risk of breast cancer (≥ 8 times the average risk) are invited to participate in more regular surveillance screening at an earlier age by the Very High-Risk (VHR) BSP, which commenced in 2013.

3.2 Screening Pathway

3.2.1 Invitation

- Invitations to attend for routine breast screening are sent to eligible women every three years based on their GP practice, along with information on breast screening, which describes the screening test and pathway involved.

- Approximately one third of the population eligible for breast cancer screening in Northern Ireland are invited to attend for screening every year.
- Each of the four Breast Screening Unit (BSUs) cover screening populations of varying sizes, with the number screened in each unit fluctuating on an annual basis, depending on the area being screened within the three-year round length.

3.2.2 Screening

- Women who accept the offer of screening attend their local BSU and undergo mammography, an imaging technique which involves low-dose radiation exposure to the breast tissue.
- The first time a woman enters the eligible age-range and attends for screening is referred to as a prevalent screen, the second and subsequent times a woman attends for screening are referred to as incident screens.
- Women should receive the results of the mammogram within two to three weeks of the screening appointment.
- A small number of women may be sent another screening appointment if their mammograms need to be repeated, for example, if the image was inadequate for diagnostic reporting.

3.2.3 Assessment

- If a potential abnormality is detected at initial screening, a woman may be asked to attend an assessment clinic for further investigations, including clinical examination, additional imaging or biopsy. A woman who receives a normal/benign result as the outcome of the assessment clinic should be returned to the routine screening programme for a further screen in three years.

3.3.4 Diagnosis

- If breast cancer is diagnosed, a woman should be referred for urgent treatment.
- If a definitive diagnosis cannot be made following the assessment process, a woman may be recalled for a further assessment at an interval shorter than the normal screening interval of three years.

3.3 Delivery

There are four BSUs in Northern Ireland; Eastern, Northern, Southern and Western. Table 2 outlines the locations and contact details of the headquarters of each unit.

Table 2: Breast Screening Units (BSUs) in Northern Ireland

Unit	Location	Contact Number
Eastern	12-22 Linenhall Street, Belfast	028 9033 3700
Northern	Antrim Area Hospital	028 9442 4425
Southern	Craigavon Area Hospital	028 3756 0820
Western	Altnagelvin Area Hospital	028 7161 1443

The Eastern Unit caters for the Belfast and South Eastern HSCT areas, while the Northern Unit covers most of the Northern HSCT, as well as providing surveillance screening for women at very high risk of breast cancer. The Southern Unit is responsible for delivering breast screening services in the Southern HSCT, while the Western Unit covers all of the Western HSCT areas and part of the Northern HSCT. The BSU in Linenhall Street provides mammography screening for women in the Belfast HSCT area. In the time period covered by this report, in other HSCT areas, most screening mammograms were carried out on mobile breast screening trailers, which rotate between a variety of locations across Northern Ireland.

4. Quality Assurance

Quality assurance (QA) is a fundamental part of all screening programmes. The aim of QA in the NI BSP is to maintain acceptable standards and continuously improve the performance of all aspects of breast screening in order to ensure that women have access to a high-quality service wherever they reside in Northern Ireland. QA helps to ensure that the benefits of breast screening outweigh the potential harms. It is a continuous process that is carried out externally by the PHA Breast Screening Team and internally by the BSUs and HSCTs.

4.1 Core QA Activities of the PHA

The core QA activities of the PHA Breast Screening Team include:

- Monitoring and review of programme management and delivery;
- Monitoring performance against agreed standards;
- Organising a rolling programme of formal QA Visits to BSUs;
- Review and monitoring of HSCT action plans to implement recommendations arising from QA visits;
- Adverse incident review and advice;
- Providing support and advice to HSCTs and BSUs.

4.2 QA Leads

The QA function is underpinned by an organised structure of public health and professional leads, supported by programme managers, information and administrative staff. There are seven QA Professional Leads in the NI BSP, covering each discipline involved in delivering the service. These include radiology, radiography, surgery, pathology, breast care nursing, administrative and clerical and medical physics. QA Professional Leads assist with the coordination of QA activities for the NI BSP and provide professional advice to the PHA Breast Screening Team on issues relevant to the commissioning of the screening programme within their area of expertise. Each QA Professional Lead chairs a QA subgroup for their speciality. These groups play an important part in the QA Advisory Structure and work together to ensure that safe and effective breast

screening continues to be available to the eligible population. This includes working to ensure relevant national and local standards are met and that appropriate continuous quality improvement processes are in place.

4.3 QA Visits

A key component of the NI BSP QA Programme is the cycle of QA visits to each of the four BSUs in rotation. The process for these visits is based on national and local guidance. Every BSU in Northern Ireland will receive a QA visit once every four years.

5. Programme Performance

This section of the report presents statistics to describe the performance of the NI BSP during 2023-2024, which have been collated and evaluated using the approach outlined below.

5.1 Programme Standards

The NI BSP uses the NHS Breast Screening Programme Standards, for the purposes of quality assurance and programme monitoring.[1] Local performance during 2023-2024 has been assessed against the programme standards valid for data collected from 1st April 2021.

5.2 Monitoring Performance

5.2.1 Data Returns

The PHA Breast Screening Team monitors the performance of each of the four BSUs and the NI BSP against national standards using data submitted through Körner returns:

KC62 – This is an annual return made by HSCTs on: outcome of initial screen, outcome of further assessment, cancers diagnosed (by size and type) and overall output and outcome measures. KC62 data are obtained from the National Breast Screening System (NBSS), the IT system that supports the NI BSP.

KC63 – This is an annual return made by HSCTs on: numbers of eligible women, invited and screened by age, numbers recalled, numbers self or GP referred, and time since most recent screen in 12-month blocks.

5.2.2 Performance Thresholds

Two performance thresholds are specified within the national standards; acceptable and achievable.

Acceptable Standards: This is the lowest level of performance which services are expected to attain in order to ensure patient safety and service effectiveness. All units are expected to exceed the acceptable threshold and to agree service improvement plans that develop

performance towards an achievable level. Programmes not meeting the acceptable threshold are expected to implement recovery plans to ensure rapid and sustained improvement.

Achievable Standards: This represents the level at which the services are likely to be running optimally. Screening services should aspire to attain and maintain performance at this level.

This report provides information on both the individual performance of the four BSUs and the overall NI BSP. Information on the performance of individual staff is not provided.

5.2.3 Performance Indicators

Performance indicators have been reported according to the corresponding stage of the screening pathway: uptake, test, referral and diagnosis. Table 3 outlines the various indicators used in assessing performance of the NI BSP during 2023-2024.*

Table 3: Indicators reported in assessing programme performance

Stage	Indicator
Uptake	Screening Uptake
	Screening Round Length
Test	Technical Recall/Repeat
	Screen to Routine Recall
Referral	Referred for Assessment (Prevalent)
	Referred for Assessment (Incident)
	Screen to Assessment (First Offered Appointment)
Diagnosis	Number of Cancers Detected
	Early Recall
	Non-Operative Diagnosis (Invasive)
	Non-Operative Diagnosis (Non-Invasive)
	Non-Invasive Cancer Detection (Prevalent)
	Non-Invasive Cancer Detection (Incident)
	Standardised Detection Rate Invasive Cancer (Prevalent)
	Standardised Detection Rate Invasive Cancer (Incident)
	Standardised Detection Rate Small Invasive Cancer (Prevalent and Incident)
	Benign Biopsy (Prevalent)
	Benign Biopsy (Incident)

* Indicators are reported to either one or two decimal places, to align with performance thresholds specified for each standard. Numbers less than five are reported as <5.

5.3 Uptake

5.3.1 Screening Uptake

Screening Uptake is the proportion of women who attend for breast screening each year, following an invitation.

- Acceptable standard: ≥ 70.0% of women invited accept the offer of breast screening.
- Achievable standard: ≥ 80.0% of women invited accept the offer of breast screening.

During 2023-2024, 73.9% of women invited (64,494 of 87,275) took up the offer to attend for breast screening in Northern Ireland.

Table 4 outlines the number of women who were invited and the number who attended for breast screening, as well as associated uptake rates, for the three-year period from 2021/22 to 2023/24. During 2023-24, 87,275 women aged between 50 and 70 were invited for breast screening in Northern Ireland, of whom 64,494 attended.

Table 4: Breast screening uptake (%) in the NI BSP 2021-2024

	2021-2022	2022-2023	2023-2024
Invited	98,452	88,483	87,275
Attended	73,607	65,748	64,494
Uptake (%)	74.8	74.3	73.9

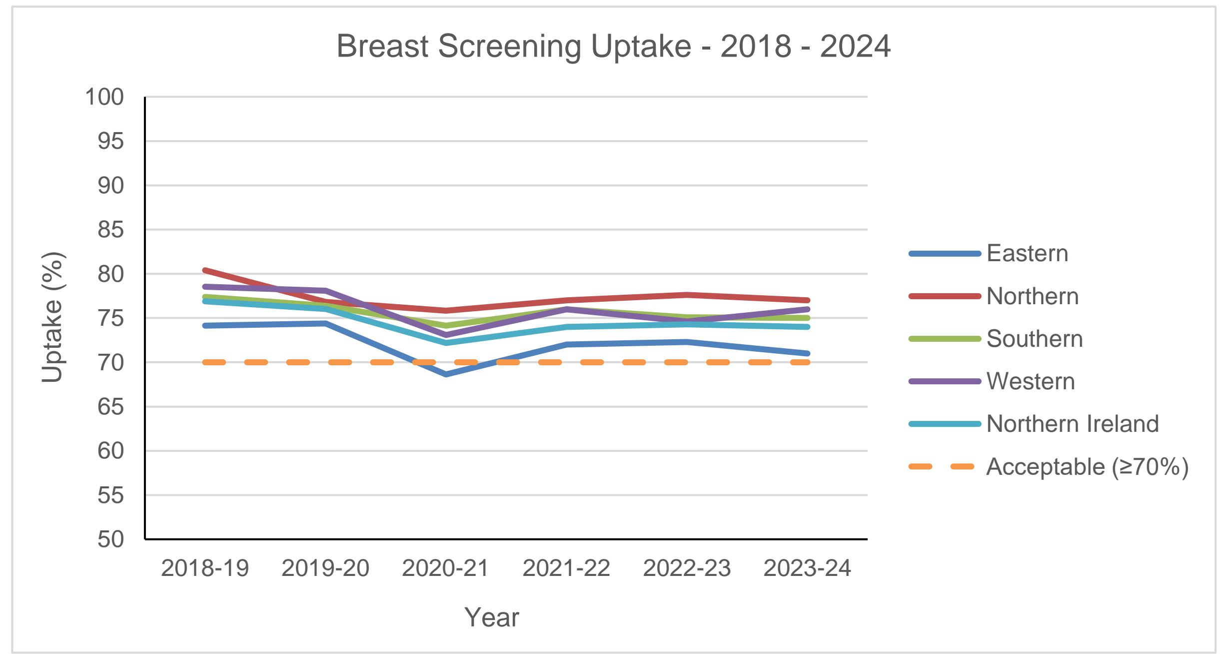
The acceptable level of uptake was maintained throughout the three-year period between 2021 and 2024. Table 5 shows uptake figures for each individual BSU and Northern Ireland overall, as well as comparative figures for England to enable benchmarking of performance.[4,5,6] Over the three-year period, all BSUs maintained uptake levels above the acceptable level.

Table 5: Breast screening uptake (%) by BSU, 2021/22-2023/24

	2021-2022	2022-2023	2023 - 2024
Eastern	72.2	72.3	72.2
Northern	77.2	77.6	77.4
Southern	76.1	75.1	75.7
Western	76.5	74.6	75.7
Northern Ireland	74.8	74.3	73.9
England[4,5,6]	62.3	64.6	70.0

Figure 1 shows trends in breast screening uptake per BSU and Northern Ireland overall from 2018/19 to 2023/24.

Figure 1: Breast screening uptake in Northern Ireland, 2018/19 to 2023/24



5.3.2 Screening Round Length

Screening Round Length is the interval between each offered invitation for screening mammography.

- Acceptable standard: ≥ 90.0% of women should be offered an appointment that is within 36 months of their previous screen.
- Achievable standard: ≥ 99.0% of women should be offered an appointment that is within 36 months of their previous screen.

During 2023-2024, 96.7% of women were offered an appointment that was within 36 months of their previous screen.

Measurement of the screening round length provides assurance that women with a previous invitation for screening have a subsequent invitation in a timescale that maximises the chance of cancer detection, whilst minimising harm to the woman. It also provides an indicator of the efficiency with which the screening programme is managed. The long-

term effectiveness of the programme is dependent on women within the target age-group continuing to be screened at regular intervals.

In 2023/24 to 2024, 96.7% of women were offered a screening appointment that was within 36 months of their previous screen. This lies above the acceptable standard of ≥90%.

Table 6 outlines the proportion of women offered a screening appointment that was within 36 months of their previous screen for each BSU and Northern Ireland overall by year, from 2021/22 – 2023/24.

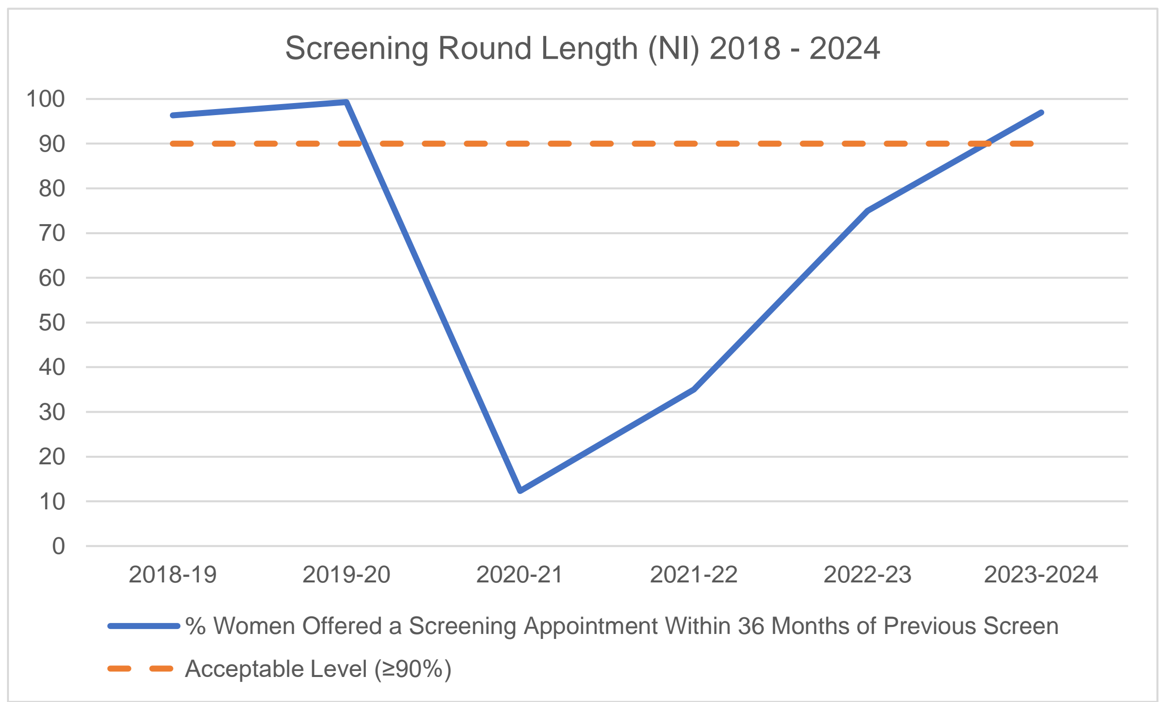
Table 6: Percentage of women with a first offered appointment within 36 months of their previous screen

	2021-2022	2022-2023	2023 - 2024
Eastern	33.6	85.1	99.1
Northern	29.6	30.4	93.5
Southern	34.2	92.7	99.8
Western	44.3	88.2	98.3
Northern Ireland	35.3	75.3	96.7

The data in this table show that the proportion of eligible women in Northern Ireland offered a screening appointment that was within 36 months of their previous screen was 96.7% in 2023-2024, an improvement from the previous years, due to recovery of the programme following the COVID-19 pandemic.

Figure 2 shows trends in the proportion of women offered a screening appointment within 36 months of their previous screen in Northern Ireland from 2018/19 to 2023/24.

Figure 2: Percentage of women offered a screening appointment within 36 months of previous screen, 2028/19 to 2023/24



5.4 Test

5.4.1 Technical Recall/ Repeat

Technical Recall/ Repeat measures the proportion of women who had additional mammograms due to technical recalls or technical repeats.

During 2023-2024, 0.07% of women screened in Northern Ireland had a repeat examination due to a technical recall. 1.8% had a repeat examination due to a technical repeat.

Technical recall:

- Acceptable standard: less than 0.7%
- Achievable standard: less than 0.2%

Technical repeat:

- Acceptable standard: less than 2.0%
- Achievable standard: less than 1.2%.

Mammograms may need to be repeated if the quality of the first image is not adequate for diagnostic reporting. Technical recall refers to when women are recalled for a further appointment for repeat images, while technical repeat refers to when women undergo repeat imaging during the initial screening appointment. BSUs should aim to deliver the optimum image quality with as low a radiation dose as possible to minimise anxiety for women, as well as their exposure to radiation. The number and type of repeat examinations undertaken are monitored to make sure good quality practice is provided. Tables 7a and 7b show the technical recall and repeat rates for each BSU and Northern Ireland from 2021/22 to 2023/24.

Table 7a: Technical Recall rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2023-2024
Eastern	0.1	0.1	0.1
Northern	0	0	0
Southern	0.1	0.1	0.1
Western	0	0	0
Northern Ireland	0.08	0.05	0.07

Table 7b: Technical Repeat rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2023-2024
Eastern	2.5	1.5	2.2
Northern	2	2	1.7
Southern	1.4	1.9	1.1
Western	2.8	1.9	1.9
Northern Ireland	2.2	1.8	1.8

The technical recall rate in Northern Ireland for 2023-24 met the achievable standard of <0.2%.

The technical repeat rate for Northern Ireland for 2023-24 was 1.8% (acceptable standard <2.0%).

5.4.2 Screen to Routine Recall

Screen to Routine Recall measures the proportion of women with a normal screening test who receive their results within two weeks of attendance for their screening mammogram.

During 2023-2024, 99.0% of women who had a normal screening test received their results within two weeks of attendance for their screening mammogram.

- Acceptable standard: ≥ 95.0% women receiving their results within two weeks of attendance for their screening mammogram.
- Achievable standard: ≥ 99.0% women receiving their results within two weeks of attendance for their screening mammogram.

To minimise anxiety, it is essential that women receive the results of screening in a timely manner. The date a woman receives her result is not recorded, therefore the date her episode is closed on NBSS is taken as a

proxy for this. This assumes the screening office has good administrative processes to minimise delays in posting the results letters. Table 8 shows the Screen to Routine Recall rate for each BSU and Northern Ireland overall, for the years 2021/22 to 2023/24.

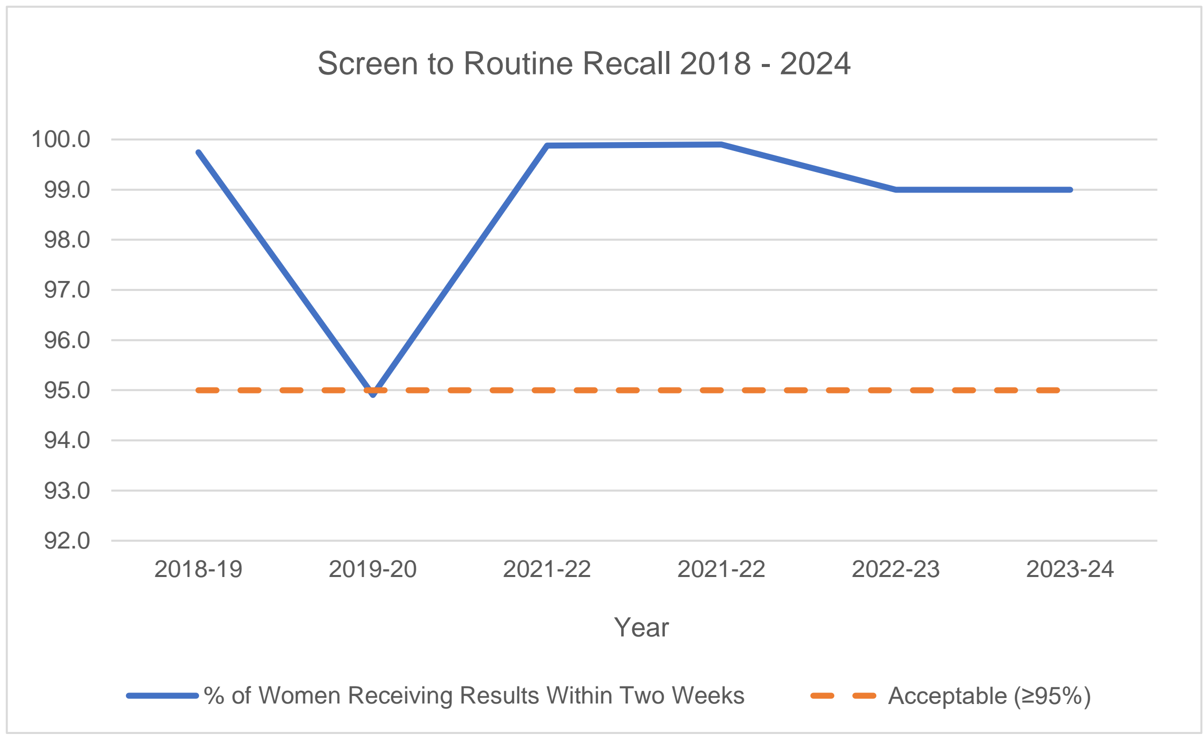
Table 8: Screen to routine recall rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2023-2024
Eastern	99.8	98.4	99.4
Northern	99.9	99.4	98.5
Southern	100	100	100
Western	99.9	98.4	97.9
Northern Ireland	99.9	99.0	99.0

The achievable standard for Screen to Routine Recall was met consistently across all BSUs and Northern Ireland overall during 2023-2024. During 2023-2024 99.0% of women with a normal screening test received their results within two weeks of their screening appointment. In the Southern Unit, 100.0% of women with a normal screening test received their results within two weeks of their screening appointment.

Figure 3 shows the trend in the proportion of women with a normal screening test receiving their results within two weeks of attendance for their screening mammogram in Northern Ireland from 2018/19 to 2023/24.

Figure 3: Percentage of women with a normal screening test receiving results within two weeks, 2018/19 – 2023/24



5.5 Referral

About four in every one hundred women are asked to come back for more tests after screening as their mammogram looks abnormal. These women are invited to attend an assessment clinic for further tests (e.g. breast examination, ultrasound scan or biopsy) which will help confirm if the woman has breast cancer. On average, one in four women referred for assessment are found to have cancer. The three in four women confirmed as not having cancer are returned to the routine screening programme to be invited for screening again in three years (unless they will be over the age of 70, when they can self-refer).

5.5.1 Referred for Assessment

Referred for Assessment measures the proportion of women screened who are referred for further assessment.

The purpose of this standard is to provide assurance that women are not referred for further tests unnecessarily. Those responsible for interpreting the images from breast screening need to make sure that they are recalling women with areas of concern which require further investigation, whilst not recalling too many women where no abnormalities are subsequently found. The percentage of women who are recalled to an assessment clinic is normally higher in those attending their first screening mammogram (prevalent screens) than in those attending for subsequent screening mammography (incident screens).

Prevalent Screen

During 2023-2024, 5.1% of women screened during a prevalent screen were referred for assessment, while the equivalent figure for incident screens was 2.1%.

- Acceptable standard: <9.0% of women screened referred for further assessment.
- Achievable standard: <7.0% of women screening referred for further assessment.

