HSC Public Health Agency

AGENDA

75th Meeting of the Public Health Agency board to be held on Thursday 21 May 2015, at 2:30pm, Fifth Floor Meeting Room, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	2.30	Welcome and Apologies		Chair
2.	2.30	Declaration of Interests		Chair
3.	2.30	Minutes of the PHA board Meeting held on 19 March 2015		Chair
4.	2.35	Matters Arising		Chair
5.	2.35	Chair's Business		Chair
6.	2.40	Chief Executive's Business		Chief Executive
~~7.~~	~~1.45~~	~~Commissioning Plan 2015/16~~ *Item deferred to next meeting*	~~**PHA/01/05/15 (for Approval)**~~	~~Mr Sullivan~~
8.	2.45	Finance Update • PHA Financial Performance Report	**PHA/02/05/15 (for Noting)**	Mr Cummings
9.	2.55	Governance and Audit Committee Update • Minutes of 19 February 2015 meeting • Verbal briefing from Chair	**PHA/03/05/15 (for Approval)**	Mr Coulter
10.	3.10	PHA Assurance Framework	**PHA/04/05/15 (for Approval)**	Mr McClean

11.	3.15	PHA Business Continuity Plan and Policy	**PHA/05/05/15 (for Approval)**	Mr McClean
12.	3.20	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 March 2015	**PHA/06/05/15 (for Approval)**	Mr McClean
13.	3.30	PHA Response to Donaldson Report	**PHA/07/05/15 (for Approval)**	Dr Harper
14.	3.45	DPH Annual Report 2014	**PHA/08/05/15 (for Noting)**	Dr Harper
15.	3.55	Update on PHA Procurement Plan	**PHA/09/05/15 (for Noting)**	Mr McClean
16.	4.05	Child Development Programme Board Update	**PHA/10/05/15 (for Noting)**	Dr Harper
17.	4.10	Any Other Business		

18. **Date, Time and Venue of Next Meeting**
    Thursday 18 June 2015
    1:30pm
    Fifth Floor Meeting Room
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 74th Meeting of the Public Health Agency board held on Thursday 19 March at 1:30pm, in Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mrs Julie Erskine	-	Acting Chair
Dr Eddie Rooney	-	Chief Executive
Mrs Pat Cullen	-	Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Dr Jeremy Harbison	-	Non-Executive Director
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

IN ATTENDANCE:

Mr Robert Graham	-	Secretariat
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

APOLOGIES:

Mrs Fionnuala McAndrew	-	Director of Social Services, HSCB

		Action
24/15	**Item 1 – Welcome and Apologies**	
24/15.1	The Chair welcomed everyone to the meeting and noted apologies from Mrs Fionnuala McAndrew.	
25/15	**Item 2 - Declaration of Interests**	
25/15.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

26/15	**Item 3 – Minutes of the PHA Board Meeting held on 19 February 2015**
26/15.1	The minutes of the previous meeting, held on 19 February 2015, were approved as an accurate record of the meeting, subject to some amendments.
26/15.2	Mrs Karp requested that paragraph 15/15.1 be strengthened to show that the Board would wish to maintain its challenge function with regard to the PEMS Report.
26/15.3	The Chair advised that Mr Mahaffy had submitted a proposed amendment to paragraph 16/15.5 to clarify that he wished the Chief Executive to contact the HSCB Chief Executive regarding a proposed HSCB Review of Commissioning.
27/15	**Item 4 – Matters Arising**
	16/15.5 Review of Commissioning
27/15.1	The Chief Executive advised that with regard to the query raised by Mr Mahaffy, he had contacted the HSCB Chief Executive to seek clarity on whether a separate HSCB review of commissioning would be taking place.
	16/15.3 Donaldson Report
27/15.2	Mr Coulter asked whether PHA was submitting a response to the Donaldson Report, and if so, would this be brought to the PHA Board. Dr Harper said that the response would be shared with the Board.
28/15	**Item 5 – Chair's Business**
28/15.1	The Chair advised members that she had circulated to members an outline of the Chair's Business since the last meeting.
28/15.2	The Chair noted that this was the last Board meeting for Miriam Karp and Jeremy Harbison as Board members and for Pat Cullen as Acting Director of Nursing. She thanked the three of them for their hard work and dedication to the Board and to the work of PHA.

28/15.3	The Chief Executive expressed his own thanks to Mrs Cullen and added that he had received praise from other Chief Executives and members of staff of other HSC organisations who had paid tribute to her work over the last period.
28/15.4	The Chair informed members that the new Chair and two new non-executive Board members had been appointed and were currently undergoing AccessNI checks.
29/15	**Item 6 – Chief Executive's Business**
29/15.1	The Chief Executive said that he had attended the launch of the Flesh and Blood campaign with the Church of Ireland and Catholic Archbishops in in Armagh.
29/15.2	The Chief Executive advised that he had attended the Social Work Awards at Belfast City Hall.
30/15	**Item 7 – Finance Update** **PHA Financial Performance Report (PHA/01/03/15)**
30/15.1	Mr Cummings advised that the Finance Report up until the end of January 2015 showed a small surplus, with a projected year end surplus of £278k. He said that he did not anticipate any issues before the end of the financial year and was confident that PHA would achieve a break-even position.
30/15.2	Members noted the finance update.
31/15	**Item 8 – Research and Health Intelligence sub-committee update**
31/15.1	Dr Harbison informed members that a meeting of the sub-committee had taken place on 2 March where the PHA response to the social work research strategy was signed off. He said that there had been update from health intelligence on the campaigns they are providing input to.
31/15.2	Dr Harbison said that the sub-committee had been given an update from R&D on the impact of being able to draw down additional funding from DHSSPS. He added that £4m had been drawn down in the last financial year, and £3.5m so far this year.

31/15.3	Dr Harbison advised that the sub-committee had taken time to consider its membership and terms of reference as he would no longer be chairing the sub-committee. He proposed that the sub-committee be temporarily stood down. Members agreed with this proposal.
31/15.4	Members noted the update from the Committee Chair.
32/15	**Item 9 – Governance and Audit Committee Update (PHA/02/03/15)**
32/15.1	Mr Coulter said that the approved minutes of the meeting of 10 December 2014 were available for members. He gave an overview of some of the key issues arising, which included a proposed audit of complaints handling, the update to the Corporate Risk Register and an update on the Lifeline contract.
32/15.2	Mr Coulter advised that at the meeting of 19 February, the Committee considered some of the papers which are brought to the Board for formal approval today, namely the review of Standing Orders and Standing Financial Instructions and the Information Governance Strategy and Framework.
32/15.3	Mr Coulter said that the Committee had considered the latest Internal Audit progress report for 2014/15, and highlighted the issues raised as part of the audit of health and social wellbeing contracts. He also updated members on the implementation of recommendations emanating from the Report to those Charged with Governance. Finally, he said that the Committee had considered the draft timetable for the preparation of the Annual Report and Accounts as well as the updated Emergency Response Preparedness Plan.
32/15.4	Members noted the update from the Committee Chair.
33/15	**Item 10 – Review of Standing Orders and Standing Financial Instructions (PHA/03/03/15)**
33/15.1	The Chair noted that the annual review of Standing Orders and Standing Financial Instructions had been undertaken.
33/15.2	Members approved the review of Standing Orders and Standing Financial Instructions.

34/15	**Item 11 – Information Governance Strategy and Framework (PHA/04/03/15)**
34/15.1	Mr McClean said that he updated Strategy and Framework had taken account of new guidance. He agreed to follow up on the issue raised by Mr Coulter at the Governance and Audit Committee regarding reporting of breaches.
34/15.2	Members noted the Information Governance Strategy and Framework.
35/15	**Item 12 – Policy on Appraisal for Medical Practitioners (PHA/05/03/15)**
35/15.1	Dr Harper advised that the policy on appraisal for medical practitioners set out the arrangements for appraisal and had been noted by the Governance and Audit Committee.
35/15.2	Members noted the Policy on Appraisal for Medical Practitioners.
36/15	**Item 13 – Board Governance Self-Assessment Tool (PHA/06/03/15)**
36/15.1	The Chair presented the Board Governance Self-Assessment tool and thanked members Miriam Karp and Brian Coulter for taking time to consider the draft response and submit suggestions.
36/15.2	Members approved the Governance Self-Assessment tool for submission to DHSSPS.
37/15	**Item 14 – PHA Annual Business Plan 2015/16 (PHA/07/03/15)**
37/15.1	Mr McClean advised that the PHA Business Plan had been prepared against DHSSPS requirements and that it had been shared with PHA's sponsor branch. However, he said that given the recent correspondence regarding savings, he had concerns regarding the achievability of the Plan. Dr Harper suggested that in light of this correspondence the Plan should be further reviewed.
37/15.2	Mr Coulter said that he did recognise the Business Plan as a formal business plan as it did not contain a finance section or any

	performance indicators. Mr Cummings said that this type of information would be found in the Commissioning Plan, whereas this Business Plan was an internal facing document. Mr McClean agreed and said that the Business Plan was prepared in a format laid down by DHSSPS.
37/15.3	The Chief Executive agreed with the points raised and acknowledged that these elements were missing from PHA's planning process, but that PHA would ensure that they form part of the new Corporate Plan. He added that there were difficulties in terms of the late receipt of DHSSPS requirements to be included in the Plan and he acknowledged the need for the Plan to reflect the difficulties of the proposed 15% savings.
37/15.4	Dr Harper proposed that PHA ask for an extension in terms of the submission of the Plan. Mr Coulter agreed and said that sections of the narrative would require to be updated. Dr Harper said that it was likely that some of the actions in the Plan may not now be able to be delivered.
37/15.5	Members agreed that the Plan could not be approved and should be brought back to a future Board meeting.
38/15	**Item 15 – eHealth and Care Strategy for Northern Ireland (PHA/08/03/15)**
38/15.1	The Chair welcomed Sean Donaghy and Jeremy Clement from HSCB to the meeting. Mr Donaghy thanked Chair for the opportunity to present the final eHealth and Care Strategy. He explained that this had been approved by the HSCB at its Board meeting last week and was being brought to the PHA Board for noting before being sent to DHSSPS for formal approval and launch.
38/15.2	Mr Clement delivered a presentation giving members an overview of the development of the Strategy, and in particular the outcome of the consultation exercise and how the Strategy has been amended following the various engagement events that have taken place.
38/15.3	Mrs McKissick said that she was interested in the interface between NI and the rest of the UK, and Europe in terms of being able to share patient records.

38/15.4	Mr Coulter said that the Strategy was very exciting and he asked about how primary care has been brought on board. Mr Donaghy said that GPs were enthusiastic about the implementation and being able to share various types of information. He said that pharmacists were also keen to become involved and that he would wish to cover both the community and voluntary sector, and the private sector.
38/15.5	Mr Coulter asked how close developments are in terms of achieving the position set out in relation to patients being able to access their own records. Mr Donaghy anticipated that significant progress would make on this over the next 12 months.
38/15.6	Mrs Karp said that she had attended one of the engagement events and she asked about the implications for those with learning disabilities and the independent living sector. Mr Clement said that there was a willingness from those with learning disabilities to become more involved in developing new technologies, but this group also cautioned about the need to ensure that the technology can be maintained as they would be heavily reliant on it.
38/15.7	The Chief Executive expressed his thanks for the presentation. He said that this Strategy sets the broader context for telemonitoring and allowing technology to be an enabler, the challenge is to get the public on board.
38/15.8	Dr Harbison said that he was very supportive of the Strategy, but asked about the funding underpinning it. Mr Donaghy explained that DHSSPS have provided funding to date and he anticipated that this continue as it is important that all HSC staff have, at the very least, the equipment to be able to undertake their role.
38/15.9	Members noted the eHealth and Care Strategy.
39/15	**Item 16 – Quality Improvement Biannual Report (PHA/09/03/15)**
39/15.1	Mrs Cullen presented the latest Quality Improvement Biannual Report for the period up to 31 October 2014. She explained that the compilation of this report is a requirement as part of the Commissioning Plan and outlined the four key areas covered in the report. She invited questions from members regarding the

report.

39/15.2 Mr Coulter asked whether the increase in the number of falls reported was due to increased reporting or awareness. Mrs Karp asked how the targets were set, and if there were targets for residential homes. Mrs Cullen said that the targets are set by DHSSPS, and that PHA works with the Trusts and RQIA to ensure that the care bundles have been implemented and to make them aware of the need to report. She also said that the Safety Forum are involved this work.

39/15.3 Mr Mahaffy expressed concern about the monitoring of incidents in domiciliary care settings and what RQIA would monitor as part of its inspection programme.

39/15.4 Members noted the Biannual Quality Report.

40/15 Item 17 – Any Other Business

40/15.1 There was no other business.

41/15 Item 18 – Date and Time of Next Meeting

Date: Thursday 21 May 2015
Time: 1:30pm
Venue: Fifth Floor Meeting Room
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: _____

Date: _____

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	Draft Commissioning Plan 2015/16
Agenda Item	7
Reference	PHA/01/05/15

Summary

Introduction
Members are asked to approve the attached draft Commissioning Plan 2015/16 for submission to the Department for consideration.

Summary
The Commissioning Plan describes the actions to be taken across Health and Social Care and responds to the Commissioning Plan Direction 2015, issued by the DHSSPS on 6 March 2015 (attached). Should members approve the attached draft plan it will be submitted to the Department no later than week commencing 25 May 2015.

Equality, Good Relations, Disability Duties and Human Rights
LCGs have undertaken a screening of local plans. These screening documents have been collated and combined with a screening of the regional component of the plan to form the overall screening report for the Commissioning Plan. The screening report outlines the cumulative impacts of the Plan on the population of N.Ireland.

The screening document specifies any mitigating actions that need to be taken to avoid any potential negative impact on the nine equality groups. It will also specify where a more in depth EQIA is likely to be required to be completed in advance of implementation.

Financial implications
The HSCB has a statutory duty to break even and operational responsibility for ensuring financial stability across the HSC. Following consultation on the draft budget for 2015/16, the DHSSPS' latest assessment of its financial position shows an unresolved gap of £31m.

In order to provide a balanced financial plan the HSCB will delay a number of key projects which will be reviewed following the conclusion of the June Monitoring Round. As such, the commitments in the Plan should only be viewed as indicative at this time.

The Plan includes an assessment of risks associated with unfunded service pressures (see Appendix 3 of the Commissioning Plan 2015/16)

Recommendation
Members are asked to approve the draft Plan as a fit for purpose response to the Commissioning Plan Direction 2015/16, to be forwarded in due course to the Department and Minister.

Equality Screening / Equality Impact Assessment	Attached
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Commissioning, HSCB
Date	13 May 2015

HSC Public Health Agency

PHA Board Report

March 2015

March 2015

Summary Position

Income	Page Reference	2014-15 £000s
Department Allocation		100,574
Income from Other Sources		1,158
Total Income		101,732
Expenditure		
Non-Trust Programme	2	46,790
Trusts	3	34,487
PHA Administration (incl. BSO)	4	20,313
Total Expenditure		101,590
Surplus/(Deficit)		142

Position Synopsis:

The year-end financial position shows a surplus of £0.1m against total income. This has resulted from a non-Trust Programme budget overspend of £0.5m which was approved in order to utilise the Management & Administration underspend of £0.6m (after a £0.465m non-recurrent retraction by the DHSSPS).

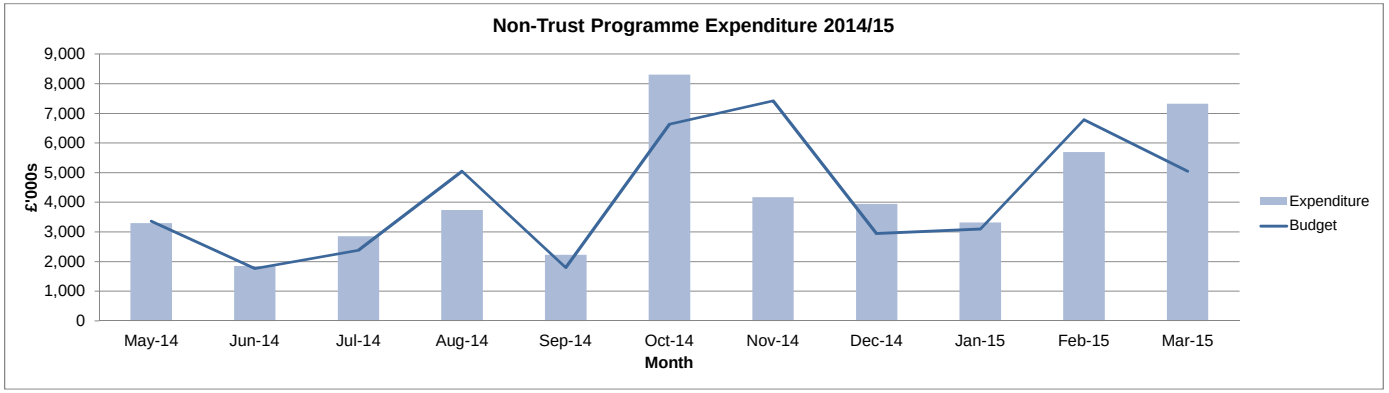
The surplus of £0.1m is within the breakeven tolerance level for PHA of 0.25%.

HSC Public Health Agency

Non-Trust Programme

March 2015

Non-Trust Programme Spend



	£'000s May-14	£'000s Jun-14	£'000s Jul-14	£'000s Aug-14	£'000s Sep-14	£'000s Oct-14	£'000s Nov-14	£'000s Dec-14	£'000s Jan-15	£'000s Feb-15	£'000s Mar-15	£'000s Total
Budget	3,368	1,769	2,389	5,051	1,804	6,639	7,432	2,944	3,092	6,794	5,051	46,333
Expenditure	3,299	1,858	2,865	3,744	2,231	8,313	4,174	3,950	3,326	5,696	7,334	46,790
2013-14 Expenditure for Comparison	*3,543*	*1,979*	*1,109*	*2,470*	*4,523*	*4,250*	*4,702*	*3,337*	*4,082*	*5,665*	*7,362*	*43,022*
Surplus/(Deficit)	69	(89)	(476)	1,307	(427)	(1,674)	3,258	(1,007)	(234)	1,098	(2,282)	(458)
Surplus/(Deficit) made up as follows:												
Health Improvement - Belfast LCG	87	2	(42)	283	22	(743)	423	37	(236)	135	(335)	(367)
Health Improvement - South East LCG	(137)	(158)	312	(271)	(302)	394	511	(102)	98	(367)	(54)	(76)
Health Improvement - North LCG	(88)	67	(305)	420	(43)	(451)	521	18	(304)	240	(125)	(50)
Health Improvement - South LCG	135	(54)	79	(90)	300	122	39	(251)	280	(88)	(311)	160
Health Improvement - West LCG	249	(146)	(200)	290	21	(505)	652	(193)	(195)	205	(140)	38
Health Improvement - Lifeline Contract	(137)	14	11	(36)	(12)	12	71	29	40	80	(75)	(4)
Health Improvement - Smoking Cessation	0	0	0	22	15	4	6	16	4	21	(26)	61
Health Protection	(60)	(12)	(482)	459	1	(18)	62	(164)	526	177	(635)	(146)
Service Development & Screening	115	65	38	(212)	(20)	3	98	8	(109)	9	(11)	(15)
Research & Development	29	(28)	71	707	(601)	(482)	683	(383)	(50)	37	(343)	(359)
Campaigns	(96)	17	(50)	(73)	16	(21)	115	52	(89)	196	(80)	(13)
Nursing & AHP	(3)	8	5	(6)	21	(29)	(2)	4	43	8	(141)	(91)
Health Improvement - Regional Projects	(25)	136	87	(186)	(4)	52	72	78	(243)	10	15	(7)
In year opportunities	0	0	0	0	159	(12)	7	(154)	0	434	(22)	412

Position Synopsis:

The current position shows an overspend of £0.458m for the year, which had been approved in order to utilise the surplus on Management & Administration budgets.

As previously reported the majority of PHA programme budgets are skewed to expend in the last quarter of the year, and this has caused a significant amount of work in the last 2 months to ensure budgets were fully utilised as planned. This profile brings with it an inherent risk of an unexpected event causing slippage when there is little opportunity to redirect it. Efforts should be made in 2015-16 to minimise the risk which this places on the PHA.

HSC Public Health Agency

Revenue Resource Limits (RRLs) to Trusts

March 2015

	Initial Annual Budget (per revised SBAs) £'000s	Closing Annual Budget £'000s	Variance £'000s
Western Trust	5,113	6,131	1,018
Northern Trust	6,129	7,302	1,173
Belfast Trust	11,178	11,924	746
South Eastern Trust	2,889	3,539	650
Southern Trust	4,595	5,458	863
NIMDTA	-	133	133
Funds identified to Trusts in Budget Paper but not allocated at start of year - now allocated	4,751	-	(4,751)
Total	**34,655**	**34,487**	**(168)**

Main Reasons for Movements in Funding

The funds shown against specific Trusts have been notified via Service & Budget Agreements and additional adjustments have been made in year. PHA have fully utilised the funds allocated during the financial year.

HSC Public Health Agency

PHA Administration

March 2015

	Total Budget £'000's	Current Month Budget £'000's	Current Month Expenditure £'000's	Current Month Variance £'000's	Year to Date Budget £'000's	Year to Date Expenditure £'000's	Year to Date Variance £'000's
Salaries	17,823	1,623	1,515	108	17,823	17,187	636
Goods & Services	2,816	506	323	183	2,816	2,323	493
DHSSPS Retraction	(465)	(39)	0	(39)	(465)	0	(465)
Sub-Total Administration	20,174	2,091	1,839	252	20,174	19,510	664
BSO	737	68	101	(33)	737	803	(66)
Total Administration	**20,911**	**2,158**	**1,939**	**219**	**20,911**	**20,313**	**598**

Position Synopsis:

An overall management and administration surplus of £598k has been generated in 2014-15. This is as a result of vacancies across the Agency and a number of allocations received late in the year for which the underlying pressure had been covered.

The BSO overspend largely related to additional software charges for BSTP agreed on a one-off basis by PHA.

The DHSSPS retracted £465k from PHA's Management and Administration budget for 2014-15 during September 2014. This has been shown separately in the table above.