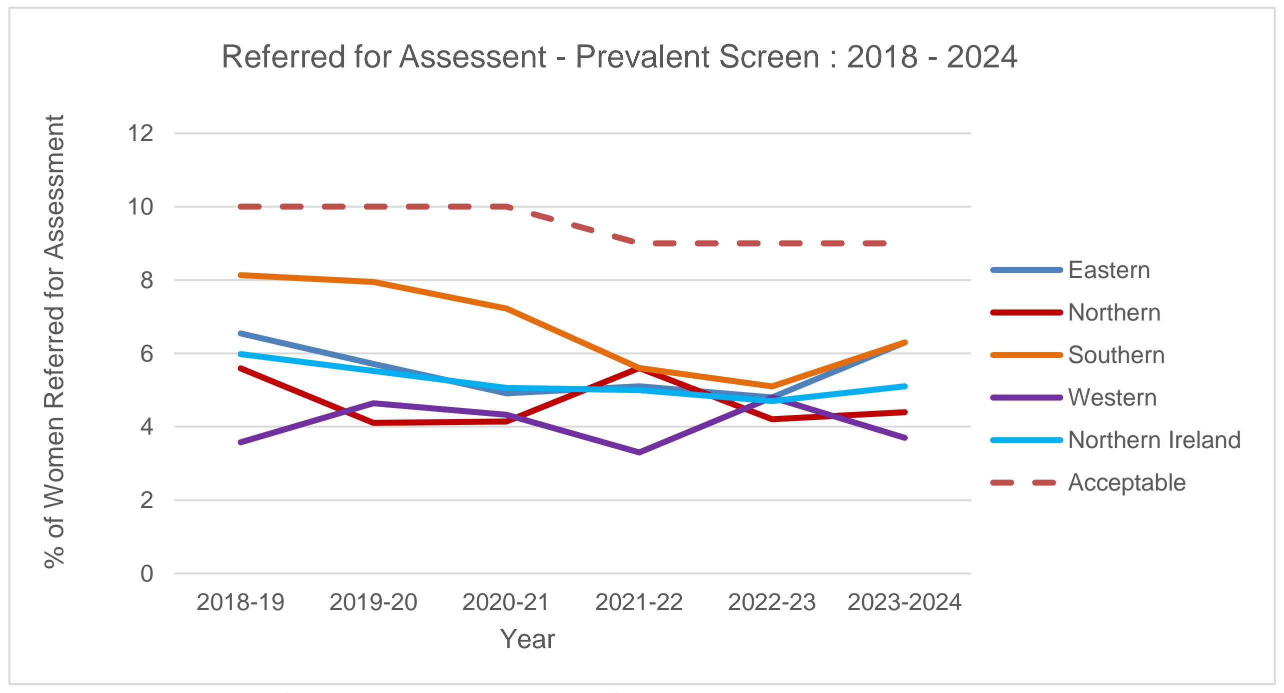
During 2023-2024, 5.1% of women were referred for assessment from a prevalent (first screen), meeting the achievable standard of <7.0%. Table 9 outlines the proportion of women referred for assessment from a prevalent screen each year between 2021 and 2024 by BSU and Northern Ireland overall. All BSUs met the achievable standard of <7.0% in each year during the period.

Table 9: Percentage of women referred for assessment by BSU and Northern Ireland overall – prevalent screen

	2021-22	2022-23	2023-2024
Eastern	5.1	4.8	6.3
Northern	5.6	4.2	4.4
Southern	5.6	5.1	6.3
Western	3.3	4.8	3.7
Northern Ireland	5.0	4.7	5.1

Figure 4 shows trends in the proportion of women referred for assessment from a prevalent screen per BSU and Northern Ireland overall from 2018/19 to 2023/24.

Figure 4: Percentage of women referred for assessment from a prevalent screen, 2018/19 – 2023/24



** Acceptable Level changed from 10% to 9% with introduction of updated standards in 2021*

Incident Screen

- Acceptable standard: <4.0% of women screened referred for further assessment.
- Achievable standard: <3.0% of women screened referred for further assessment.

During 2023-24, 2.1% of women were referred for assessment from an incident (subsequent screen), meeting the achievable standard of <3.0%. Table 10 outlines the proportion of women referred for assessment from an incident screen each year from 2021/22 to 2023/24 by BSU and Northern Ireland overall.

Table 10: Percentage of women referred for assessment by BSU and Northern Ireland overall – incident screen

	2021 - 2022	2022-2023	2023-2024
Eastern	1.7	1.7	2.0
Northern	2.3	1.8	1.8
Southern	2.7	2.8	3.0
Western	1.5	1.9	1.9
Northern Ireland	2.0	2.0	2.1

Figure 5 shows trends in the proportion of women referred for assessment from an incident screen per BSU and Northern Ireland overall from 2018/19 to 2023/24.

Figure 5: Percentage of women referred for assessment from an incident screen, 2018/19 – 2023/24

* Acceptable Level changed from 7% to 4% with introduction of updated standards in 2021

5.5.2 Screen to Assessment (First Offered Appointment)

Screen to Assessment measures the proportion of women who are offered an appointment at an assessment centre within three weeks of attendance for their screening mammogram.

During 2023/24, 98.7% of women referred for assessment were offered an assessment appointment that was within three weeks of their screening mammogram.

- Acceptable standard: ≥95.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.
- Achievable standard: ≥99.0% women receiving an appointment for assessment within three weeks of attendance for their screening mammogram.

Monitoring this standard aims to minimise the time taken for women who need further investigations to obtain a definitive malignant, benign or normal diagnosis. In 2023-2024, 98.7% of women who were referred for assessment in Northern Ireland were offered an assessment appointment that was within three weeks of their screening mammogram.

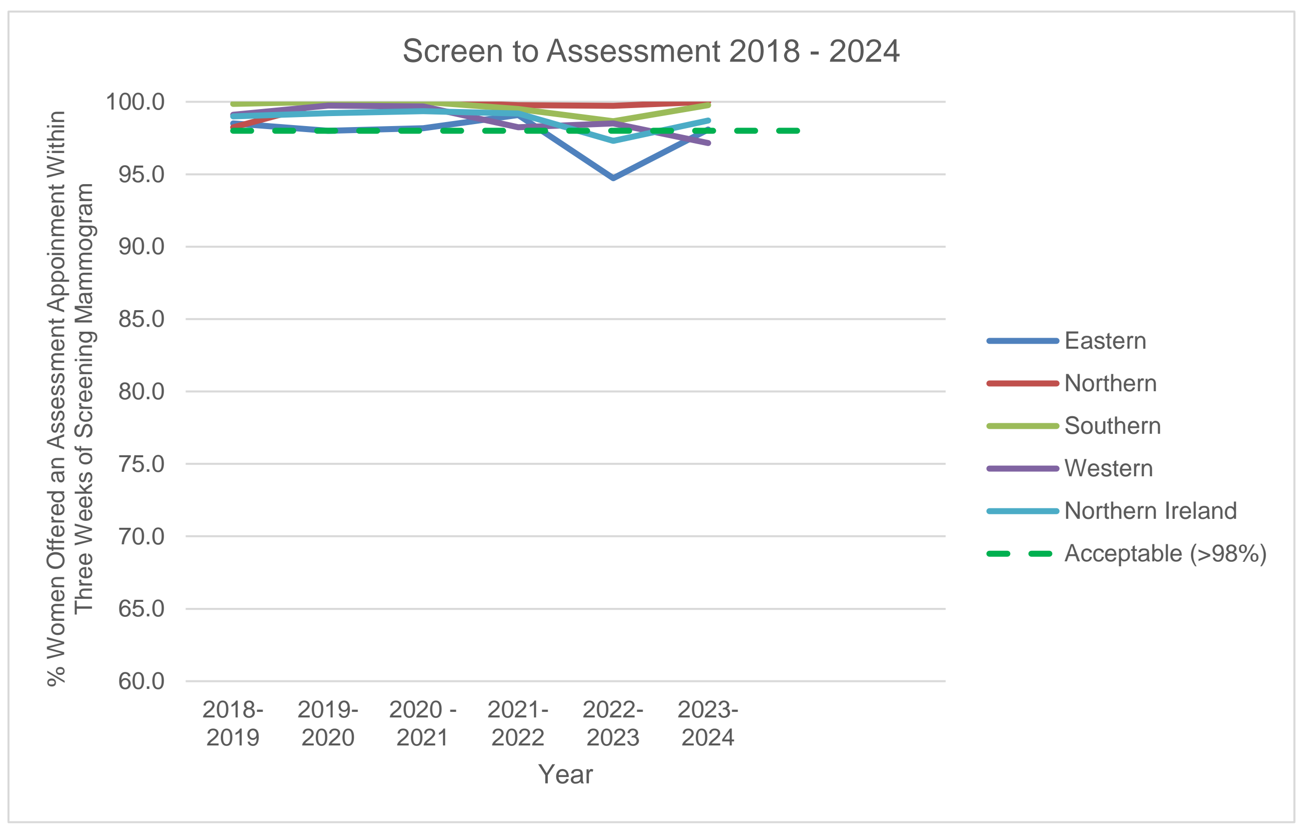
Table 11 outlines the achievement of this standard by BSU and Northern Ireland overall for each individual year from 2021/22 to 2023/24. The acceptable standard was consistently met in all BSUs during 2023/24.

Table 11: Screen to assessment rate (%) by BSU and Northern Ireland overall

	2021 - 2022	2022-2023	2023-2024
Eastern	99.1	94.7	98.1
Northern	99.8	99.7	100.0
Southern	99.5	98.7	99.8
Western	98.3	98.5	97.2
Northern Ireland	99.2	97.3	98.7

Figure 6 shows trends in the proportion of women referred for assessment who are offered an assessment appointment within three weeks of their screening mammogram per BSU and Northern Ireland overall from 2018/19 to 2023/24.

Figure 6: Percentage of women offered an assessment appointment within three weeks of screening mammogram, 2018/19 – 2023/24



5.6 Diagnosis

5.6.1 Number of Cancers Detected

565 breast cancers were detected through screening in Northern Ireland between 2023-2024.

In 2023/24,565 breast cancers were detected through screening in Northern Ireland. 468 (83%) of these were invasive cancers. The remainder were made up of micro-invasive and non-invasive cancers.

5.6.2 Early Recall

Early Recall measures the proportion of women screened who are referred for further tests and invited back to assessment at an interval of at least one year (short-term recall).

During 2023/24, 0.02% of women who were screened and referred for further tests were placed on short-term recall.

- Acceptable standard: <0.25% of women who are screened and referred for further tests should be placed on short-term recall.
- Achievable standard: <0.12% of women who are screened and referred for further tests should be placed on short-term recall.

Table 12 illustrates the proportion of women placed on short-term recall within each BSU and Northern Ireland overall from 2021/22 to 2023/24. Performance in each BSU and Northern Ireland overall consistently met the achievable threshold of <0.12%.

Table 12: Short-term recall rate (%) by BSU and Northern Ireland overall

	2021-2022	2022-2023	2023-2024
Eastern	0.00	0.03	0.02
Northern	0.07	0.03	0.02
Southern	0.00	0.00	0.00
Western	0.01	0.02	0.01
Northern Ireland	0.01	0.02	0.02

5.6.3 Non-Operative Diagnosis Rate

Non-Operative Diagnosis measures the proportion of women who have a non-operative diagnosis of cancer by needle histology or cytology after a maximum of two assessment clinic visits, as a proportion of all women screened diagnosed with breast cancer. This standard is reported separately for invasive and non-invasive cancers.

During 2023/24, diagnosis was established prior to surgery for 100% of women with an invasive screen-detected cancer and 92.9% of women with a non-invasive screen-detected cancer.

It is important to minimise the number of operative procedures and to enable treatment planning in advance of surgery. To achieve this, the majority of women should receive a non-operative pathological diagnosis of cancer. However, some women may need to have a surgical biopsy i.e. a biopsy taken during surgery, if the diagnosis is difficult to establish beforehand.

Invasive Cancer

- Acceptable standard: ≥99.0% of invasive screen-detected cancers should be diagnosed before surgery.

100% of invasive screen-detected cancers in Northern Ireland diagnosed during 2023-2024 had a non-operative pathological diagnosis of cancer, meeting the acceptable standard of ≥99%.

Table 13 shows non-operative diagnosis rates for invasive screen-detected cancers for each BSU and Northern Ireland overall from 2021/22 to 2023/24. The performance of all BSUs exceeded the acceptable standard of ≥99.0%.

Table 13: Non-operative diagnosis rate (%) – invasive cancer

	2021-2022	2022-2023	2023-2024
Eastern	100.00	100.00	100.00
Northern	100.00	100.00	100.00
Southern	100.00	100.00	100.00
Western	100.00	97.67	100.00
Northern Ireland	100.00	99.53	100.00

Figure 7 shows trends in the proportion of invasive screen-detected cancers with a diagnosis established prior to surgery per BSU and Northern Ireland overall from 2018/19 to 2023/24.

Figure 7: Percentage of invasive screen-detected cancers with a diagnosis established prior to surgery, 2018/19 – 2023/24

Non operative diagnosis for invasive cancers : 2018 - 2024

% Women with a Pre-Operative diagnosis of Invasive Cancer

100.00
98.00
96.00
94.00
92.00
90.00

2018 - 2019
2019 - 2020
2020 - 2021
2021-2022
2022-2023
2023-2024

Eastern
Northern
Southern
Western
Northern Ireland
Acceptable Level (≥99%)

Non-Invasive Cancer

- Acceptable standard: ≥90.0% of non-invasive screen-detected cancers should be diagnosed before surgery.
- Achievable standard: ≥95.0% of non-invasive screen-detected cancers should be diagnosed before surgery.

92.9% of non-invasive screen-detected cancers in Northern Ireland diagnosed in 2023/24 had a non-operative pathological diagnosis of cancer, meeting the acceptable standard of ≥90.0%. Table 14 illustrates non-operative diagnosis rates for non-invasive screen-detected cancers for each BSU and Northern Ireland overall from 2021/22 to 2023/24. Performance dropped below the acceptable level of ≥90.0% in the Eastern

Unit (87.0%). This was discussed by the QA committee and it was noted that this may be due to small numbers.

Table 14: Non-operative diagnosis rate (%) – non-invasive cancer			
	2021-2022	**2022-2023**	**2023-2024**
Eastern	92.3	100.0	87.0
Northern	95.2	93.8	90.5
Southern	100.0	100.0	95.0
Western	90.9	73.7	100.0
Northern Ireland	94.3	93.0	92.9

5.6.4 Non-Invasive Cancer Detection

Non-Invasive Cancer Detection measures the number of non-invasive carcinoma (in situ) cancers that are detected per 1,000 women screened.

In 2023/24, the non-invasive cancer detection rate was 2.2 per 1,000 women screened during a prevalent screen and 1.2 per 1,000 women screened during an incident screen.

Prevalent

- Acceptable standard: $\geq$0.5 non-invasive cancers detected per 1,000 women screened.

The non-invasive cancer detection rate from a prevalent screen was 1.9 per 1,000 eligible women screened in 2023/24, meeting the acceptable standard. Table 15 outlines non-invasive cancer detection rates for the prevalent screen during each year between 2021/22 to 2023/24.

Table 15: Non-invasive cancer detection rate (%) by BSU and Northern Ireland overall – prevalent screen			
	2021-2022	**2022-2023**	**2023-2024**
Eastern	0.9	2.6	2.0
Northern	3.0	0.9	2.5
Southern	1.4	0.0	0.7
Western	2.4	2.6	0.9
Northern Ireland	1.6	1.8	2.2

Incident

- Acceptable standard: ≥0.6 non-invasive cancers detected per 1,000 women screened.

The non-invasive cancer detection rate from an incident screen was 1.2 per 1,000 women screened in 2023/24, meeting the acceptable standard. Table 16 outlines non-invasive cancer detection rates from incident screens during each year from 2021/22 to 2023/24.

Table 16: Non-invasive cancer detection rate (%) by BSU and Northern Ireland overall – incident screen			
	2021-2022	**2022-2023**	**2023-2024**
Eastern	1.5	0.9	0.8
Northern	1.3	1.0	1.1
Southern	1.4	1.5	1.7
Western	1.1	1.2	1.5
Northern Ireland	1.4	1.1	1.2

5.6.5 Standardised Detection Ratio for Invasive Cancer

The Standardised Detection Ratio (SDR) is the ratio of the observed number of invasive cancers to the expected number in the eligible population invited and screened, given the age distribution of the population.

The SDR for invasive cancers in Northern Ireland in 2023/24 was 1.2 for prevalent screens and 1.2 for incident screens.

It is important to be able to compare cancer detection between screening services with differing mean ages of screening populations. This is corrected for by using a standard detection ratio. This allows the observed invasive cancers to be compared to the expected number of invasive cancers, given the age distribution of the population. The expected number of cancers is based on applying criteria from the Swedish Two Counties randomised control trial which is used as a comparator of performance. A 20% increase on the original expected levels has been

used since 2021 to account for the increase in background incidence in invasive breast cancer in the population since the previous rates were applied in 1993.[1] An SDR of one indicates the observed number of invasive cancers is the same as that expected; greater than one indicates a higher detection rate, and less than one a lower detection rate.

Prevalent Screen

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for invasive cancers from a prevalent screen in Northern Ireland during 2023-2024 was 1.2, meeting the achievable standard. Table 17 shows the SDR for invasive cancers from a prevalent screen each year from 2021/22 to 2023/24 for each BSU and Northern Ireland overall.

Table 17: Standardised detection ratio invasive cancer by BSU and Northern Ireland overall – prevalent screen

	2021-2022	2022-2023	2023-2024
Eastern	0.9	1.2	1.3
Northern	0.9	1.0	1.1
Southern	1.4	1.2	1.3
Western	1.2	1.9	1.1
Northern Ireland	1.1	1.3	1.2

Incident Screen

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for invasive cancers from an incident screen in Northern Ireland during 2023-24 was 1.2, meeting the achievable standard. Table 18 shows the SDR for invasive cancers from an incident screen each year from 2021/22 to 2023/24 for each BSU and Northern Ireland overall.

Table 18: Standardised detection ratio invasive cancer by BSU and Northern Ireland overall – incident screen			
	2021-2022	2022-2023	2023-2024
Eastern	1.2	1.4	1.3
Northern	1.1	0.8	1.0
Southern	1.3	1.4	1.3
Western	1.0	1.2	1.2
Northern Ireland	1.1	1.2	1.2

5.6.6 Standardised Detection Ratio for Small Invasive Cancer

The Standardised Detection Ratio for Small Invasive Cancer is the ratio of the observed number of small invasive cancers (<15mm) to the expected number in the eligible population invited and screened, given the age distribution of the screened population.

This standard is measured for both prevalent and incident screens combined.

The SDR for small invasive cancers in Northern Ireland in 2023/24 was 1.1.

Prevalent and Incident Screen:

- Acceptable standard: SDR ≥1.0
- Achievable standard: SDR ≥1.2

The overall SDR for small invasive cancers in Northern Ireland during 2023-24 was 1.1, meeting the acceptable standard. Table 19 shows the SDR for small invasive cancers from 2021 – 2024 for each BSU and Northern Ireland overall.

Table 19: Standardised detection ratio small invasive cancer by BSU and Northern Ireland overall – prevalent and incident screens			
	2021-2022	2022-2023	2023-2024
Eastern	1.0	1.0	1.2
Northern	1.0	0.7	1.0
Southern	1.5	1.3	1.2
Western	1.0	1.2	1.0
Northern Ireland	1.1	1.0	1.1

5.6.7 Benign Biopsy Rates

The Benign Biopsy Rate is a measure of the number of women per 1,000 women screened who had surgery for benign breast disease i.e. an open surgical biopsy with a benign or normal histological outcome.

The aim of this standard is to minimise harm to women due to unnecessary surgery. The number of open surgical biopsies performed because of screening that prove to be benign should be as low as possible.

Prevalent Screen

- Acceptable standard: <1.5 benign biopsies per 1,000 women screened.
- Achievable standard: <1.0 benign biopsies per 1,000 women screened.

The Northern Ireland benign biopsy rate from prevalent screens during 2023-2024 was 0.57 per 1,000 women screened.

Table 20 shows benign biopsy rates from prevalent screens for Northern Ireland overall from 2021/22 to 2023/24. Due to small numbers these data are not presented at BSU level.

Table 20: Benign biopsy rate (%) for Northern Ireland overall – prevalent screen

	2021-2022	2022-2023	2023-2024
Northern Ireland	0.77	0.80	0.57

Incident Screen

- Acceptable standard: <1.0 benign biopsies per 1,000 women screened.
- Achievable standard: <0.75 benign biopsies per 1,000 women screened.

The Northern Ireland benign biopsy rate from incident screens during 2023/24 was 0.16 per 1,000 women screened, meeting the achievable standard. Table 21 outlines benign biopsy rates from incident screens for

Northern Ireland overall from 2021/22 to 2023/24. The performance of all BSUs consistently exceeded the achievable standard throughout the three-year period. Due to small numbers these data are not presented at BSU level.

Table 21: Benign biopsy rate (%) for Northern Ireland overall – incident screen			
	2021-2022	2022-2023	2023-2024
Northern Ireland	0.21	0.15	0.16

6. Very High-Risk Breast Screening Programme

Surveillance screening for women at very high risk (VHR) of developing breast cancer was introduced in Northern Ireland in 2013. In September 2020, the programme title was changed from the 'Higher Risk Breast Surveillance Screening Programme' to the 'Very High-Risk Breast Screening Programme (VHR BSP)', to reflect national guidance. This title change does not indicate any increase in cancer risk for those enrolled in the programme.

Women at VHR are defined as those with more than or equal to eight times the relative risk of developing breast cancer compared to women in the general population. A woman may be at VHR of developing breast cancer due to a genetic mutation, most commonly in the BRCA gene, or a result of previous radiotherapy to the chest area. Women may be referred into the VHR BSP by a specialist in genetics, family history or oncology, where their family or medical history indicate a higher risk of developing breast cancer. The VHR BSP offers breast imaging at an earlier age and on a more regular basis than the routine BSP. Women enrolled in the programme are invited for annual Magnetic Resonance Imaging (MRI), mammography, or both depending on their age and reason for referral, up until their 50th birthday. After this, some women will remain within the VHR BSP, while others will enter routine breast screening. The protocols for each risk category determine screening frequency.

The VHR BSP is provided regionally at Antrim Area Hospital, in the Northern HSCT. The VHR BSU at Antrim Area Hospital is managed by a lead radiologist, with input from other radiologists, radiographers and administrative support. The programme is managed in line with the Northern HSCT VHR Breast Screening Operational Policy and overseen by a VHR BSP Coordinating Group, chaired by the PHA Consultant Lead for the NI VHR BSP. The VHR BSP Coordinating Group meets twice per year (and by exception) and includes representation from all HSCTs and disciplines involved in the delivery of the VHR BSP. A representative from BRCA Link NI (a voluntary organisation helping people to access information and support about BRCA genetic mutations), who were involved in the establishment of the VHR BSP, also sits on the VHR BSP

Coordinating Group. The programme is included in the QA Visits to the Northern Unit and in internal QA activities undertaken by the Northern HSCT.

In line with the NI BSP (outlined in section 6), the VHR BSP uses the NHS Breast Screening Programme Standards, for the purposes of quality assurance and programme monitoring.[1]

National standards for the VHR BSP came into effect for data collected from April 2021. Table 21 below outlines those standards applicable for the VHR BSP.

Table 22: Very High Risk Standards, valid for data collected from 1st April 2021.

Standard	Description	Acceptable level	Achievable level
Screening Uptake	The proportion of eligible women who have a technically adequate screen ≤ 6 months from date of first offered appointment.	≥ 85.0%	≥ 95.0%
Screening Round Length (shadow)	The proportion of eligible women whose date of first offered appointment is ≤ 12 months from their previous episode.	To be set	To be set
Screen to Routine Recall	The proportion of women who have a results letter with no referral for further testing produced on NBSS ≤ 2 weeks from a technically adequate screen.	≥ 95.0%	≥ 99.0%
Rate of Referral to Assessment	The proportion of eligible women with a technically adequate screen who are referred for assessment.	< 10.0%	< 7.0%
Time to First Offered Appointment for Assessment	The proportion of women referred for assessment whose date of first offered appointment at an assessment centre is ≤ 3 weeks (≤ 21 calendar days) from attendance for the screening mammogram.	≥ 95.0%	≥ 99.0%

* Round length for the VHR BSP remains in shadow format, as data continues to be evaluated in order to determine an acceptable and achievable level.

Once Northern Ireland have implemented the new software system to support breast screening (see section 9.2), VHR activity data and standards will be available for presentation.

7. Promoting Informed Choice

Although the overall uptake of breast screening in Northern Ireland meets the acceptable standard, uptake rates within certain geographical areas and subpopulations of women remain consistently lower than the general population. During 2023/24, the PHA Breast Screening Team, in partnership with other stakeholders, continued to work to ensure that all eligible women in Northern Ireland can make an informed choice about attending for breast screening and that the service is as accessible as possible.

Key actions to promote informed choice during 2023/24 included:

Regional Group on Promoting Informed Choice in Breast Screening.

This group is chaired by a member of the PHA Breast Screening team and has representation from all BSUs, as well as HSCT Health Promotion staff. The remit of the group is to identify opportunities to promote informed choice in the NI BSP, with a particular focus on women from disadvantaged communities, women who have learning/physical/sensory disabilities, women from minority ethnic groups, older women and other women considered to have additional needs. The group also aims to identify and share good practice in relation to promoting informed choice within breast screening and to advise on the provision of information to the public and health care professionals.

Inclusion of Promoting Informed Choice meetings in QA Visits to BSUs.

The PHA Breast Screening Team includes standalone meetings related to promoting informed choice in breast screening in the four-yearly QA Visits to BSUs. A dedicated chapter on promoting informed choice is included within each QA visit report.

Working with the Women's Resource and Development Agency (WRDA).[6]

In 2015, the PHA commissioned the WRDA, a local not-for-profit organisation, to raise awareness of the Breast, Cervical and Bowel Cancer Screening Programmes and to promote informed choice among

individuals from communities and populations with historically lower cancer screening uptake rates compared with the general population. The aim of the WRDA's programme of work is to provide individuals with sufficient information to enable them to make an informed decision about participating in cancer screening programmes. The WRDA recruit, train and support Peer Facilitators to deliver Educational Awareness Sessions to targeted service user groups, including people from deprived areas, those from ethnic minorities, those from the LGBT+ community, homeless individuals and those with physical disabilities, learning disabilities or mental health issues. WRDA also carry out Bespoke Workshops for those latter groups with additional support needs.

Collaborating with HSCTs to ensure that comprehensive, up to date, information on screening is available on their website.

8. Other developments in the Breast Screening Programme

8.1 Digital mammography equipment and breast screening mobile unit replacement

In 2021 the PHA and the five HSC Trusts established a project to support the development of a regional business case to replace, and add to, the mammography equipment used by the screening and symptomatic breast services and the breast screening mobile trailers. This regional capital business case was finalised in 2023 and led by the Belfast HSC Trust on behalf of the Northern Ireland Breast services. Procurement followed shortly after this.

8.2 Maintaining the integrity and functionality of NBSS in Northern Ireland

A project was established by the PHA in 2021 to obtain and implement a software solution to allow NBSS, the IT system underpinning the Breast Screening Programme, to continue to be updated and operate effectively. The project involves multiple stakeholders within Northern Ireland and the NHS in England.

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Northern Ireland
Abdominal Aortic Aneurysm (AAA)
Screening Programme

Annual Report 2019-2023

(version 1.0)

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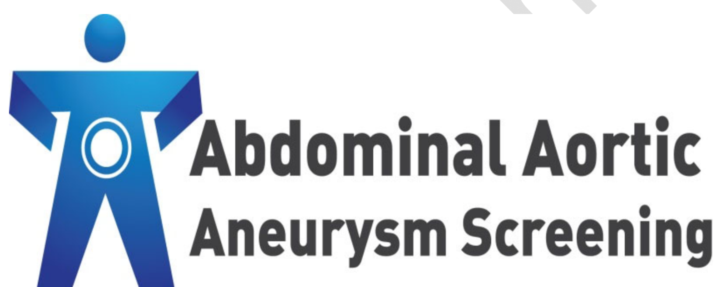

About this publication

Document title:	*NI AAA Screening Programme Annual Report 2019 - 2023*
Version:	Version 1.0
Authors:	*Jacqueline McDevitt (PHA), Gemma Reid (PHA), Claire Black (BHSCT), Leanne McClay (BHSCT) Christine McKee*
Owners:	*NI AAA Screening Programme*
Final approved release date:	

Distribution to:

- Co-Director of Surgery and Specialist Services - Belfast Health and Social Care Trust
- NI AAA Screening Programme Team - Belfast Health and Social Care Trust
- Deputy Director Public Health, Screening - Public Health Agency
- NI AAA Screening Programme Team - Public Health Agency
- NI AAA Screening Programme Co-ordinating Group

The final version of the report will be circulated to the above distribution list**.**

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Section 1:

Summary and Highlights for 2019-2023

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

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

All men registered with a GP in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65, who have never been screened before, can self-refer by contacting the screening programme office on 02896 151212.

This report combines 4 years of data, the period during which the programme temporarily paused due to the Covid-19 Pandemic and also includes the recovery period of the programme.

The overall performance of the programme for 2019 – 2023 is as follows –

Table 1 : Performance Summary for 2019 – 2023

Cohort	19/20	20/21	21/22	22/23
Number of cohort men invited to a screening appointment	9655	10107	10222	10911
Number of cohort men who attended a screening appointment	8130	8633	8055	8716
Newly detected AAA's	83	104	99	99
Large aneurysms referred to the vascular team	29	28	43	41
Self-referrals	264	10	26	118

Highlights of some of the work carried out by the programme from 2019 – 2023 are outlined on the following page.

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- The seventh annual service user event took place on the 27th June 2019.

- The first edition of the NI Abdominal Aortic Aneurysm (AAA) Screening Programme's Service User newsletter was published in January 2021. The aim of the newsletter is to keep service users up to date with all aspects of the programme, particularly service developments. The first issue focused on service provision during the COVID-19 pandemic.

- The second edition of the NI Abdominal Aortic Aneurysm (AAA) Screening Programme's Service User newsletter was published and posted to surveillance men in March 2022.

- A patient satisfaction survey was posted to all surveillance men alongside the service user newsletter in March 2022. The survey was also handed out to men attending their initial screening appointment for a period of 6 weeks.

- In May 2022 programme representatives attended the Balmoral show to raise general awareness of the programme and encourage further self-referrals.

- The eighth annual service user event took place on the 20th September 2022.

- In November 2022, the programme successfully recruited and appointed two new Patient Representatives to its main management group (the Co-ordinating Group) to ensure continuity of service user involvement and build on existing successful engagement initiatives.

- The programme continued to work in partnership with appropriate prison healthcare providers to facilitate screening clinics for eligible men.

- New AAA video produced.

- A number of recovery weekend clinics were held at the Royal Victoria Hospital from September 2022 to April 2023.

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Section 2:

Background and Programme Objectives

What is an AAA?

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

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

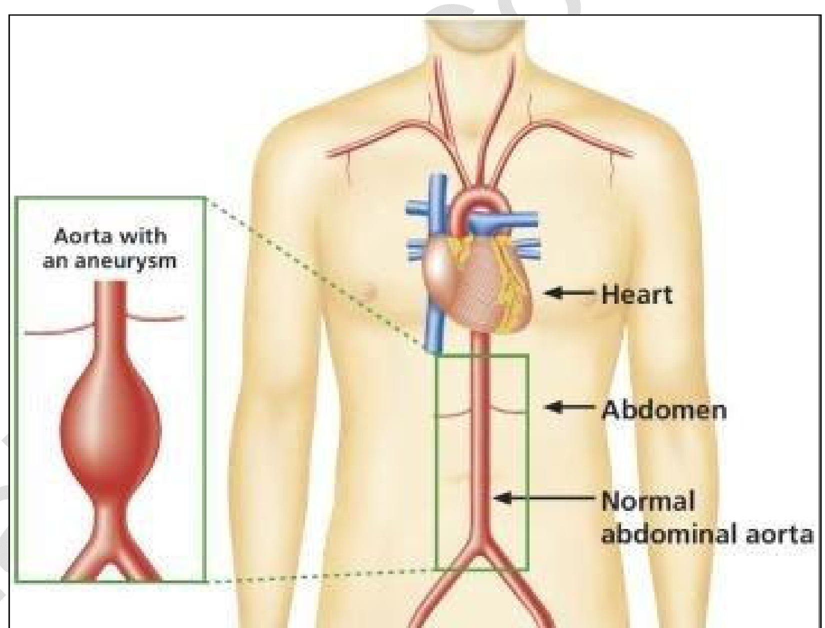

Image courtesy of the NHS England AAA Screening Programme

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

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Aim of the Northern Ireland AAA Screening Programme

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

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

Programme Objectives

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

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

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[1] Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: https://view-health-screening-recommendations.service.gov.uk/abdominal-aortic-aneurysm/

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

- Continuing to build on existing relations with the other three UK AAA Screening Programmes (England, Scotland and Wales) .

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

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

- Promoting and participating in research initiatives.

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Section 3:

Governance and Accountability

The Public Health Agency

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

- Leading on the implementation of screening policy, including the introduction of new screening programmes and any changes required to existing screening programmes.
- Ensuring the delivery of high quality, safe, effective and equitable screening programmes for people in Northern Ireland.
- Supporting continuous quality improvement through programme monitoring and evaluation, and adverse incident investigation and management.

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

The Belfast Health and Social Care Trust

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

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

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

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

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potential treatment options.

The Trust also has responsibility for:

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

Audit and Research

Both organisations take joint responsibility for developing and facilitating audit and research activities related to the programme as and when these become available.

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Section 4:

COVID-19 pandemic and recovery of the programme

As part of the HSC response to the COVID-19 pandemic, all NI AAA Screening Programme invitations to routine screening and surveillance screening appointments were temporarily paused from Monday 23rd March 2020. These measures were in line with a ministerial press release in Northern Ireland; similar action was taken by the AAA Screening Programmes in England, Scotland and Wales. All men in the 2019/20 cohort had been offered an initial appointment by the 23rd March however, due to the pause of the programme, over 500 appointments for men in this cohort year were cancelled by the provider. Again, due to the pause of the programme almost 2000 men who did not attend (DNA) their first appointment were not offered a second timed appointment.

On the 23rd March 2020 10 men with an AAA measuring 5.5cm were referred to the vascular team. Due to Covid-19 pre-assessment was paused and there was a delay with other tests, for example, echocardiograms etc. Guidance released from the vascular society also stated that only AAAs greater than 7cm should be operated on.

Surveillance clinics for men with medium AAAs (4.5-5.4cm) restarted on 10th July 2020 based on risk prioritisation strategy and for small AAAs (3.0-4.4cm) in November 2020. Initial AAA screening did not resume until Monday 1st March 2021 meaning initial screening invitations were paused for 50 weeks. Self-referrals to the screening programme were paused from 23rd March 2020, the programme started to accept self-referrals again from February 2021.

When the programme restarted in July 2020 operational changes were required to allow for social distancing and increased infection control measures. Some staff were still redeployed to help with the COVID-19 Pandemic. Clinic capacity was reduced and appointment slots were increased from 15 to 30 minutes to allow for increased cleaning between appointments and phone call entry to clinics as the use of waiting rooms were prohibited. The programme also introduced a pre-appointment phone call to confirm men were planning to attend their appointment and to provide COVID-19 guidance.

In 21/22 the programme made some progress to recover by double booking of appointments at the end of clinics, changing the DNA 2nd timed

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appointment to an open invitation letter, reverting back to the 15-minute appointment time, pre-COVID phone calls two days prior to appointments and allocation of capital funding for the purchase of four additional ultrasound machines however the programme was still 10 months behind.

In October 2022 the programme reduced the initial screening appointment from 15 to 10 minutes. The programme continued to send open invitation letters to men who DNA'd their first appointment instead of a second timed appointments. In 22/23 extra funding was successfully secured to increase the capacity of initial screening appointments. A number of weekend clinics were held at the Royal Victoria Hospital from September 2022 to April 2023. The extra clinics reduced the backlog of delayed invitations from 10 months to 3 months so that men from the 23/24 cohort were being invited for their screening appointment in June 2023.

It is important to highlight the hard work and dedication of all those involved in the screening programme within the Belfast Health and Social Care Trust and the PHA and to acknowledge their commitment to the recovery of the programme.

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Section 5:

Programme Delivery and the Screening Pathway

The programme is run by a multidisciplinary team of staff. All staff play an important role at various stages in the screening pathway.

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

Ten screening technicians (7.0WTE) run clinics on a daily basis. There are 24 clinic locations across Northern Ireland, including health and wellbeing centres and community hospitals (see **Appendix 1**).

Eligibility for Screening

All men in Northern Ireland who are registered with a GP are eligible for screening in the year they turn 65 (1 April to 31 March). This includes those men in prison or other secure accommodation. Any man who already has a known AAA can transfer to the care of the screening programme. However, if a man has previously had surgery for an AAA he does not require screening.

Men over the age of 65 and registered with a GP, who have not previously been scanned as part of the programme or been told they have an aneurysm, are also eligible for screening. These men can contact the screening programme office on 02896 151212 to request an appointment.

Details of all men registered with their GP who are eligible to be invited for screening are transferred to the Belfast Trust IT system on an annual basis. Daily updates are then automatically provided with changes to any demographic information.

The Screening Pathway

Appendix 2 provides an overview of the whole screening pathway. The key stages within the pathway are:

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

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Screening Invitation

The programme office sends all eligible men an invitation letter to attend a local screening clinic. This includes those men registered with a GP during the year in which they turn 65 and those eligible men over the age of 65 who have self-referred to the screening programme.

Invitations for men on surveillance are also sent:

- Men who have a small aneurysm detected will be invited back every *twelve months* for a surveillance scan.
- Men who have a medium aneurysm detected will be invited back every *three months* for a surveillance scan.

The Scan

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

The Result

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

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

- **NO AAA FOUND**: **aortic diameter less than 3cm**

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

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

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

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

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

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- **LARGE AAA**: **aortic diameter measuring 5.5cm or over**
Men who have a large aneurysm detected are referred to a vascular surgeon within the Royal Victoria Hospital at the Belfast Health and Social Care Trust for further investigation and to discuss possible treatment options. All men referred are required to be seen at outpatients within two weeks of the initial scan.

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

Surveillance

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

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

Referral and Treatment

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust.

All men referred to the vascular service are required to be seen by a consultant vascular surgeon within two weeks of the scan when the large AAA was detected. During this period, the man will have a CT scan to confirm the size of the aneurysm. This detailed imaging will help decide if the man is suitable for treatment and if so, what the best option is. All men diagnosed with a large AAA are discussed at a weekly vascular multidisciplinary team meeting (MDT) and also undergo vascular pre-assessment by a specialist nurse and vascular anaesthetist. If suitable, the vascular consultant will then discuss treatment options at outpatient review. The two main treatment options are open surgery or endovascular (EVAR) surgery. Open surgery requires a longer hospital stay and initial recovery period. Endovascular treatment, with a stent graft, allows for quicker recovery but has a longer follow-up period with X-ray surveillance. The decision regarding the choice of

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operation depends on many factors and is discussed in detail by the vascular team. The nominated consultant will then discuss the appropriate options with the man to enable him to make an informed choice. For some men further investigation and optimisation of underlying medical issues may be required prior to treatment of their AAA.

End Point of Screening Programme for Men

As outlined within Public Health England guidance[2], active inclusion in the screening programme ends when:

- the scan is found to be within normal limits.
- an AAA reaches 5.5cm diameter on ultrasound and the man has been referred to the vascular unit.
- the director of the local screening programme, or the GP, decides referral for treatment should be considered based on other factors (for example, symptoms or co-morbidities).
- three consecutive scans show an aortic diameter less than 3cm on ultrasound where the initial scan was 3cm or greater.
- the man has had 15 scans at one-year intervals and the AAA remains below 4.5cm .
- the man declines to be in the screening programme, fails to attend consecutive appointments as per local policy, moves out of the area and becomes the responsibility of another screening programme (if one exists) or dies.

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[2] https://www.gov.uk/government/publications/aaa-screening-standard-operating-procedures

Section 5:

Programme Performance

This section of the report focuses on the performance of the programme. Data included covers the 19/20, 20/21, 21/22 and 22/23 cohorts, the self-referrals and others offered screening through the programme. All data outlined within this report have been provided by the Belfast Trust programme team and quality assured by the Public Health Agency.

Eligible Cohort

The table below details the number of men who were eligible to be offered AAA screening by the programme from the 19/20, 20/21, 21/22 and 22/23 cohorts.

Table 2: AAA Screening cohort for 2019 - 2023

Category / Men:	19/20	20/21	21/22	22/23
Eligible screening cohort	**9785**	**10110**	**10233**	**10943**

Self-referrals

Men over 65 who have never been screened can self-refer to the programme and request a screening appointment. The figure below shows the number of self-referrals the programme has had since it started.

The number of self-referrals to the programme has reduced significantly from 2016-17. The Programme has been unable to facilitate or participate in as many promotional events compared with previous years which has contributed to the decrease in self-referrals. Self-referrals were also paused from 23rd March 2020 due to the COVID-19 pandemic, the programme started to accept self-referrals again from February 2021. The numbers of men eligible to self-refer will also reduce the longer the programme runs as men are automatically called for screening.

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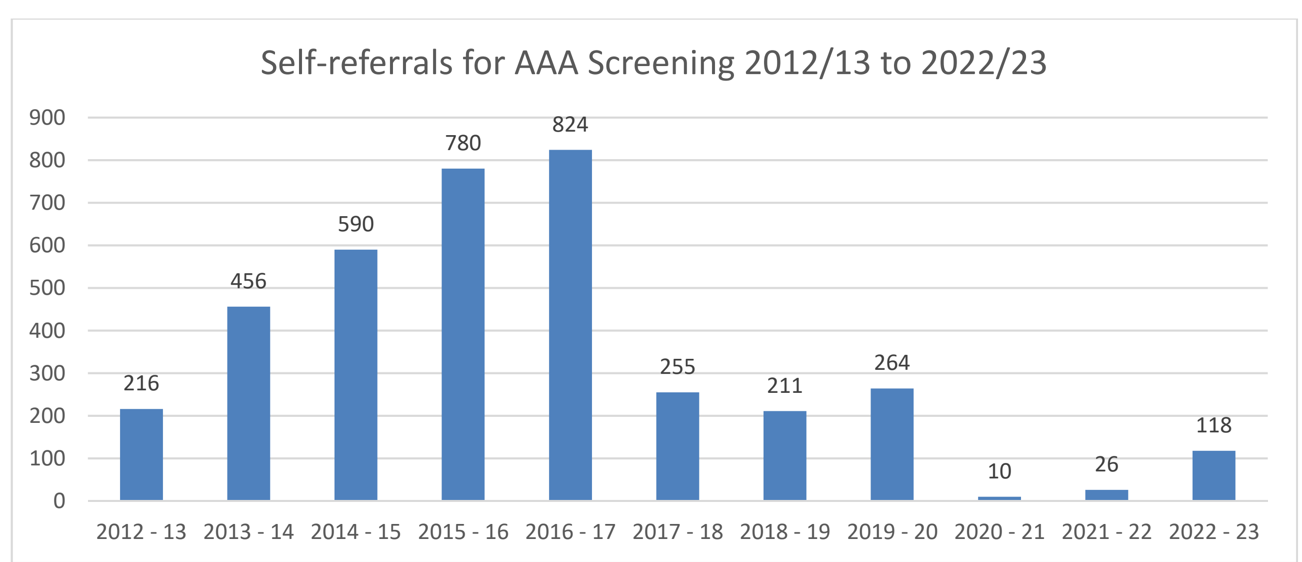
Figure 1: Self-referrals for AAA Screening 2012-13 to 2022-23



AAAs Detected and Prevalence

Table 3 below outlines the number of AAAs detected during 19/20, 20/21, 21/22 and 22/23 screening years, including cohort men and self-referrals. It also notes the number of overall referrals for large AAAs to the Vascular Unit within the Belfast Trust and the prevalence rate.

Table 3: AAAs detected by the Screening Programme 2018-19

Detected AAAs:				
	19/20	20/21	21/22	22/23
AAAs newly detected by the programme (including self-referrals)	95	107	100	100
Referrals to the Vascular Unit	29	28	43	42
Prevalence (calculated using the cohort year only)	1.0%	1.2%	1.2%	1.1%

Figure 2 below outlines the AAA detection rate for the programme, broken down by year. AAA screening should remain cost effective unless the prevalence of AAAs in 65-year-old men falls below 0.35%.[3]

[3] **Impact of the first 5 years of a national abdominal aortic aneurysm screening programme** Jacomelli J, Summers L, Stevenson A, Lees T, Earnshaw JJ Br J Surg. 2016 Aug

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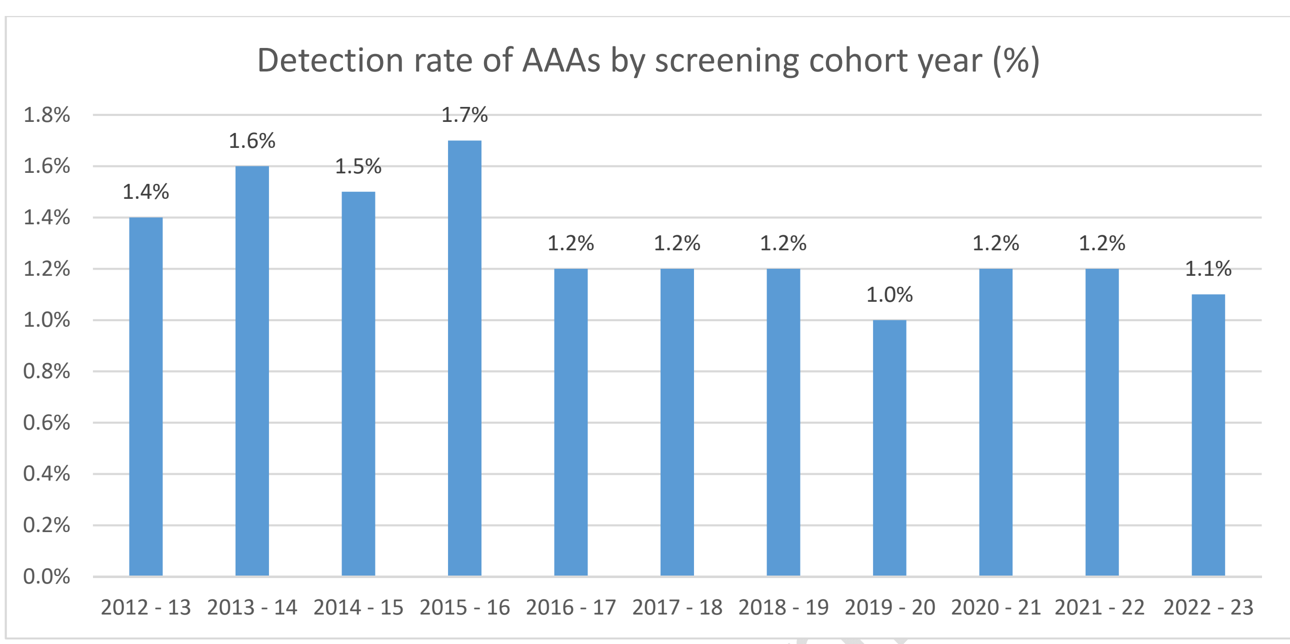
Figure 2: Detection rate of AAAs by screening cohort year



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Performance against Key Pathway Standards for 2019 - 2023

The table below compares the programme's overall performance against key national pathway standards for 2019 - 2023.