Prompt Payment Statistics

	March 2015 Value £'000	March 2015 Volume of Invoices	Cumulative position as at 31 Mar 2015 £'000	Cumulative position as at 31 Mar 2015 Volume of Invoices
Total bills paid (relating to Prompt Payment target)	5,485	1,103	34,624	9,024
Total bills paid on time (within 30 days or under other agreed terms)	5,327	1,021	32,372	8,024
Percentage of bills paid on time	**97.1%**	**92.6%**	**93.5%**	**88.9%**

The BSO has not yet been able to provide a comprehensive prompt payment report which is accurate for PHA, but the importance of providing this continues to be pressed at the BSO Customer Forum meetings. In the interim HSCB Finance, on behalf of PHA, continue to generate a prompt payment report based on the audited method which was used to provide the Annual Accounts figures. This will ensure consistency of information reported to PHA on a monthly basis, while BSO work to produce a meaningful report.

PHA staff continue to work steadily on the finance systems to clear invoices promptly, with March cumulative performance by value increasing slightly (0.7%) compared to the position reported in February. The March 30-day performance was 92.6% (89.0% February) by volume, and 97.1% (89.7% February) by value of all undisputed invoices paid within 30 days of receipt. In addition, the overall 10 day performance was 76.1% by volume for the year, which exceeds the 2014-15 10 day target of 50%

The cumulative position for the year by volume of invoices (88.9%) and by value (93.5%) remains short of the 95% DHSSPS target.

HSC Public Health Agency

MINUTES

Minutes of the 28th Meeting of the Governance and Audit Committee held on Thursday 19 February 2015, at 10 am, Meeting Room, 5th floor, 12-22 Linenhall Street, Belfast, BT2 8BS

Present:

Mr Brian Coulter	-	Chair
Mrs Miriam Karp	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

In Attendance:

Miss Rosemary Taylor	-	AD Planning & Operational Services
Mrs Catherine McKeown	-	Internal Audit
Mr David Charles	-	Internal Audit
Ms Tracey McCaig	-	Finance, HSCB
Ms Christine Hagan	-	ASM Chartered Accounts
Ms Dorinna Carville	-	Northern Ireland Audit Office
Mr Mark Anderson	-	Sponsor Branch, DHSSPSNI
Mr James Devlin	-	Emergency Planning, Public Health (for item 11)
Mrs Cathy McAuley	-	Secretariat

Apologies

Mr Edmond McClean	-	Director of Operations,PHA
Mr Paul Cummings	-	Director of Finance, HSCB
Mr Simon Christie	-	AD Finance, HSCB

		Action
01/15	**Item 1 - Welcome and Apologies** The Chair welcomed everyone to the meeting and noted apologies and said that Mr James Devlin will join today's meeting for item 11.	
02/15	**Item 2 - Declaration of Interests** The Chair asked if anyone had any interests to declare relevant to any items on the agenda. None were declared.	
03/15	**Item 3 - Chair's Business** No chair's business.	
04/15	**Item 4 - Notes of previous Meeting – 8 December 2014** The minutes of the previous meeting, held on 8 December 2014 were approved.	
05/15	**Item 5 - Matters Arising** There were no matters arising.	

06/15	**Item 6.1- Corporate Risk Register** Miss Taylor presented the Corporate Risk Register as at December 2014 for noting and summarised the report. She said this quarter saw changes to the corporate risk register; • CR32 new risk added Programme Budget Expenditure • CR31 Shared Services reduced from high to medium rating • CR25 PHA Belfast Accommodation reduced from extreme to high Members expressed concern that the further element of clinical audit mechanisms to manage the long term risks on the register which dated back to 2012. Miss Taylor acknowledged members concerns and assured the committee that actions were being taken against these risks and that progress was being made. She added that numerous risks had been removed or de-escalated to directorate level risk registers. Mr Karp highlighted her concern in relation to CR32; Programme Budget Expenditure and CR30 Management of the Lifeline Contract, and in particular the 9 month extension which has been granted pending the outcome of the business case. Miss Taylor said that staff continue to work on addressing the issue of demand management and that a business case for the future service is currently being developed. Members expressed concern that the clinical audit review was still outstanding and queried why ministerial approval was required. Miss Taylor said that as the review falls under use of external consultant, regulations stated that ministerial approval was required; she also advised that Dr Rooney had raised this with the DHSSPS. Members asked for an update to be brought to GAC.	Dr Harper
	The Chair advised that CR25; PHA Belfast Accommodation remains a concern to the committee. Miss Taylor said that the PHA have now been advised that they will not be considered as part of the wider DFP Asset Management Unit review of public bodies located in leased property assets in Belfast City Centre. She added the PHA has been advised to engage with the Health Estates Division (DFP) to take this matter forward. Miss Taylor said that the recent move of SBNI to the HSC Leadership Centre, had resulted in space becoming available in Ormeau Baths, however Ormeau Baths was not a long term solution as the lease is due to end in 2017. In respect of CR32: Programme Budget Expenditure members asked about the management and admin budgets for 2015/15. Miss Taylor said that the PHA had not yet received any official notification from the DHSSPS regarding proposed budget reductions for 2015/16.	

Members approved the risk register.

07/15 **Item 6.2 - Review of Standing Financial Instructions**
Members approved the revised Standing Financial Instructions and recommended they are taken forward to the PHA Board for approval.

08/15 **Item 6.3 - Review of Standing Orders**
Members approved the revised Standing Orders subject to two minor amendments as below and recommended they are taken forward to the PHA Board for approval.

Page 104, paragraph (1.5) (1.5.1) Establishment of a Governance and Audit Committee " shall hold office for three years"

Members requested that a report on PHA complaints procedure should be brought to GAC in June in line with the GAC terms of reference.

09/15 **Item 7- Information Governance Strategy 2015-19**
Miss Taylor summarised the IG strategy and framework. Members welcomed the strategy but suggested that sections (6.0) and (6.6) should reference members as well as employees. They also asked that it should include reporting on breaches to GAC.

Members approved the Information governance strategy subject to the above amendments and recommended it to the PHA Board approval.

10/15 **Item 7.1- Information Governance Action Plan**
Miss Taylor presented the action plan to members for noting.

Members noted the updated action plan.

11/15 **Item 8 - Internal Audit Progress Report**
Mrs McKeown gave a summary of the progress report against the 2014/15 audit plan and audit summaries of the final audit reports issued since the last audit committee meeting.

<u>Management of Health and Social Wellbeing Contracts (Inc. visits to voluntary organisations)</u>
Mrs McKeown advised that the audit had received a satisfactory level of assurance, with limited assurance on procurement of contracts. She advised that there was one priority one finding in respect of contracting with trusts. She advised the committee that all recommendations had been accepted by management.

	A long discussion was held regarding the specific assurances on procurement of health and social wellbeing improvements contracts which included contracts with HSC Trusts. Members raised concerns regarding the management of contracts and the consistent application of procedures. Mrs McKeown reassured the committee that there were mechanisms and systems in place and that these procedures were being managed. She said that while limited assurance was provided in respect of three organisations audited, issues have been raised with relevant organisations. Given their concerns, members requested that the Director of Public Health provide a report to Committee on the 'Managing Obesity Network Programme' incorporating management responses to the priority one weaknesses identified and indicating measures taken more generally by PHA to monitor outcomes and to secure vfm in projects such as this one where Trusts are charged with delivery. The Chair requested that this report be provided to members asap given the identified problems and the sizeable funding involved.	Dr Harper
	<u>Procurement and contract Management</u> Miss McKeown advised that procurement and contract management had received a satisfactory level of assurance and that one priority one weakness was identified and advised the committee that all recommendations had been accepted by management. <u>Financial Review 2014/15</u> Miss McKeown advised that following a Financial Review in December in terms of processes in respect of e.g. payroll, travel claims, non-pay expenditure, a satisfactory level of assurance was given and that no priority one weakness were identified. All recommendations had been accepted by management. Mrs McKeown gave a summary of the BSO shared services assurance report and advised the recommendations in the reports are the responsibility of BSO to take forward. Members noted the report.	
12/15	**Item 8.2 - IA Benchmarking Report**	

Mrs McKeown summarised the key results from the on-going benchmarking programme across units in the BSO; the results included value for money, audit coverage and staffing.

Members noted the report.

13/15 **Item 9.1- Finance: Report to those charged with Governance Progress report**

Ms McCaig presented the progress report on the implementation of recommendations of the report to those charged with governance and summarised the report to members.

Members noted the report.

14/15 **Item 9.2 - Fraud Liaison Officer Update**

Ms McCaig advised that at the last report to the GAC there were no open cases of actual or suspected fraud. However she added that she was advised just yesterday (18/02/15) of one case of suspected fraud which has been relocated from HSCB to PHA. An update will be available at the next meeting.

Members noted the report.

15/15 **Item 9.3 - Timetable for the Annual Accounts and Reports Process**

Ms McCaig advised that the Department had not yet issued a circular setting out the timetable for Statutory reporting, auditing, laying and publishing process for 2014/15 covering annual accounts, governance statement and the annual report. However it is expected that the dates will be similar to last year. She summarised the timetable and the key dates for PHA.

Members noted the report and process.

Item 10 - External Audit: PHA Audit Strategy

Ms Hagan presented the PHA Audit Strategy to members for noting and summarised the audit approach. She advised that ASM would conduct the audit of the 2014-15 financial statements and key risks and that key dates had been agreed with finance colleagues.

Members noted the strategy.

16/15 **Item 11- Emergency Preparedness and Response Annual Report**

Mr Devlin joined the meeting and apologised for the late submission of the report due to the work with Ebola. He summarised the key findings which included performance management with Trusts and training, testing and exercising.

Members noted the report.

17/15	**Item 12 - Item to be brought to the PHA Board** • Review of Standing Financial Orders **GAC/02/02/15** • Review of Standing Financial Instructions **GAC/03/02/15** • Information Governance Strategy and framework **GAC/04/02/15**
18/15	**Item 13 - Date and time of next meeting** Date: 15 April 2015 Time: 9.30 am Venue: Meeting Room 5th floor, 12-22 Linenhall Street Belfast

Signed: Brian Coulter (Chair)

Date: 15 April 2015

Public Health Agency

For Approval

Assurance Framework 2013/15 – review as at April 2015

Background

Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements.

The PHAs Assurance Framework is designed to meet these duties. It provides the systematic assurances required by the PHA Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary in discharging our functions and duties.

Review

As per the reporting arrangements documented within the Assurance Framework 2013-2015, a review is required on a bi-annual basis.

The Assurance Framework has been circulated to each PHA Directorate, Finance colleagues within HSCB, and Equality and HR colleagues within BSO. The following amendments have been made:

Page	Paragraph / Dimension	Amendment
3	Strategic Context Paragraph 3	Wording changed: "The PHA also has a range of statutory duties in the area of Public Health and, Supervision of Midwives" - amended to read "The PHA also has a range of statutory duties in the area of Public Health, Supervision of Midwives and to involve and consult."
6	Corporate Control Paragraph 1	Wording changed: "the statutory duty to seek views from, and consult with" removed and replaced by "the statutory duty to Involve and Consult with".
9	Dimension 1 Report on compliance with Controls Assurance Standards	Reports to AMT & GAC - frequency changed from Bi-Annual to Annual.
11	Dimension 1 Equality Scheme and subsequent review	Reports to AMT & PHA board - frequency changed from "reviewed within 5 years of approval (16/08/2012)" to "reviewed within 5 years of submission (27/04/2011)".

13	Dimension 1 Principal Area/Function/Reporting Arrangements	Principal Area/Function changed to: “Information Governance Strategy incorporating Information Governance Framework 2015-2019”. Reports to AMT, GAC & PHA board – frequency changed from three yearly reporting to four yearly reporting.
14	Dimension 1 PPI (update report)	Reports to AMT changed from Noting to Approval.
20	Dimension 2 Principal Area/Function/Reporting Arrangements	Principal Area/Function changed to: “Patient and Client Experience Standards and PCE updates”. Gaps in Controls/Assurances and Actions to Remove Gaps now removed.
20	Dimension 2 Quality Improvement Plans – Performance Management Report	Reports to AMT – frequency changed from Annual to Bi-annual.
27	Dimension 3 Fraud Prevention and Detection Report	Reports to GAC – frequency changed from quarterly to “when appropriate – not less than 1 per annum”.
29	Dimension 4 PEMS report	Reports to PHA board - frequency changed from October/January/February to October/January/June (end of year report).

Recommendation

The Board is asked to approve the amendments to the Assurance Framework 2013-2015 noted above, as at April 2015.

15 April 2015

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	PHA Assurance Framework
Agenda Item	10
Reference	PHA/04/05/15

Summary

The PHA's Assurance Framework provides the systematic assurances required by the PHA board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary in discharging our functions and duties.

The attached documents reflect a review of the Assurance Framework 2013-15 as at April 2015.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The revised Framework was approved by AMT on 24 March and by the Governance and Audit Committee on 15 April.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	15 April 2015

HSC Public Health Agency

Assurance Framework 2013-2015

Review as at April 2015

INTRODUCTION

The PHA has a duty to carry out its responsibilities within a system of effective control and in line with the objectives set by the Minister. It must also demonstrate value for money, maximizing resources to support the highest standards of service.

A key element of a system of effective control is the management of risk. It is vital the PHA discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible to meet corporate objectives and to continuously improve quality and outcomes. This means that equal priority needs to be given to the obligations of governance across all aspects of the organization whether financial, organisational or clinical and social care and for governance to be an integral part of the organisation's culture. Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements.

In order to meet these duties, the PHA has prepared this Assurance Framework. The framework will provide the systematic assurances required by the PHA Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary in discharging our functions and duties.

BACKGROUND

In April 2009, DHSSPS issued 'An Assurance Framework: *A Practical Guide for Boards of DHSSPS Arm's Length bodies'.* The Framework guidance is intended to help the boards of HSC organisations improve the effectiveness of their systems of internal control, by showing how the evidence for adequate control can be marshalled, tested and strengthened within an Assurance Framework.

The HSC Paper Performance and Assurance Roles and Responsibilities (MIPB 74/09) issued in April 2009, sets out performance and assurance roles and responsibilities in relation to four key HSC domains and identifies the key functions and associated roles and responsibilities of DHSSPS, HSCB, PHA, BSO, Trusts and other Arm's Length Bodies.

In September 2011 the DHSSPS produced a Framework Document to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems than govern their relationships with each other and the Department. The Framework Document outlines the four performance and assurance dimensions previously introduced in the MIPB 74/09 paper.

STRATEGIC CONTEXT

The PHA is governed by Statutory Instruments: HPSS (NI) Order 1972 (SI 1972/1265 NI14), the HPSS (NI) Order 1991 (SI 1991/194 NI1), the Audit and Accountability (NI) Order 2003 and the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The primary functions of the PHA can be summarised under 3 broad headings:[1]

- Improving health and social well-being and reducing health inequalities;
- Health protection;
- Professional input to commissioning of health and social care services and providing professional leadership.

In carrying out these functions the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being. The PHA also has a range of statutory duties in the area of Public Health ~~and~~ , Supervision of Midwives and PPI under the duty to Involve and Consult. It is also responsible for the commissioning and quality assurance of existing and new screening programmes. In discharging these duties the Agency shall maintain the highest standards of decision-making. The detail of these duties is set out in various legislation, regulations or other guidance documents.

The Agency's Business Plan 2014/15 sets out the key priorities that will be taken forward by the PHA that will help to improve health and social wellbeing and protect the health of the community. The priorities and targets set have been shaped by the Ministerial priorities as set out in the Commissioning Plan Direction (Northern Ireland) 2013 and the longer term goals that have been set out in the PHA Corporate Strategy 2011-15. The Business Plan is focused around the 4 key goals as set out in the Corporate Strategy 2011-15. These are:

- Protecting Health
- Improving Health and Wellbeing
- Improving quality & Safety of Health and Social Care Services
- Improving Early Detection of Illness

In working to deliver these goals, the PHA has identified a number of common themes that shape how the organisation takes forward its work and these have been reflected in the Business Plan 2014/15 under the following sections:

- Using evidence, fostering innovation & reform
- Developing our people and ensuring effective processes

[1] DHSSPS Framework Document September 2011

PHA ASSURANCE FRAMEWORK

The PHA assurance framework is based broadly around the four HSC performance and assurance dimensions as set out in the DHSSPS Framework Document (September 2011) namely:

1. Corporate Control – the arrangements by which the PHA directs and controls its functions and relates to stakeholders.

2. Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and client's needs.

3. Finance – the arrangements for ensuring the financial stability of the PHA, for ensuring value for money and ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework.

4. Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

The Framework Document states that "each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance."

The PHA Assurance Framework must also link with its corporate objectives and risks. An effective Assurance Framework provides a clear, concise structure for reporting key information to boards, and should be read alongside the corporate risk register to provide structured assurance about how risks are managed effectively to deliver agreed objectives.

As the PHA works closely with the HSCB in carrying out many of its functions, it is important that the arrangements put in place to provide assurance to the board are closely related to those of the HSCB.

The following tables form the basis of the Assurance Framework and have been structured according to the DHSSPS performance and assurance dimensions, with a link to the relevant corporate objectives and primary risks.

This Assurance Framework provides the organisation with a simple but comprehensive method for effectively managing the principal risks to meet its

objectives. It also provides a structure for acquiring and examining the evidence to support the Governance Statement and the Mid-Year Assurance Statement.

LINKS TO OTHER PHA POLICIES AND DOCUMENTS

The following policies and documents should be read in conjunction with the PHA Assurance Framework:

- PHA Risk Management Strategy and Policy
- PHA Corporate Risk Register
- PHA Corporate Strategy 2011 – 2015
- PHA Annual Business Plan 2014/15
- PHA Governance Framework

REVIEW AND APPROVAL

The Assurance Framework will be reviewed on a bi-annual basis. It will be brought to the Governance and Audit Committee and the PHA board on an annual basis for approval.

Dimension 1: Corporate Control

The dimension of 'corporate control' encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the PHA is fulfilling its essential obligations as a public body. For that reason, most of the requirements reflect those in place across the wider public sector; however, there are a number that have been instituted specifically for the field of health and social care, notably the statutory duty of care created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, and the statutory duty to ~~seek views from, and consult with,~~ Involve and Consult with the recipients of health and social care created by sections 19 and 20 of the HSC (Reform) Act (NI) 2009.

The staple public sector requirements include the existence of appropriate board roles, structures and capacity; compliance with prescribed standards of public administration, national or regional policy on procurement and pay, operation of a professional internal audit service and corporate and business planning approvals. The accounting officer letter of appointment will spell out the principles underlying many of these obligations, while the letters appointing chairs and non-executive members of the board will also give due emphasis to this aspect of the appointees' duties.

The table below highlights the corporate control requirements for the PHA along with how the PHA meets each obligation by way of providing assurances to the board and its Committees.

DIMENSION 1 - PHA Corporate Control Arrangements

Link to Corporate Objectives: Corporate Objective 6 - Developing our People and ensuring effective processes

Principal Area/ Function/ Reporting Arrangements	**Principal Risks**	**Existing Controls & Assurances**								**Gaps in Controls/ Assurances**	**Action to Remove Gaps**
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Governance Statement signed by Chief Executive	All risks on Corporate Risk Register	AMT	Approval	Annual	Governance & Audit Committee	Recommendation to the board	Annually	Approval	Annual		
Mid Year Assurance Statement signed by the Chief Executive	All risks on Corporate Risk Register	AMT	Approval	Annual	Governance & Audit Committee	Recommendation to the board	Annually	Approval	Annual		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Corporate Strategy	All risks on Corporate Risk Register	AMT	Approval	3-4 years				Approval	3-4 years		
Annual Business Plan	All risks on Corporate Risk Register	AMT	Approval	Annual				Approval	Annual		
An Assurance Framework to strengthen board-level control and assurance and strengthen the Governance Statement	All risks on Corporate Risk Register	AMT	Approval	Bi-Annual	Governance & Audit Committee	Approval	Bi-Annual	Approval	Annual or more frequently if required		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Report on compliance with controls assurance standards	All risks on Corporate Risk Register	AMT	Approval	~~Bi-Annual~~ Annual	Governance & Audit Committee	Approval	~~Bi-Annual~~ Annual	Noting	Annual		
Corporate Risk Register (supported by Directorate Risk Registers)	All risks on Corporate Risk Register	AMT	Approval	Quarterly	Governance & Audit Committee	Scrutiny	Quarterly	Noting	Annual or more frequently if required		
PHA Annual Report	N/A	AMT	Approval	Annually	Governance & Audit Committee	Recommendation to the board	Annual	Approval	Annual		
Governance & Audit Committee Annual Report	N/A				Governance & Audit Committee	Approval	Annually	Noting	Annual		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Response to DHSSPS consultation proposals	N/A							Approval	As Required		
Sealing of Documents	N/A							Approval	As Required		
Review of Standing Orders and Standing Financial Instructions	N/A	AMT	Approval	Annually	Governance & Audit Committee	Recommendation to the board	Annually	Approval	Annual		
Register of Board Members Interests	N/A							Noting	Annual		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Gifts and Hospitality Register	N/A	AMT	Noting	Annually	Governance & Audit Committee	Noting	Annually				
Equality Scheme and subsequent review	N/A	AMT	Approval	Reviewed within 5 years of ~~approval (16/08/2012)~~ submission (27/04/2011) or on request by ECNI				Approval	Reviewed within 5 years of ~~approval (16/08/2012)~~ submission (27/04/2011) or on request by ECNI		
Equality Action Plan	N/A	AMT	Approval	Every 5 years (after 31/3/13)				Approval	Every 5 years (after 31/3/13)		
Disability Action Plan	N/A	AMT	Approval	Every 5 years (after 31/3/13)				Approval	Every 5 years (after 31/3/13)		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Report on progress in respect of Equality and Disability duties under Section 75 of the NI Act 1998 and Disability Section 49A of the Disability Discrimination Order (DDO) 2006	N/A	AMT	Approval	Annual				Approval	Annual		
Article 55 Review (report to Equality Commission on staffing composition)	N/A	AMT	Approval	Three-yearly				Approval	Three-yearly		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Information Governance Strategy incorporating Information Governance Framework 2015-2019 ~~Strategies (including Records Management strategy)~~	N/A	Information Governance Steering Group	Approval	~~Three-yearly~~ Four-yearly	Governance & Audit Committee	Approval	~~Three-yearly~~ Four-yearly	Noting	~~Three-yearly~~ Four-yearly		
Information Governance Progress Reports	N/A	Information Governance Steering Group	Noting	Quarterly	Governance & Audit Committee	Noting	Quarterly	Noting	Annually		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
PPI (update report)	N/A	AMT	~~Noting~~ Approval	Bi-annual				Noting	Bi-annual		
Remuneration of Executive Directors	N/A				Remuneration & Terms of Service Committee	Approval	Annual				
Absence Report (in Annual Report)	N/A							Noting	Annual		
Approval of New/Revised PHA Strategies and Policies	N/A	Relevant Sub Committee & AMT	Approval	As Required	Relevant Committee	Approval	As Required	Approval	As Required		

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Business Continuity Plan (Annual Review)	N/A	AMT	Approval	Annually	Governance & Audit Committee	Noting	Annually	Approval	Annually		
Emergency Preparedness Plan	N/A	AMT	Approval	Annually	Governance & Audit Committee	Noting	Annually	Approval	Annually		
Internal Audit Reports	All Risks on Corporate Risk Register				Governance & Audit Committee	Noting	Quarterly				
Mid Year & End of Year Head of Internal Audit Report	N/A				Governance & Audit Committee	Noting	Bi-annually				

Principal Area/ Function/ Reporting Arrangements	Principal Risks	Existing Controls & Assurances								Gaps in Controls/ Assurances	Action to Remove Gaps
		Reports to AMT/Sub Committees/Groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Minutes of Governance and Audit Committee	N/A				Governance & Audit Committee	Approval	Quarterly	Noting	Quarterly		
Minutes of Remuneration and Terms of Service Committee	N/A				Remuneration & Terms of Service Committee	Approval	Bi-Annually	Noting	Bi-Annually		
Chief Executive Report	N/A							Noting	Monthly		

DIMENSION 2 – Safety and Quality

The second dimension covers the arrangements whereby the PHA ensures that health and social care services, are safe and effective and meet people's needs. This covers a broad field and applies to all programmes of care and to infrastructure.