Table 4: Performance against Key Pathway Standards for 2019 - 2023

	Pathway Standard	**Acceptable**	**Achievable**	**19/20**	**20/21**	**21/22**	**22/23**
1a	Completeness of offer – initial screening Percentage of eligible subjects who are offered screening[4]	≥ 90.0%	≥ 99.0%				
1b	Completeness of offer – surveillance Percentage of eligible subjects who are offered screening	≥ 95.0%	100%	*99.8%*	*41.6%*	*98.6%*	*97.8%*
2a	Coverage – initial screening Percentage of eligible subjects who are tested	≥ 75.0%	≥ 85.0%	*68.6%*	*15.6%*	*14.4%*	*70.4%*
	COHORT TOTAL[5]			*83.1%*	*85.4%*	*78.7%*	*79.6%*
2b	Coverage – surveillance Percentage of eligible subjects who are tested	≥ 85.0%	≥ 95.0%	*94.6%*	*38.1%*	*93.3%*	*88.1%*
3	Provision of sufficient opportunity to attend Percentage of subjects not responding to first offer to whom a confirmed second offer is made[6]	≥ 90.0%	100%				
4a	Uptake – initial screening	≥ 75.0%	≥ 85.0%	*84.2%*	*85.4%*	*78.8%*	*79.9%*

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[4] Due to the pause to the programme and to aid with the restoration of the programme men were not offered a second timed appointment. They were sent an open invitation letter asking them to contact the screening unit to arrange a second appointment. This was being managed manually and not on the IT system.

[5] This is the coverage figure for the total cohort screened irrespective of the date they were screened. The national standard coverage is the total screened by 31st June.

[6] Due to the pause to the programme and to aid with the restoration of the programme men were not offered a second timed appointment. They were sent an open invitation letter asking them to contact the screening unit to arrange a second appointment. This was being managed manually and not on the IT system.

	Pathway Standard	Acceptable	Achievable	19/20	20/21	21/22	22/23
	Percentage of subjects offered screening who are tested[7]						
4b	<u>Uptake – surveillance</u> Percentage of subjects offered screening who are tested	≥ 90.0%	≥ 95.0%	*94.8%*	*91.6%*	*94.6%*	*90.1%*
5	*<u>Quality of images/samples/testing technique</u>* *Percentage of assessed images of acceptable quality*	*≥ 95.0%*	*≥ 99.0%*				
6	*<u>Quality of images/samples/testing technique</u>* *Percentage inaccurate calliper placement determined by review of static images*	*≤ .02%*	*0.0%*				
7	<u>Definitive outcome of scan</u> Percentage of screening encounters where aorta could not be visualised	≤ 3.0%	≤ 1.0%	1.1%	0.4%	1.1%	1.0%
8	<u>Accurate assessment of outcomes</u> Percentage of incomplete screening episodes	≤ 0.75%	≤ 0.20%	*0.02%*	*0%*	*0%*	*0%*
9	<u>Timely referral</u> Percentage of men with AAA ≥ 5.5cm	≥ 95.0%	100%	*100%*	*100%*	*100%*	*100%*

[7] This is the uptake figure for the total cohort irrespective of the date they were offered screening or screened. The national standard for uptake is the total number offered a screening appointment and screened by 31st June. The screening programme was unable to calculate the national standard figure because screening was delayed by a year and 2nd timed appointments were not being offered, men that DNA' d their 1st appointment were being sent an open invitation letter which was being managed manually.

	Pathway Standard	Acceptable	Achievable	19/20	20/21	21/22	22/23
	referred within one working day						
10	Accuracy of diagnosis; reduction in inappropriate referrals Percentage of referred men subsequently found to have an aorta < 5.5cm on confirmatory CT or MRI scan	≤ 3.0%	≤ 1.0%	*0%*	*0%*	*2.3%*	*2.4%*
11	Timely treatment/intervention by specialist (measured from latest successful screen) Percentage of men with aorta ≥ 5.5cm seen by vascular specialist within 2 weeks	≥ 90.0%	≥ 95.0%	*79.3%*	71.4%	81.4%	85.7%
12a	Timely treatment/intervention by specialist (measured from date of referral) Percentage of men with aorta ≥ 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within 8 weeks	≥ 60.0%	≥ 80.0%	*21%*	12.0	14.7%	10.8%

The acceptable threshold is the lowest level of performance which screening services are expected to attain. The achievable threshold represents the level at which the screening service is likely to be running optimally.[8]

[8] https://www.gov.uk/government/publications/population-screening-our-approach-to-screening-standards/our-approach-to-nhs-population-screening-standards#performance-thresholds

The NI programme has adopted an additional standard outlined below in relation to AAAs measuring over 7cm.

Table 5: Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)

	Pathway standard Acceptable	Pathway standard Achievable	19/20	20/21	21/22	22/23
Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)	n/a	n/a	100%	0%	100%	100%

The standard below was withdrawn as a national standard however it continues to be monitored at national level across vascular services.

Table 6: 30 day mortality (following elective surgery on screen-detected AAAs)

	Pathway standard acceptable	Pathway standard Achievable	19/20	20/21	21/22	22/23
30 day mortality (following elective surgery on screen-detected AAAs)	**n/a**	**n/a**	0%	0%	2.9%	0%

The figures for the above are <10.

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Table 7: Uptake by Trust

The highest uptake each year is in the South Eastern HSCT with the lowest uptake in Belfast HSCT for 19/20,20/21 and 21/22 and Southern HSCT in 22/23.

19/20			
HSCT	**Number screened**	**Number invited**	**%**
Belfast	1,607	1,957	82.1%
Northern	2,035	2,385	85.3%
South Eastern	1,530	1,755	87.2%
Southern	1,574	1,889	83.3%
Western	1,382	1,667	82.9%
Northern Ireland	**8,128**	**9,653**	84.2%

20/21			
HSCT	**Number screened**	**Number invited**	**%**
Belfast	1,743	2,094	83.2%
Northern	2,069	2,430	85.1%
South Eastern	1,731	1,955	88.5%
Southern	1,576	1,857	84.9%
Western	1,511	1,768	85.5%
Northern Ireland	**8,630**	**10,104**	85.4%

21/22			
HSCT	**Number screened**	**Number invited**	**%**
Belfast	1,617	2,150	75.2%
Northern	1,990	2,503	79.5%
South Eastern	1,591	1,924	82.7%
Southern	1,501	1,932	77.7%
Western	1,351	1,708	79.1%
Northern Ireland	**8,050**	**10,217**	78.8%

22/23			
HSCT	**Number screened**	**Number invited**	**%**
Belfast	1,887	2,415	78.1%
Northern	2,116	2,635	80.3%
South Eastern	1,723	2,074	83.1%
Southern	1,580	2,033	77.7%
Western	1,406	1,749	80.4%
Northern Ireland	**8,712**	**10,906**	79.9%

* *Total figures differ slightly to table 1 as some men screened did not have a GP post code recorded.*

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Section 7:

Health Inequalities

Population screening programmes need high levels of participation to achieve their desired public health impact. Informed personal choice is central to the screening strategy and the decision to have a screening test or not is for the individual involved. However, people may choose not to make a decision about screening, are not aware of the offer or do not attend their appointment.

Health inequalities are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. The Marmot Review, Fair Society, Healthy Lives (2010) highlighted the social gradient of health inequalities, i.e. the more disadvantaged the person's social position the worse their health.

Studies on inequalities in AAA screening have found a number of factors:

- the Multi-centre Aneurysm Screening Study (MASS) found that higher age and social deprivation are associated with poorer screening attendance and having an AAA[9]
- a Scottish analysis found that both urban residence and social deprivation were associated with lower uptake among men invited for AAA screening[10]

In April 2020 the English AAA Screening programme introduced a new screening standard –

AAA-S07: coverage: initial screen in the most deprived 30% of local areas is the proportion of men in the eligible cohort who were tested and who lived in a lower super output area (LSOA) classed as decile 1 to 3 in the English indices of deprivation 2019.

Men living in more deprived areas are less likely to attend for screening but are more likely to have an aneurysm. It is therefore important for the AAA screening programme to engage with men living in more deprived areas to make sure they can make a personal informed choice.

This standard only focuses on one aspect of inequalities in access to AAA screening. It is acknowledged that there are many sources of inequalities which need to be identified and reduce drivers of inequalities relevant to the local area.

[9] https://journals.sagepub.com/doi/10.1177/096914130301100112
[10] https://onlinelibrary.wiley.com/doi/pdf/10.1002/bjs.9803

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The performance thresholds for this standard are –

- Acceptable level: greater than or equal to 75.0%
- Achievable level: greater than or equal to 85.0%

The following table and chart show the coverage for initial AAA Screening appointments in Northern Ireland (NI) broken down by deprivation decile 1-3 for the 19/20, 20/21, 21/22 and 22/23 total cohorts.

Table 8: % men in Northern Ireland who attended for Abdominal Aortic Aneurysm screening by deprivation decile 1 – 3 for 19/20, 20/21, 21/22 and 22/23

	No. eligible NIMDM 2017 Decile 1-3 (SOA)	No. screened NIMDM 2017 Decile 1-3 (SOA)	% screened (coverage) NIMDM 2017 Decile 1-3 (SOA)	Total cohort No. eligible	Total cohort No. screened	% screened (coverage)
19/20	2996	2352	78.5%	9785	8130	83.1%
20/21	3042	2440	80.2%	10110	8633	85.4%
21/22	2327	3212	72.4%	10233	8055	78.7%
22/23	2481	3340	74.3%	10943	8716	79.6%

Source: AAA Screening Programme, Public Health Agency and Belfast Health and Social Care Trust
Data refers to men screened by their cohort year irrespective of the date they were screened
Deprivation data is based on the Northern Ireland Statistics and Research Agency, NI Multiple Deprivation Measure 2017 (Super Output Area (SOA) level) and contact post code.
https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017

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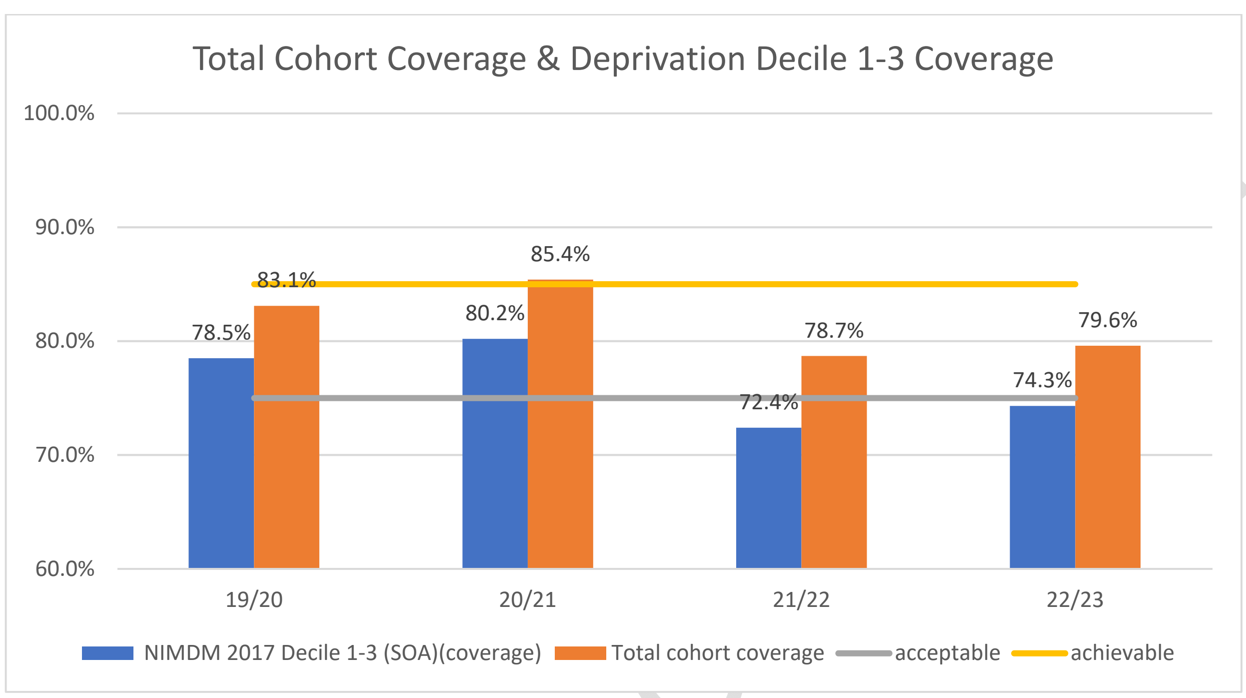
Figure 3: % Coverage by NI Multiple Deprivation Measure 2017 quintile (SOA) 1-3 and 8-10 for cohorts 19/20, 20/21, 21/22 and 22/23



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Section 8:

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) enables the public to influence the planning, commissioning and delivery of health and social care (HSC) services. It includes actively engaging with communities, specifically those who use services such as screening. The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HSC organisations within Northern Ireland.

During 2019-2023, the Northern Ireland AAA Screening Programme completed the PPI projects outlined below.

- The programme's annual **Service User Event** (for men with a screen-detected AAA and their wives/companions) continues to be popular and well-supported by service users and programme providers. The programme's seventh Service User Event took place on 27th June 2019. The user event was cancelled in 2020 and 2021 because of the COVID-19 pandemic. The eighth annual service user event returned in September 2022 celebrating ten years of AAA screening. Presentations included information about AAA surgery by Mr Andrew McKinley, Clinical Lead Surgeon, BHSCT and smoking cessation information by Darren Whiteside, Stop Smoking Specialist, BHSCT. The event was well attended by service users and feedback from the event was very positive.

- Members of the screening team attended The Royal Ulster Agricultural Society (RUAS) Balmoral Show in May 2022 to raise general awareness of the programme and encourage self-referrals. 85 men registered as a self-referral for screening.

- In November 2022 the programme appointed two new patient representatives to the NI AAA Screening Programme's Coordinating Group. Tom and Paul are both currently under the care of the surveillance element of the programme at the Belfast Health and Social Care Trust. Tom and Paul attended their first AAA Screening Programme Coordinating Group meeting in December 2022 providing vital feedback regarding some of the programme's processes.

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Section 9:

Role of Primary Care

Primary Care teams are integral to the successful delivery of the NI AAA Screening Programme. Since the programme began in 2012, the considerable contribution and partnership working with primary care teams has been invaluable, particularly in the areas outlined below.

Supporting men with a screen-detected AAA

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

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

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

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

Providing information to facilitate screening appointments for eligible men

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

- Ensuring patient records are accurate – information is downloaded into the programme's IT system on eligible men registered with GPs; programme staff liaise with practices about any discrepancies.
- Seeking information about particular needs of men invited for screening, e.g. a physical or sensory disability, limited mobility or a learning disability – this helps facilitate the screening appointment and allows appropriate arrangements to be made e.g. extra time for the appointment if required.
- Organising an appropriate interpreter or signer when required to facilitate an appointment.

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Promoting screening

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

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

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Appendices

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1 Map of Screening Locations

2 The Screening Pathway

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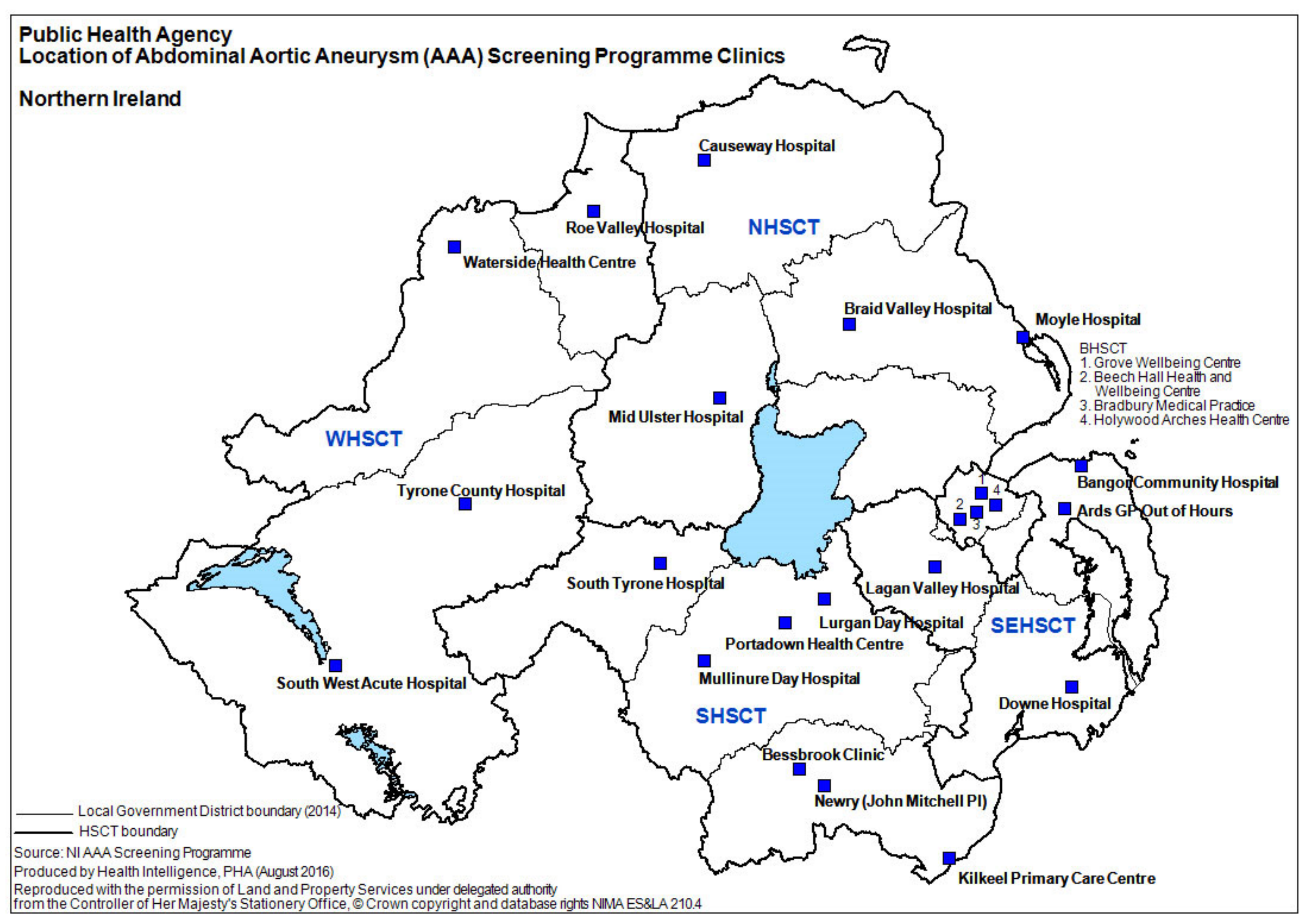
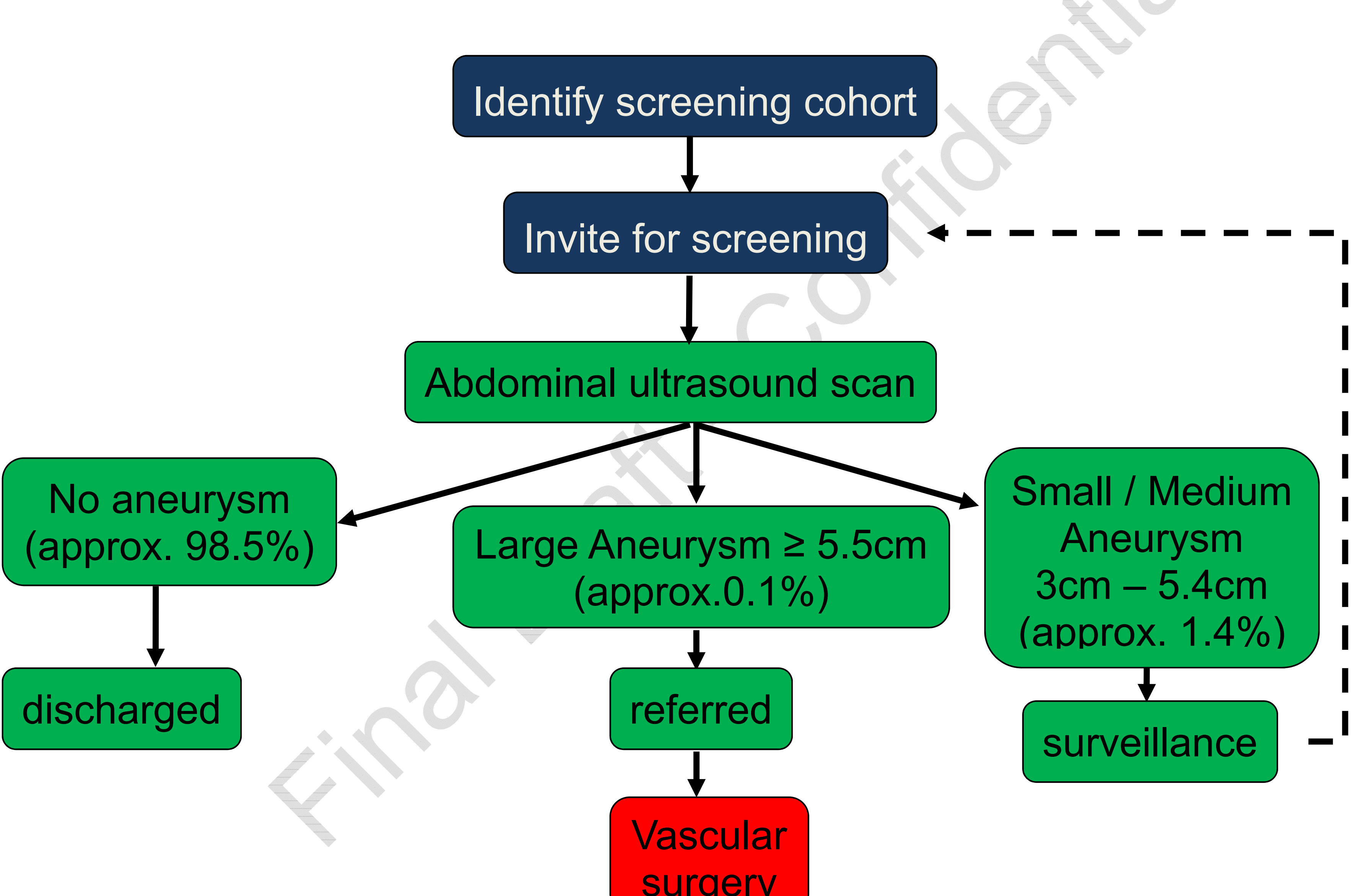
Appendix 1 – Map of Screening Locations



Appendix 2 – The Screening Pathway



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Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme

Annual Report 2023/2024

(version 1.0)

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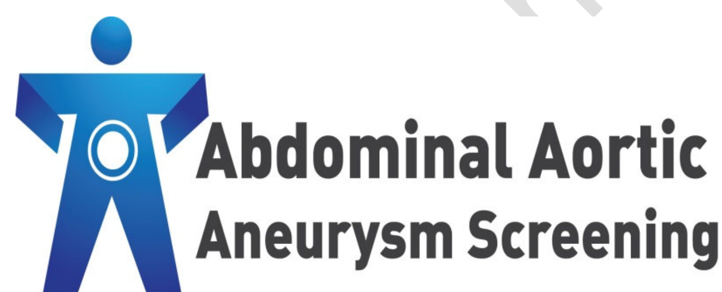

About this publication

Document title:	*NI AAA Screening Programme Annual Report 2023/2024*
Version:	Version 1.0
Authors:	*Gemma Reid (PHA), Claire Black (BHSCT), Leanne McClay (BHSCT), Christine McKee (PHA)*
Owners:	*NI AAA Screening Programme*
Final approved release date:	

Distribution to:

- Co-Director of Surgery and Specialist Services - Belfast Health and Social Care Trust
- NI AAA Screening Programme Team - Belfast Health and Social Care Trust
- Deputy Director of Public Health, Screening - Public Health Agency
- NI AAA Screening Programme Team - Public Health Agency
- NI AAA Screening Programme Co-ordinating Group

The final version of the report will be circulated to the above distribution list.

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Section 1:

Summary and Highlights for 2023-2024

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

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

All men registered with a GP in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65, who have never been screened before, can self-refer by contacting the screening programme office on 02896 151212.

The overall performance of the programme for 2023 – 2024 is as follows –

Table 1 : Performance Summary for 2023 – 2024

Cohort	23/24
Number of cohort men invited to a screening appointment	10907
Number of cohort men who attended a screening appointment	8736
Newly detected AAA's	74
Large aneurysms referred to the vascular team	43
Self-referrals	31

Highlights of some of the work carried out by the programme from 2023- 2024 are as follows -

- The ninth annual service user event took place on the 1st December 2023.
- A new information sheet was introduced on 1st September 2023. The new information sheet is for men who have had abdominal aortic aneurysm (AAA) screening and no aneurysm has been detected. The

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information sheet is given to men at their screening appointment and advises them that their result of no aneurysm detected will be sent to their GP and includes information about how they can share their screening story with Care Opinion. This was introduced following shared learning visits to the Welsh Screening Programme in May 2023, South Devon & Exeter AAA Screening Programme in October 2023 and Leicestershire AAA Screening Programme in January 2024.

- The screening programme worked with Care Opinion to produce a leaflet specific for the AAA Screening programme to hand out at screening appointments, this started in March 2023 and stories shared from March 2023 to April 2024 are detailed under section 8.

- The third and fourth issue of the NI Abdominal Aortic Aneurysm (AAA) Screening Programme's Service User newsletter was published and posted to surveillance men in June 2023 and February 2024.

- The AAA Screening Programme's ninth annual service user event was held in Belfast on Friday 1st December which brought together a wide range of health care professionals and men who have, or had, an AAA detected through screening.

- The screening team attended Maghaberry and Magilligan prison in November 2023. The team visit on an annual basis offering screening to eligible men.

- The programme made a full recovery following backlogs made by the COVID-19 pandemic.

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Section 2:

Background and Programme Objectives

What is an AAA?

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

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

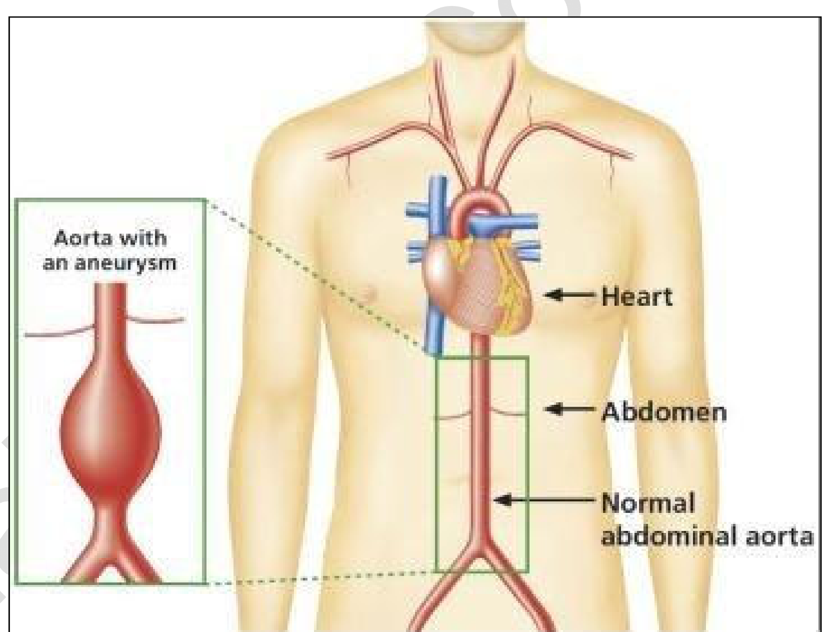

Image courtesy of the NHS England AAA Screening Programme

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

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Aim of the Northern Ireland AAA Screening Programme

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

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

Programme Objectives

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

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

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[1] Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: https://view-health-screening-recommendations.service.gov.uk/abdominal-aortic-aneurysm/

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

- Continuing to build on existing relations with the other three UK AAA Screening Programmes (England, Scotland and Wales).

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

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

- Promoting and participating in research initiatives.

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Section 3:

Governance and Accountability

The Public Health Agency

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

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

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

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

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

The Belfast Health and Social Care Trust

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

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

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

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

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potential treatment options.

The Trust also has responsibility for:

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

Audit and Research

Both organisations take joint responsibility for developing and facilitating audit and research activities related to the programme as and when these become available.

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Section 4:

Programme Delivery and the Screening Pathway

The programme is run by a multidisciplinary team of staff. All staff play an important role at various stages in the screening pathway.

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

Ten screening technicians (7.0WTE) run clinics on a daily basis. There are 24 clinic locations across Northern Ireland, including health and wellbeing centres and community hospitals (see **Appendix 1**).

Eligibility for Screening

All men in Northern Ireland who are registered with a GP are eligible for screening in the year they turn 65 (1 April to 31 March). This includes those men in prison or other secure accommodation. Any man who already has a known AAA can transfer to the care of the screening programme. However, if a man has previously had surgery for an AAA he does not require screening.

Men over the age of 65 and registered with a GP, who have not previously been scanned as part of the programme or been told they have an aneurysm, are also eligible for screening. These men can contact the screening programme office on 02896 151212 to request an appointment.

Details of all men registered with their GP who are eligible to be invited for screening are transferred to the Belfast Trust IT system on an annual basis. Daily updates are then automatically provided with changes to any demographic information.

The Screening Pathway

Appendix 2 provides an overview of the whole screening pathway. The key stages within the pathway are:

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

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Screening Invitation

The programme office sends all eligible men an invitation letter to attend a local screening clinic. This includes those men registered with a GP during the year in which they turn 65 and those eligible men over the age of 65 who have self-referred to the screening programme.

Invitations for men on surveillance are also sent:

- Men who have a small aneurysm detected will be invited back every *twelve months* for a surveillance scan.
- Men who have a medium aneurysm detected will be invited back every *three months* for a surveillance scan.

The Scan

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

The Result

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

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

\- **NO AAA FOUND**: **aortic diameter less than 3cm**
Over 98% of men will have this result. This means that the aorta is not enlarged (there is no aneurysm). No treatment or monitoring is needed and the men will be discharged from the screening programme. They will not need to be screened again.

\- **SMALL AAA**: **aortic diameter measuring between 3cm and 4.4cm**
Men who have a small aneurysm detected will be invited back every twelve months for a surveillance scan to monitor the size of the aneurysm. Some small aneurysms will grow in size over time and become medium or large aneurysms.

\- **MEDIUM AAA**: **aortic diameter measuring between 4.5cm and 5.4cm**
Men who have a medium aneurysm detected will be invited back every three months for a surveillance scan to monitor the size of the aneurysm. Some medium-sized aneurysms will grow over time to become large aneurysms.

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- **LARGE AAA**: **aortic diameter measuring 5.5cm or over**
Men who have a large aneurysm detected are referred to a vascular surgeon within the Royal Victoria Hospital at the Belfast Health and Social Care Trust for further investigation and to discuss possible treatment options. All men referred are required to be seen at outpatients within two weeks of the initial scan.

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

Surveillance

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

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

Referral and Treatment

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust.

All men referred to the vascular service are required to be seen by a consultant vascular surgeon within two weeks of the scan when the large AAA was detected. During this period, the man will have a CT scan to confirm the size of the aneurysm. This detailed imaging will help decide if the man is suitable for treatment and if so, what the best option is. All men diagnosed with a large AAA are discussed at a weekly vascular multidisciplinary team meeting (MDT) and also undergo vascular pre-assessment by a specialist nurse and vascular anaesthetist. If suitable, the vascular consultant will then discuss treatment options at outpatient review. The two main treatment options are open surgery or endovascular (EVAR) surgery. Open surgery requires a longer hospital stay and initial recovery period. Endovascular treatment, with a stent graft, allows for quicker recovery but has a longer follow-up period with X-ray surveillance. The decision regarding the choice of

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operation depends on many factors and is discussed in detail by the vascular team. The nominated consultant will then discuss the appropriate options with the man to enable him to make an informed choice. For some men further investigation and optimisation of underlying medical issues may be required prior to treatment of their AAA.

End Point of Screening Programme for Men

As outlined within Public Health England guidance[2], active inclusion in the screening programme ends when:

- the scan is found to be within normal limits .
- an AAA reaches 5.5cm diameter on ultrasound and the man has been referred to the vascular unit.
- the director of the local screening programme, or the GP, decides referral for treatment should be considered based on other factors (for example, symptoms or co-morbidities) .
- three consecutive scans show an aortic diameter less than 3cm on ultrasound where the initial scan was 3cm or greater.
- the man has had 15 scans at one-year intervals and the AAA remains below 4.5cm .
- the man declines to be in the screening programme, fails to attend consecutive appointments as per local policy, moves out of the area and becomes the responsibility of another screening programme (if one exists) or dies.

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[2] https://www.gov.uk/government/publications/aaa-screening-standard-operating-procedures

Section 5:

Programme Performance

This section of the report focuses on the performance of the programme. Data included covers the 23/24 cohort, the self-referrals and others offered screening through the programme. All data outlined within this report have been provided by the Belfast Trust programme team and quality assured by the Public Health Agency.

Eligible Cohort

The table below details the number of men who were eligible to be offered AAA screening by the programme for 2023 – 2024.

Table 2: AAA Screening cohort for 2023 - 2024

Category / Men:	23/24
Eligible screening cohort	**11271**

Self-referrals

Men over 65 who have never been screened can self-refer to the programme and request a screening appointment. The figure below shows the number of self-referrals the programme has had since it started.

The number of self-referrals to the programme has reduced significantly from 2016-17. The Programme has been unable to facilitate or participate in as many promotional events compared with previous years which has contributed to the decrease in self-referrals. Self-referrals were also paused from 23rd March 2020 due to the COVID-19 pandemic, the programme started to accept self-referrals again from February 2021. The numbers of men eligible to self-refer will also reduce the longer the programme runs as men are automatically called for screening.

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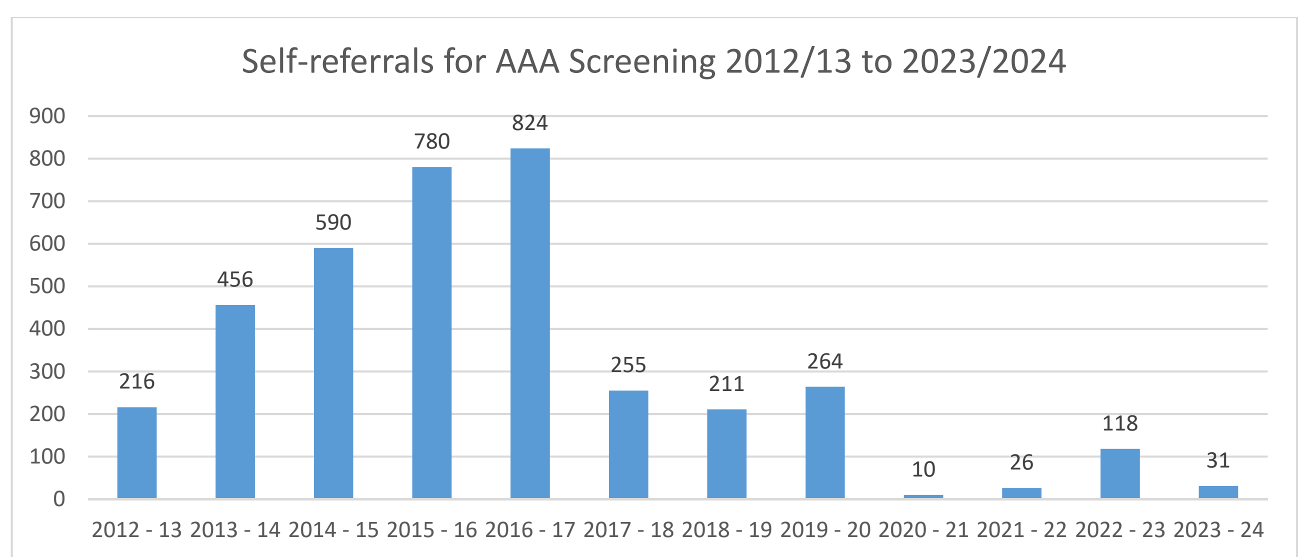
Figure 1: Self-referrals for AAA Screening 2023 to 2024



AAAs Detected and Prevalence

Table 3 below outlines the number of AAAs detected within the 23/24 cohort, including cohort men and self-referrals. It also notes the number of overall referrals for large AAAs to the Vascular Unit within the Belfast Trust and the prevalence rate.

Table 3: AAAs detected by the Screening Programme for the 23/24 cohort

Detected AAAs:	23/24
AAAs newly detected by the programme within the 23/24 cohort (including self-referrals)	73 plus 1
Referrals to the Vascular Unit (April 2023 – March 2024)	43
Prevalence (calculated using the cohort year only)	0.8%

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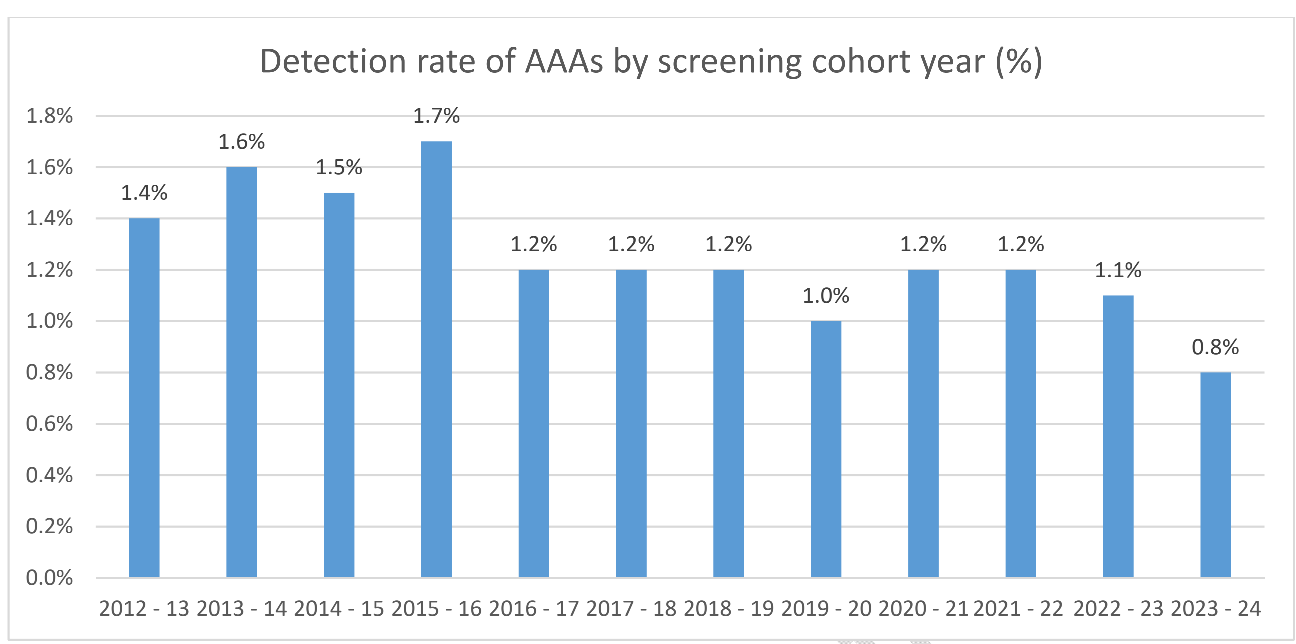
Figure 2 below outlines the AAA detection rate for the programme, broken down by year. AAA screening should remain cost effective unless the prevalence of AAAs in 65-year-old men falls below 0.35%.[3]

[3] **Impact of the first 5 years of a national abdominal aortic aneurysm screening programme** Jacomelli J, Summers L, Stevenson A, Lees T, Earnshaw JJ Br J Surg. 2016 Aug

Figure 2: Detection rate of AAAs by screening cohort year



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Performance against Key Pathway Standards for 2023 – 2024

The Department of Health and the Northern Ireland Screening Committee (NISC) formally endorsed the revised national standards for the NHS Abdominal Aortic Aneurysm Screening Programme updated in February 2022 as the standards to be adopted by the Northern Ireland Screening Programme. These new standards were to be adopted from 1st April 2023 to support performance monitoring of the programme.[4]

The table below compares the programme's overall performance against key national pathway standards for 2023 - 2024.

Table 4: Performance against Key Pathway Standards for 2023 – 2024

	Pathway Standard	Acceptable	Achievable	
1	Completeness of offer – initial screening Percentage of eligible subjects who are offered screening	≥ 95.0%	≥ 99.9%	96.8%
2	Completeness of offer – annual surveillance Percentage of eligible subjects who are offered screening	≥ 95.0%	≥ 99.0%	97.9%
3	Completeness of offer – quarterly surveillance Percentage of eligible subjects who are offered screening	≥ 95.0%	≥ 99.0%	98.4%
4	Coverage – initial screening Percentage of eligible subjects who are tested	≥75.0%	≥ 85.0%	77.5%
5	Coverage – annual surveillance Percentage of eligible subjects who are tested	≥ 85%	≥ 95%	91.8%
6	Coverage – quarterly surveillance Percentage of eligible subjects who are tested	≥ 90.0%	≥ 95.0%	93.1%
7	Coverage: initial screening Percentage of eligible subjects who are tested in the most deprived 30% of local areas	≥ 75.0%	≥ 85.0%	70.6%

[4] https://www.gov.uk/government/publications/aaa-screening-quality-standards-and-service-objectives/abdominal-aortic-aneurysm-screening-programme-standards-valid-for-data-collected-from-1-april-2022

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	Pathway Standard	Acceptable	Achievable	
8		≥ 75.0%	≥ 85.0%	80.1%
9	Uptake – annual surveillance Percentage of subjects offered screening who are tested	≥ 90.0%	≥ 95.0%	93.8%
10	*Uptake – quarterly surveillance* *Percentage of subjects offered screening who are tested*	*≥ 90.0%*	*≥ 95.0%*	*94.7%*
11	*Non-visualised initial screens* *Percentage of initial screens where aorta could not be visualised*	*≤ 3.0%*	*≤ 1.0%*	1.1%
12	Time to internal quality assurance Proportion of abnormal screens (aorta greater than or equal to 3.0 to less than 5.5cm) reviewed less than or equal to 21 calendar days of the initial screen date	≤ 60.0%	≤ 95.0%	94.7%
13	Time to nurse assessment Percentage of men who had a small or medium aneurysm detected at initial screen and the number of men who had a medium aneurysm detected at the annual surveillance scan who had a nurse assessment less than or equal to 12 weeks of their conclusive scan	≤ 50.0%	≤ 80.0%	100%
14	Time to first vascular surgeon assessment Percentage of men with an aorta greater than or equal to 5.5cm appropriately referred, or an aorta greater than or equal to 4.0cm that has grown 1cm or more in 1 year, seen by vascular surgeon less than or equal to 2 weeks of their last conclusive ultrasound scan	≥ 90.0%	≤ 95.0%	83.3%
15	Timely treatment/intervention by specialist (measured from date of referral)	≥ 60.0%	≥ 80.0%	17.1%

	Pathway Standard	Acceptable	Achievable	
	Percentage of men with aorta ≥ 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within 8 weeks			

The acceptable threshold is the lowest level of performance which screening services are expected to attain. The achievable threshold represents the level at which the screening service is likely to be running optimally.[5]

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

Table 5: Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)

	23/24
Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)	100%

The standard below was withdrawn as a national standard however it continues to be monitored at national level across vascular services.

Table 6: Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)

	23/24
30 day mortality (following elective surgery on screen-detected AAAs)	0%

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[5] https://www.gov.uk/government/publications/population-screening-our-approach-to-screening-standards/our-approach-to-nhs-population-screening-standards#performance-thresholds

Section 6:

Health Inequalities

Population screening programmes need high levels of participation to achieve their desired public health impact. Informed personal choice is central to the screening strategy and the decision to have a screening test or not is for the individual involved. However, people may choose not to make a decision about screening, are not aware of the offer or do not attend their appointment.

Health inequalities are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. The Marmot Review, Fair Society, Healthy Lives (2010) highlighted the social gradient of health inequalities, i.e. the more disadvantaged the person's social position the worse their health.

Studies on inequalities in AAA screening have found a number of factors:

- the Multi-centre Aneurysm Screening Study (MASS) found that higher age and social deprivation are associated with poorer screening attendance and having an AAA[6]
- a Scottish analysis found that both urban residence and social deprivation were associated with lower uptake among men invited for AAA screening[7]

In April 2020 the English AAA Screening programme introduced a new screening standard –

AAA-S07: coverage: initial screen in the most deprived 30% of local areas is the proportion of men in the eligible cohort who were tested and who lived in a lower super output area (LSOA) classed as decile 1 to 3 in the English indices of deprivation 2019.

Men living in more deprived areas are less likely to attend for screening but are more likely to have an aneurysm. It is therefore important for the AAA screening programme to engage with men living in more deprived areas to make sure they can make a personal informed choice.

This standard only focuses on one aspect of inequalities in access to AAA screening. It is acknowledged that there are many sources of inequalities which need to be identified and reduce drivers of inequalities relevant to the local area.

The performance thresholds for this standard are -

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[6] https://journals.sagepub.com/doi/10.1177/096914130301100112
[7] https://onlinelibrary.wiley.com/doi/pdf/10.1002/bjs.9803

Acceptable level: greater than or equal to 75.0%

Achievable level: greater than or equal to 85.0%

The following table and chart shows the coverage for initial AAA Screening appointments in Northern Ireland (NI) broken down by areas of deprivation for the 23/24 cohort.