In addition to the numerous operational/professional requirements that concern or touch on safety and quality, there are more general requirements with which compliance is demanded. In the latter category, those issued by DHSSPS include the Quality Standards[2], Care Standards, and applicable Controls Assurance standards The most notable, being the statutory duty of quality created under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003.

The table below highlights the safety and quality functions required by the PHA. It also shows how the PHA meets each obligation by way of providing assurances to the board and its Committees.

[2] The Quality Standards for Health and Social Care: Supporting good governance and best practice in the HPSS (DHSSPS, March 2006)

DIMENSION 2 - PHA Safety and Quality Assurance Arrangement

Link to Corporate Objectives: Corporate Objective 1 - Protecting Health
Corporate Objective 3 - Improving Quality & Safety

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal/ Function/Reporting Arrangements	**Principal Risks**	**Reports to AMT/sub committees/ groups**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Learning lessons from Serious Adverse Incident reporting	Corporate Risk 19	AMT Bi-annual learning Report)	Approval	Quarterly (bi-annual report and statistical analysis report presented in alternate quarters)	Governance & Audit Committee (Quarterly Analysis and Learning Report)	Noting	Biannual	Approval	Biannual		
Implementation of RQIA and other independent review recommendations relevant to PHA	N/A	AMT	Noting	6 Monthly				Noting	6 Monthly		

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal/ Function/Reporting Arrangements	**Principal Risks**	**Reports to AMT/sub committees/ groups**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Director Public Health Annual Report	N/A							Noting	Annually		
Statutory Midwifery Supervision – Compliance with Statutory requirements	Corporate Risk 19	AMT	Approval	Annually				Noting	Annually		Schedule revised follo wing updated NMC/Mott Mac processes for reviews and reporting
Complaints	Corporate Risk 19	AMT	Approval	Annually or more frequently if required	Governance & Audit	approval	Annually or more frequently if required	Noting	Annually		

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal/ Function/Reporting Arrangements	**Principal Risks**	**Reports to AMT/sub committees/ groups**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Patient & Client Experience Standards and PCE updates.	Corporate Risk 19	AMT	approval	Bi-annual				noting	Annually	~~No AMT update this year so far. Updates due in October and March~~	~~Information presented to Regional PCE steering & working Group bi-annually Information presented to AMT/Board annually but information is available quarterly. Updates due in October and March~~
Quality Improvement Plans – Performance Management Report	Corporate Risk 19	AMT	Approval	~~Annually~~ Bi-annually				Approval	Annually		

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal/ Function/Reporting Arrangements	**Principal Risks**	**Reports to AMT/sub committees/ groups**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Healthcare Associated Infections (HCAI) report	N/A	AMT	Approval	Quarterly				Noting	Quarterly		
AHP Update Reports: Public Health Commissioning Professional	N/A							Noting	Annual		
Connected Health Updates	N/A							Noting	Three per annum		
AHP Strategy	N/A	AMT	Noting	Bi-annual							

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal/ Function/Reporting Arrangements	**Principal Risks**	**Reports to AMT/sub committees/ groups**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Family Nurse Partnership Annual Report	N/A	AMT	Approval	Annual				Approval	Annual		

DIMENSION 3 - FINANCE

Appropriate financial accountability mechanisms are necessary to:

- Ensure that the optimum resources are secured from the Executive for Health and Social Care
- Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money
- Deliver and maintain financial stability
- Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost
- Facilitate the development of innovative and effective models of care

The table below highlights the PHA finance requirements. It also identifies how the PHA meets each obligation by way of providing assurances to the board and its Committees.

DIMENSION 3 - PHA Finance Assurance Arrangement

Link to Corporate Objectives: Corporate Objective 6 - Developing our People & Ensuring Effective Processes

Principal Area/Function/ Reporting Arrangement	Principal Risks	Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
		Reports to AMT/sub committees/ groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Finance Report from Director of Finance (HSCB)	N/A	AMT	Review and Noting	Monthly				Review and Noting	Monthly		
DHSSPS Monitoring Returns (Monthly 2-12) Including info on HSC Financial Position, Capital Resource Limit and Expenditure, Non-Current	N/A	Senior Finance Team	Review and noting	Monthly (2-12)				Prompt pay figures now reported as part of the board report	Monthly		

Principal Area/Function/ Reporting Arrangement	Principal Risks	Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
		Reports to AMT/sub committees/ groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Assets, Provisions and Prompt Payment statistics											
Response to Budget Proposals prepared by PHA contributed to by the Finance Dept contribution to development of Joint Commissioning Plan	N/A	AMT	Approval	Annual				Approval	As determined by DHSSPS		
PHA Financial Plan (consistent with DHSSPS principles of 'Promoting Financial Stability'	N/A	AMT	Approval	Annual				Approval	Annual		

Principal Area/Function/ Reporting Arrangement	Principal Risks	Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
		Reports to AMT/sub committees/ groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Annual Report and Accounts GAC and PHA board full accounts and supporting financial excerpt in Annual Report. AMT summary financial statements	N/A	AMT	Noting (Primary statement only at draft submission stage)	Annual	Governance & Audit Committee	For review of full draft and Recommendation to the board	Annual	Approval	Annual	Not formally presented to AMT prior to The Board due to time constraints	Discussed informally with AMT officers
External Audit Report to Those Charged with Governance	N/A	AMT	Noting and provision of responses to recommendations.	Annually	Governance & Audit Committee	Review and Noting of recommendations and appraisal of management responses	Annual	Noting	Annual	Not formally presented to AMT prior to The Board due to time constraints	Discussed informally with AMT officers
External Audit Progress Report	N/A				Governance & Audit Committee	Review and Noting	Quarterly				

Principal Area/Function/ Reporting Arrangement	Principal Risks	Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
		Reports to AMT/sub committees/ groups			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Fraud Prevention and Detection Report	N/A				Governance & Audit Committee	Noting	~~Quarterly~~ When appropriate – not less than 1 per annum				
Use of External Management Consultants	N/A	AMT	Noting	Annually or more frequently as required.							
PHA Capital Expenditure in excess of £50,000	N/A	AMT	Approval or recommendation to board	As required				Approval or recommendation on to DHSSPS/DFP dependant on delegated limits	As Required		
Disposal of PHA Assets in excess of £50,000	N/A	AMT	Recommendation to Board	As required				Approval	As Required		

DIMENSION 4 - Operational Performance and Service Improvement

Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and Ministerial objectives and targets.

The table below highlights the PHA requirements identifying how the PHA meets each obligation by way of providing assurances to the board and its Committees.

DIMENSION 4 - PHA Operational Performance and Service Improvement Assurance Arrangement

Link to Corporate Objectives: **Corporate Objective 2 - Improving Health & Wellbeing**
Corporate Objective 4 - Improving Early Detection
Corporate Objective 5 - Using Evidence, Fostering Innovation & Reform

		Existing Controls / Assurances								Gaps in Controls/ Assurances	Actions to Remove Gaps
Principal Area/ Function/Reporting Arrangements	**Principal Risks**	**Reports to Sub-Committee of the Board**			**Committee of the Board (*following approval by AMT*)**			**The Board (*following approval by AMT*)**			
		To	**Purpose**	**Frequency**	**To**	**Purpose**	**Frequency**	**Purpose**	**Frequency**		
Performance Report (including commission direction targets and corporate objectives)	N/A	AMT	Noting	Quarterly				Noting	Quarterly		
Commissioning Plan	N/A	AMT	Approval	Annually				Approval	Annual		
PEMS report	N/A							Noting	October / January ~~February~~ June (end of year report)		

Public Health Update Reports: Health Improvement Health Protection Service Development & Screening Research & Development	N/A							Noting	Annually		

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	PHA Business Continuity Plan and Policy
Agenda Item	11
Reference	PHA/05/05/15

Summary

The PHA's Business Continuity Plan (BCP) has been revised to align it to the new International Standard on Business Continuity Management Systems (ISO 22301) and a section added noting that the plan has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. In addition, the content of the BCP has been reviewed by each Directorate and updated as necessary.

The PHA's Policy on Business Continuity Management has also been amended slightly in order to reflect the new International Standard and a section added noting that the policy has been screened for equality implications.

Equality Screening / Equality Impact Assessment	Equality Impact Assessment is not required.
Audit Trail	The revised Plan was approved by AMT on 31 March and by the Governance and Audit Committee on 15 April.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	15 April 2015

Public Health Agency

POLICY ON BUSINESS CONTINUITY MANAGEMENT

Version	**2.0**
Date version 1 approved by AMT	**31/01/12**
Reviewed policy approved by AMT	**31/03/15**
Scheduled review date	**31/03/18**

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Glossary

Business Continuity Management (BCM)	Holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised, might cause. It provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of key stakeholders, reputation, brand and value-creating activities
Business Continuity Management Programme	Ongoing management and governance process supported by top management and appropriately resourced to ensure that the necessary steps are taken to identify the impact of potential losses, maintain viable recovery strategies and plans, and ensure continuity of products and services through training, exercising, maintenance and review
Business Continuity Plan (BCP)	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level
Civil Contingencies	Civil contingencies are the events and situations impacting on the community which may or may not occur, but would lead to an emergency if they did. Civil contingencies covers all the hazards and threats which could impact upon human welfare, the environment, national security or the continuity of essentials of life services
Disruption	Event, whether anticipated (e.g. a labour strike or hurricane) or unanticipated (e.g. a blackout or earthquake), which causes an unplanned, negative deviation from the expected delivery of products or services according to the organisation's objectives
Emergency	An event or situation that threatens serious damage to human welfare, the environment or the security of the UK
Emergency Planning	Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency
Incident	Situation that might be, or could lead to, a business disruption, loss, emergency or crisis
Risk	Something that might happen and its effect(s) on the achievement of objectives
Risk Management	Structured development and application of management culture, policy, procedures and practices to the tasks of identifying, analysing, evaluating, controlling and responding to risk

1 Purpose

1.1 The aim of this policy is to detail a comprehensive framework for Business Continuity Management so that the Public Health Agency (PHA) can continue to function through an operational interruption.

1.2 This document sets out the general principles and processes for the development, maintenance and review of Business Continuity plans for the PHA.

1.3 This Policy is separate from but complements the PHA Risk Management Policy. It has been approved by the PHA Board and is based on BS25999 -1, Business Continuity Management – Code of Practice and ISO 22301:2012 (the new international standard for Business Continuity Management systems).

2 What is Business Continuity Management?

2.1 Business Continuity Management is a business-owned, business driven process that establishes a fit-for-purpose strategic and operational framework that:-

- Proactively improves an organisation's resilience against the disruption of its ability to achieve its key objectives;
- Provides a rehearsed method of restoring an organisation's ability to supply its key products and services to an agreed level within an agreed time after a disruption; and
- Delivers a proven capability to manage a business disruption and protect the organisation's reputation and brand.

2.2 Business Continuity Management involves managing the continuation or recovery of business activities in the event of a business disruption and management of the overall programme through training, exercises and reviews, to ensure that Business Continuity plans stay current and up-to-date.

3 Relationship with Business Planning and Risk Management

3.1 Business Continuity Management shall be part of the planning cycle undertaken within the Public Health Agency. The cycle applies to all levels of planning in the Organisation. All levels shall have business plans, risk registers, Business Continuity plans and processes in place for ongoing maintenance and review. Directorate level Business Continuity plans are not mandatory but may be developed if required. The planning cycle is set out in Figure 1 below:-

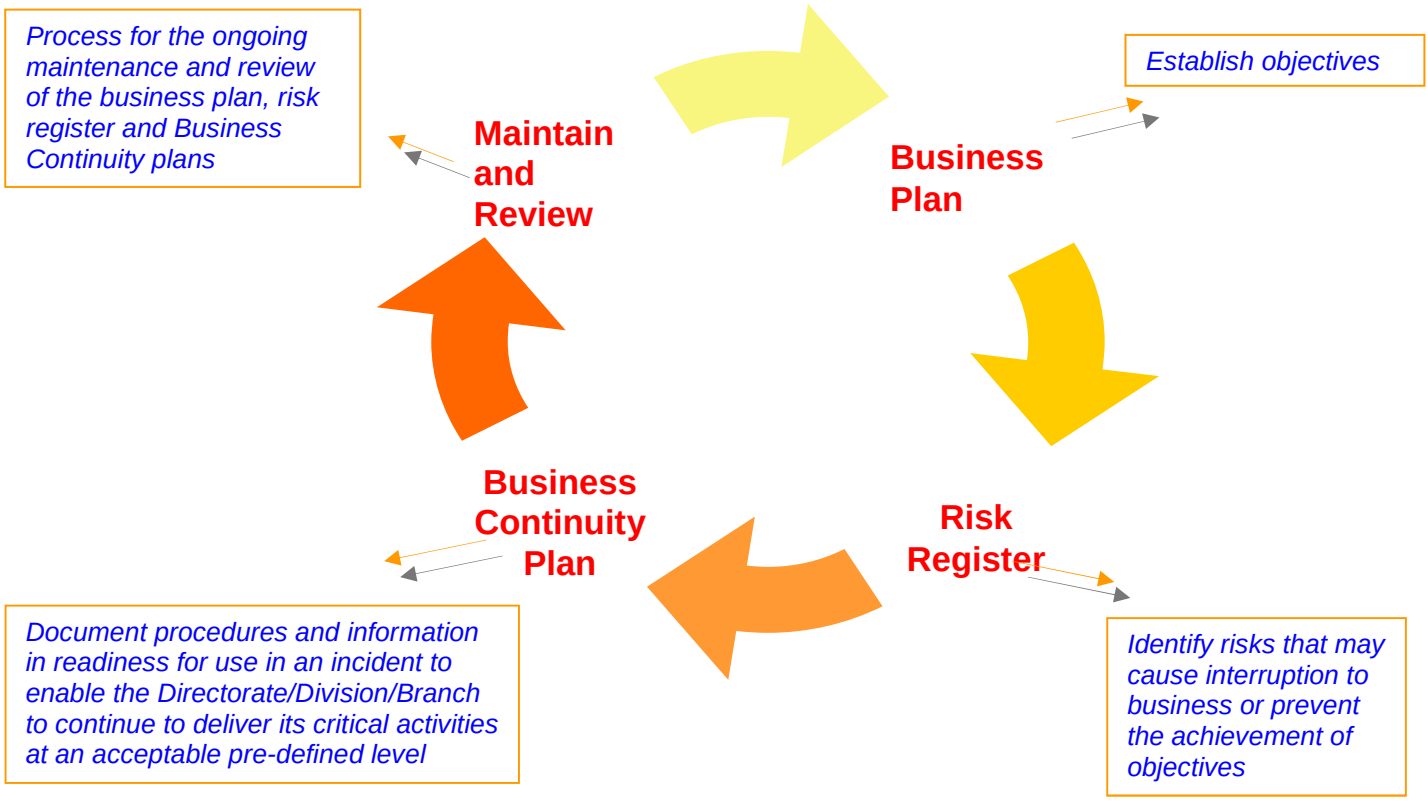

Figure 1

4 Civil Contingencies and Business Continuity Management

4.1 Civil contingencies activities are those undertaken by individuals and organisations to prevent emergencies and critical business interruptions, to mitigate and control their effects and to prepare to respond. These activities include horizon scanning, risk assessment, Business Continuity Management, Integrated Emergency Management, preparedness, validation, response and promotion of recovery and restoration.

4.2 Business Continuity Management provides an organisation with the resilience to continue to function during an emergency and to return to full functionality effectively and efficiently once the crisis has passed.

5 Policy Statement

5.1 PHA is committed to the vision of protecting public health and improving the health and social wellbeing of people in Northern Ireland. It is essential that, irrespective of demands and circumstances, the PHA is able to deliver its critical functions and services.

5.2 PHA shall develop, exercise, maintain and review the Business Continuity Plan for its critical functions and services in the event of a service disruption or disaster. The Business Continuity Plan will facilitate the rapid, efficient and cost effective continuity of the Organisation's functions and services.

6 Framework and Approach

6.1 PHA shall establish a framework of plans which shall be underpinned by a corporate Business Continuity Plan. The corporate Business Continuity Plan shall take account of the key functions and services in the organisation and plan for their ongoing delivery in the event of an interruption to normal business. Further plans shall be developed at Directorate level to support the corporate plan and ensure resilience of key products and services. Directorate level Business Continuity Plans are not required but may be developed if required.

6.2 PHA shall ensure that it adopts a Business Continuity Management Programme which is compatible with the strategic direction of the organisation and shall integrate Business Continuity Management requirements into the organisation's business processes.

6.3 PHA will strive to conform to ISO 22301:2012.

7 Roles and Responsibilities

PHA Board

The PHA Board is responsible for ensuring that the appropriate Business Continuity arrangements are in place to enable the time critical services and functions to be delivered in the event of an interruption to normal business. The Board will receive assurance through an effective Business Continuity Plan, which is fully compliant with the new International Standard ISO 22301:2012.

Chief Executive

The Chief Executive has overall responsibility for ensuring that the PHA has effective, ISO 22301:2012 compliant, Business Continuity arrangements in place to respond to an incident affecting PHA functions and service provision. Supported by the Agency Management Team, the Chief Executive will champion the Business Continuity Management process and ensure this is fully embedded across the Agency. This commitment will include ensuring the provision of support and training for management and staff as appropriate.

Agency Management Team

AMT is responsible for overseeing the development of the Corporate Business Continuity Arrangements, including approving the Business Continuity Plan for onward transmission to the PHA Board.

Directors will develop and maintain a culture of Business Continuity Management within their areas of responsibility. This includes:-

- Ownership of the Corporate and any Directorate Level Business Continuity Plan(s) for their area of responsibility.
- Raising awareness and ensuring that line managers and all staff are aware of their Business Continuity responsibilities.
- Regularly reviewing the PHA Corporate Business Continuity Plan and the prioritised, time critical functions and continuity strategies identified within the Plan, highlighting any changes required or new threats anticipated.
- Participating in the testing of the Business Continuity Plan.
- Satisfying themselves that Business Continuity incidents are being actively managed, with the appropriate strategies in place and working effectively, and proposing new or alternative strategies as appropriate.
- Ensuring that the PHA meets its legal and regulatory Business Continuity requirements.
- Demonstrating commitment to the continual improvement of Business Continuity Management across the PHA.

Director of Operations

The Director of Operations is the lead Executive Director for Business Continuity Management, with responsibility for ensuring that effective and robust Business Continuity processes and systems are established, implemented and monitored within the PHA.

Assistant Directors

In conjunction with the relevant Director, Assistant Directors are responsible for:-

- Contributing to ownership, implementation and monitoring of the corporate and any directorate level Business Continuity Plan for their area of responsibility.

- Ensuring that staff within their area are aware of their Business Continuity responsibilities.

Line Managers and all Staff

All staff are expected to:-

- Familiarise themselves with their individual roles as set out in the PHA Business Continuity Plan and comply with Business Continuity measures when it is invoked.

- Have knowledge of and comply with the PHA's Policy on Business Continuity Management.

- Alert Management to emerging threats or weaknesses in service provision in accordance with the Business Continuity Management Policy and Business Continuity Plan.

- Participate fully in the regular Business Continuity Plan review process.

8 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This plan will therefore not be subject to an Equality Impact Assessment.

The plan has also been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

The Business Continuity Plan will be included in the PHA's Register of Screening documentation and maintained for inspection whilst it remains in force**.**

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 March 2015
Agenda Item	12
Reference	PHA/06/05/15

Summary

This report provides an update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2014 and in the PHA Corporate Business Plan 2014-15.

The updates provided are for the period ending 31st March 2015. This is the final update for this year.

The update includes SIX of the SEVEN Commissioning Plan Direction targets which are highlighted and a further 79 key targets from the Corporate Business Plan. These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

There are a total of **85 targets**.

Of these: **61** are coded as green for achievability, **19** as amber and **3** as red. Two targets have no RAG status recorded as the PHA is not in a position to take forward the actions outlined. This compares to 65 Green, 16 Amber and 2 Red at the end of December.

Three targets moved from Amber to Green, seven from Green to Amber and one from Amber to Red.