Table 7: % men in Northern Ireland who attended for Abdominal Aortic Aneurysm screening by deprivation decile 1 – 3 for 19/20, 20/21, 21/22 and 22/23

	No. eligible NIMDM 2017 Decile 1-3 (SOA)	No. screened NIMDM 2017 Decile 1-3 (SOA)	% screened (coverage) NIMDM 2017 Decile 1-3 (SOA)	Total cohort No. eligible	Total cohort No. screened	% screened (coverage)
23/24	3468	2450	70.6%	11271	8736	77.5%

Source: AAA Screening Programme, Public Health Agency and Belfast Health and Social Care Trust
Data refers to men screened by their cohort year
Northern Ireland Statistics and Research Agency, NI Multiple Deprivation Measure 2017 (Super Output Area (SOA) level)
https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017

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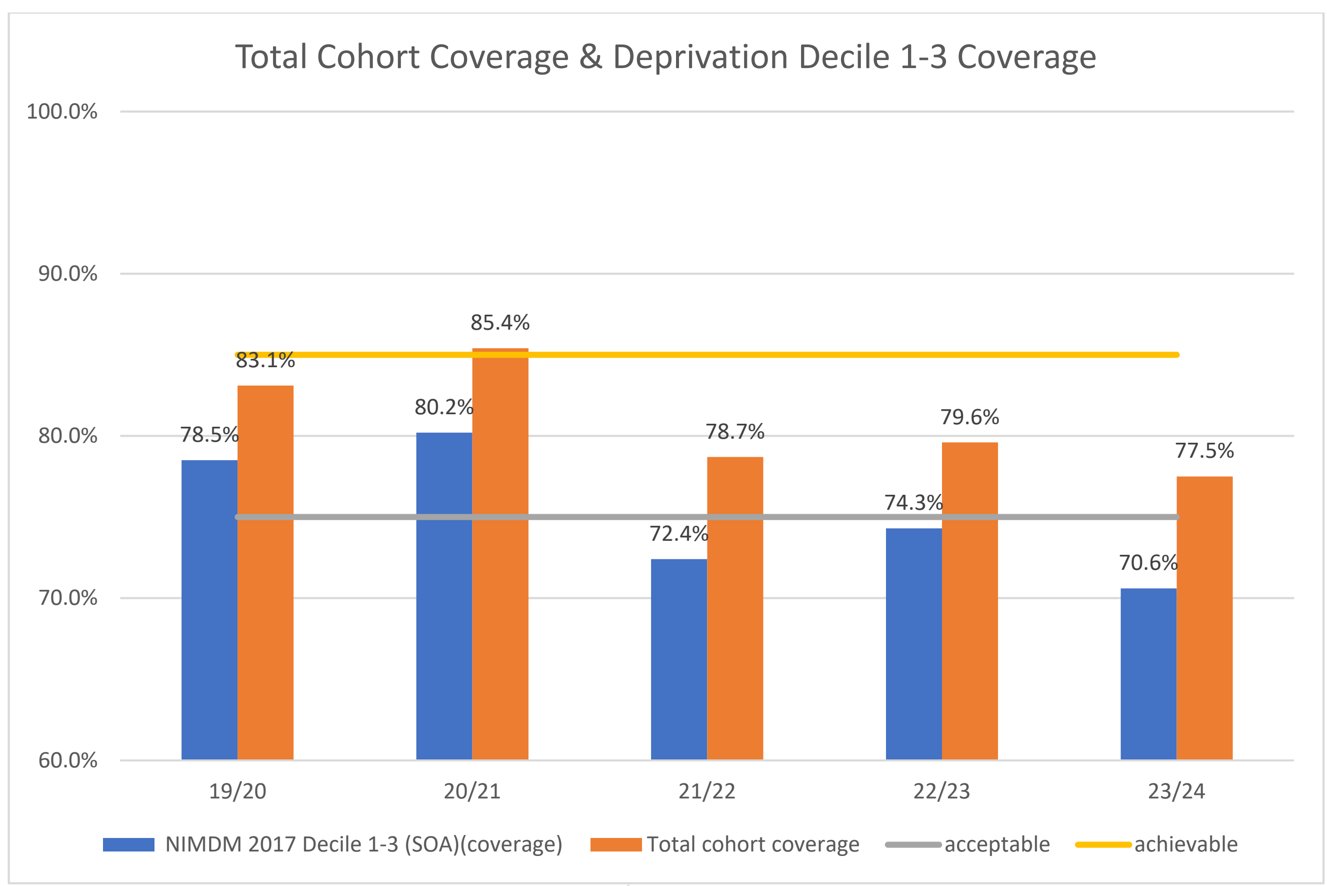
Figure 3: % Coverage by NI Multiple Deprivation Measure 2017 quintile (SOA) 1-3 and total coverage for 19/20, 20/21, 21/22, 22/23 and 23/24



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Trust uptake

Similar to previous years the highest uptake is in the South Eastern Health and Social Care Trust and the lowest uptake is in the Belfast Health and Social Care Trust.

Table 8: Trust uptake for 2023-2024

Health and Social Care Trust	No invited for screening 23/24	No screened 23/24	Uptake by Trust %
Belfast	2,224	1,729	77.7%
Northern	2,830	2,271	80.2%
South Eastern	2,029	1,666	82.1%
Southern	2,087	1,647	78.9%
Western	1,736	1,422	81.9%
Northern Ireland	**10,906***	**8,735***	**80.1%**

** One record was postcode unknown.*

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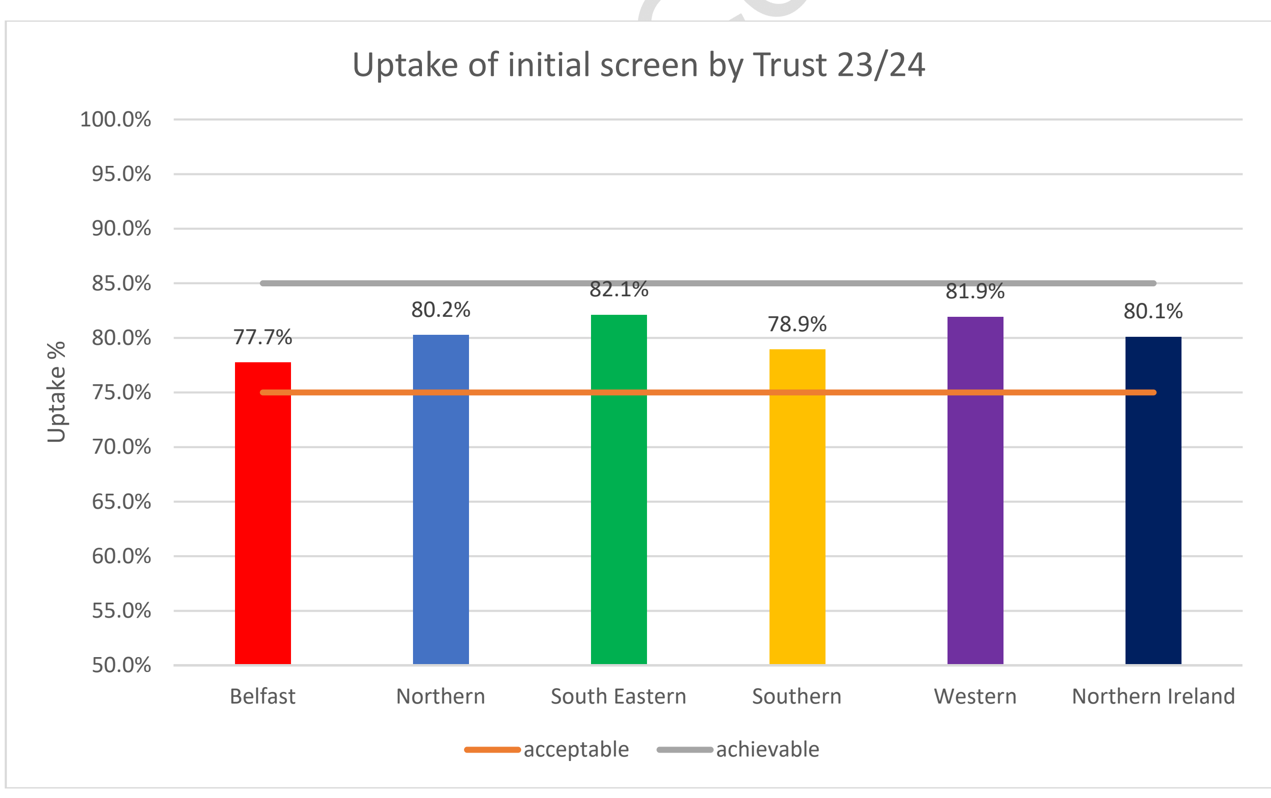

Section 7:

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) enables the public to influence the planning, commissioning and delivery of health and social care (HSC) services. It includes actively engaging with communities, specifically those who use services such as screening. The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HSC organisations within Northern Ireland.

During 2023-2024, the Northern Ireland AAA Screening Programme completed the PPI projects outlined below.

- The AAA Screening Programme's ninth annual service user event was held in Belfast on Friday 1st December 2023 and brought together a wide range of health care professionals and men who have, or had, an AAA detected through screening. The event was facilitated by PHA and Belfast HSC Trust staff and included presentations about programme updates, prehabilitation and vascular surgery, promotion of the programme, arm chair exercises, cookery demonstrations and a group discussion exercise. Over 60 service users and staff attended the event and feedback was very positive.

- The screening programme worked with Care Opinion to produce a leaflet specific for the AAA Screening programme to hand out at screening appointments. Care Opinion is a place where service users can share their experience of health or care services, and help make them better for everyone. Staff started to hand out the care opinion leaflet in March 2023 and 101 stories were received up until 31st March 2024. Feedback is anonymous and the service user is asked to share what was good and what could have been better.

  The majority of feedback from the 101 stories was very positive with some minor issues that the programme will be looking to improve going forward.

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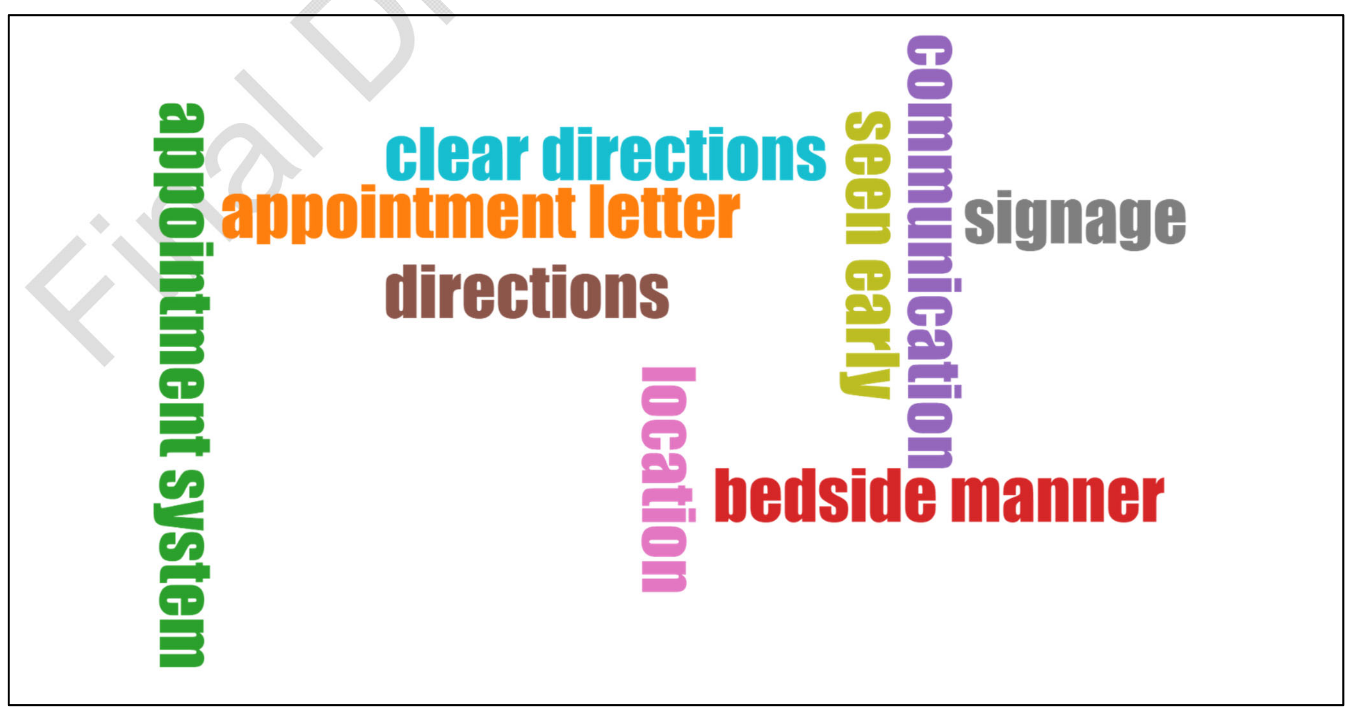
Infographic 1: Word cloud for what was good?

Infographic 2: Word cloud for what could have been better?



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Section 8:

Role of Primary Care

Primary Care teams are integral to the successful delivery of the NI AAA Screening Programme. Since the programme began in 2012, the considerable contribution and partnership working with primary care teams has been invaluable, particularly in the areas outlined below.

Supporting men with a screen-detected AAA

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

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

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

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

Providing information to facilitate screening appointments for eligible men

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

- Ensuring patient records are accurate – information is downloaded into the programme's IT system on eligible men registered with GPs; programme staff liaise with practices about any discrepancies.
- Seeking information about particular needs of men invited for screening, e.g. a physical or sensory disability, limited mobility or a learning disability – this helps facilitate the screening appointment and allows appropriate arrangements to be made e.g. extra time for the appointment if required.
- Organising an appropriate interpreter or signer when required to facilitate an appointment.

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Promoting screening

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

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

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Section 9:

Programme Promotion

During 2023-24, representatives from the programme attended a number of health fayres to promote the programme.

- COLIN Neighbourhood Partnership Men's Health Day - Brook Leisure Centre - 14/06/23.
- Annual Community Health Information Morning - Glen Community Centre – 08/08/23.
- European Vascular Society Conference Public Engagement Event 26/09/2023.
- Volunteers Now Men's 55+ Health Day - Girdwood Community Hub – 13/10/23.
- NIAS Association of Retired Personnel (NIASARP) AGM - Tullyglass Hotel Ballymena – 21/02/24.

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Appendices

1 Map of Screening Locations

2 The Screening Pathway

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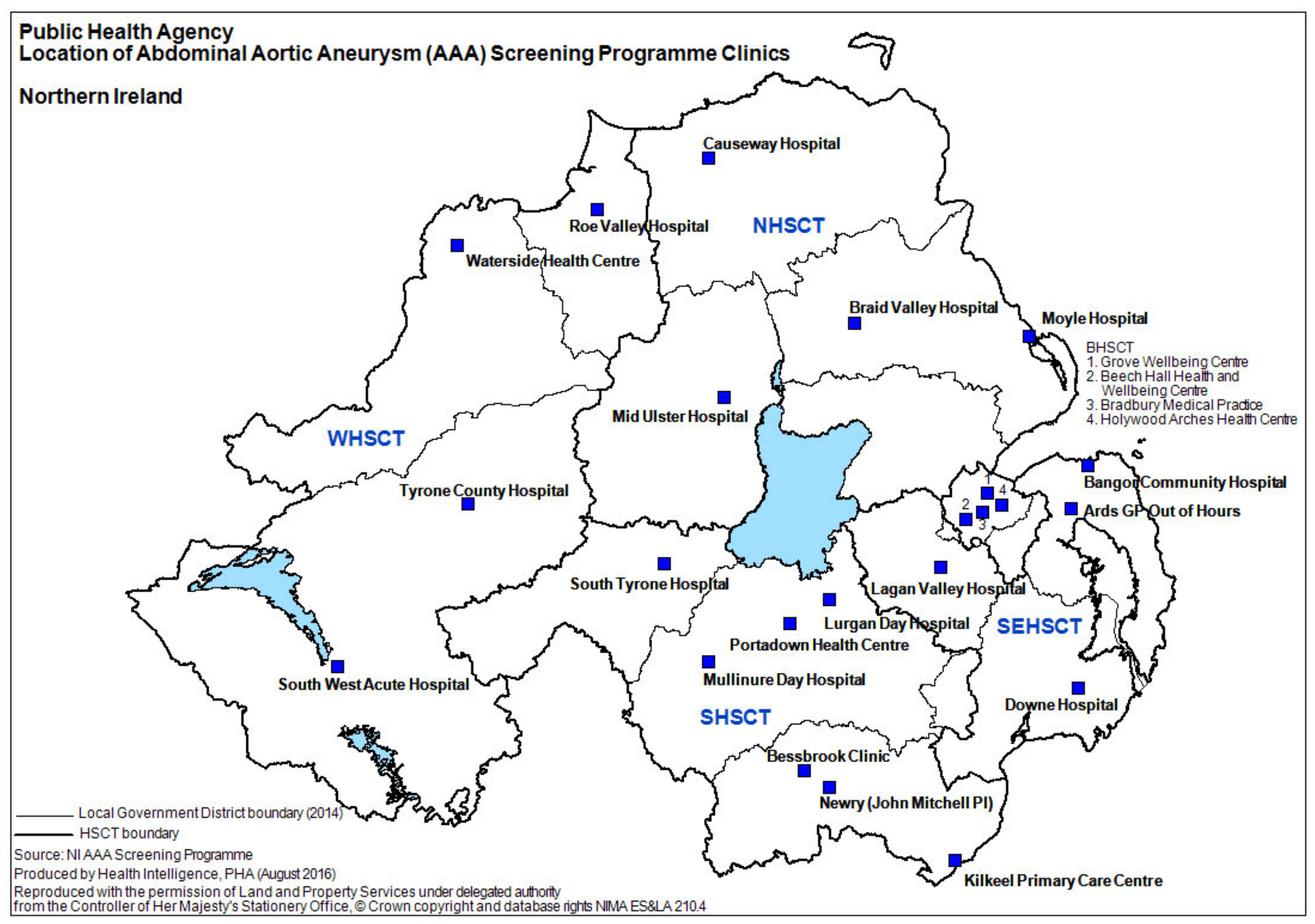
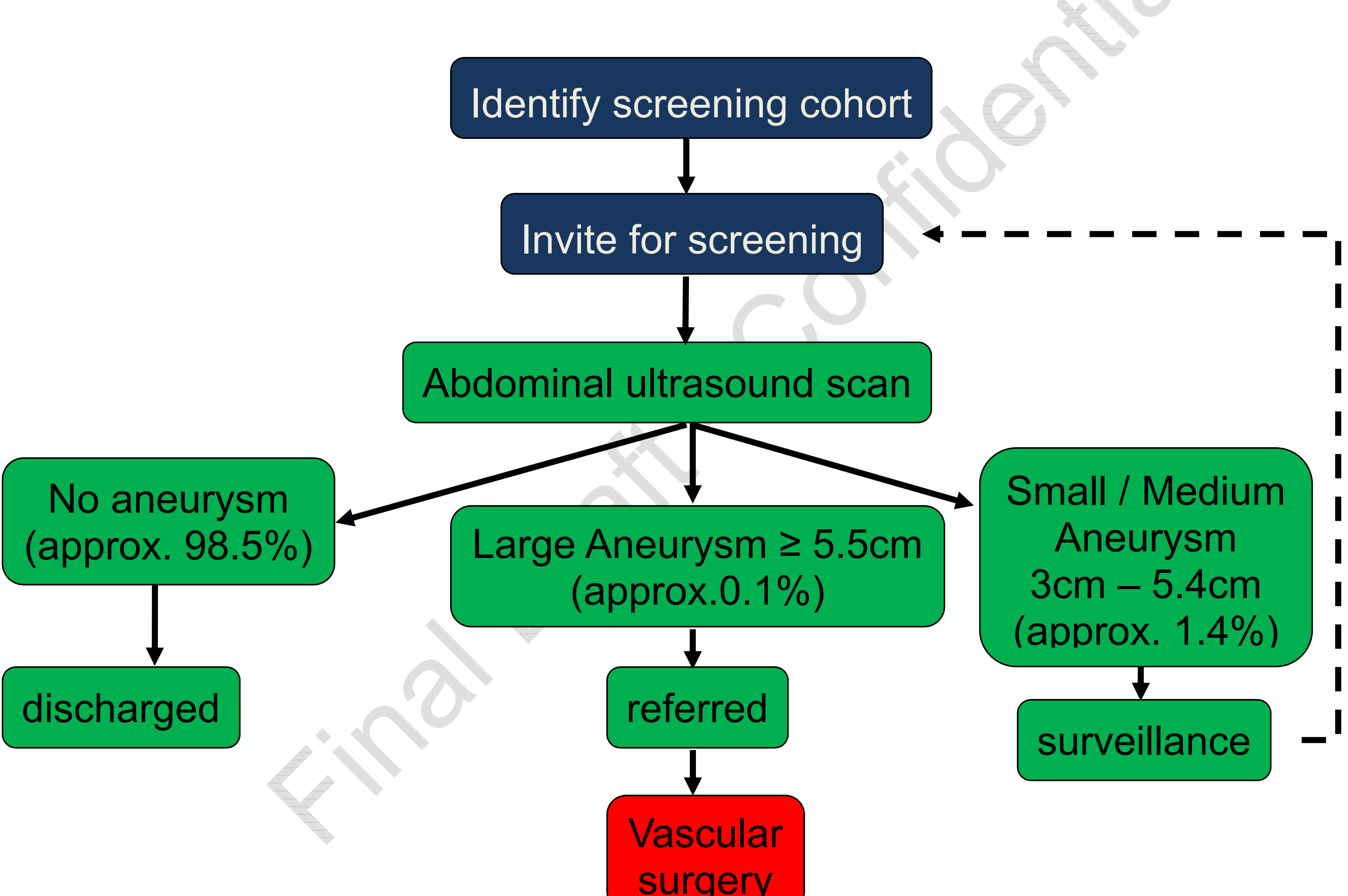
Appendix 1 – Map of Screening Locations



Appendix 2 – The Screening Pathway



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Finance Report
Month 9 - December 2025

Leah Scott
Director of Finance &
Corporate Services
February 2026

Introduction

This summary report outlines the agency's statutory duties and provides an update on the financial position at month 9, building on the PHA Financial Plan 2025/26 which has been formally approved by AMT and the PHA Board.

Section A: Statutory Targets

- **Break-even**

The PHA is directed to achieve financial balance, with the statutory duty to break-even within a tolerance level of 0.25% of an underspend of the final agreed Revenue Resource Limit (RRL) or £20,000 of an underspend, whichever is the greater.

- **Financial Planning**

The agency must annually plan service delivery in a way that meets our statutory responsibilities and ensures that expenditure is contained within the total RRL/CRL.

- **Prompt Payment**

The Department requires that PHA pay at least 95% of invoices (by volume) within 30 days, to their non-HSC trade payables in accordance with Government Accounting guidance.

Section B: Summary Position

The position at 31 December 2025 (Month 9) reflects a year-to-date (YTD) surplus of £444k and a forecast full year surplus of £447k. This is as a result of:

- a forecast deficit of £1,143k in relation to the underfunded pay award; and
- a forecast surplus on vaccines of £1,589k mainly in relation to a reduction in the Shingles and Flu vaccination budget requirement. It is expected DoH will retract this funding non-recurrently in the near future, eliminating this surplus.

As you will be aware the Executive approved the Ministerial Direction to implement the 2025/26 pay award in full. Following the December monitoring round the DoH confirmed the funding available is limited to one third of the total cost for all HSC organisations.

Subsequent to the retraction of £1,589K identified above, the agency is currently forecasting a 447K surplus (excluding AFC pay award). An additional disclosure of the £1.143K deficit is required to reflect the AFC funding gap in the overall financial position at year-end. This is in line with the DoH guidance which requires the pay award funding gap and the remaining funding gap to be reported separately.

It is currently anticipated that this element of the pay award will remain unfunded in this financial year. The implications of this for the statutory breakeven position and NIAO audit opinion is currently being considered, and once further clarification is received an update will be provided to AMT and Board.

Table 1: PHA Summary Revenue position – December 25	Dec 25 Budget £'000	Dec 25 Actual £'000	Dec 25 Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000		Forecast Expenditure £'000
Programme Expenditure by Trust	4,697	4,697	0	36,406	36,406	0		48,988
Programme Expenditure by PHA	3,538	3,345	193	40,562	40,822	(261)		60,226
Total Programme Expenditure	**8,235**	**8,042**	**193**	**76,968**	**77,228**	**(261)**		**109,214**
Management & Admin	**2,729**	**2,731**	**(2)**	**24,784**	**24,075**	**709**		**33,502**
Ringfenced by Trust	164	164	0	1,480	1,480	(0)		1,974
Ringfenced by PHA	44	63	(19)	428	451	(22)		629
Total Ringfenced	**209**	**228**	**(19)**	**1,909**	**1,931**	**(22)**		**2,603**
Other Revenue Income	**-**	**-**	**-**	**(50)**	**(67)**	**17**		**(50)**
PHA Total	**11,172**	**11,001**	**172**	**103,611**	**103,167**	**444**		**145,269**

Total Funding Available 2025-26 (Appendix 1)	**145,716**
Forecast Surplus/(Deficit)	**447**
Surplus on Vaccinations (£1.5m to be retracted by DoH)	1,589
Deficit on under-funded pay award	(1,143)
Total	**447**

The PHA funding allocation of £145.7m is set out in **Appendix 1**.

The DoH receive a budget allocation from the minister each year. The Department is then responsible for the allocation of funds across HSC organisations while ensuring financial balance is achieved. During the year the supplementary monitoring process provides a formal system for reviewing plans and priorities for the current year in line with the most up to date position. This process allows organisations to identify underspend and/or additional pressures arising from which organisations may secure additional funds however they may also be faced with additional savings targets should a funding gap exist across HSC.

Other additional ad-hoc funds may be allocated during the course of the year for specific areas of costs arising which were not included in the opening allocation e.g. pay awards.

Section C: Expenditure to month 9

The PHA has reported a YTD **surplus position of £444k at 31 December 2025** and is forecasting an underspend position for the year, as outlined in Section B above. **Table 2** provides a breakdown of expenditure by budget area.

Table 2: Breakdown by Budget Area	Dec 25 Budget £'000	Dec 25 Actual Exp £'000	Dec 25 Variance £'000	YTD Budget £'000	YTD Actual Exp £'000	YTD Variance £'000	Forecast Expenditure £'000
Programme Expenditure							
HSC Trust (See Table 3)							
Public Health	3,438	3,438	(0)	25,193	25,193	0	33,642
Population Health & Wellbeing	1,258	1,258	0	11,213	11,213	(0)	14,951
Sub Total By Trust	4,697	4,697	(0)	36,406	36,406	(0)	48,988
PHA Internal							
Public Health	2,860	2,614	246	23,796	24,082	(286)	31,487
Population Health & Wellbeing	611	663	- 52	15,883	16,003	(120)	23,452
Finance & Corporate Services	-	-	-	-	7	(7)	-
Population Data & Intelligence	67	48	19	799	761	38	4,252
Chief Executive & Board	0	20.50	(21)	34	77	(42)	986
Other	-	-	-	-	(173)	173	-
Sub Total By PHA Internal	3,538	3,345	193	40,512	40,755	(243)	60,176
Sub Total Trust + PHA Internal	8,235	8,042	193	76,918	77,161	(243)	109,164
Management & Admin							
Public Health	1,263	1,204	59	11,359	10,454	905	14,521
Population Health & Wellbeing	717	644	72	6,500	6,024	476	8,286
Finance & Corporate Services	349	390	(41)	3,109	3,002	108	4,118
Population Data & Intelligence	222	238	(16)	2,254	2,277	(23)	3,260
Chief Executive & Board	632	156	476	1,342	1,577	(235)	3,360
Other	(539)	0	(539)	(547)	-	(547)	(1,094)
SBNI	85	99	- 14	768	742	26	1,051
Sub Total - Management & Admin	2,729	2,731	- 2	24,784	24,075	709	33,502
Ringfenced							
Trust	164	164	0	1,480	1,480	(0)	1,974
PHA Direct	44	63	(19)	428	451	(22)	629
Sub Total	209	228	(19)	1,909	1,931	(22)	2,603
PHA TOTAL	11,172	11,001	172	103,611	103,167	444	145,269

In respect of the year to date position:

Trust Programme - A _balanced position_ is shown with all allocations to Trusts from PHA being considered to be fully spent.

PHA Internal Programme – An _overspend of £243k_ is shown on PHA Internal programme budgets (i.e. Non-Trust) for the year-to-date.

- The *Public Health Services* Directorate shows an overspend of £286k for the year to date, due to a number of pressures which were approved within the Programme budget, funded from Admin slippage, to ensure that the PHA achieves an overall breakeven position for the full year.
- The overspend on the *Population Health & Wellbeing* Directorate & *Chief Executive & Board* relates to timing of expenditure, and no surplus is currently forecast for the full year
- The *Other* line relates to year-end accruals which were not required and have therefore been swept up and held centrally, effectively becoming a funding source for 2025/26.

Management & Administration - A *surplus of £709k* is shown on the Management & Administration budget at month 9, reflecting underspends generated by the current level of vacancies across the Agency. This underspend was anticipated at the start of the year, and the Financial Plan approved a number of Programme pressures to absorb this slippage and manage the overall breakeven position.

Work on the realignment of budgets in line with the Reshape & Refresh programme has been completed and revised Directorate structures are now shown in the table above. The *Other* line reflects the fact that the Reshape & Refresh budget exceeds the funding available, and management are working to reduce this funding gap by the end of January 2026.

Ringfenced Funding – a small *overspend of £22k* is shown for the year to date. The full year budget comprises NI Protocol funding (£62k), Tackling Paramilitarism / Fresh Start (£408k) and COVID (£2,133k, mainly for vaccinations). This position will be kept under close review during the year, and any potential slippage highlighted at an early stage if it arises.

Trust Allocations: Table 3 below summarises the allocations to the respective Trusts in 2025/26 to date.

Table 3: Trust Allocations	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS £'000	Other - Yet to be allocated £'000	Total Planned Expenditure £'000
Public Health								
Health Protection	2,719	2,745	1,945	2,362	2,002	5	-	**11,778**
Service Development & Screening	8,356	3,576	971	2,505	3,227	-	-	**18,634**
Living Well	1,037	576	589	480	497	-	52	**3,231**
	12,111	**6,896**	**3,505**	**5,347**	**5,725**	**5**	**52**	**33,642**
Population Health & Wellbeing								
Ageing Well	265	67	197	107	45	-	-	**680**
Early Years	741	1,026	625	891	779	-	-	**4,062**
MH&LD	4,554	1,094	373	589	240	73	-	**6,922**
Nursing	857	306	341	944	807	31	-	**3,287**
	6,417	**2,493**	**1,536**	**2,531**	**1,871**	**104**	**-**	**14,951**
Trust allocated pay award - Yet to be allocated	140	77	41	70	66	0	-	**394**
Total Core Funding	**18,668**	**9,466**	**5,082**	**7,947**	**7,662**	**110**	**52**	**48,988**
Ringfenced - Covid	180	168	578	481	566	-	-	**1,974**
Total Current RRLs	**18,848**	**9,633**	**5,660**	**8,429**	**8,228**	**110**	**52**	**50,961**

Nursing: *The budget associated with the former Nursing & AHP Directorate is shown as a single line as it has not yet been split into the new thematic areas.*

All funding allocated to Trusts by PHA is considered to be fully spent unless notified otherwise by the Trust. Any notified underspends are retracted by PHA, hence no variance occurs for PHA on Trust allocations.

Section D: Risks

The following significant assumptions, risks or uncertainties facing the organisation were managed throughout the year to arrive at the draft breakeven position noted.

1. **HSC-wide funding gap**: the opening allocation letter from the DoH in June 2025 confirms a significant funding gap of some £600m across the HSC. To address the funding gap the Department established a Systems Financial Management Group (SFMG) to realise cash releasing savings in-year and put the HSC on a more sustainable footing. While significant savings have been achieved the DoH continue to report a deficit of £230M (@Jan 26) which includes the 2025/26 AFC pay award (209M). The DoH are therefore unlikely to breakeven in the 2025/26 year.

   In response to the significant funding gap the PHA are currently undertaking an exercise to model the impact of future savings cuts of 5%, 10% and 15%, a response is due to DoH by mid-February 2026.

2. **2025/26 Pay Award:** The Minister has approved the payment of a pay award for 2025/26, however only 33% of this has been funded in the current year to date. Recent correspondence from DoH indicates that approximately £1.1m (66%) of the pay award will not be funded in year, and the shortfall is currently expected to generate a deficit position for all HSC organisations including the PHA, with this position planned to be reported in the year-end financial position.

3. **Recurrent pressures funded from non-recurrent sources:** in the 2025/26 Financial Plan, a number of high-priority public health initiatives were approved to progress, funded from in-year slippage, mainly from vacancies within Administration budget. These initiatives have recurrent tails, and appropriate recurrent funding will need to be identified within 2026/27 baseline budgets, otherwise the projects will need to be curtailed where possible.

4. **EY Reshape & Refresh review and Management and Administration budgets:** The PHA is has undergone a significant review of its structures and processes, and final structures are nearing completion. The current model has been costed at approximately £1m more than the funding available and, although current vacancy levels mean there is no issue in-year, there is a concern that once all posts are filled the structure will be unaffordable. Management are working to refine the structure and bring the cost into line with available funding to reduce the risk of an overspend in the future. It is expected that the gap will be reduced to £0.5m through the removal of posts by the end of month 10 (January 2026).

5. **Demand-led budgets:** a number of significant areas of expenditure are demand-led and subject to significant fluctuations (vaccines administration, smoking cessation etc.). There is inherent risk in these areas, and they will be kept under close review.

Section E: Prompt Payment

Prompt Payment performance for December shows that PHA is above the 95% prompt payment target on value but has dropped slightly below the target on volume. The year to date position shows that the PHA is achieving its target on volume and value. Prompt payment targets will continue to be monitored closely over the 2025/26 financial year.

Table 4: Prompt Payment Performance	December 2025 Value	December 2025 Volume	Cumulative position as at December 2025 Value	Cumulative position as at December 2025 Volume
Total bills paid (relating to Prompt Payment target)	£4,320,945	296	£52,980,342	3,572
Total bills paid on time (within 30 days or under other agreed terms)	£4,233,892	276	£50,310,387	3,431
Percentage of bills paid on time	**98.0%**	**93.2%**	**95.0%**	**96.1%**

The 10-day prompt payment performance remains above the current DoH target for 2025/26 of 70%, at 84.4% on volume for the year to date.

Section F: Capital position

The PHA has a capital allocation (CRL) of £12.345m at 31 December 2025. This mainly relates to projects managed through the Research & Development (R&D) team, with £7.1m previously held by PHA now retracted by DoH and issued to Trusts directly. The overall summary position, at the end of December 2025, is reflected in **Table 5** below.

Table 5: PHA Summary capital position – 31 December 2025

Capital Summary	Total CRL	Year to date spend	Full year forecast	Forecast Surplus/ (Deficit)
	£'000	£'000	£'000	£'000
HSC R&D:				
R&D - Health ALBs	240	-	240	-
R&D - held for Trusts	3,124	-	3,124	-
R&D - Other Bodies	3,253	3,023	3,253	-
R&D - Capital Receipts	(547)	(175)	(547)	-
Subtotal HSC R&D	**6,071**	**2,848**	**6,071**	**-**
Other:				
Congenital Heart Disease Network	724	-	724	-
iReach Project	656	287	656	-
R&D - NICOLA	835	116	835	-
Monitors for Directors	5	-	5	-
Planning Laptops	19	19	19	-
R&D VPAG	243	-	243	-
R&D VPAG Trusts	1,901	-	1,901	-
R&D VPAG Other Bodies	1,891	-	1,891	-
Subtotal Other	**6,274**	**422**	**6,274**	**-**
Total PHA Capital position	**12,345**	**3,269**	**12,345**	**-**

R&D expenditure 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.

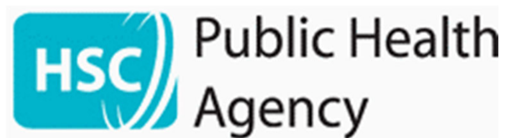
The relatively low level of expenditure to date is in line with expectations, and a breakeven position is expected for year-end. Any departure from this position will be notified to AMT and Board as early as possible.

Recommendation

The PHA Board are asked to note the PHA financial update as at December 2025.

Appendix 1 – Breakdown of Funding Allocation 2025/26

Letter	Description	Total Allocation
DoH Allocation Letters:		
PHA 1	Opening PHA Allocation - 26 June 2025	**£140,362,212**
PHA 2	Primary HPV - transferred from SPPG	£729,601
	Trust Vaccination of relevant vaccinators against Hepatitis B	£20,000
	Sessional vaccinator funding for spring 2025 Covid Vaccination Programme	£42,313
	Trust spring 2025 Covid-19 vaccination clinics	£542,652
	Gonorrhoea Vaccination Programme	£100,000
	Joint Health and Education Partnership Lead Post (Technical Transfer - Direct)	£40,000
	Child Criminal Exploitation (ARCS Funding for SBNI Post) (Technical Transfer - Direct)	£55,000
	Cross Government Trauma Informed Practice Hub (Technical Transfer - Direct)	£328,000
	Drug Related Intimidation Response Scoping (Technical Transfer - Direct)	£80,000
	"Shingrix for all" Shingles Vaccination Programme	£3,000,000
	Protect Life 2	£200,000
PHA 3	Substance Use Strategy (Naloxone)	£40,000
	Retraction - Various Projects (Ward Sisters Initiative; Nursing Home In-Reach; Dysphagia Project and Partnership Working Officers) - to be transferred to SPPG	(£4,473,755)
PHA 4	Retraction - Nursing Band 8B IRO R Donaldson - to be transferred to SPPG	(£97,758)
	Child Criminal Exploitation (funding for SBNI post) (DoH Matched Funding)	£55,000
	Online Safety Strategy funding for SBNI	£101,200
	Waste Water based epidemiology programme for Northern Ireland (Pilot)	£90,792
	Protect Life 2	£100,000
PHA 5	Sessional vaccinators & Trust vaccination clinics for the autumn 2025/26 Covid 19 Programme	£1,552,947
	PHA Accommodation funding for County Hall, Tower Hill & Gransha	£212,944
	PHA accommodation funding for Linenhall Street	£227,879
	To Support Care Home staff access to LearnHSCNI online training platform	£25,000
	Cancer Strategy Implementation - ACST Programme Lead	£29,559
	Retraction - "Shingrix for all" Shingles Vaccination Programme	(£500,000)
	Retraction - Deemed Consent Organ Donation	(£288,000)
PHA 6	Cancer Strategy Implementation - ACST Training places	£1,787
	Tier 2 Drug and Alcohol Services	£121,500
	Changes to the childhood vaccination schedule	£1,138,311
PHA 7	Farm Families Health Checks	£187,000
PHA 8	PHA - Pay Award for Agency & Locum, Agenda for Change Staff, Agenda for Change - 3rd Party Organisations, Consultants, Resident Doctors & Dentists	£571,698
	PHA - Recovery of BSO Charges	£48,669
	PHA - Pay Award - Trusts	£395,746
Assumed allocations to come from DoH (currently included in budget):		
	Clinical Excellence Award	£58,272
	Waste Water Pilot	£31,059
	Senior Executives Pay Award	£120,000
	Covid retraction (ringfenced)	(£25,000)
Funding confirmed from NIMDTA		£490,690
Total Funding for 2025-26		**£145,715,318**



item 12

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	26 February 2026
Title of paper	Complaints, Compliments and Claims Quarterly Report
Reference	PHA/07/02/26
Prepared by	Alastair Ross / Ashley Stoney
Lead Director	Aidan Dawson

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is for the Board to note the latest report on complaints and claims against the PHA.

2 Background Information

Following the receipt of an internal audit recommendation, the Agency now produces a quarterly Complaints Report to ensure that senior leaders within the PHA, at both Executive and Non-Executive level, are adequately briefed in respect of complaints handling.

This Report has been updated and now includes information in respect of compliments received by the Agency as well as claims.

3 Key Issues

During the first three quarters of 2025/26, the PHA received seven formal complaints, four of which have been closed. In the same period eight compliments have been received and two claims have been closed.

It should be noted that the quarter 3 report presents the position as at 31 December 2025 and consequently does not reflect any subsequent changes to Agency reporting following the implementation of the HSC Model Complaints Handling Procedure on 1 January 2026.

4 Next Steps

The next Report will be brought to the Board in May 2026.

2025/2026

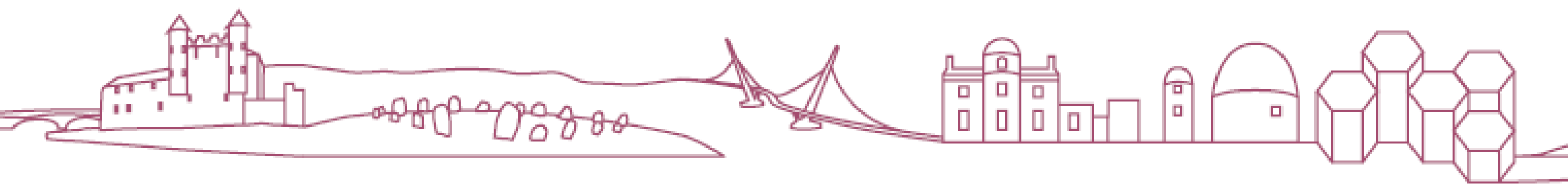
Complaints, Compliments and Claims

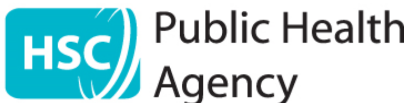
Quarterly Report

Internal Qtr 3 Report

Position as at 31 December 2025

Report Prepared by PHA Complaints Office





CONTEXT

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

SECTION 1 - COMPLAINTS

1.1 Definition

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

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

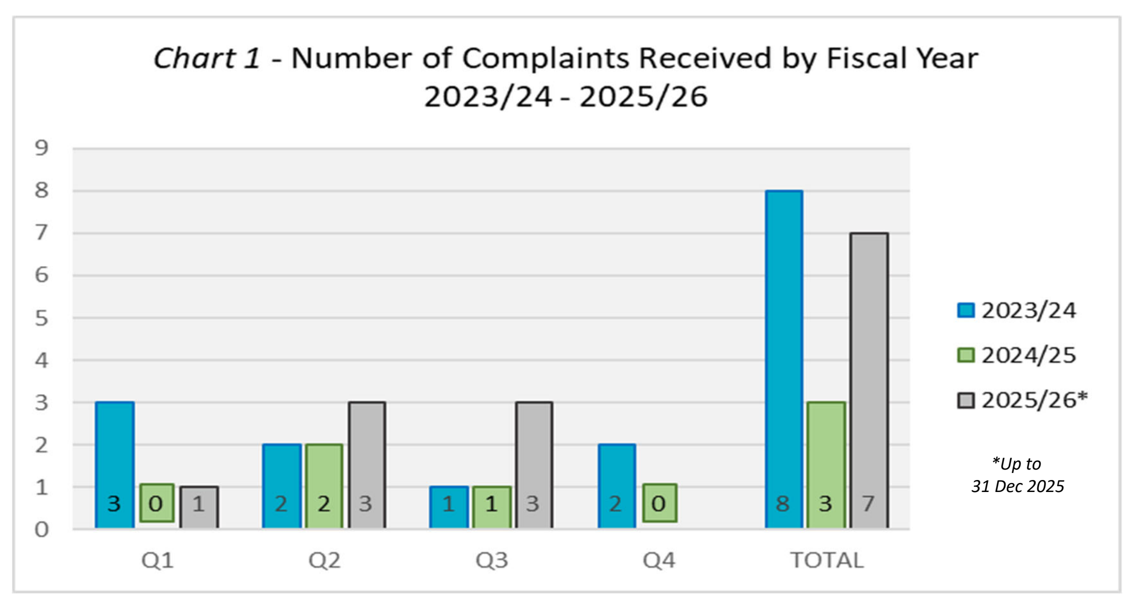
1.2 Key Performance Indicators

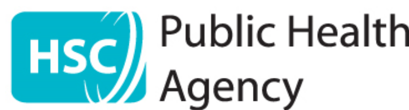
The management of complaints are monitored in line with the following key performance indicators:

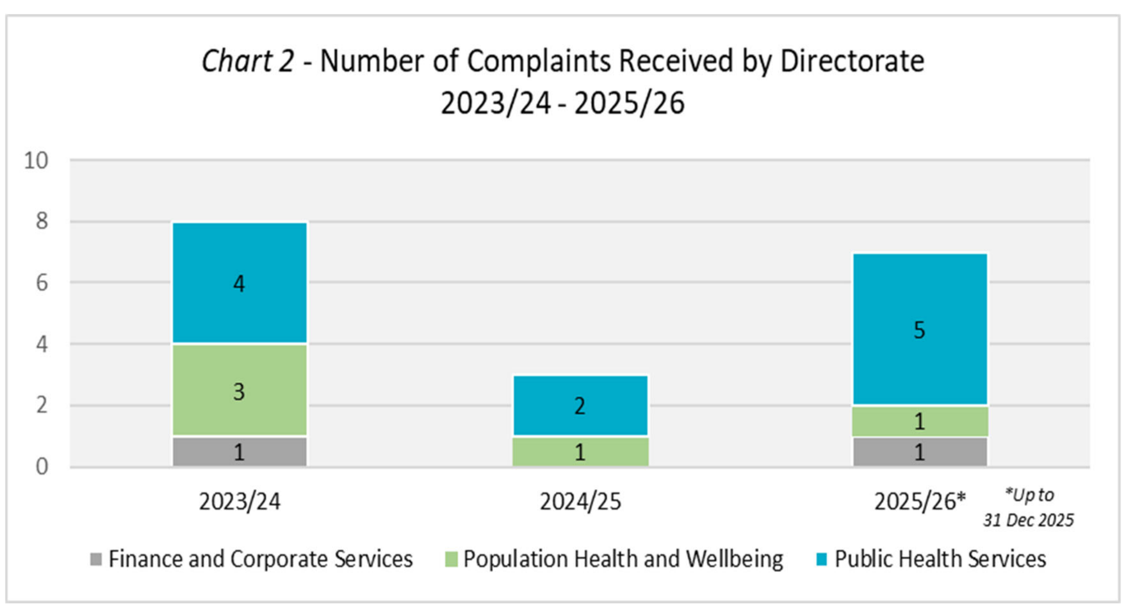
a. A complaint should be acknowledged in writing within 2 working days of receipt;
b. A complaint should be responded to within 20 working days of receipt;
c. Where a full response within 20 days is not possible, a complainant should be updated every 20 working days on the progress of their complaint.

1.3 2025/26 Overview

During the period, 1 April 2025 - 31 December 2025, the PHA received seven formal complaints, during the same period in 2024/25, the PHA received three formal complaints. Further detail in relation to the receipt of complaints by fiscal year and Directorate is set out across Charts 1 and 2.







1.4 2025/26 Closed Complaints

The PHA has closed four complaints during 2025/26. Tables 1, 2 and 3 provide information in respect of closed complaints.

Table 1 Performance Against Key Performance Indicators (KPI) for Closed Complaints 2023/24 - 2025/26

		KPI 1		KPI 2		KPI 3	
	Number of Complaints Closed	Number of complaints acknowledged within 2 working days of receipt	Percentage of complaints acknowledged within 2 working days of receipt	Number of complaints responded to within 20 working days of receipt	Percentage of complaints responded to within 20 working days of receipt	Number of complainants updated every 20 days (where KPI 2 was not met)	Percentage of complainants updated every 20 days (where KPI 2 was not met)
2023/24	7	6	85%	4	57%	3	100%
2024/25	4	4	100%	2	50%	2	100%
2025/26*	4	3	75%	3	75%	1	100%

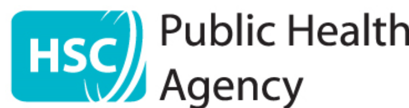


Table 2 Tenure of Closed Complaints 2023/24 - 2025/26

	Average time taken to conclude Complaint (working days)	Longest time taken to conclude Complaint (working days)	Shortest time taken to conclude Complaint (working days)
2023/24	27 Days	106 Days	3 Days
2024/25	25 Days	37 Days	16 Days
2025/26*	26 Days	51 Days	11 Days

**Position as at 31 December 2025*

Table 3 Synopsis of Closed Complaints 2025/26

PHA Ref	Responsible Directorate	Synopsis of Complaint and Response
C01/2526	Public Health Services	Complaint - Complaint in relation to the application of an extension to the Adult Step 2 contract and the implications for the future provider. Response - Complainant was advised that the extension put in place was in accordance with agreed procurement processes. Clarity was also provided in relation to the contents of the 'Intention to Award' which had been issued to the provider by the Agency.
C02/2526	Public Health Services	Complaint - Complaint relating to an advert placed by the PHA in the Belfast Pride Festival Guide for 2025. Response - Complainant was advised that the advertisement was placed as a means for the Agency to engage with the LGBTQIA+ community to provide health information and promote relevant services. It was also clarified that while the PHA places advertisements in a range of physical and digital publications to reach diverse audiences; this does not imply endorsement of the broader content or views expressed within those publications.
C03/2526	Population Health & Wellbeing	Complaint - Complaint in relation to the content of a response provided by the Agency addressing the PHA's understanding of the moderation practices and impartiality of Care Opinion. Response - Complainant offered an apology for the manner in which the Agency's correspondence was received. Clarification was provided in relation to the Agency's contractual relationship with Care Opinion.