The "Red" targets are:

- 2.8 : 100% compliance with pre-school child health protection programme (CHPP). No change in status since first quarter. (Page 13)
- 6.17 : Facilities management. Moved from Amber to Red in Quarter 2 to reflect lack of suitable alternative accommodation in Belfast. (Page 55)
- 6.22 : Target to achieve payment of 95% of all undisputed invoices within 30 days. Achieved 88.9% by Quarter 4. (Page 57)

Equality Screening / Equality Impact Assessment	N/A

Audit Trail	This report was approved by AMT on 12 May.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	12 May 2015

HSC Public Health Agency

DRAFT

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Commissioning Plan Directions &

Corporate Business Plan 2014 - 2015

Update for Period Ending 31st March 2015

Overview

This report provides an update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2014 and in the PHA Corporate Business Plan 2014-15.

The updates provided are for the period ending 31st March 2015. This is the final update for this year.

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1. PROTECTING HEALTH						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		Jun	Sep	Dec	Mar	
1.1) Successfully implement the 2nd phase of the children's seasonal flu immunisation programme by achieving a 60% uptake rate for all pre-school children aged 2 years old and over and a 75% uptake rate for all primary school children	Additional staff have been appointed by Trusts, the Child Health Computer system has been updated. Training was organised for primary care and school health staff over the summer, over 1000 staff attended around 30 training events. A launch for the school based programme took place in early September and for the primary care based programme at the beginning of October. Specific leaflets have been produced for the different groups. This objective has been largely achieved. The target for primary school children has been exceeded and stands at 80%, the highest uptake in the UK and a considerable achievement given the size of the task. The uptake for pre-school children aged 2 years and over has fallen slightly short of the target, standing at around 55%. This is considerably above the UK average – latest figures from England show an uptake of just below 40% for this age group. The slight shortfall for the pre-school children is more than made up for by the uptake in the school children, such that the "average" uptake across these groups has been exceeded. As the flu vaccine season is now over no further measures can be undertaken at this point.	G	G	A	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
1.2) **Secure a further reduction of 9% in the total of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and of in-patient episodes of MRSA bloodstream infection compared to 2013/14.** **(DHSSPS Commissioning Directions target)**	This HCAI reduction target is a composite target comprising individual Trust reductions in MRSA and CDI cases to be delivered during 2014-15. The regional MRSA position is above trajectory for delivery at 31st Dec - 47 cases have been reported compared to an upper trajectory limit of 37 cases. Within this regional position one Trust (South-Eastern) is on or below its individual trajectory limits. Two Trusts (Belfast and Southern) have now breached their individual MRSA target for 2014-15. The regional CDI target has been breached at 31st Dec – 291 cases have been reported compared to an annual target of 288 cases. Within this regional position one Trust (Southern) is below its individual trajectory limit. Two Trusts (Belfast and Southern) have now breached their individual CDI target for 2014-15.	A	A	A	A	RQIA is currently reviewing Trust governance arrangements in the context of infection prevention and control. PHA has met with RQIA to discuss preliminary findings emerging from this RQIA work and to provide contextual information relating to annual peer group analyses. Findings from this RQIA review will inform further work in individual Trusts and at regional level. DHSSPS hosted the first meeting of its newly established strategic group for HAI and AMRS (SAMRHAI) on Wed 25th Mar. PHA is represented on this group through DPH, AD (HP) and HCAI/AMRS Lead Cons. Terms of reference are currently being reviewed and are to be finalised. Work on annual peer group analyses for 2014 (calendar year) has been undertaken. Analyses will be shared with senior colleagues all Trusts and DHSSPS this week (w/c 4th May). Discussions with Trusts (following analyses) will focus on factors influencing current CDI & MRSA position and potential areas to address improvement during 2015/16. SAMRHAI chair has requested feedback for next meeting on (i) current position influencing factors and (ii) activity related to CDI and SA rates/cases. PHA will work collaboratively with Trusts on same for June SAMRHAI meeting.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
1.3) Test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruptive events.	Testing and servicing arrangements to respond to emergencies is a continuing on-going process. PHA are participating in a DoH led national pandemic exercise and as such work has been on-going to review our arrangements for pandemic response. A group has been set up under the new Joint Emergency Preparedness Team (JEP Team) to take this specific work forward. This year's emergency planning Controls assurance Standard has been completed and PHA has been assessed as having substantive compliance. Relevant plans have been reviewed and updated following incidents such as Ebola. The HSCB and PHA have also jointly tested the setting up of an EOC and the learning is now being applied.	G	G	G	G	

2. IMPROVING HEALTH AND WELLBEING & TACKLING HEALTH INEQUALITIES

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.1) Develop a strategic level implementation plan supported and agreed by a Regional Project Board and local strategic partnerships, to take forward implementation of the Public Health Strategic framework (Making Life Better.)	DHSSPS wrote to PHA asking for Regional Project Board to be established after the summer. Meetings have been held with District Council Chief Executives. Project Manager has been recruited Meetings of the Regional Project Board took place in October 2014 and February 2015. Members agreed the strategic focus of implementation as a focus on key areas of work which stand the best chance of making a sustained positive impact in NI through collaboration and collective efforts of key partners. A regional implementation plan is being developed.	G	A	A	A	The strategic framework document wasn't published until 29th July. Action is progressing in line with revised timescale. A workshop is planned for May 2015.

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.2) Provide a summary report of how the PHA have used the NICE public health guidance published up to end March 2014 to improve the health of the population of NI through its health improvement, health protection and service development functions. Following the establishment of a Regional endorsement process the PHA will also highlight for priority endorsement those pieces of recent guidance which have already been published.	Report submitted to DHSSPS in July 2014.	G	G	G	G	
2.3) With the HSCB, (a) make an action plan and (b) deliver on the outcomes in the implementation plan for the 'Making it Better Through Pharmacy Services in the Community' Strategy.	DHSSPS issued an implementation plan on 4th February 2015 with a range of actions to be taken forward by HSCB/PHA from 1st April 2015.	G	G	A	A	Subject to available resources, these actions will be factored into work plans from 2015/16.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.4) Work with the HSCB to progress the programme of training and accreditation for health plus pharmacies during 2014/15 and agree priorities for commissioning public health services through these pharmacies during 2015/16.	The PHA and HSCB have established the Health + Pharmacy Alliance. A further phase of training is being delivered to pharmacists and health advisers of participating pharmacies. An accreditation process has been agreed by the Alliance. There remains disagreement about the measurement framework. The restrictions of retail merchandising which contravene NICE guidance has not been accepted by all parties. The HSCB and PHA remain in discussion with both the DHSSPSNI and the Regulator regarding standards and their implementation.	A	A	A	A	A paper outlining the position with a number of options was prepared and considered by the senior management teams of HSCB and PHA and an agreed position has been communicated to all members of the Alliance. Further discussion with the Alliance has indicated support for the agreed position but not by all members. Accreditation scheme has been finalised and support promotional materials developed.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.5) Pilot and monitor the roll-out of two brief alcohol intervention programmes in two different settings outside the health and social care sector, with appropriate arrangements in place for subsequent evaluation.	Criminal Justice sector based proposal continues to progress. Acute hospital based service development proposal agreed 'in principle' by Hospitals Related Commissioning Group. Two year incremental service development proposal agreed to build upon existing services already in place within Trusts. Continuation of this enhanced model is dependent upon resources being identified within 2015/16.	A	A	A	A	Criminal Justice Setting on track for delivery. Tender specification has been issued and contract awarded. Work to begin in March 2015 and will continue until March 2016. Difficulty in securing an additional setting outside of HSC due to poor evidence base in other settings and competing pressures as a result of implementing commissioning framework. Delivery of brief intervention programmes in acute hospitals dependant on funding being secured for expansion of existing service. Non recurrent, 3mth fixed term, funding has been identified to enable service provision over the Jan-March 2015 period. IPTs have been prepared and forwarded to Trusts (Dec 14). As of early Jan, Trusts have started to return completed IPTs. Subsequent to approval of completed IPTs, it is anticipated that enhanced liaison service provision will be initiated, in particular, to provide a 7 day service model. Continuation of this enhanced model is dependent upon resources being identified within 2015/16.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.6) Provide the Department with a written progress report on the implementation of the recommendations arising from the National Confidential Inquiry into Suicide and Homicide (NCISH) report on its longitudinal study into suicide in Northern Ireland.	Report has been provided to the Department.	A	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Give Every Child the Best Start in Life						
2.7) Improve long-term outcomes for the children of teenage mothers by continuing to roll out the Family Nurse Partnership Programme, by expanding to the two remaining Trusts and rolling out the new Information System.	The Northern and South Eastern Trusts are in the preparatory phase for the establishment of two new Family Nurse Partnership Teams. Both Trusts have arranged staff awareness information days. The Trusts are also establishing their local Family Advisory Boards and the first meetings of this local stakeholder forums will be in September. When Trusts receive financial allocation letters, team recruitment can begin. Recruitment process for the Supervisors and Family Nurses has commenced to allow the teams to attend the training The information system is in the final stages of development. The system is live and all the Family Nurses are using either the desktop or tablet version. The development of the reports is currently underway. Hewitt Packard have raised concerns about their capacity to finish the project within the current resource. Additional Resources is required to finish the database . The new Supervisors and Family Nurses have attend training in England. They have been released by their existing employers to attend this training. The Resources for the two new teams have been procured. An additional 10K has been secured to allow Hewlett Packard to start the work on the reports and work towards completing the database.	A	A	A	A	Additional resources are required for the two sites and discussions are underway with HSCB Director of Finance and Director of Commissioning regarding the need for FNP to be prioritised. The HSC have agreed to fund the 2 new sites following departmental approval. Discussions with Hewlett Packard are underway to understand the issues and agree a solution. An action plan has been developed and agreement on the priority areas need agreed and resources to finish the database and work will be completed as resources become available.

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.8) Ensure that the rate for each core contract within the pre-school child health promotion programme offered and recorded by Health Visitors is 100% and that universal services are offered to all preschool children and their families.	100% compliance with CHPP will not be achieved this year. Improved compliance is expected year on year against DHSSPS IoP. Work force planning issues affecting capacity are being addressed. 60 Student Health Visitors will be available for recruitment as qualified Health Visitors in October 2015 on completion of the Health Visitor course. Second set of regional data in relation to IoPA28 received March 31st and indicates small improvement in Child Health Promotion Programme (CHPP) compliance – trend analysis commencing.	R	R	R	R	Compliance with CHPP is on HSC Trust Risk Registers; Discussions with DHSSPS,HSCB&PHA colleagues to secure additional funding as outlined in Pressures funding applications in order to improve CHPP compliance; Assurances to be sought from Directors of Children's Services at Bi-monthly monitoring meeting (Chairperson: Michael Bloomfield); Standing item on Healthy Futures Programme Board meetings
2.9) Take forward the commissioning of health visiting services within Trusts, to ensure that the services in place reflect the model of service detailed within the Departmental Strategy, 'Health Futures	PHA AD Public Health Nursing &, Nurse Consultants working with Trusts to ensure that plans are in place including the recruitment into permanent vacancies using all available Student Health Visitors on this year's course into permanent posts. Regional guidance being developed regarding competencies for Band 5 Public Health Nurses to support the health visiting workforce. All students who have completed the course (Sept / Oct 2014) have been recruited onto permanent contracts. All permanent funded vacancies filled with exception of two posts in Western HSCT (unable to recruit).	A	A	A	A	Recruitment of Health Visitors and School Nurses and vacancy levels will continue to be monitored; Information software is being developed that will support caseload management, performance monitoring and commissioning against Healthy Futures. 60 Student Health Visitors will complete course Oct 2015. Information received from HSCTs regarding predicted retirements / resignations over the next three years for planning purposes and the high number (n=50) will need to be taken into consideration in future planning. Regional workforce planning meetings with Trusts to commence. PHA has set up regular meetings with Trust Assistant Directors, Heads of Service and Workforce Leads to review and monitor health visiting workforce.

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.10) Support implementation of the Early Intervention Transformation programme and parenting programs under Delivering Social Change (DSC).	Final Approval secured from EITP Programme Board 12th December 2014. Revised proposal for 5 Pilot services linked to parenting programmes and Family Group Conferencing. Revised sites identified and agreed through engagement with Outcomes Groups. Procurement process instigated December 2014. Centre for Effective Services undertook review of parenting programmes and produced recommendations for commissioning and development-November 2014.	G	G	G	G	
2.11) Roll out of Infant Mental Health training to HSC and early year's workforce.	370 staff from HSC and early year's sector undertaking IMH training commissioned by PHA. Final Plan for service development and workforce training approved by PHA November 2014. Plan subject to a public consultation launched Mar-2015.	G	G	G	G	
2.12) Coordinate implementation of the Breastfeeding Strategy for Northern Ireland.	Significant progress continues across majority of workstrands. BSISG Action plan revised 12 March 15 with many actions closed and a new neonatal workstrand added. Regional Breastfeeding Lead continues to chair the following workstrands; • Workplace • Baby Friendly settings • User Involvement • Joint chair of new Neonatal workstrand BFI KPI met in advance of target now 93%.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Ensure a Decent Standard of Living						
2.13) Develop and implement programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services, including delivery of the detailed action plan for the MARA programme.	MARA project rollout progressing as planned with all locality offices now engaged. Paper submitted by Colette Brolly to Mary Black on Future Direction for MARA/ Discussions ongoing with DARD and DSD re connections with Affordable Warmth.	G	G	G	G	
2.14) Support the Building Shared Communities programme of DSD and the associated work in 6 pilot sites.	PHA is participating in the Building Successful Communities Programme Board and has engaged with the six local areas, five of which are located in Belfast.. Action plans have been agreed in all six local areas and PHA has ensured linkage to the quality of life objective with improving health and wellbeing alongside improvements to physical infrastructure, in particular housing. Action has included a number of 'quick wins' alongside action which will take longer to achieve. DSD has secured budget for the programme proceeding as planned. An evaluation strategy has also been agreed.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
Build Sustainable Communities						
2.15) Develop the skills and capacity of social enterprises and communities to respond to HSC procurement opportunities, including exploration of social clauses and community benefit plans.	Representatives of Operations and Health Improvement completed a series of meetings with colleagues from HSCB, BSO, Trusts and DHSSPS to discuss a co-ordinated approach to social clauses / social considerations.	A	A	A	A	A guidance paper was issued by HSCB. Guidance now specifically precludes us from developing skills and capacity with regard to procurement, but there are opportunities to work with Councils in this regard, and this could be taken forward through the new working arrangements with the new councils.
2.16) Take forward with partners the PHA approach to healthy ageing including: reducing isolation; signposting and referral to services; falls prevention; and health and wellbeing improvement programmes.	Each locality is working with LCGs and Trusts to agree a shared model and investment programme aimed at reducing social isolation. All localities are delivering falls prevention programmes that meet NICE guidelines and continue to influence the development of age friendly communities. Work continues to advance at regional level and each locality has engaged with [local] councils in relation to the Age Friendly initiative. Age Friendly has been highlighted in the public health strategic framework 'Making Life Better'.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.17) Contribute to the implementation of the Learning Disability Healthcare and Improvement action plan. The PHA will also establish and lead a new Regional Learning Disability Health Care and Improvement Steering Group to progress the impact of the Directly Enhanced Service (DES) providing for an annual health screening for every person with a learning disability. This group will ensure the application of evidenced based care, oversee the standardisation of practice across all providers and evaluate progress being made.	The Regional Learning Disability Healthcare & Improvement Steering Group (RLDHIS) has been established and is working to progress improvement in the healthcare and health & social wellbeing of people with learning disabilities and to reduce inequalities in health for this client group. Further to Q3 update, the Regional Health & Social Wellbeing Improvement Forum (one of three work-streams of the Regional Learning Disability Health Care and Improvement Steering Group) has developed a 2 year work-plan to deliver and implement on the Health and Social Wellbeing Improvement recommendations and actions contained in the regional Learning Disability Health Care & Improvement Steering Group's Action Plan. The Regional Health & Social Wellbeing Improvement Forum's Action Plan was approved by the Regional Learning Disability Health Care and Improvement Steering Group in July 2014 – the majority of year 1 (2014/15) actions within this action plan have been achieved / delivered by 31 March 2015 with 2 actions remaining on track for achievement with some delay. Revised deadlines have been agreed for these outstanding 2 actions with the Regional Learning Disability Health Care and Improvement Steering Group within 2015/16 (q.1 and q.2 respectively). The Health Care Facilitators work has been progressed in all areas as agreed and rolled forward within the two year plan as appropriate. The Review of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings which was launched in December 2014. Following this the Regional Contact with General Hospitals Forum was established. The Forum is currently working to identify key priority areas to shape the workplan going forward.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
2.18) Implement the DARD Farm Family Check scheme to meet the needs of farmers and their families in rural areas.	The Farm Family Health Check Programme exceeded its target for 2014/15 with a total number of 2773 clients presenting for a health check. Off those clients 1470 (53%) were advised to see their GP, 166 were directly referred to the MARA project and 442 to a farm safety course facilitated by DARD. The programme will be jointly funded by DARD and PHA for another year, allowing an opportunity for a comprehensive evaluation to take place.	G	G	G	G	
Make Healthier Choices Easier						
2.19) Commission drug and alcohol services across all 4 tiers of provision to support implementation of the New Strategic Direction on Alcohol and Drugs 2011-16 and the PHA/HSCB Drug and Alcohol Commissioning Framework 2013-16	Commissioning Framework Consultation completed. Actions being taken forward to implement the framework include; 1. Business cases and service specifications currently being developed for AMT approval. New contracts to be in place April 2015 2. Review of Tier 4 in-patient services completed, including public consultation. HSC Board endorsed revised proposals based upon a 3 site/30 bed arrangement – aim to initiate new regional Network process early 2015. 3. A review of Tier 3 (community based) specialist services is being initiated – progress to be updated later in 2014. 4. Acute hospital based service development proposal agreed 'in principle' by Hospitals Related Commissioning Group. Awaiting decision re potential additional funding – 2yr incremental service development proposal agreed to build upon existing services already in place within Trusts	G	G	G	A	Consultation complete. Response completed and approved by PHA Commissioning framework has not been finalised. Work on specification is prioritised over this task. It is hoped that the framework will be finalised by April 2105

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.20) Develop and implement the Hidden Harm Action Plan.	Regional and local delivery remains on track.	G	G	G	G	
2.21) Implement the DHSSPS Tobacco Strategy including Brief Intervention Training, smoking cessation services, enforcement control and public information.	Implementation of Tobacco Strategy progressing with oversight of TSISG. The Public Health Agency re-run Make them Proud (Why strand) and Stop for Good (How strand) has been running from January to March 2015. Tobacco Enforcement activity has been retained in a steady state in to 2015/16 as the next phase of RPA takes effect in councils. The brief for the new PIC is being developed and will be procured in 2015/16. The monitoring return timeframe for tobacco differs and Quarter 4 data will be signed off by TSISG on 30th July 2015.	G	G	G	G	
2.22) Implement the DHSSPS Obesity Strategy including, weight management programmes for children, adults, and pregnant women; development of a common regional Physical Activity Referral programme; implementation of Active Travel programme in schools; and public information.	Implementation being taken forward through the Regional Obesity Prevention Implementation Group (ROPIG). Evaluation of weigh to a healthy pregnancy pilot completed. Review of weight management programmes in adults completed. Plans to address wider physical activity issues are being taken forward, incorporating Physical Activity Referral Programmes and walking initiatives. Year one programme of 'Active Travel' has been delivered, and year two ongoing (led by Sustrans). The obesity public information campaign, 'Choose to Live Better' is ongoing.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
2.23) Develop a commissioning plan with agreed standards and commission a range of mental health promotion and suicide prevention services.	Commissioning plan progressing in line with procurement protocols. Standards complete.	A	A	A	G	

3. IMPROVING THE QUALITY OF HSC SERVICES						
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
3.1) Implement the Quality 2020 Strategy across the agreed work streams and publish both a PHA Annual Quality Report for 2013/14 and, with HSCB, a 2013/14 Annual Quality Report for the HSC sector.	The first HSCB and PHA Annual Quality report was submitted to the Dept. on 29th September. In line with recommendations from the Dept. it was formally launched on world Quality day 13th November and placed on the website. It has been circulated to HSCB and PHA chief executives and directors for dissemination to staff. Action Completed work will begin on Annual Quality report for 2014/15 in February.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.2) **Continue to lead and monitor the programme of work, and delivery of care, to develop and implement Normative Nurse Staffing including:** **•develop normative staffing ranges for district/community nursing with minimum data sets and monitoring arrangements developed** **•apply the Normative Nurse Staffing Tool to all inpatient and specialist adult hospital medical and surgical care settings** **•develop and introduce Normative staffing ranges for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy Healthy Futures.** **(DHSSPS Commissioning Directions target)**	***Phase 1 – Acute Medical and Surgical wards*** • DHSSPS documents for Delivering Care now on PHA & NIPEC websites • Target positions agreed with all HSCTs following meetings with HSCB/PHA during March 2015. • Recurrent financial allocations made to Trusts and end of March 15 allocation letters sent out from HSCB to CEO. • Monitoring arrangements agreed with Trusts. Implementation plan for operational roll out of Phase 1 due in from all HSCTs by 30/4/15. • Implementation of the 100% supervisory role as a key development has been agreed as part of the allocations. ***Phase 2 – ED*** Regional responses were collated to respond to the NICE guidance for 24hour consultant led ED settings. The comprehensive literature review conducted by NICE was utilised to inform the working methodology and set out the key metrics for review in NI emergency departments. Process for progressing collection of data in each ED has been agreed with the Regional Expert Reference Group: - A Telford exercise, alongside a review of HSCB information on triage category times, attendances by hour, age profile of attendances will be developed as a run chart for each ED site. This exercise will be completed the last week of April and reported to Delivering Care Steering Group on 7th May	A	A	A	G/A	**Lead officer has reported Phase 1 complete (Green) and Phases 2 – 4 as ongoing (Amber)** ➢ KPIs continue to be developed for Phase 1 ➢ Recruitment plans and absence management plans will be reviewed for each HSCT to achieve required NTBR. The evaluation of the final report will require peer review by the Delivering Care Working Group which may be delayed until June 2015.

	2015. - Regional guidance for the above process for this exercise was shared with each Trust. ***Phase 3 – District Nursing*** • Expert Reference Group for District Nursing met to review progress on core definitions for district nursing activity. • PHA currently progressing scoping paper to inform Phase 3. • Key metrics agreed: - Caseload analysis & weighting - Population analysis - Patient dependency - Professional judgement - Activity • BHSCT to report on Keith Hurst pilot to the Steering Group on 7th May 2015. • HSCB/PHA supported site visit to Cumbria to review application of Hurst data. ***Phase 4 – HV*** • Literature Review updated. • Agreed action plan signed off • Funding for caseload weighting secured. This has progressed alongside software development eCATS. Customer specification for pilot site agreed. South Eastern Trust to test for regional rollout. • Expert Reference Group established and influencing factors to be finalised by May 2015. • Progress report due 7th May 2015. • Project map and timeframes to be reviewed at next Steering Group for Phase 2,3 & 4.					Frontline professional input will be sought to assist PHA to complete caseload weighting exercise. Professional activity and interface with HSCB activity & community indicators not yet agreed regionally. Transferability of ICT requirements witin YARRA to be agreed. Hurst approach will have cost implications. ➢ Delays resulted from software issues. ➢ Action plan timeframe changed as a result.

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.3) Develop, with the HSCB, the regional e-health and care strategy to support transitional change in how and where care is delivered reflecting public health, nursing and other priorities.	The Regional eHealth and Care Strategy consultation was completed in January 2015. A response document and implementation plan is currently being presented to DHSSPS for approval. Mobile working for community nursing and midwifery staff is currently being piloted in the NHSCT and progress on an electronic multiprofessional patient record is being made through a regional "pathway to paperless" project involving all trusts.	G	G	G	G	
3.4) **Deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.**	At the end of March 2015 a total of 489,324 Monitored Patient Days have been delivered to 2,315 patients through the Telemonitoring NI contract. Additionally a total of 16,438 Monitored Patient Days have been delivered to 49 patients through the U-Tell service for Diabetes and INR. Total MPD for the year is 505,762 delivered to 2,364 patients.	G	G	G	G	**(DHSSPS Commissioning Directions target)**
3.5) **Deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.**	At the end of March 2015 a total of 987,332 Monitored Patient Days have been delivered to 3,748 patients. We have exceeded both the MPD and indicative patient numbers targets.	G	G	G	G	**(DHSSPS Commissioning Directions target)**

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.6) Support the development of a highly trained professional workforce with adherence to appropriate standards and robust accountability arrangements	PHA supports fully the development of a highly trained professional workforce. Specifically, PHA Medical Director/DPH and the Director of Nursing and AHPs meet regularly with professional colleagues in DHSSPS, Trusts, under and post graduate training bodies, professional organisations and RQIA as the regulator. Related work is proceeding through a range of mechanisms, notably the implementation arrangements for Q2020. Under Q2020, a Leadership Attributes Framework has been developed and launched on 12 November to coincide with World Quality Day. Work is underway to advise/assist HSC organisations in embedding this Framework within existing staff training and development processes. Work is underway to harmonise logistical processes affecting Junior Doctors moving within and between Trusts. Work is also being carried out across all Trusts with clinical and social care staff to standardise the minimum mandatory training requirements within Trusts. This should also reduce duplication in existing separate arrangements.	G	G	G	G	
3.7) Promote the use of PEWS across Paediatric settings and provide a report to the Department on progress towards agreed regional system(s) in paediatric settings.	Draft PEWS agreed and being tested by Trust teams There has been regional agreement on 4 age bracketed Paediatric Early Warning Score charts and an escalation protocol. Following preliminary testing some minor amendments were made to charts and these are currently with medical illustration.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.8) Produce a report assessing the impact of the work undertaken by the Safety Forum to promote and ensure compliance with the use of VTE risk assessment in hospitalised patients and report to the Department.	Draft report written regarding Safety Forum's role in VTE risk assessment which finished in 2012. Will finalise and share before sending to Department	G	G	G	G	
3.9) **Assist the Department to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements (DHSSPS Commissioning Directions target)**	The DHSSPS, working in conjunction with the PHA and Health & Social Care Trusts, have carried out the Inpatient Patient Experience Survey. This has been fed back to the Regional Patient Experience Steering Group and the findings will be incorporated in to the 2015/16 patient experience work plan. In addition, the PHA has worked with HSC Trusts to develop a comprehensive improvement patient experience programme of work for 2014/15 to complement and support the DHSSPS regional survey. At this time we believe the target will be achieved. The DHSSPS have shared the outcomes from the 'in patient survey' with the PCE steering group. The PCE working group will support Trusts to implement improvements in 2015/16. The target has been achieved.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.10) Continue the roll out and implementation of the 10,000 Voices Project, providing strategic direction, collaborating with HSC Trusts regarding implementation of outcomes and producing an Annual report.	The first phase of 10'000 Voices, which focused on unscheduled care, has been completed. Annual report and public facing report on phase one have been compiled, and presented at SMT/AMT, HSCB and PHA Boards. Phase 1 unscheduled care Phase 2 care in your own home Nursing and Midwifery KPI survey in conjunction with phases 1 & 2. In year funding (April 2014 – M arch 2015) was approved extended to March 2015. Business case for recurrent funding was approved in principle awaiting allocation by HSCB. The Analysis and Evaluation of the 'nursing KPIs', 'care in your own home' and 'NIAS' reports to be complete by March 2015. Regional survey in unscheduled care recommenced January 2015 and staff survey commenced January 2015. At this time we believe the target will be achieved. Recurrent funding has been confirmed for the 10,000voices initiative. Regional survey in unscheduled care – patients and staff. Annual report published. Nursing KPIs and Care in Your own Home reports completed. New areas for 2015/16 to be agreed. Target achieved.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.11) Establish a process to monitor and demonstrate improved outcomes based on the four key regional priorities identified in the Public Health Agency Annual report (2013/14) Patient Experience Standards	Process established with HSC Trusts to monitor and demonstrate improvement outcomes based on the four key regional priorities identified in the Public Health Agency Annual report (2013/14). Trusts have indicated they will achieve these targets. Update received from Trusts regarding the four regional priorities in November 2015. At this time we believe the target will be achieved Trusts reported progress in the four key regional priorities quarterly. All Trusts have implemented or have plans to implement.	G	G	G	G	
3.12) Take forward the Mixed Gender Accommodation work which provides assurance of gender segregation in inpatient accommodation based on an agreed regional policy statement on gender segregation / gender appropriate accommodation which will be developed in partnership with DHSSPS	A regional policy statement has been developed in conjunction with the DHSSPS; this is currently in draft and will be issued to HSC Trusts. An assurance template for scoping the management of mixed gender accommodation has been agreed and is due to be issued to Trust. At this time we believe the target will be achieved A baseline survey has been developed in conjunction with the DHSSPS and is currently with the DHSSPS for approval prior to dissemination for completion by the Trusts. Regional policy statement was developed in July 2014 and forwarded to the DHSSPS as RQIA required a joint statement. DHSSPS are updating to include legislation. Each Trust has a policy in place. Each policy has a system for monitoring and escalation of MGA. Regional baseline survey of MGA was completed and this will form the basis for on-going future work and improvements. The outcome will inform the level of assurance that can be provided.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
3.13) Lead the Regional implementation of the DHSSPS Promoting Good Nutrition Strategy and lead a process across Trusts to identify the percentage of patients who have nutritional screening undertaken within 24 hours of admission to hospital.	• Promoting Good Nutrition Regional Steering Group meet regularly • Work plan is well underway and will have a focus on protected mealtimes and food first. There has been focus on the following areas: ▪ Regional Medicines Management Initiative, Training to support the implementation of the PHA nutritional Guidelines for Residential NH . • Promoting Good Nutrition will continue to link with the specialist services team members to progress the regional model for parenteral nutrition. • Trusts continue to implement the 10 key characteristics across services • A scoping exercise of current training on food and nutrition across all HSC, universities and other training bodies and recommendations developed to address issues The PHA has developed a Key Performance Indicator (KPI) as part of the Regional KPI nursing group work (in conjunction with CNO and HSC Trusts, this has been agreed at end of March 2015, this will identify the % of patients who have nutritional screening undertaken within 24 hours of admission to hospital across all Trusts. A measurement plan is developed through SharePoint and Trusts will commence reporting of this from April 2015.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.14) Continue to work with NIPEC and Trusts to agree and monitor key KPIs for nursing	The Public Health Agency and DHSSPS Chief Nursing Officer (CNO), through the Regional Nursing KPI Steering Group, has agreed a suite of KPIs indicators with senior Trust colleagues and the CNO. Trusts are already reporting two of these (Falls and Pressure Ulcers) to PHA. There is agreement that the Trusts will commence reporting quarterly through the PHA from April 2015, as they are finalised.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.15) Ensure adherence to statutory midwifery supervision	LSAMO continues: • Annual LSA Conference held 30 January 2015; theme practice, evidence and toolkits. Evaluated very well • Quarterly returns to NMC/Mott MacDonald • LSA communication with NMC FtP and registration as needed. • Provision of monthly LSA Briefings for SoMs • Annual upload of c 1450 Intentions to Practise (ItPs) to NMC successfully checked and completed by 31 March • Follow up of recommendations from NMC review continues • Communication with SoMs, senior teams in Trusts and Education re updates on the NMC and supervision • SoM investigations instigated, LSA action plans and practice programmes put in place as required, • King's Fund report to NMC concluded; NMC decision in January 2015 to remove supervision of midwives from statute. NMC states 'business as usual' in interim; however LSA liable to not meet some standards (such as SoM: midwife ratios) as the legislative change approaches (will take 18-24 months) • Feedback on the NMC's review of Guernsey maternity services. • Inviting private /independent midwives to meet with NI's senior midwives in June; • LSA audit toolkit and benchmarking against Morecambe bay , PHSO and Guernsey reports	G	G	G	G	

	to SoM teams for completion in March 2015 • Improving knowledge and practice - LSAMO concluded the multidisciplinary work with NIPEC around 'Midwives and Medicines' interactive, online pdf toolkit, maternity kardex. CEC running on-going awareness sessions for midwives: http://www.nipec.hscni.net/MidwivesandMedicines/NIMidwives&Medicines.pdf King's Fund report to NMC concluded; NMC decision in Jan 2015 to accept their recommendations to remove supervision of midwives from statute; includes the disestablishment of the LSA and the LSAMO role. NMC states 'business as usual' in the interim; however, the LSA may become unable to meet some standards (such as SoM: midwife ratios) as the legislative change approaches (will take 18-24 months) because there will be little incentive for midwives to do a course (or Trusts to commission) for a role that will no longer exist. In mitigation: LSAMO is part of the (CNO NI commissioned) NIPEC working group doing a review of Supervision of Midwives in NI to highlight the good points (as per King's Fund and NMC) and look as ways forward and possible models, including rebading the QUB course to take leadership, clinical governance, patient safety. Regulation and legislation into account. The NIPEC report will inform the other three countries especially DH England which leads on statute for the four UK countries.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.16) Lead on phase 2 of the review of AHP support for Children with statements of Special Educational Needs within Special Schools and Mainstream Education	Phase 2 focusing on AHP support for children with statements of SEN enrolled in mainstream schools is drawing to a close, with quantitative and qualitative data collected being analysed. Collection of data in phase 2 was very challenging as it was difficult for AHPs to identify these children with statements of SEN enrolled in mainstream schools on their caseloads. It has also been more difficult to target service users and gather their views in phase 2, due to the challenges of identifying who they are and the complexity added by the much larger number of schools applicable to phase 2. Therefore, whilst phase 3 will commence as planned, further phase 2 qualitative data, eg in the form of online parent questionnaires, will continue to be accepted.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.17) Take forward any DHSSPS agreed actions for implementation within the Regional Learning System and continue to implement arrangements to support learning from SAIs throughout the region.	The Department established the RLS Steering Group to review arrangements for monitoring and learning from AI and SAIs. A pilot was established to scope the regional processes: completion October 2014. Staff hosted by PHA. The PHA work closely with the HSCB to continue to implement arrangements to support learning from SAIs throughout the region. This is done in a variety of ways for example learning letters, learning matters newsletter and bi-annual learning report. The report from the RLS review is due to be issued by the DHSSPS in early February 2015 any agreed actions for implementation will be considered and action plan put in place following publication of this. DHSSPS conducted a pilot to review and identify the best methodology for a RLS. Pilot report has been shared by the DHSSPS with the HSCB and PHA. DHSSSPS agreed to fund the HSCB/PHA to project manage improvements by reviewing codes and Adverse incident reporting. However this was not progressed by the DHSSPS due to financial savings. HSCB/PHA continues to support the HSC Trusts in the management of SAIs. New SAI procedure has been implemented, family and friend policy and patient leaflets developed. Daily review of SAIs, themes and trends identified and dissemination of learning through Learning letters, Learning Matters Newsletter and SAI Learning Report to support staff by improving systems to improve patient care. This target has been achieved.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
3.18) Take forward a program of quality improvement work including Safety Forum initiatives and Quality Improvement Plans.	All SF work streams progressing satisfactorily except Primary care work which has exhausted the non-recurrent funding for GP 1 day/week. All work streams beginning to suffer due to dramatically expanded workload over period 2011-2014 but no increase in resource.	A	A	A	A	TYC is providing funding for GP sessions in 2015/16. Director of Nursing will meet with Lead Officer to discuss Safety Forum work plan for 2015/16
3.19) With HSCB, support the implementation of the Northern Ireland Maternity Strategy, including promoting safe and effective care.	*Maternity Strategy Implementation Group (MSIG)* – the group has now met three times. Service user representatives are being included in both the Pre-conceptual care Sub Group and the Communications Sub Group core membership. MSLCs will be approached to seek representation on these groups and ongoing attendance and contact with MSLCs will continue. *Community Maternity Care Project* - A draft report has been produced summarising the findings of the engagement activities with women, midwives, obstetricians and GPs. This report will be submitted to the Project Groups for review and comment. The Core Pathway for Antenatal Care in Pregnancy has been circulated widely to stakeholders for any comments by 2 April 2015. A Self-Referral letter for use by women to access midwifery services in the early stages of pregnancy has been considered by the Trusts and sign off is imminent. *Electronic Referral* - Project team representatives met with Dr Jimmy Courtney, Clinical Advisor to the e-Health team in HSCB to discuss the best approach to developing this function for the CCG system in Northern Ireland. A way forward has	G	G	G	G	

	been proposed and a final template has been developed with maternity and primary care representatives. This is to be considered by the Next Steps Group which oversees the development of the CCG referral system. *Maternity Quality Improvement Collaborative* – Vaginal examination sticker received very positive feedback following 6 month period of testing. Amendments were agreed to the Obstetric Early warning Score. A revised version to be issued following discussion with procurement to ensure full utilisation of existing stock. CTG stickers – a subgroup has been established to review sticker contents in line with the revised NICE intrapartum guidance issued in Dec 14. *Regional Maternity Dashboard* – regional data was sent to all Trusts to show full 2013/14 and 2014/15 data, including some excel and PDF charts. *NIMATs* - Staff from Northern Ireland Electronic Care Record (NIECR) have been in discussions with the NIMATs Steering Group to look at how better we can communicate better between NIMATs and ECR, it is anticipated that this will take the format of the reports which are generated from the NIMATs system being uploaded on to ECR. Working groups have been established to look at specific areas including the recording of: multiple births/ deaths/stillbirths /anaesthetics. Recent changes include adjustments to the Antenatal Summary Present Pregnancy Screens, Screening; Interface with NIBTS.					

	Multiple Pregnancy –, a Regional Care Pathway for Multiple Pregnancy was agreed in response to NICE Clinical Guideline 129 on the management of Multiple Pregnancy. A Commissioner Specification has been issued to Trusts for implementation from April 2015 on. Funding to support the development of appropriate services for women with a multiple pregnancy has been confirmed. *Booking Scans* – Work has been ongoing by the obstetric imaging review subgroup around information gathering on existing services. Site visits had happened in most Trusts by the end of March 2015. *Review of Antenatal Education* - the Review and EITP Workstrand 1 groups are working cohesively to ensure the model for antenatal education is the same for throughout the service. The group hopes to progress development of minimum curricula content and tools required for delivery to be undertaken based on the Solihull approach, including use of web-based resources. *Pre-conceptual care* - Trusts have nominated midwifery links to take part in a Pre-conceptual Care Sub Group focusing on Folic Acid uptake. Draft Terms of Reference have been developed for consideration by the Group and the membership of the Group will include Midwifery, GP, Pharmacy, Family Planning, Health Improvement, Service User, SHINE and Surestart representatives. *10,000 Voices* - The regional report with the findings from experience of maternity care has now					

	been completed and will be published in April 2015. Individual Trusts are in the process of sharing the findings with midwives in their Trusts so that both the positive messages and the areas for learning and development can be shared. *Northern Ireland Maternity Survey* of all mothers' views (undertaken by QUB) started in January 2015 and will run until June 2015. *Guidelines and Audit Implementation Network (GAIN) Regional Guidelines for Admission to and Transfer from Midwife-led Care* – there have been several Working Group meetings and a Steering Group meeting on the 23rd February 2015. A Regional Normal Labour Care pathway was discussed and an initial draft agreed. Amendments have been made to the guideline which is now in final draft form as Version 7. Members of the Steering Group also agreed that the Normal Care pathway with a few amendments should be adopted regionally.					
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		Jun	Sep	Dec	Mar	
3.20) Commission patient	Draft tender documentation drafted for generic self-	G	A	A	A	Additional recurring funding has been

and carer education programmes for people with long term conditions, subject to funding.	management programs.					confirmed for the CAWT project "CHOICE" which provides structured patient education (SPE) to children with diabetes and their families. This investment will ensure all children and their families are enrolled in an SPE program after diagnosis and will receive annual updates thereafter. Draft tender documentation for generic self-management programmes have been prepared but require additional funds in 2015/16 for implementation to happen.
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**

3.21) Work with HSCB to take forward implementation of Service Frameworks specifically for cardiovascular, respiratory and cancer, where the PHA has the lead role.	**Service Framework for Cardiovascular Health and Wellbeing** – Implementation in progress. Detailed implementation plan sent to DHSSPS in December 2014. Progress on identifying baselines for a number of KPIs has been delayed (due to issues with identifying data sources and changes to existing data sources). Issues and delays were highlighted in plan issued to DHSSPS in December 2014, and detailed in the Briefing Paper issued to the Departmental Service Framework Programme Board, in advance of their planned meeting on 19 February 2015 (meeting subsequently cancelled). Baselines for the remaining KPIs will be identified via relevant networks/clinical advisory groups and agreed with the CVSFW Steering Group. Agreed baselines will be included in the Progress Report for the period up to March 2015, which will be issued to DHSSPS in July 2015, as outlined in the Detailed Implementation Plan. **Revised Service Framework for Respiratory Health and Wellbeing –** The Respiratory Service Framework was out for public consultation which closed in January 2015. Awaiting further communication from DHSSPS. **Service Framework for Cancer Prevention, Treatment and Care –** The Cancer Service Framework is currently undergoing a fundamental review which is due to be completed in September 2015	G	G	G	G	
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**

3.22) Work with HSCB to take forward relevant recommendations from the Hyponatraemia Inquiry Report and Francis Inquiry.	The report of the Hyponatraemia Inquiry has not yet been published. **NO STATUS RECORDED AS REPORT NOT PUBLISHED**					
3.23) Take forward the introduction of self-referral physiotherapy in South Eastern Trust as an early implementer, and assess the outcomes of early implementation to inform a decision on whether and how to roll out self-referral physiotherapy to all Trusts. (This will be dependent on improved performance, on the basis of current access arrangements, against the 9 week target.)	**NO RAG STATUS TO BE RECORDED** **THIS IS RESPONSIBILITY OF HSCB**					
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**

3.24) Take forward the implementation of independent prescribing within podiatry and physiotherapy, through the working group, agreeing the action plan and commencing implementation.	Communication has been received from the Department that the legislative framework is now in place to allow the PHA to take forward the implementation of independent prescribing for podiatry and physiotherapy. The PHA has set up a regional implementation group which has met twice in 2015. Terms of reference and an action plan have been agreed to support implementation. The group has representation from all trusts. The PHA will seek formal assurance from Trusts in the next number of months that all governance processes are in place. Nominations from HSC Trusts have been sought for the Regional Non Prescribing Working Group. The first meeting of this group took place in January 2015 and 2 further meetings have taken place to date. A number of AHP clinicians are actively practising as independent prescribers across HSC in N Ireland. Further work is on-going to fully implement independent prescribing across all trusts.	A	A	A	G	

4. IMPROVING THE EARLY DETECTION OF ILLNESS						
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
4.1) Continue to improve informed choice in cancer screening (particularly amongst groups in greatest need.	Good progress being made on implementing the Informed Choice Action Plan.	G	G	G	G	
4.2) **Introduce the extension of the Bowel Cancer Screening Programme to invite people up to the age of 74 years with a screening uptake of at least 55% in those invited. (DHSSPS Commissioning Directions target)**	Age extension was introduced from 1st April 2014. 49.04% of the eligible population were invited to participate in screening April 2014 – March 2015. Uptake is measured at 12 weeks and 6 months after the issue of an invite. The 12 week uptake for Northern Ireland April – Dec 2014 is 54.31% Quarter 3 uptake (Oct – Dec) by trust is as follows: Belfast: 53.41% Northern: 57.85% South Eastern: 60.93% Southern: 53.72% Western: 54.43%	G	G	G	G	
4.3) Complete the roll out of digital mammography.	Roll out of digital mammography on course to be completed by end of September 2014.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
4.4) Lead the implementation of the new UK New-born Blood Spot Screening Programme standards.	Progressing developments to adopt revised UKNSPC standards	G	G	G	G	
4.5) Develop, in conjunction with the BSO and Trusts, the Child Health System (CHS) to a level where it can comprehensively report on activity across the Child Health Promotion programme (0-19 years). In addition, put in place mechanisms to ensure timely and continuous update to the CHS to reflect changes within the child health promotion programme.	In 2014/15 the planned work program is 1. Immunisation schedule updated. 2. The electronic interface with the Department of Education is being actively discussed with a view to testing and implementation being complete by September 2015. Not in a position to confirm whether this will be completed by 1st September 2015. 3. Amend CHS software so that records of children who are adopted can be retired and information transferred to new record with new health and care number - Business Case being prepared. 4. Test electronic interface between CHS and laboratory for bloodspot screening - testing is underway. ***5.*** Put CHS in the Data warehouse starting with Modules 1 and 3 - this should take place in-year.	G	G	G	A	1. Immunisation schedule updated as planned. 2. Electronic interface with C2k not completed. This will happen 2015/16. 3. Specification being prepared for "retiring" adopted child health records. 4. System being tested. This will be further delayed as a result of recently announced changes to immunisation schedule for meningitis B and ACWY. 5. Modules 1 and 3 are in the data warehouse. A data quality exercise has to be completed next.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
4.6) Implement actions allocated to the PHA arising from the agreed Community Resuscitation Strategy for Northern Ireland.	An IPT for in-year investment in Community Resuscitation (CR) has been sent to the Ambulance service asking them to be the single provider of community resuscitation services. PHA will participate in regional group to be convened by NIAS to oversee developments in CR. PHA will work with PMSI to develop a dataset using existing information systems to monitor outcomes of Out of Hospital Cardiac Arrest OHCA). First meeting of Implementation Group scheduled for 2nd February 2015 and a scoping exercise is planned to take place thereafter.	G	G	G	A	The Regional Group has met on one occasion An IPT was sent to NIAS for completion but with the financial crisis in 2014/15 this did not progress PHA will work with PMSI on developing this dataset

5. USING EVIDENCE, FOSTERING INNOVATION AND REFORM

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.1) Publish the new HSC R&D Strategy and its implementation plan including metrics to assess success of implementation.	DHSSPS has received consultation responses (40) – awaiting update from DHSSPS	A	A	A	A	Awaiting completion of updated strategy document from DHSSPS
5.2) Consolidate the infrastructure for accessibility of routinely collated datasets and support the establishment of the Administrative Data Research Centre & Honest Broker service for HSC research purposes.	HSC R&D Division has on-going input on the Honest Broker Governance Board & the ADRC Steering Group	G	G	G	G	
5.3) Support researchers to secure research funding from external sources including NIHR evaluation, trials & studies co-ordinating centre (NETSCC), Horizon 2020 & US Ireland Partnership.	120 people attended the workshops and positive feedback received	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
5.4) Work with HSCB to promote a research culture in Social Care and work towards commissioning a call in Social Care Research.	Workshop was well attended and future events being planned	G	G	G	G	
5.5) Work with stakeholders to explore themes for a potential call in obesity research.	Continued liaison with PHA colleagues with one Enabling application on Obesity being funded by Health Improvement in line with the PHA Action Plan	G	G	G	G	
5.6) Work with stakeholders to explore themes for a potential call in Suicide research.	Suicide Phase III studies due to complete in 2014-15 – launch events to be scheduled	G	A	G	A	Current commissioned research due to report will inform next steps
5.7) Ensure the delivery of a commissioned research to evaluate Telemonitoring NI.	Further delay to project start due to issues relating to data and information governance	G	G	G	A	QUB to advise on elements likely to be outstanding beyond December 2015.