C04/2526	Public Health Services	Complaint - Complaint in relation to the inaction of an email by the Agency regarding a conduct concern within a HSC Trust. Response - The Agency's failure to respond to the complainant's email was accepted. The complainant was advised that a number of procedural changes had been implemented within the Directorate to prevent similar issues from occurring in the future.

1.5 2025/26 Open Complaints

As of 31 December 2025, the PHA had three complaints under active review. Table 4 outlines the details of these open complaints.

Table 4 Synopsis of Open Complaints 2025/26

PHA Ref	Responsible Directorate	Synopsis of Complaint
C06/2526	Public Health Services	Complaint in relation to the adequacy of the Agency's work on cancer prevention, particularly in relation to ovarian cancer.
C07/2526	Public Health Services	Complaint in relation to the Agency's alleged inaction on the potential impact of wind turbine noise.
C08/2526	Finance and Corporate Services	Complaint in relation to the Agency's failure to issue an environmental information regulation response within the statutory timeframe.

1.6 Northern Ireland Public Services Ombudsman

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

As at 31 December 2025, the PHA is aware of no open PHA investigations with the Ombudsman.

SECTION 2 - COMPLIMENTS

2.1 Definition

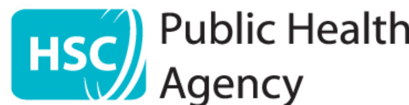
A compliment is an expression of appreciation felt by service users, carers, relatives, members of the public and/or external professional bodies for the work undertaken by the PHA.

Between 1 April and 30 December 2025, the PHA Complaints Office was notified of eight compliments received - to note that three compliments relate to the same subject matter.

A summary of compliments is provided in Table 5.

Table 5 Compliments Received 2025/26

PHA Ref	Directorate in Receipt of Compliment	Sender of Compliment	Compliment
01/2526	Chief Executive's Office	Representative from GP NI training Webinar	*'"The GPs really liked the flyer and thought that it was really clear and easy to understand, so well done one and all."*
02/2526	Public Health Services	Representative from Tourism NI	*"I wanted to write to express my sincere thanks to you and your team for your involvement in the 153rd Open - a truly momentous event. The success of the event was in no small measure due to the commitment, professionalism and enthusiasm of all partners involved in the working groups including you and your team."*
03/2526	Public Health Services	Representative from NI Environment Agency	*"I would like to extend my sincere thanks for your valued participation in the recent public consultation 'Drop In' events held in Eglinton and the Millennium Forum. Your presence and expertise were instrumental in making these events such a success. Feedback from attendees has been very positive. Many participants specifically commented on the benefit of having all partners present together, which not only streamlined communication but also showcased the strength and value of our collaborative working."*
04/2526	Public Health Services	Representative from Department of Agriculture, Environment and Rural Affairs	*"… I know that my officials have been in discussion with your team and the PHA, and I wanted to express my gratitude for the thoughtful advice and support of the PHA…."*



05/2526	Public Health Services	Pharmacy Adviser (Strategic Planning and Performance Group)	*"… [PHA Staff Member] was exceptionally professional and helpful throughout the visit. She provided reassurance to the pharmacist, answering his questions and ensuring that he fully understood his next steps following the visit. Karen spoke with the pharmacist in a calm and reassuring manner. Her detailed knowledge of the stop smoking service made the visit run smoothly and efficiently.'*
06/2526 07/2526 08/2526	Public Health Services	Members of Public	(1) *'Please, please pass my sincere thanks and deep appreciation to Dr Joanne for her wealth of information but especially for her stamina during a very lengthy radio segment.'* (2) *'Congratulations to Joanne McClean for her management of a challenging interview this morning on the Nolan Show. Her competence shines through and certainly would provide any reasonable person with a sense of her having ownership of and competence in management of the flu programme.'* *(3) 'Excellent interview with Nolan this am. Extremely informative, balanced great advice. My thanks to the PHA for all the work they do to keep the people of NI healthy. Special thanks to Dr McClean for her wonderful interview.'*

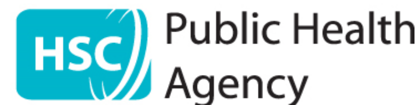
SECTION 3 - CLAIMS MANAGEMENT

3.1 Potential Liabilities

Claims within the PHA are aligned to four types of potential liability:

- Clinical/Medical Negligence,
- Employer's and Occupier's Liability,
- Injury Benefit and
- Employment Law.

The level of provision made in respect of potential liabilities for claims is based on professional legal advice from the Directorate of Legal Services. Information in respect of provisions are set out in the PHA Annual Report.



3.2 2025/26 Closed Claims (Settled and Withdrawn)

Two claims relating to the PHA have been closed during the period 1 April 2025 to 31 December 2025. Further detail in relation to these claims is set out at table 6.

Table 6 Synopsis of Closed Claims 2025/26

Date Opened	Date Closed	Type of Potential Liability	Outcome	Claim Synopsis
March 2023	May 2025	Employment Law	Withdrawn	The Safeguarding Board for Northern Ireland (SBNI) and the PHA were named as Respondents, in relation to a claim lodged with the Office of the Industrial Tribunal and Fair Employment Tribunal. The claim was in relation to the claimant's personal employment status which precluded them from contributing to the HSC Pension Scheme. Outcome - Claim withdrawn with a legally binding agreement in place. The outworking's are being managed through collaboration of the HR Team, the Directorate of Legal Services and SBNI.
May 2025	November 2025	Employment Law	Withdrawn	Claim lodged with the Office of the Industrial Tribunal and Fair Employment Tribunal alleging discrimination on the grounds of age, sex and/or religious belief/political opinion. Outcome - Claim withdrawn with no further action required.

3.3 2025/26 Open Claims

There are currently no open claims in relation to the PHA during the 1 April 2025 to 31 December 2025 period.

PHA Complaints Office
complaints.pha@hscni.net

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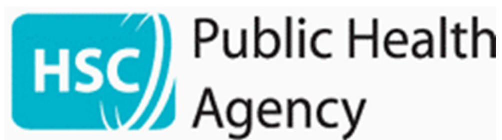


item 13

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	26 February 2026
Title of paper	Workforce Information Report
Reference	PHA/08/02/26
Prepared by	Karyn Patterson
Lead Director	Leah Scott

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide an overview of all workforce related information and activity for the period 1st October – 31st December 2025.

2 Key Issues

This report provides a summary of workforce information and activities for the period 1 October to 31 December 2025, highlighting key trends, statistical changes, and significant workforce developments and priorities.

3 Next Steps

This report is presented for noting only.

Our People

for the Period Ending December 2025

A Review of Quarter 3 -
September - December 2025

Prepared by Mrs Karyn Patterson,
Senior HR Business Partner

Key Messages

This quarterly Workforce Information report sets out the data as available from HRPTS to end of December 2025. Within this there are a number of key messages to note as follows;

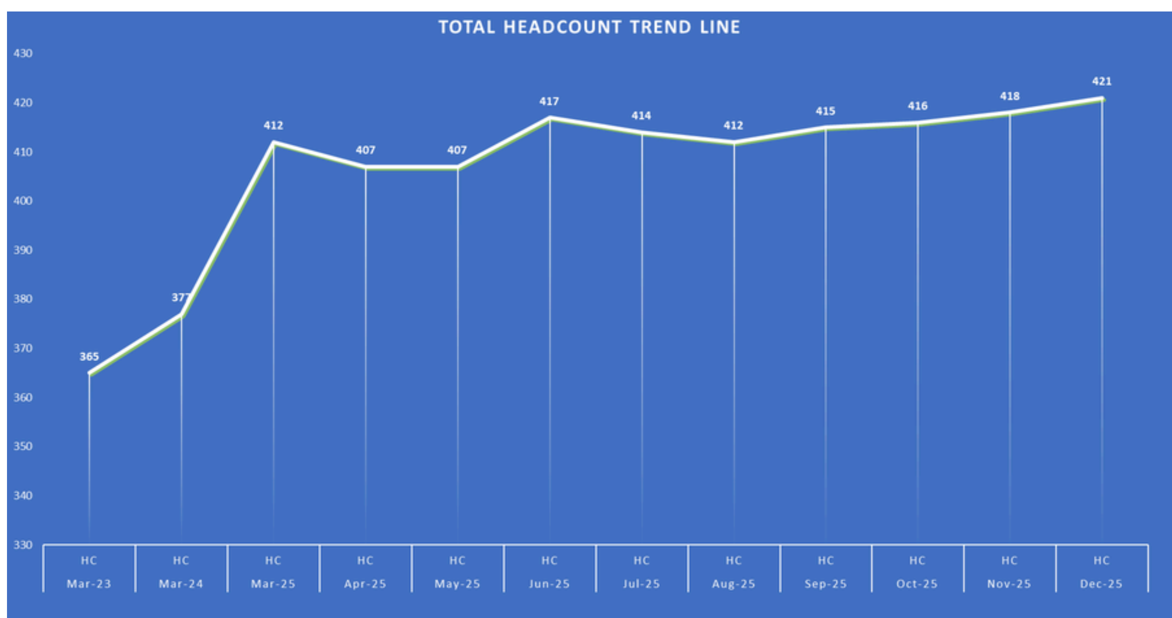
- **Workforce Data**
  - Overall Headcount has increased by 3.7% in the rolling 12 months to end of December 2025.
  - Permanent Staff has increased by 4.68%.
  - Temporary Staff make up 9.7% of the entire workforce compared with 10.6% at the same time in 2024.
  - 'Pure' Temporary staff with 2+ years service is 17.
  - Turnover for the rolling 12 months to end of December is down at 5.92% compared to 6.78% for the same period in 2024/25.
  - Appraisal Compliance for the current year has achieved the 95% target.
  - The Age profile continues to confirm the need to take action in relation to succession planning.

- **Sickness absence rates**
  - Overall sickness absence is starting to recover, with rates remaining higher than 2024/25 whilst marginally below the 2023/24 year.
  - Long Term absence, which is being appropriately managed, remains the most significant element with short term absence relatively low and stable.
  - Mental Health remains the highest reason for absence although notably the highest sub category has moved from stress to anxiety.

- **Organisational Development**
  - A new People Strategy has been developed through co-design with:
    - 1 ambition
    - 3 priorities
    - 4 years to deliver

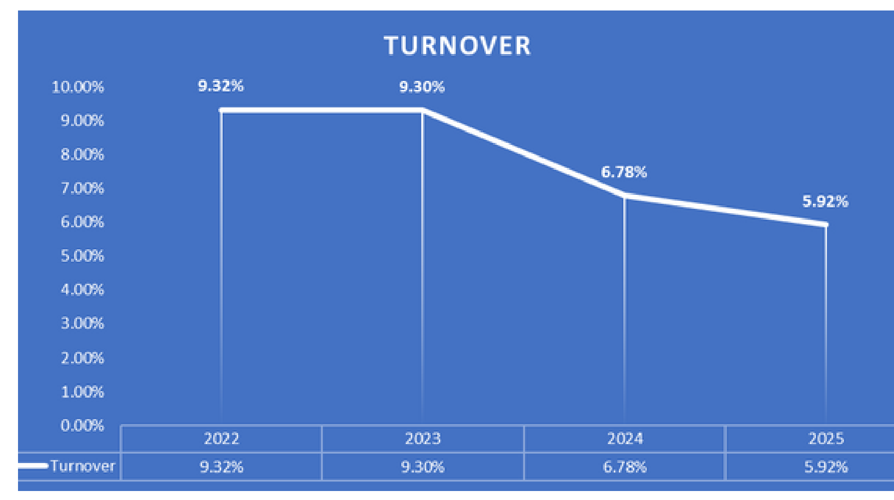
Workforce Data

- Overall Headcount has increased by 3.7% in the rolling 12 months to end of December 2025. Notably there has been a continual rise over the past 2 years with a 15.34% rise in Headcount since March 2023.
- Whole time equivalent (WTE) has similarly increased, at the slightly slower rate of 13.41%. The trend line is seen below:



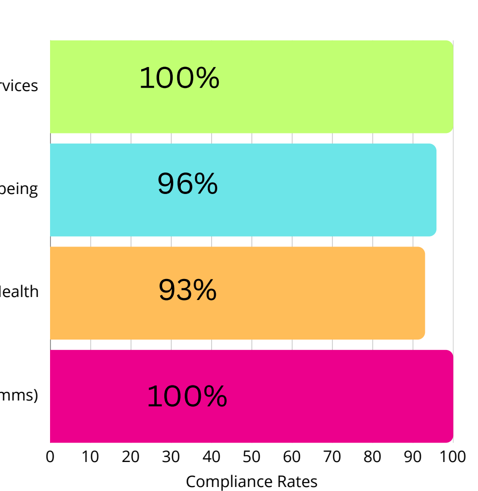
- Over the past 12 months, permanent staffing has increased by 4.68% with a 22% rise when compared to March 2023. Importantly this rise has seen an improved balance of permanent to temporary staffing with temporary staff making up 9.7% of the entire workforce in December 2025 compared with 10.6% at the same time in 2024 and 14.8% in March 2023.
- ‘Pure’ Temporary staff with 2+ years service is 17.

- Turnover for the rolling 12 months to end of December 2025 is again showing a decline, down at 5.92% compared to 6.78% for the same period in 2024.

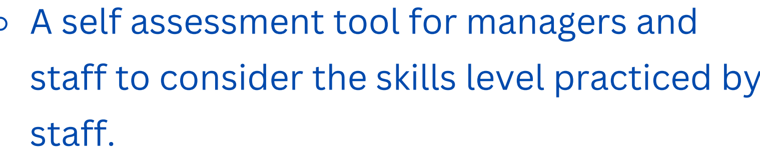


Appraisal

- Compliance for the 25/26 year to date has reached the required 95% compliance. Any areas where there are appraisals outstanding are highlighted through regular Directorate reports.

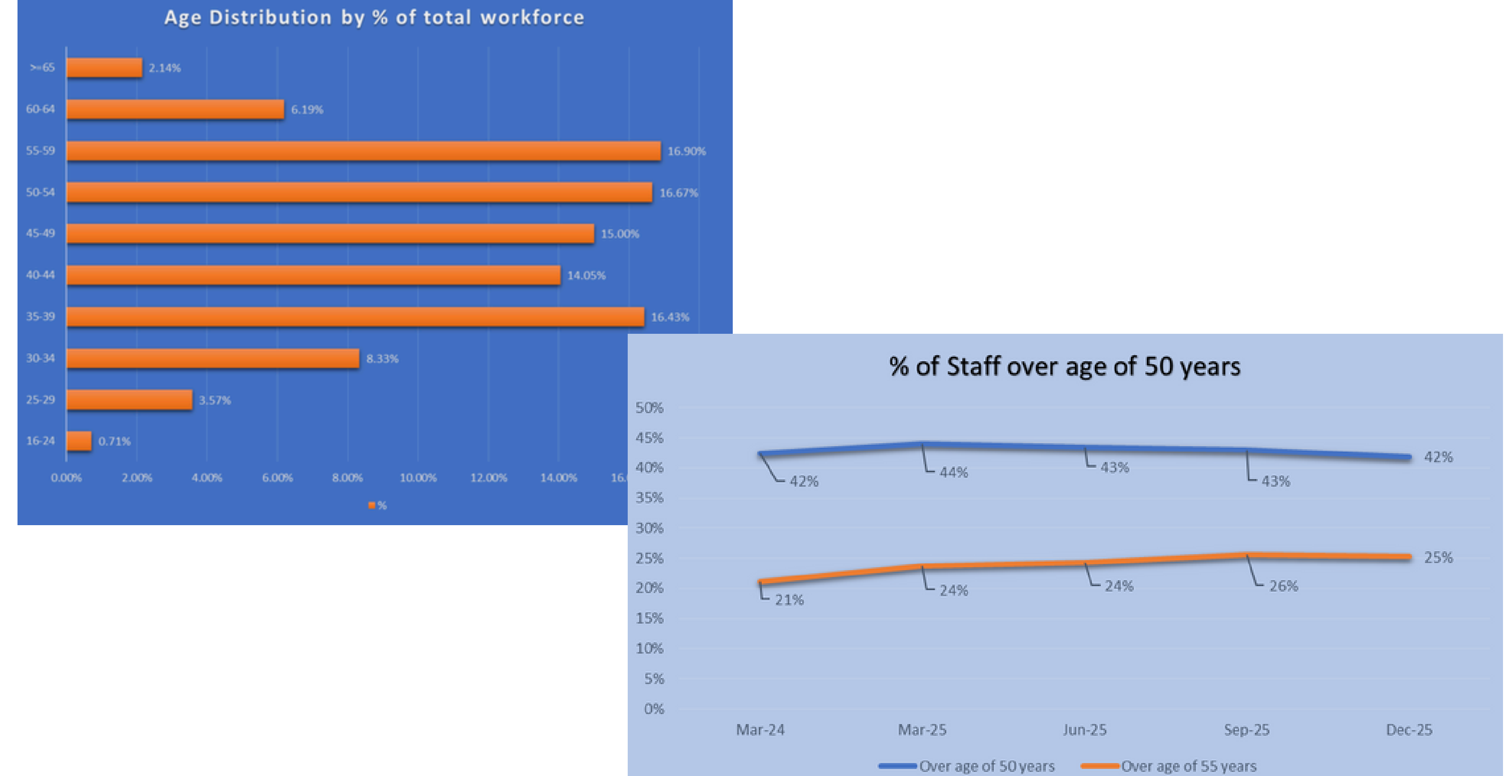


- Planning has commenced for the 2026/27 Appraisal year which will incorporate:
  - A refreshed presentation aimed at improving user experience of the Skills and Development Framework.
  - A self assessment tool for managers and staff to consider the skills level practiced by staff.
  - Training on the refreshed tools.
  - General training on conducting appraisal.



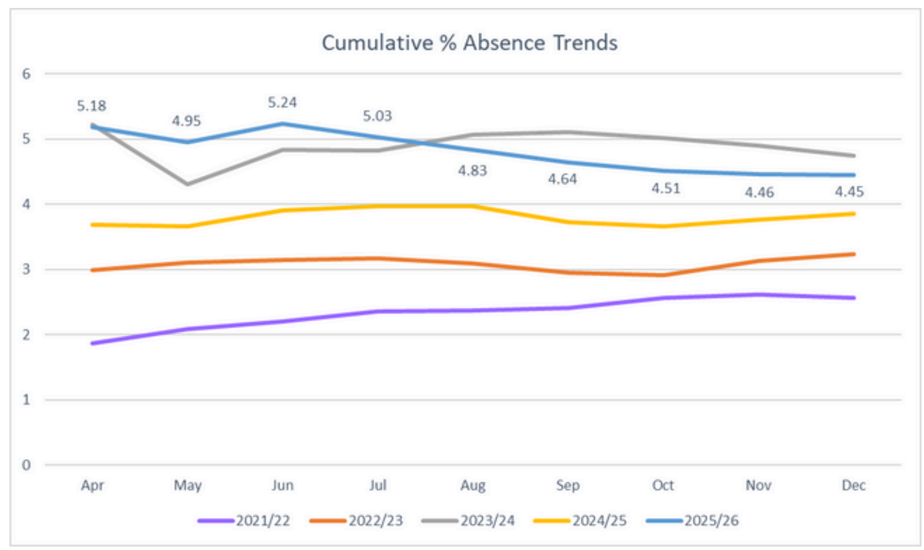
Age Profile

- At the end of December 2025, 41.9% of the PHA workforce was aged 50 years or over, with 60% of this group over the age of 55 years.
- Whilst the total number of staff aged 50+ has been a relatively static position, notably the proportion of staff over the age of 55 years has increased over the past number of years



Sickness Absence

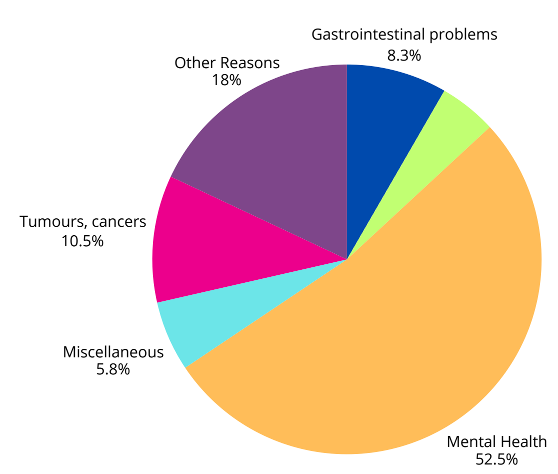
- Overall sickness absence is starting to show a recovery remaining below the absence target of 4.57%, however remaining above the position for 2024/25 and just marginally dropping to below the next highest year of 2023/24. The Trend lines can be seen in the diagram below;



- Long Term absence remains the greatest proportion with a number of staff experiencing significant conditions - at the end of December 2025, 2 staff were on no pay and 4 were on half pay, all of which are being actively managed.

Top Reasons for absence

- As can be seen Mental Health remains the most significant absence reason with the breakdown of this type being spread across:
  - Anxiety - 37.12%
  - Stress (general) - 34.11%
  - Stress (work related) 13.39%
  - Grief / Bereavement - 7.73%
  - Depression - 6.90%
  - Other - 0.76%



Key Actions to Address Sickness Absence

- Communication throughout the period of absence to ensure appropriate support including timely Occupational Health referrals.
- Promotion of Health & Wellbeing tools and resources to all staff.
- Where work related stress occurs, the stress toolkits are available for use by Managers to discuss and find solutions to support staff in returning to work.

It should be noted that a new regional Sickness Absence policy is scheduled for implementation from April 2026, with the emphasis being on supporting staff back to work as early as possible.

Organisational Development

Members will recall that a closure report on the 2023-2025 PHA People Plan was presented at the November meeting with 93% of targets fully or substantially achieved as the plan drew to a close.

Since then a new PHA People Strategy, which commenced its development journey in April 2025 has been progressed through the co-design, final development and consultation phases. At this stage a new People Strategy document is prepared for the period 2026-2030 and is now in a presentational design phase before formal launch in the coming weeks. Here is an overview of the key components:

One Ambition

To create **a compassionate and inclusive workplace**—where compassion drives respectful relationships, proactive support, and understanding of diverse needs—**empowering our people** through openness, collaboration, and excellence **to improve health and wellbeing for everyone** in Northern Ireland.

3 Priorities
4 Years
40 ACTIONS

01 Shaping Our Workforce

Strategic Workforce Planning to meet future Public Health Needs

We will actively plan our workforce needs to ensure **readiness**, **capability** and **adaptability**, which will result in having the right people, in the right place, at the right time.

02 Investing in Our Workforce

Workforce Development and Capacity Building

We will invest in our People to ensure they feel **valued**, **equipped** and **enabled** to delivery on Public Health outcomes through our Corporate Plan.

03 Supporting our Workforce

Creating a culture of Inclusion, Collaboration and Innovation

We will lead with **care and compassion** seeking to develop an inclusive and safe environment where all our staff feel **empowered, valued, supported** and **engaged.**