6. DEVELOPING OUR STAFF AND ENSURING EFFECTIVE PROCESSES						
Target from Corporate Business Plan	**Progress**	**Achievability** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
6.1) Review the existing PHA Corporate Strategy and develop a new PHA Corporate Strategy for the next 4 years.	While the publication of the next PHA Corporate Strategy will be put back to align with NI Executive timescales (as per DHSSPS advice), work has commenced on the development of the PHA corporate priorities and subsequent development of the corporate strategy (2016 – 2020). The project board has met on a monthly basis since June 2014. A number of engagement events have taken place including a board workshop held in September 2014, a staff workshop held on 9th December 2014 and two external stakeholder engagement events held in March 2015. The information collated at these events will help inform the structure and priorities of the Corporate Strategy for 2016-2020.	G	G	G	G	
6.2) Continue to take forward actions to embed a culture which places value on staff, ensures clear and known organizational priorities and establishes a clear, transparent leadership and accountability framework.	Team meetings, Team development events, OWD working group, dissemination of information via Connect, E-learning and bespoke training developed and implemented. Health & Well-being Group and internal communications sub group established. Involvement of staff in development of Annual Business Plan, and the Corporate Strategy (workshop for all staff held December 2014)	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.3) Ensure that by 30th June 2014 90% of staff will have had an annual appraisal of their performance during 2013/14.	As at June 30th 2014 approximately 95% of PHA had received their annual appraisal for 2013/2014.	G	G	G	G	
6.4) Ensure that by 31 March 2015 100% of doctors working in PHA have been subject to an annual appraisal.	On target. All doctors in PHA undergo annual appraisal every year in line with DHSSPS guidance.	G	G	G	G	
6.5) Reduce or maintain staff absence rates to 3.75%	The corporate cumulative annual absence level for the PHA for the period from 1 April 2014 – 31 March 2015 is 2.55%. There were 15,221.69 hours lost due to sickness absence, or, the equivalent of 46 hours lost per employee. Based on a 7.5 hour working day, this is equal to 6.13 days per employee. This is 3.57 days lower than the national average of 9.7 days per employee for the Health Sector (*CIPD Absence Management Report 2014*).	G	G	G	G	
6.6) Work through the ICT programme board (in conjunction with NIPEC) to meet the recording care requirements for nurses and midwives to work effectively within the integrated system of care.	The regional eHealth and Care Strategy has made changes to the governance structure of ehealth programmes and projects by setting up an ehealth Strategic board to replace ICT programme board. A "Pathway to Paperless" task and finish group will make recommendations to this board in June 2015 as to requirements for clinical recording within a multiprofessional patient centred record.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.7) Continue to lead on the implementation of PPI policy across the HSC and produce a report summarising best practice in PPI across all HSC bodies, as well as identifying any barriers to effective personal and public involvement and means of overcoming same.	The PHA continues to provide leadership on the implementation of PPI policy across HSC, primarily through work with the Regional HSC PPI Forum. A number of work streams are being progressed including: • PPI Training – Design & development of a HSC wide generic PPI training programme has been commissioned and has been piloted. An e-learning component is also being developed, with completion due in summer 2015. • Forum Action Plan. This is focused on the work of the 4 sub-groups, training, standards, monitoring & communications. work continues to progress well in all 4 sub-groups • Report and Research – the PHA has commissioned research into the identification of barriers to involvement and ways of overcoming these. This has been done in partnership with the PCC and R&D colleagues in the PHA. The research team have commenced their work, but there were delays in securing ethics and governance approvals with a knock on effect for completion of the research and the subsequent compilation of the report. This has been notified to the DHSSPS and an extension secured to the end of September 2015.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.8) Pilot a model to monitor PPI compliance across HSC in accordance with the agreed PPI Standards	The PHA, working through the Regional HSC PPI Forum has led on the development of PPI Standards with associated KPIs. These have been approved by the Forum and PHA Management. The Standards have been endorsed by the DHSSPS and were launched in March 2015. The PPI Standards form the basis of the Monitoring and Performance Management Templates and processes for both internal and external monitoring. <u>Internal</u> The internal monitoring of PPI in the PHA has commenced, with each Division tasked with competing a monitoring template. This will be analysed with a report being made available to the PHA AMT. <u>External</u> The external monitoring of PPI with HSC Trusts has commenced in line with Departmental agreement. The monitoring template was completed and followed by verification visits at the end of March. Final reports will be completed for the next round of accountability meetings in June 2015.	G	G	G	G	
6.9) Achieve substantive compliance with the information management controls assurance standard	Following the assessment of the information management CAS for 2014/15 (substantive compliance), an action plan is in place to further develop this work and improve the score for 2015/16.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.10) Carry out an independent evaluation of the Board governance arrangements in line with DHSSPS requirements.	The PHA Board self-assessment was audited by Internal Audit in 2013/14. DHSSPS have confirmed that this satisfies the independent evaluation requirement. PHA completed the 2014/15 self-assessment (approved at March PHA Board.)	G	G	G	G	
6.11) Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	The Business Continuity Plan has been revised and updated (including compliance with ISO22301:2012.) The plan was scheduled to be tested 31/03/2015- unfortunately this had to be postponed due to urgent financial business.	G	G	G	A	The test is being rescheduled for first quarter 2015.
6.12) Continue to ensure that business cases are prepared for capital/revenue/external consultancy expenditure in line with Departmental guidance, and approved within the Agency structures or submitted to the Department where appropriate in line with delegated limits, on a timely basis. An annual assurance that effective processes are in place for the production of business cases will be brought to the PHA Board.	The PHA has effective processes in place for the production of business cases. Updated and revised business case guidance was brought to AMT 20 May 2014 and subsequently issued to staff and placed on the Connect, reminding them of the correct processes. Staff complete the appropriate business case documentation in respect of investments and as part of procurement for approval in line with the SoDA Advice continues to be provided by Finance and Operations Directorates.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.13) Establish a process by June 2014 to provide assurance to the PHA board that the PHA has adopted and maintained good procurement practice in line with DHSSPS requirements, and report to the board accordingly in September 2014 and March 2015.	The PHA SFI set out the required processes for procurement. The SODA was updated in 13/14, (reviewed 14/15) and the e-procurement system ensures that only authorised staff can order and approve. Single Tender Actions must be approved by the Chief Executive or Director of Operations, following PALS advice; monitoring reports on STAs are brought to GAC. Social care procurement continues to be developed, with reporting to the PHA procurement board. Reports on progress against the procurement plan are also brought to the PHA Board and the next update is due to be considered by PHA Board in May 2015.	G	G	G	G	
6.14) Prepare and submit a Property Asset Management Plan, in line with Department requirements.	The PAM plan for 2014/15 was approved by AMT (6th May 2014) and submitted to DHSSPS in line with the required timescales. Following DHSSPS queries, a revised plan was submitted in July 2014 and again 24 September 2014	G	G	G	G	
6.15) Prepare and submit a Sustainable Development Report, in line with Department requirements.	A sustainable development report, in line with Department requirements was submitted to the DHSSPS within the required timescales	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
6.16) Continue to implement the PHA Procurement Plan.	PHA continues to work with PALS and Legal Services to progress the procurement plan in line with the relevant regulations. Tenders for RSE, Drugs & Alcohol phase 1 and mental health training have been awarded. Tenders for Drug and Alcohol phase 2 and Self Harm services are currently being evaluated and will be finalised shortly. Tenders for workstream 2 under the Early Years Intervention Programme have been advertised and are due to be awarded by August 2015. Preparation for the next phase of tenders in Mental Health and Obesity is progressing. The procurement plan will continue to be updated to reflect priorities and requirements.	A	A	G	G	PHA continues to liaise closely with both PALS and DLS, to progress queries, and ensure that the PHA is applying appropriate processes.

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.17) Continue to manage and review PHA facilities, in particular ensuring arrangements are in place to manage the end of the lease for Anderson House, and to put appropriate arrangements in place for the management of 21 Linenhall street	Anderson House lease reviewed, SOC prepared and preferred option to retain agreed by Agency management Team given pressures in Gransha Park. On advice of DHSSPS LPS have been asked to negotiate lease terms with the landlord, before DHSSPS will consider the SOC. On advice of DHSSPS a condition survey was carried out in March 2015. The SOC is currently being revised and updated in April 2015. PHA, along with other Regional HSC organisations has agreed a new facilities management contract for Belfast facilities (will take effect from 01/06/2015) As the preferred option for new accommodation has now been withdrawn by the landlord, the PHA is liaising with DHSSPS to seek their advice and approval to identify and consider alternative options. New and appropriate accommodation will therefore not be available for PHA Belfast based staff in 2014/15.	A	R	R	R	The revised SOC for Anderson House will be submitted April 2015. PHA has been, and continues to be, in communication with DHSSPS and Health Estates to seek an urgent way forward to identify and acquire suitable alternative/additional accommodation for Belfast based PHA staff. A meeting has been organised with DFP Health Estates division to discuss.
6.18) Develop and agree a new Internal communications strategy to ensure PHA business is supported by efficient and effective internal communication systems.	The internal communications audit has now been completed (by 215 members of staff) and will help influence the development of the internal communications strategy and action plan Analysis of the Audit results has been completed and a draft Action Plan presented to OWDG and at the Ops Managers Meeting. All Directorates have had input into the filtering of recommendations and a draft strategy/action plan will be circulated shortly.	G	G	G	A	Action Plan Revised -Connect redevelopment approved by AMT -Draft strategy carried forward to Qtr1 of 2015/16

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		Jun	Sep	Dec	Mar	
6.19) Develop the PHA external communications mix to ensure that PHA digital communications and social media channels are further enhanced to reach new audiences and maximise the delivery of key messages to the public.	Corporate and Public Affairs has increased its use of social media channels for disseminating and sharing information, engaging with groups and individuals, and highlighting key issues. Bespoke rich content has been developed to enhance digital communications, such as 'infographics' and video and online output is used to complement more traditional communications methods such as the issuing of news releases. This has helped the PHA reach new audiences in a targeted, efficient and economical way.	G	G	G	G	
6.20) Develop and deliver a range of integrated communication solutions to target audiences in line with key PHA priorities. Public Information Campaigns to include smoking cessation, mental health promotion, obesity prevention, seasonal flu, cancer awareness, organ donation, sexual health and bowel cancer screening programme subject to DHSSPS approval, will be taken forward.	Development of public information campaigns (smoking, obesity, mental health, organ donation, flu, bowel cancer screening, sexual health and cancer awareness. Mass media advertising key component of integrated communications mix which includes development/refresh of health topic websites, PR and social media). Campaigns approved by DHSSPS/NI Executive and assigned a budgetary ceiling. Planning and development for all underway. Web editor recruited from agency to manage health topic websites in support of campaigns. All Completed	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability Jun	Sep	Dec	Mar	Mitigating actions where performance is Amber / Red
6.21) Ensure effective finance systems, processes and forecasts are in place, consistent with best practice and agreed Departmental requirements and timescales. These will take into account savings delivery plans where appropriate.	Financial forecasts are in line with best practice and kept under continuous review to ensure effective & consistent with best practice. This is especially important in light of new finance systems and Shared Services implementation by BSO. In 2014/15 a focus will be maintained on the development of the new Collaborative Planning (CP) budgetary control system.	G	G	G	G	
6.22) Ensure the prompt payment of invoices in line with Departmental standards and timescales.	Significant work has taken place to ensure PHA staff are able to expedite clearance of invoices on the FPM system. Training and user guides have been delivered and regular follow-ups have been made through 2014/15 at the staff, Director & AMT level and follow-ups will continue in 2015-16. In 2014-15, payment of 95% of all undisputed invoices within 30 days was a difficult challenge but PHA were able to pay 88.9% within 30 days (by volume of invoices). PHA is able to pay 76.1% of undisputed invoices within 10 days which exceeds the agreed target of 50%. Key to achieving this target is the embedding of effective processes & controls by Shared Services (BSO), which is kept under continuous monitoring.	A	A	A	R	Training and user guides have been delivered and regular follow-ups have been made through 2014/15 both by Shared Service Accounts Payable staff and by HSCB Financial Governance on behalf of PHA, at the staff, Director & AMT level and follow-ups will continue in 2015-16. The 50% target in 2014/15 of paying undisputed invoices within 10 days is being achieved.

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	PHA Response to Donaldson Report
Agenda Item	13
Reference	PHA/07/05/15

Summary

Following the publication of the Donaldson Report – "The Right Time, The Right Place" on 27 January 2015, the Department launched a consultation on 24 February 2015. The closing date for responses is 22 May 2015.

The response will then be considered for approval at the PHA Board meeting on 21 May 2015, for submission to the Department.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This response was approved by AMT at its meeting on 12 May 2015.
Recommendation / Resolution	For Approval
Director's Signature	CHarper
Title	Director of Public Health
Date	28 April 2015

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

THE DONALDSON REPORT

RECOMMENDATIONS

Consultation Response Questionnaire

CONSULTATION RESPONSE QUESTIONNAIRE

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

E-mail: qualityandsafety@dhsspsni.gov.uk

Written: Donaldson Consultation
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Tel: (028) 9052 2424
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Responses must be received no later than 22 May 2015

I am responding: as an individual ☐
on behalf of an organisation ☑
(please tick a box)

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Background

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement on governance arrangements across the HSC.

Sir Liam was subsequently tasked with investigating whether an improvement in the quality of governance arrangements is needed and whether the current arrangements support a culture of openness, learning and making amends.

The Donaldson Report was published by the Health Minister Jim Wells on 27 January 2015. It sets out 10 recommendations which refer to a wide range of areas across the health service in Northern Ireland. The full report can be accessed at:

http://www.dhsspsni.gov.uk/donaldsonreport270115.pdf

Purpose

This questionnaire seeks your views on the recommendations arising from the Donaldson Report, and should be read in conjunction with the report which includes the recommendations.

The consultation questionnaire

The questionnaire can be completed by an individual health professional, stakeholder or member of the public, or it can be completed on behalf of a group or organisation.

Part A: provides an opportunity to answer questions relating to specific recommendations and/or to provide general comments on the recommendations.

Part B: provides an opportunity for respondents to give additional feedback relating to any equality or human rights implications of the recommendations.

When responding to Part A please indicate which recommendation(s) you are providing feedback on:

Please tick which recommendations you are providing feedback on	
Recommendation 1	✓
Recommendation 2	✓
Recommendation 3	✓
Recommendation 4	✓
Recommendation 5	✓
Recommendation 6	✓
Recommendation 7	✓
Recommendation 8	✓
Recommendation 9	✓
Recommendation 10	✓
General Comments	✓

Part A
Feedback on Recommendations

Recommendation 1

We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.

The Report states that 'A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.'

The process of creating these recommendations will entail Personal and Public Involvement (PPI) on behalf of the panel and consultation with all relevant stakeholders.

Q1. Do you agree that a panel of experts should be appointed to make recommendations on the configuration of Health and Care services in Northern Ireland? If so, should this panel be made up of international experts?

Strongly agree Agree Neither Disagree Strongly disagree

We accept that an external expert can bring new thinking and fresh perspectives and that their conclusions may also be more acceptable to local politicians. However, we also believe that there are experts within the HSC who know the evidence base for good practice, know the local circumstances and challenges, and are skilled in population health planning. We would wish therefore to see a process led by skilled and experienced local experts with input from external experts. The locally-led group should work with political representatives, the public, service users, clinical and social care staff, commissioners and other stakeholders to develop a clear and coherent operational model for future health and social care services in Northern Ireland.

Q2. If such a panel is appointed, should political representatives have the final say in accepting any recommendations?

Strongly agree Agree Neither Disagree Strongly disagree

While we understand the spirit of this recommendation in that it asks for decisions to be made that are not popular politically, we believe that elected political representatives have to retain the authority and responsibility to make those decisions. To be consistent with democratic principles, political representatives should have the final say in accepting any recommendations. A blanket in-advance acceptance of the recommendations of an external panel of experts would therefore, in our view, be counter to democratic principles.

Q3. Are there alternative ways for Northern Ireland to determine a configuration of health and social care services commensurate with ensuring world-class standards of care?

If you consider there is, please complete the box below

We recommend a consistent and sustained engagement between political representatives and the HSC and DHSSPS to develop a clear and coherent vision for the future provision of core health and social care services in Northern Ireland. We believe it should be possible to develop and deliver a solution that would meet the needs of patients and clients, the standards for modern services, and political expectations.

The transformation from a traditional model of care to a consistently world-class healthcare system will require planned changes to working patterns and a sufficiently sized and supported workforce. While changes to the structure of the acute hospital networks are likely, these may not necessarily result in hospital closures. This requires a clear vision and consistent pursuit of that vision. Service changes must be based on analyses of patient and client needs, clear care pathways and service models to meet those needs from primary to secondary and community care, and planned and managed change.

Recommendation 2

We recommend that the commissioning system in Northern Ireland should be redesigned to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.

The Report states that 'The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.'

In response to this finding the Minister announced, on 27th January 2015, that Departmental officials have been asked to undertake a review of the effectiveness of existing commissioning arrangements. This is due to report in the summer of 2015.

Q1. Do you agree with this recommendation?

Strongly agree Agree Neither Disagree Strongly disagree

The introduction of primary percutaneous coronary intervention (PCI) and associated developments in cardiology in Northern Ireland was highlighted in the Donaldson Report as an example of successful clinically-led commissioning and effective service change. The Public Health Agency recommends that we should learn from that experience and apply the success factors from that work, in future commissioning arrangements. The PCI work was primarily a process led by an experienced public health clinician and a senior nurse, supported by commissioning staff. They engaged throughout the process with local clinicians and service users. Other examples of successful commissioning include the introduction of immunisation and screening programmes, and development of a wide range of multi-sectoral, multi-agency health improvement programmes. These examples show that complex, multifaceted programmes can be commissioned once for the region through a single process that is managed and led by experienced public health practitioners working with local clinical and social care staff, service users and relevant other stakeholders. That model of commissioning is lean, efficient and effective.

A single professionally-led, regionally-managed integrated process that involves local and other stakeholders, brings greater consistency in care and costs, reduces risks and re-work caused by variation, and results in better quality care at less cost. Such an approach would realise the goal of person-centred commissioning. It would also enable new models of care between primary and secondary care, and issues of workforce supply, e-health developments, and configuration of services, to be addressed as one coordinated managed process. We would therefore recommend that model for any future commissioning arrangements.

Given our experience and achievements in commissioning public health programmes effectively and efficiently, we do not believe that a tariff system is required. Tariff creates incentives, but also perverse incentives. It is also costly to administer, would increase the management costs in the HSC and thereby reduce the funding available to maintain frontline services. Results from tariff in the NHS are mixed and there is no evidence base on the effectiveness of tariff.

In summary, we agree with the Donaldson recommendation to make the commissioning system simpler and more capable of reshaping services. Our view is that the approach to commissioning public health programmes should be adopted for all commissioning. Future commissioning would therefore be based on a single, professionally-led, regionally-managed integrated process with strong involvement of local and other stakeholders.

Recommendation 3

We recommend that a new costed, timetabled implementation plan for Transforming Your Care should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.

The Report states that 'The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.'

In his presentation to the Health Committee on 28 January 2015 Sir Liam stated that he had highlighted paramedics and pharmacists as examples of areas where innovations could take place to improve the quality of care whilst potentially releasing some of the pressure on hospitals.

Existing Transforming Your Care documents, including the Vision to Action Consultation and the Strategic Implementation Plan, can be found at http://www.dhsspsni.gov.uk/index/tyc.htm

Q1. Do you agree with the recommendation for a new Transforming Your Care implementation plan?

Strongly agree Agree Neither Disagree Strongly disagree

Prevention and early intervention to maintain health, wellbeing and independence, are core elements of a public health approach to improving population health. They are also important elements in Transforming Your Care (TYC). The HSC must support the prevention and early intervention agenda if it is to optimise health and wellbeing, reduce demand and make health and social care more affordable. Achieving this goal requires investment in secondary care as well as public health programmes, primary and community care. For example, in timely senior decision making to avoid the costs that arise through inappropriate care, and/or long waits for investigation or treatment.

PHA agrees with the Donaldson recommendation for a costed, timetabled implementation plan for TYC. However, that plan needs to be rooted in the clear and coherent operational model for future health and social care services in Northern Ireland referred to in relation to recommendation 1. Without a clear operational vision, the plan will fail.

Equally, implementation of the vision and plan should be led by the appropriate HSC staff with skills and experience in leading substantial health and social care change.

In summary, a costed, timetabled implementation plan for Transforming Your Care should be produced. It should be rooted in a clear and coherent operational model for future services. Implementation of the vision and plan should be led by the appropriate HSC staff with skills and experience in leading substantial health and social care change.

Q2. Do you agree that alternative models of working for healthcare professionals, including pharmacists and paramedics, should be examined to help address the pressure on hospital services? If so, which staff groups do you feel could have an expanded role?

Strongly agree Agree Neither Disagree Strongly disagree

We agree with the principle of ensuring that patients are seen and managed by a professional with the skills to make the correct decision about the treatment and care they need. However, the new ways of working should be driven by data on the needs of patients presenting to General Practice or Hospital Care. It would be wrong to prejudge the outcome of that analysis and would advise instead that service development proposals should be based on data rather than opinion.

From the analysis the PHA has done on Emergency Department services and Paediatrics, we would highlight the opportunity to develop Advanced Nurse Practitioners in these two service areas. There may be opportunities in other services, subject to analysis of patient needs.

We would also highlight that services work more effectively when staff in those services are clear about their roles and work together to a common goal of holistic patient and client care. To ensure the best care for patients and clients, any new ways of working require a change management approach with staff affected involved in the process of design and implementation.

Recommendation 4

We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.

The Report states that 'Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.'

The Department launched a policy framework for long term conditions – *Living With Long Term Conditions* – in April 2012. The Public Health Agency chairs a Regional Implementation Group, which includes representatives from the Long Term Conditions Alliance and other key stakeholders, which is overseeing the development of an action plan on long term conditions. This will include consideration of key metrics.

The Living with Long Term Conditions document can be accessed at:
http://www.dhsspsni.gov.uk/long-term-condition.htm

This supports the delivery of the Programme for Government which makes a commitment to enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme. Between 2011/12 – 2012/13 there was a 13% increase in the number of people enrolled in such programmes and a 25% increase in the frequency of such programmes.

Q1. Do you agree with the proposed focus on enabling people with long term conditions with the skills to manage their conditions?

Strongly agree Agree Neither Disagree Strongly disagree

Better management, including prevention of long term illnesses, is an important part of improving health and wellbeing and reducing inequalities. Implementation of Making Life Better, Quality 2020, the Long Term Conditions Policy Framework and Transforming Your Care should lead to a healthier and more independent population. The Long Term Conditions Policy Implementation Group is ideally placed to oversee the work to improve management of long term conditions and the Long Term Conditions Alliance have several representatives on that Group.

The Implementation Group is developing a proposal which would largely meet the requirements of Recommendation 4. However, the Long Term Conditions Alliance includes organisations that provide programmes to improve people's skills in self-management of their long term condition, and it would not be appropriate therefore to specify that the Alliance would 'overseer' those programmes.

Metrics to ensure the quality, outcomes and experience of programme participants are part of the investment proposal for self-management programmes. Those metrics will also be aligned to key performance indicators in Service Frameworks, particularly those for Respiratory, Cardiovascular disease and Cancer.

Recommendation 5

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.

The Report states that 'The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced

inspections of acute hospitals from 2015, but these plans are relatively limited in extent.'

In response to this recommendation the Minister announced, on 27th January, that he was seeking to speed up the roll out of unannounced inspections in acute hospitals, and that the 2003 Quality, Improvement and Regulation Order would be reviewed with a view to introducing a stronger system of regulation of acute health care providers. That announcement also advised that proposals would be submitted to the Executive for changes to the existing system of regulation of non-acute services.

More information on the role of RQIA and regulation can be found at www.rqia.org.uk

He also announced that a review of the operation of whistleblowing in health and social care bodies would be undertaken with recommendations on how to improve its effectiveness.

Q1. Do you agree that the regulatory role of RQIA should be expanded to focus more upon the services delivered by acute hospitals in Northern Ireland?

Strongly agree | Agree | Neither | Disagree | Strongly disagree

The PHA supports the recommendations in the Donaldson Report regarding a more fully developed regulatory function in health care and routine unannounced inspections. We believe that these will add to our collective understanding of good practice in the HSC system and areas for improvement.

Q2. Do you agree that the functions of RQIA should be tested against the option of outsourcing this function?

Strongly agree | Agree | Neither | Disagree | Strongly disagree

In relation to the recommendation to test the outsourcing of RQIA functions, our view is that NI needs an effective regulator with a strong local presence, good local knowledge, and ability to secure credible external independent experts when required. In our experience, RQIA provides that function effectively. We would be concerned that an outsourced provider would not have the local contacts, understanding or buy-in that RQIA brings.

Q3. Do you agree that the current policy on whistleblowing needs to be examined? If yes, are there any comments you wish to make on how the review is conducted or its scope?

Strongly agree | Agree | Neither | Disagree | Strongly disagree

The policy on whistleblowing should be reviewed across the HSC as a whole and we welcome the Minister's statement to review current arrangements. Staff, and anyone else who is concerned about the quality or safety of HSC services, should be enabled to raise their concerns freely through the appropriate governance mechanisms, and should understand clearly how those concerns have been handled.

Recommendation 6

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:
• deaths of children from natural causes should not be classified as Serious Adverse Incidents;
• there should be consultation with those working in the mental health field to make sensible changes to the rules and timescales for investigating incidents involving the care of mental health patients;
• a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);
• a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;
• a limited list of Never Events should be created
• a portal for patients to make incident reports should be created and publicised
• other proposed modifications and developments should be considered in the context of Recommendation 7.

The Report states that 'The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.'

The Minister has announced that he will be instructing the HSCB and PHA to prioritise changes to the Serious Adverse Incident (SAI) system. He has also announced that a Never Events list will be developed for Northern Ireland and that he is beginning the process for creating a statutory duty of candour Northern Ireland.

An Adverse Incident is defined as 'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.' Particular criteria will then be used to determine whether an adverse incident constitutes a Serious Adverse Incident (SAI). More information on the background and procedure for the management of SAIs can be found at:
http://www.dhsspsni.gov.uk/saibackground

Never Events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. For more information about the system of Never Events in England, please see:
http://www.england.nhs.uk/ourwork/patientsafety/never-events/

Q1. Do you agree with the proposed changes to the Serious Adverse System (SAI) in Northern Ireland?

Strongly agree Agree Neither Disagree Strongly disagree

We welcome the opportunity to revise the Serious Adverse Incident process. Our own engagement with HSC organisations identified a desire in all organisations to reduce the processing aspects, improve the quality of incident investigations, and distil pertinent learning, particularly system-design learning.

The Safety Forum in the PHA has already started work to improve the quality of incident investigation reports and distillation of system learning. They are commissioning training for staff who conduct incident investigations with a view to bringing a clearer focus on identifying system issues and human factor-contributors more accurately.

In addition, PHA is working with the HSCB governance office and Trust governance leads to improve the feedback at Trust level to staff who report incidents so that they are informed by the Trust of action being taken as a result of the incident they reported.

We agree that some child deaths should not be classified as serious adverse incidents and have developed draft proposals to change the reporting of child deaths. We are working with DHSSPS to introduce the new arrangements as an interim measure pending any longer term changes to the serious adverse incident process.

In relation to mental health-related incidents, the timescales in the current process were set through engagement with practitioners in mental health and with RQIA. We would welcome further change to the handling of such incidents and would wish to see those introduced by summer 2015 as an interim immediate measure pending any longer term changes.

In relation to patient-reported incidents, we see value in such an approach if resources are made available to investigate and respond to such incidents, and if safeguards are in place for staff involved. Based on our experience with the serious adverse incident system, very substantial clinical, social care and analytic capacity would be needed in Trusts, HSCB and PHA to support such a system. Given the current capacity challenges in managing serious adverse incidents, and the plans to develop learning from adverse incidents, we would see patient-reported incidents as a further phase of work rather than a priority in the current context.

Q2. Do you agree with the creation of a list of Never Events for Northern Ireland? If so, what do you consider as Never Events?

Strongly agree Agree Neither Disagree Strongly disagree

We would give qualified support the introduction of a *Never Event List*, but would have some concerns that it will become a black and white yardstick against which the performance of individuals is measured. In our view, this would not be helpful as it may create a 'blame and shame' culture which in turn would reduce openness and be counterproductive to a learning culture.

Q3. Do you agree with the introduction of a Duty of Candour in Northern Ireland?

Strongly agree Agree Neither Disagree Strongly disagree

While we would acknowledge the spirit and intention behind a statutory duty of candour, we believe that the duty in itself will not bring a more open culture and may in fact have a negative effect on openness, particularly given the media and political scrutiny of the HSC highlighted in the Donaldson Report. Doctors and other professions are already required to report concerns about the safety of services or patient care. To be of benefit, a duty of candour would therefore need to add to what is already in place. The benefits and risks should be considered very carefully to ensure absolute clarity on what is required, in what circumstances, and of whom. This is not a straightforward task given the complexities of clinical and social care and the subtle judgments that have to be made at many points in any given situation. Health and social care is not black and white.

Recommendation 7

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:
• carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;
• improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;
• instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;
• facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;
• bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;
• developing valid metrics to monitor progress and compare performance in patient safety;
• analysing adverse incidents on a sampling basis to enhance learning from less severe events;

• giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;
• fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;
• creating a cadre of leaders in patient safety across the whole health and social care system;
• initiating a major programme to build safety resilience into the health and social care system.

The Report states that 'There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. We believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities (including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.'

Q1. Do you agree that a National Institute for Patient Safety should be introduced in Northern Ireland?

Strongly agree Agree Neither Disagree Strongly disagree

In relation to the recommendation to establish a Northern Ireland Institute for Patient Safety, we think this recommendation is at odds with messages elsewhere in the Donaldson report about the need to streamline processes, reduce complexity, and clarify leadership. We also think it is at odds with the overall financial context, and the desire to reduce administrative spend. Therefore, rather than creating a new separate organisation, we believe it would be more efficient and effective to invest the resources required to create the Institute, in the existing infrastructure in the HSC Safety Forum. The Safety Forum has now a well-established programme of collaborative quality improvement work led and owned by clinical and social care staff from the frontline. It has initiated work in new areas including paediatrics, primary care and mental health. It also supports bespoke work on implementation of RQIA reports, e.g. on Hospital at Night, and has also taken on work to address some of the limitations of the current serious adverse incident process, e.g. training for staff in systems analysis to improve the quality of incident investigation reports.

Additional investment in the Safety Forum would enable it to take on the functions outlined in the Donaldson Report, while avoiding the overheads associated with a separate organisation.

The PHA agrees with the Donaldson Report comment that *"There is a big space for a*

creative, positive and enhancing role". Through our engagement with clinical and social care staff, service managers, service users and commissioners, we believe that the HSC has the talent to create a clear and coherent operational model for future health and social care services in Northern Ireland, and has the skills and experience to implement that vision. The essential ingredients are effective leadership and authority.

We understand how the organisational structure between the PHA and HSCB would *"seem very odd to the outsider".* However, we also see the tangible benefit of the structure for public health as the PHA has worked successfully with a range of partners in the HSC and beyond, to achieve many notable successes. A number of important public health indicators have improved since 2009. The profile of public health has increased since the PHA was established in 2009. The PHA is the visible 'go to' organisation for public health and there is therefore clear leadership for the public health agenda – the 'who's in charge' question. We would accept that that is less clear for other HSC functions.

The effectiveness of the PHA reflects the skills of the staff and the very lean organisational structure. Functions are led and managed by public health doctors, nurses, allied health professionals, and specialists in health intelligence, communications and governance. This has enabled us to set a clear direction, maintain our focus on that direction, and support staff to implement change through lean decision-making.

We believe it would be helpful to replicate these success factors in any future administrative and commissioning arrangements. In particular, we would wish to see the clear leadership for public health retained and the lean organisational PHA approach replicated in any future arrangements.

Q2. Do you agree with the suggested functions which should be included? Do you feel there are additional functions relevant to the proposed institute?

Strongly agree Agree Neither Disagree Strongly disagree

See answer to Question 1.

Recommendation 8

We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.

The Report states that 'The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.'

Q1. Do you agree that systems metrics should be introduced so that regular benchmarking can take place from regional level down to individual service level?

Strongly agree Agree Neither Disagree Strongly disagree

Significant progress has already been achieved in establishing a small number of system metrics from regional to local level for health and social care. Specifically, the Annual Quality Reports contain metrics that are reported by Arms Length Bodies that provide or commission health and social care; those reports also include metrics specific to the work of the organisation. A Task Group under Q2020 has developed those metrics and is continuing the work to identify metrics in areas such as community and social care, research and population health. The aim is to describe the system as a whole through a set of balanced metrics.

There is, however, a need to also streamline the number of metrics across the system for which data is being collected, analysed and reported. Multiple initiatives and requirements place a significant workload on staff across the HSC and these generate an opportunity cost that deflects from core business of the patient and client care. In addition, metrics should be developed using valid methods by people with expertise in the topic area and in the science of defining metrics. As far as possible, metrics should be collected and reported using existing information systems, or through systems that facilitate data collection and reporting electronically. The proposed roll out of a single IT system under Quality 2020 would meet this goal.

The measures used in validated programmes in North America should be considered against existing metrics in NI and through UK national audits or equivalent programmes e.g. Confidential Inquiries.

Q2. Do you agree with the establishment of a Clinical Leadership Academy in Northern Ireland?

Strongly agree | Agree | Neither | Disagree | Strongly disagree

In relation to the recommendation regarding a clinical leadership academy, we would support that recommendation in principle. The HSC needs to develop and also support clinical leadership roles and social care leadership roles. However, the benefits of clinical and social care leaders will only be realised if they are then enabled to lead within their organisations. The leadership academy must therefore be within the context of a new management model based on closer working between care professionals and managers. The best health and social care systems have an ethos of clinical and social care leadership with managers working alongside to effect changes that make sense to patients, clients, carers and the public.

Recommendation 9

We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.

The report states that 'The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the longstanding quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.'

Q1. Do you agree that Northern Ireland should seek to put itself in a position where it has the best technology and innovation from all corners of the world and is recognised as the best in Europe? Should this include the development of a technology hub to identify the best technological innovations?

Strongly agree | Agree | Neither | Disagree | Strongly disagree

The HSC is already at the forefront of using technology to enable better care for patients and clients. The Northern Ireland Electronic Care Record has won two national awards and we should seek to build on this success. As a system, we are in the process of finalising an e-health strategy and there is a very extensive work programme already in place under the e-health governance structures. We believe that those structures and that work programme and strategy should be the vehicle for deciding priorities and implementing those quickly.

We have some concerns that an information and digital technology hub in Northern Ireland would follow a model of 'technology looking for a problem'. We would recommend instead, an approach that starts with a problem faced by HSC staff, and then finds solutions, some of which may be technology-based. The NI Electronic Care Record took that approach and has been clinically-led and clinically-informed. It therefore provides a solution to real-world problems and helps staff to do their jobs more effectively and productively – right treatment first time and every time. It has therefore been adopted rapidly by staff as they see the benefit to their work. We would recommend that approach rather than a specific technology hub.

Current technology-based work that is already underway through the e-health strategy includes care pathways, discharge summaries, medicines reconciliation, e-referral triage, support to clinical multidisciplinary team meetings in cardiology, roll-out of a system to enable frontline staff to collate and report quality indicators electronically, assessment of a clinical noting system, and introduction of electronic prescribing in secondary care. These developments will reduce the risk of errors, improve communication and information sharing, and thereby improve safety, flow, quality and productivity.

PHA would support implementation of the e-health strategy and existing work programme based on a problem-orientated, clinician/practitioner-led approach. We would have concerns that a technology hub would put the technology before the service problem and would therefore be less effective.

Recommendation 10

We recommend a number of measures to strengthen the patient voice:
• more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;
• the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;
• the Patients and Client Council should have a revised constitution making it more independent;
• the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;
• one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).

The Report states that 'In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.'

The Minister has announced that a framework to strengthen the voice of patients at every level will be designed applying the best available worldwide evidence on measuring patient/client experience.

Q1. If you are unhappy with the response of a care provider regarding your care, do you agree that the substance of it should be looked at by people who are genuinely independent?

Strongly agree Agree Neither Disagree Strongly disagree

The PHA believes that independence is currently available through HSC Trusts using the independent assessor's panel hosted by the HSCB. This resource has been available since 2012 and can provide straightforward access to an independent element into an investigation or review and enable the ombudsman to be the third stage in this process.

The PHA wishes to highlight the potential benefit of a patient/client advocate role (PALs) as is developed in England. These posts provide support to patient, clients and their families and cares working to intervene early to prevent complaints in the first place and also allow valuable insight to be collected from those patients/clients who wish to draw something to the attention of organisation, but not actually log a complaint. An initiative such as this would require investment.

Q2. Do you agree with the proposed changes to the Patient and Client Council?

Strongly agree Agree Neither Disagree Strongly disagree

The PHA has worked collaboratively with the PCC on a number of initiatives and will continue to do so. The PHA endorse the recommendations to further strengthen the voice of the patient and client within its structures and strengthen its independence.

Q3. Do you agree that the organisations representing patients and clients with chronic diseases should be given a more powerful and formal role within the commissioning process? If so, do you have any comments on how this could be best achieved?

Strongly agree Agree Neither Disagree Strongly disagree

Service user and carer involvement is already embedded in commissioning and there are already excellent examples of engaging organisations representing patients and clients with long term conditions such as the Long Term Conditions Alliance, the Neurological Long Term Conditions Network, and through the implementation of service frameworks.

The 10,000 voices campaign, now supported by recurrent funding to HSC Trusts, is designed to go directly to patients and clients to shape and improve the input to and outcome of the commissioning process. This work is currently being linked with the Patient/Client Experience initiative to strengthen the feedback to commissioners.

Q4. Do you agree that patient experience surveys should be used to rate hospitals and allocate resources accordingly?

Strongly agree Agree Neither Disagree Strongly disagree

A regional steering group has been established chaired by the Director of Nursing & Allied Health Professions (PHA) and Director of Finance (HSCB)

The PHA in partnership with the HSCB and HSC Trust have developed a system to collect patients client experience standards, collocate and share results and work in partnership with Trusts to take forward action plans. This system has been developed through engagement with a wide range of stakeholders over a number of years and is based on the best research evidence available. This system embraces health, social care, hospital, community and other care settings.

Data is collected from a standard questionnaire completed by patients/clients or their carers, observations of practice and patient stories. This triangulated approach strengthens the quality of the evidence collected. There are items covering the domains specified in the Departmental standards for Patient/Client Experience. Bi-annual reports are shared publicly.

The work plan of the Steering Group includes improved coordination between the 10,000 Voices work and the Patient Clients experience feedback system. This is being taken forward to try to prevent duplication of effort and minimise unnecessary bureaucracy to frontline staff.

The validated surveys used by the Centres for Medicare & Medicaid Services are administered by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The tool has 27 items with 18 substantive items covering areas such as nursing communication, cleanliness of hospitals, communications about medicines and pain management.

While this process has been developed in partnership with service and based on evidence and research it provides an assessment of patient hospital experience only and therefore in its current format would have limited value in the wider Health and Social Care system. The process also has a number of criteria which exclude some patients. The tool also does not include an ability gauge the views of carers when the patient/client does not have the ability to participate, this includes any patient under 18 years or any patient with a mental health condition.

There are some areas where we believe the HSC should consider reflecting on the HCAHPS work including a question related to overall rating and willingness to recommend a hospital.

The scores are primarily designed for use at the hospital level. While HCAHPS does publicly report hospital comparisons they acknowledge that adjustments need to be made for factors beyond a hospitals control. The Centres for Medicare & Medicaid Services (CMS) does not endorse the use of HSCAHPS scores for comparisons within hospitals.

General Comments

Please use the box below to insert any general comments you would like to make in relation to the recommendation from the Donaldson Report.

The Public Health Agency (PHA) welcomes the publication of the report of the Donaldson Review and recognises the opportunity that exists for Northern Ireland's Health and Social Care (HSC) system to challenge traditional models of care and take radical steps to improve the way services are commissioned and delivered. The Review identified examples of innovation and progress, as well as structures that are out of harmony with the needs of service users, staff and the system. The PHA would wish to see the momentum generated by The Donaldson Review used to achieve world-class, user-centred, data-driven Health and Social Care. We have highlighted strengths in HSC that can be built upon and also areas where change would be welcome.

Part B
Equality Implications

Section 75 of the Northern Ireland Act 1998 requires the Department to “have due regard” to the need to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without. The Department is also required to “have regard” to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

The Department has also embarked on an equality screening exercise to determine if any of these recommendations are likely to have a differential impact on equality of opportunity for any of the Section 75 groups. We invite you to consider the recommendations from a section 75 perspective by considering and answering the questions below. Answering these questions will contribute to the completion of the Department's Screening template and the screening outcome.

Q1. Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

Yes ☐ No ☑

Comments:

Q2. Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Yes ☐ No ☑

Comments:

Q3. Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.

Yes ☐ No ☑

Comments:

Q4. Are there any aspects of these recommendations where potential human rights violations may occur?

Yes ☐ No ☑

Comments:

Please return your response questionnaire.
Responses must be received no later than 22 May 2015
Thank you for your comments.

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided

- the Department should not agree to hold information received from third parties "in confidence" which is not confidential in nature

- acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: **http://www.informationcommissioner.gov.uk/**).

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February 2015

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	Director of Public Health Annual Report 2014
Agenda Item	14
Reference	PHA/08/05/15

Summary

The Board are asked to note a DRAFT copy of the 2014 DPH Annual Report. The Report will be launched at the Public Health Annual Scientific Conference on Wednesday 10 June 2015.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This draft was considered by AMT at its meeting on 12 May 2015.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Public Health
Date	28 April 2015

Director of Public Health Annual Report 2014

Public Health Agency

Breastfeeding
Tackling inequalities
Healthwise
Faresharе
Obesity
Hepatitis
Breast screening
Diabetes
Community networks
Mental health
Pregnancy
Social networks
Brain manual
CAESAREAN
SECTION
Each Step
Counts
SSI surveillance
Tuberculosis
LAMP test
Ebola
HPV
Healthy Hearts in the West
Glaucoma
Weight loss
Radiotherapy
Advice 4 health
Cook it!
Heart attacks
Be cancer
aware
Quality
and safety

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Foreword

Dr Carolyn Harper

"One of the signs of passing youth is the birth of a sense of fellowship with other human beings as we take our place among them"

Virginia Woolf

Welcome to the *Director of Public Health Annual Report 2014*. The theme of this year's report is 'Making Life Better – Improving Health and Care for Adults'. *Making Life Better* is the new 10 year strategic framework for public health in Northern Ireland, designed to improve health and wellbeing and reduce inequalities. The framework contains six themes, reflected throughout the articles in this report, but particularly the themes 'Equipped throughout life – ready for adult life' and 'Empowering healthy living'.

Why adults?

Adults make up over half of the Northern Ireland population. They fulfil many roles and have very different experiences. Achieving optimal health and wellbeing relies on multiple factors: housing, nutrition, safety, physical activity, opportunity for education and work, meaningful relationships, community involvement, and many other diverse elements related to individuals' needs.

Access or lack of access to these opportunities can have significant positive and negative effects on health and wellbeing. Adults are the backbone of the population, providing economic activity and caring roles for the young and older members of society, sometimes all at once. Their health and wellbeing is therefore paramount. Healthy adults will be healthier older people. At a time when life expectancy is increasing and our population is ageing, it is essential that people are supported to enjoy as many of their increased years as possible in good health.

Meeting the challenges

Society, health and healthcare have developed enormously in recent decades. However, the health and wellbeing enjoyed by some is not enjoyed by all, or even a majority of the population. Inequalities are a key challenge for our society and there is evidence that the bigger the gap between the most and least deprived, the worse the health of the population as a whole. Inequalities are therefore everyone's concern.

Adults from all backgrounds should be empowered to make positive choices for themselves and their families that will have positive impacts on their health for years ahead. The Public Health Agency (PHA) works with partner organisations and the public to raise awareness of health problems and healthy behaviours, support interventions and services that enable people to make these choices, and change behaviour and teach new skills.

Prevention is a key goal in public health, helping adults manage their own health and avoid the need for hospital and other health services. For those who do face health problems, the PHA works alongside other organisations to develop high quality services that meet patients' expectations and needs. Screening services aim to detect disease early to improve outcomes, and the PHA has a lead role in ensuring these programmes are of high quality. Threats to health such as emerging infections must also be managed and the Health Protection service reviews such threats, communicates with the public and takes action when necessary.

My report outlines some of the key programmes and services working to ensure the adult population of Northern Ireland is as healthy as possible. I hope you enjoy reading it.

Dr Carolyn Harper
Director of Public Health

Further information

Dr Carolyn Harper
Director of Public Health
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Introduction

Report structure

This is the sixth *Director of Public Health Annual Report*, detailing the main public health challenges in Northern Ireland. It also provides information on the wide variety of work undertaken by the PHA and its partners during 2014 to improve the health and social wellbeing of the population. Each year, the report focuses on an overarching area, which this year is 'Adults aged 18–64 years'.

The report structure reflects the main areas of public health action:

- improving health and reducing inequalities;
- improving health through early detection;
- improving health through high quality services;
- improving health through research;
- protecting health.

For ease of reference, the sections are colour coded.

On page 94, the report also lists core tables for 2013 relating to key statistical data on, among others, population, birth and death rates, mortality by cause, life expectancy, immunisation and screening. In addition to the core tables, a specific set of tables relating to various aspects of adults aged 18–64 years are published alongside this report.

Both sets of tables are available as a portable document format (PDF) file on the PHA website at: www.publichealth.hscni.net

Background

The PHA was established to:

- protect public health and improve the health and social wellbeing of people in Northern Ireland;
- reduce inequalities in health and social wellbeing through targeted, effective action;
- build strong partnerships with key stakeholders to achieve tangible improvements in health and social wellbeing.

The PHA takes direct public health action and commissions or facilitates action by others, including a wide range of community, voluntary and statutory partners across all sectors.

Overview

Being a healthy and happy adult in Northern Ireland

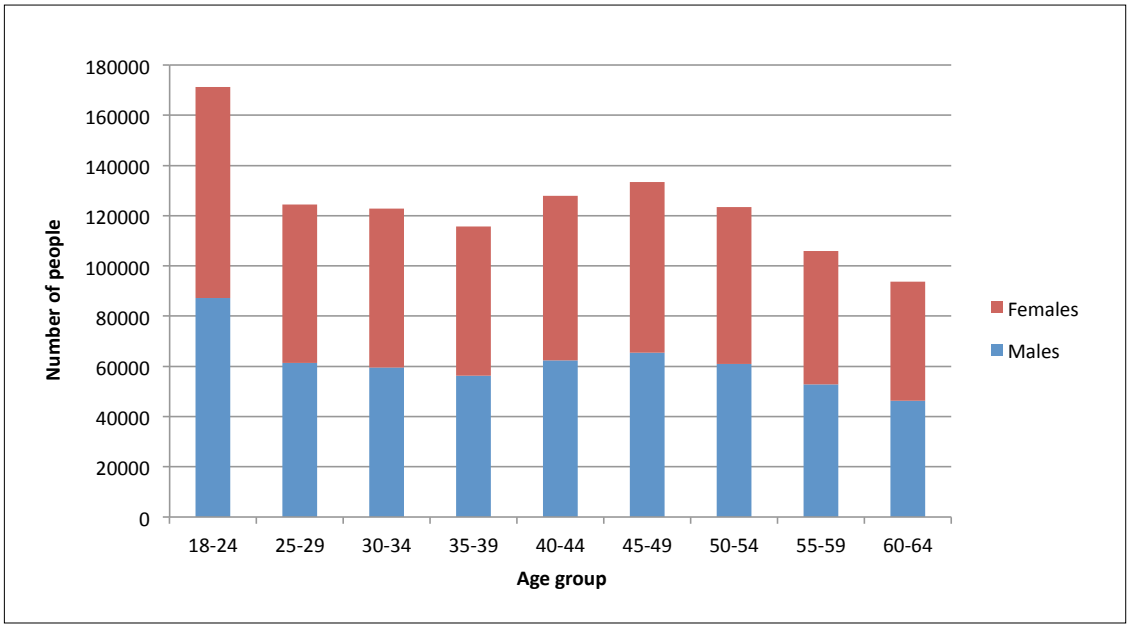
Adulthood takes up the largest portion of the human lifespan, ranging from young adults gaining independence to adults approaching retirement and old age. Given this scope and the differences between individuals, it follows that there are many diverse experiences of adulthood. Although every journey is different, all should have the opportunity for positive and healthy experiences, building on the foundations of a solid childhood and adolescent experience. As we know, however, opportunity and health are not evenly spread across our population.

At a time of cultural and economic uncertainty, amid increased recognition of the importance of early years for children and the opportunities and challenges of the increasing population of older people, adults risk being somewhat overlooked. Projections into 2020 predict the Northern Ireland population will reach 1.9 million, with a growing number of children and older people, but a largely static number of adults aged 16–64 years.[1] Adults are a vital asset to the population and this section of the report describes some important aspects of adult life in Northern Ireland.

The adult population of Northern Ireland

Adults aged between 18–64 years constitute approximately 61% of the 1.83 million people in Northern Ireland, with slightly more females than males (50.6% and 49.4%).[2]

Figure 1: Adult population in Northern Ireland aged 18–64 years

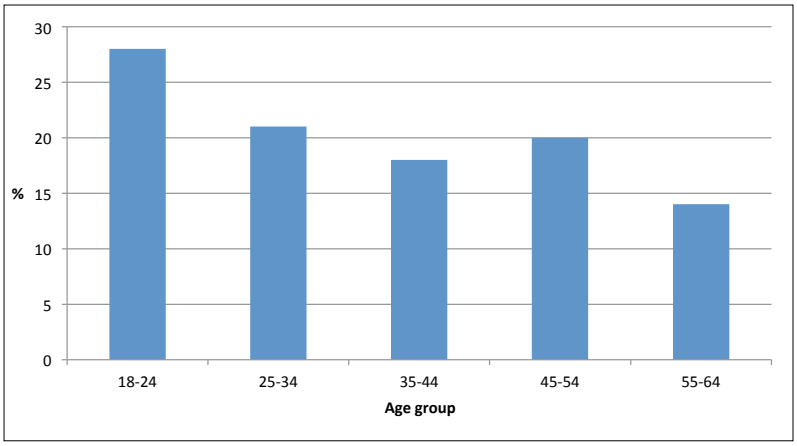


Source: Northern Ireland Statistics and Research Agency (NISRA)[2]

Census data show that 98.4% of adults aged 16–74 years usually resident in Northern Ireland are of white ethnicity. The main ethnic minority groups are Asian (1.1%), black (0.2%) and mixed (0.2%).[3] Usual residents from these ethnic groups have a younger age profile than those of white ethnicity.[4]

Like the rest of the UK, the proportion of the adult population in Northern Ireland of no religion is growing. In 2013, 17% of respondents reported being of no religion, double that of a decade before when only 8% of respondents declared they were of no religion.[5]

Figure 2: Proportion of adults in Northern Ireland of no religion, by age, 2013



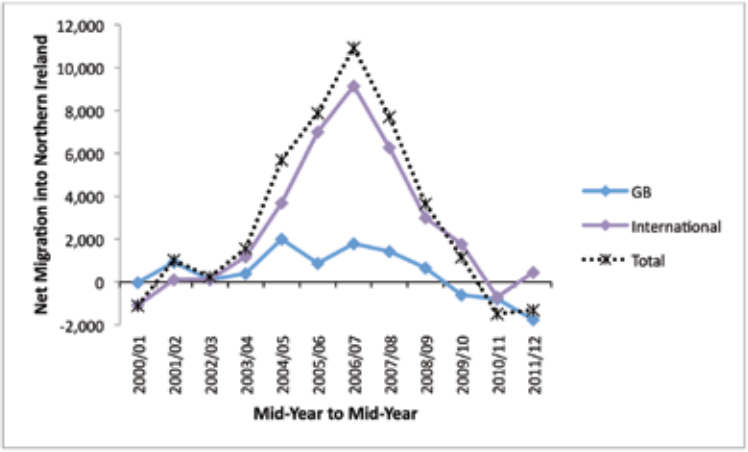
Source: Northern Ireland Life & Times

Life events of adults in Northern Ireland

Northern Ireland has experienced increased migration since 2004 due to the European Union expansion, reaching a peak in 2007. Since 2007, net migration has been decreasing and since 2010, there has been a net outflow from the region. However, the overall Northern Ireland population has continued to grow due to more births than deaths.

Although measuring emigration can be challenging, data show that adults aged 16–64 years are more likely to emigrate than younger or older age groups.[6] The reasons for emigration are not clear, but given that adults are more likely to emigrate than other age groups, it may involve looking for job opportunities elsewhere.

Figure 3: Estimated net migration into Northern Ireland (July 2000–June 2012)



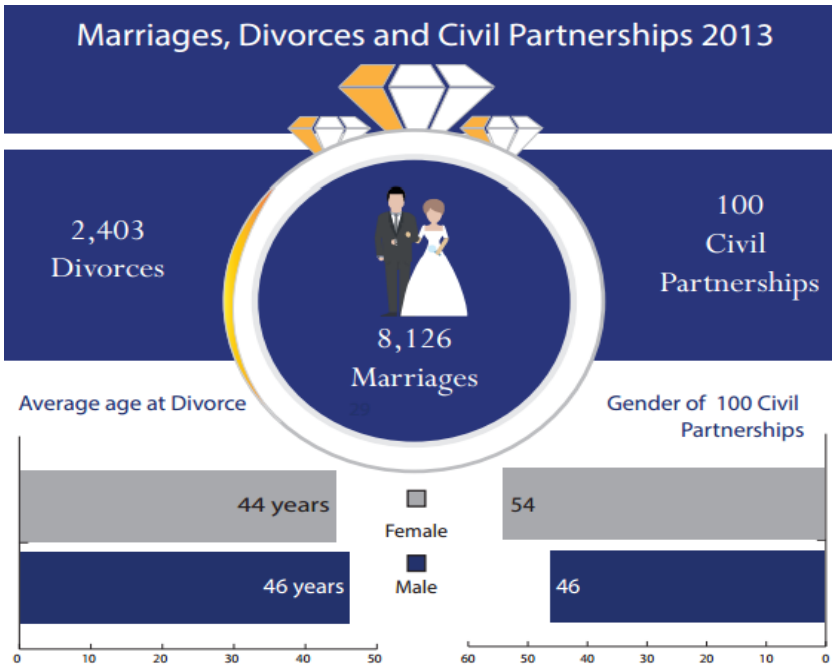
Source: NISRA[6]

Getting married is less common than it used to be. However, over the last 10 years marriages have increased in number by 5% to 8,126 in 2013. People now tend to get married older than previously – brides and grooms were on average aged 31 and 34 years respectively in 2013, approximately five years older than was the case two decades ago.[7] The number of civil partnerships has stayed largely static since 2005 and in 2013 there were 100 civil partnerships formed. The average age of both male and female partners was 35–36 years. The divorce rate remains largely unchanged over the last 20

years at 1.7 per 1,000 of the population over 16 years of age, which equates to approximately 1,900 divorces among adults aged 18–64 years. Over the past 10 years, there has been an increasing proportion of those getting married for whom it is not their first marriage.[8]

In the 2011 Census, 53% of the population (over the age of 16 years) were living in a couple, compared with 10 years earlier when 56% of people were living in a couple. Although people were less likely overall to be living in a couple in 2011, they were more likely to be cohabiting (increase from 4% in 2001 to 6% in 2011) and less likely to be married (decrease from 51% in 2001 to 47% in 2011).[9,10]

Figure 4: Marriages, divorces and civil partnerships, 2013



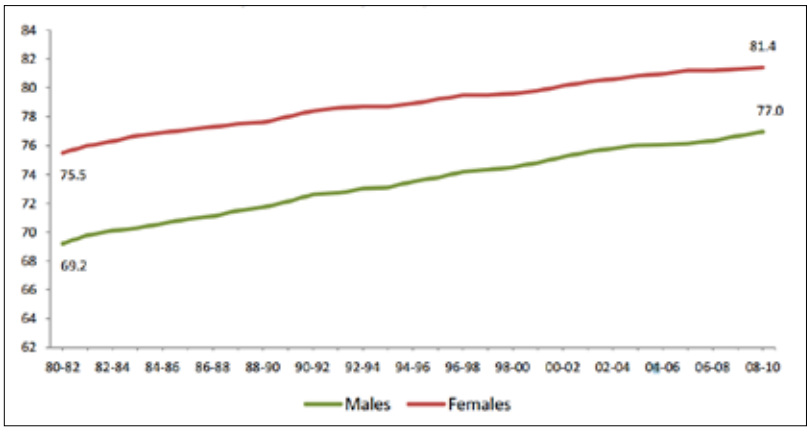
Source: NISRA[11]

Although births have been gradually declining since the 1960s, during the past decade in Northern Ireland, birth numbers initially increased to a peak in 2008, after which they have remained broadly stable at around 25,000 per year. Women are having their first baby at an older age. In 2013, the average age of first time mothers was 28 years, compared with 24.5 years in 1983. Also in 2013, more than half of all babies were born to mothers aged 30 years or over. The majority of births in 2013 (90%) were to mothers themselves born in the UK or Ireland, although this is a decrease from 96% 10 years ago. This is partly driven by women coming to live in Northern Ireland from the A8 countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia).[12]

Societal change is evident in the patterns of births in the region. Thirty years ago, 1 in 10 births were to unmarried parents. In 2013, 43% of births occurred outside marriage. This varies across Northern Ireland and by age of mother. Cohabiting parents have increased threefold in the last 20 years. Increasing numbers of multiple births are due to the growing proportion of older mothers as well as increased use of fertility treatment.[12]

Life expectancy has been increasing steadily in Northern Ireland over the last three decades as shown in Figure 5. Today in Northern Ireland, a young adult aged 18 years can expect to live another 61 to 65 years, for males and females respectively.[13]

Figure 5: Life expectancy in Northern Ireland



Source: DHSSPS[14]

Although this is good news, further analysis shows that this increase in life expectancy has been driven mainly by falling mortality in those over 60 years of age (primarily due to improvements in mortality rates for coronary heart disease and stroke) while young adult males aged 15–44 years and females aged under 30 years actually experienced a reduction in life expectancy of 0.1 years between 2001–03 and 2008–10. The difference in life expectancy between men and women in 2008–10 was 4.4 years. The gap in life expectancy between the least and most deprived 20% of the population is substantial – 7.6 years for men and 4.5 years for women.[14]

Healthy life expectancy is the number of years we can expect to live in good health. The Northern Ireland average is 59 years for men and 62 years for women. However, the gap in healthy life expectancy between the most and least deprived in the population is greater than 10 years.[15]

Figure 6: Breakdown of the gap between the most and least deprived males, by cause of death, 2008–10[14]

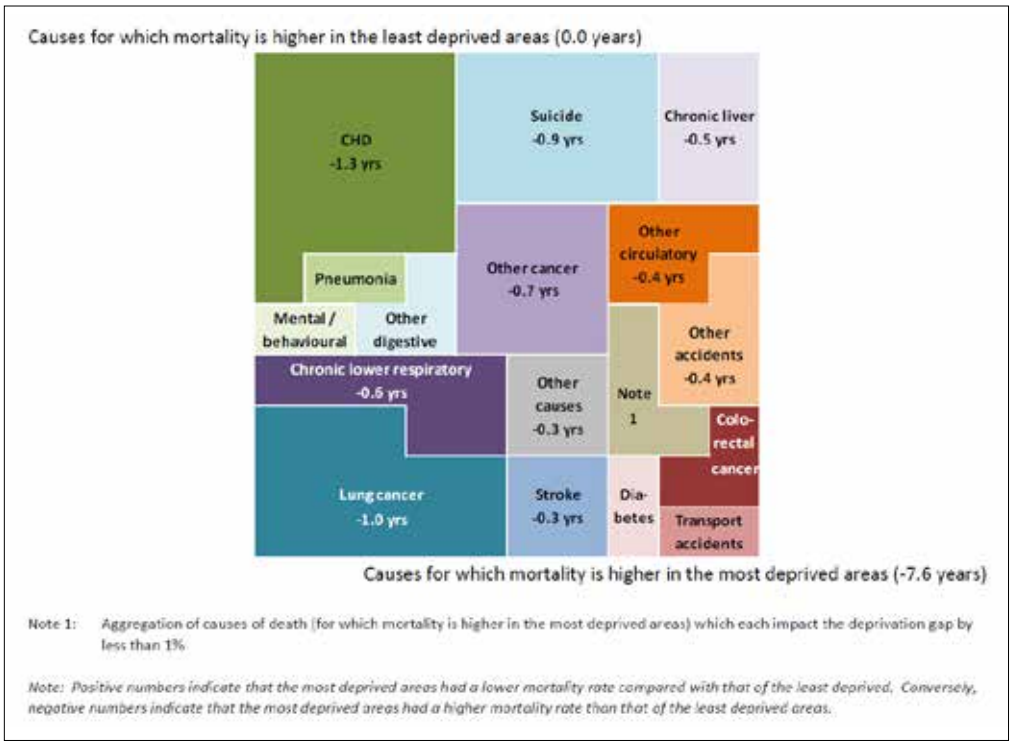
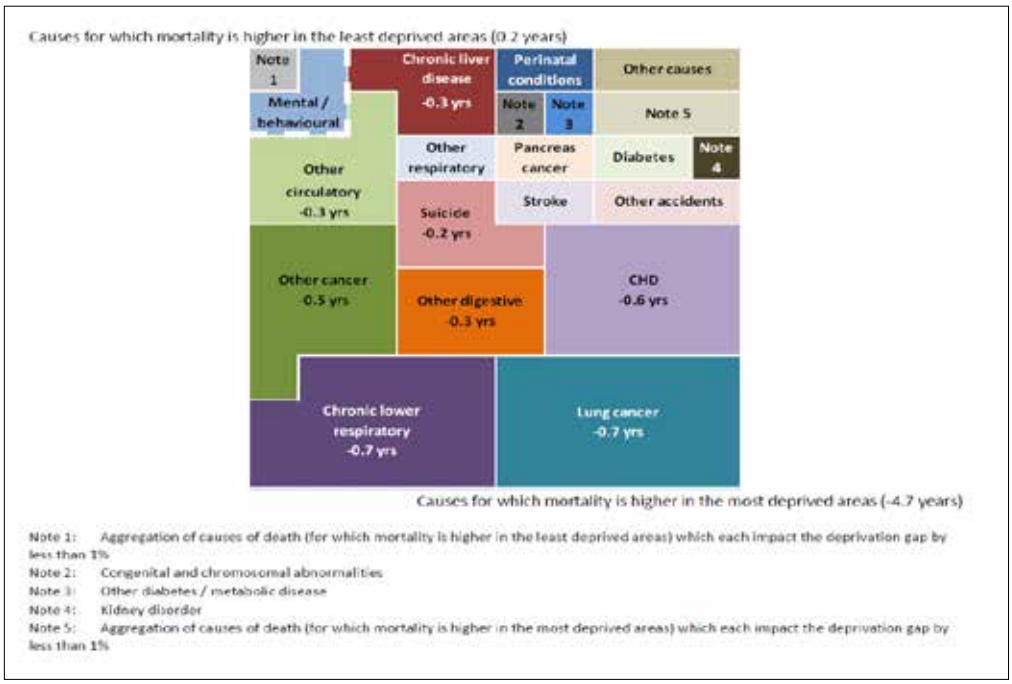
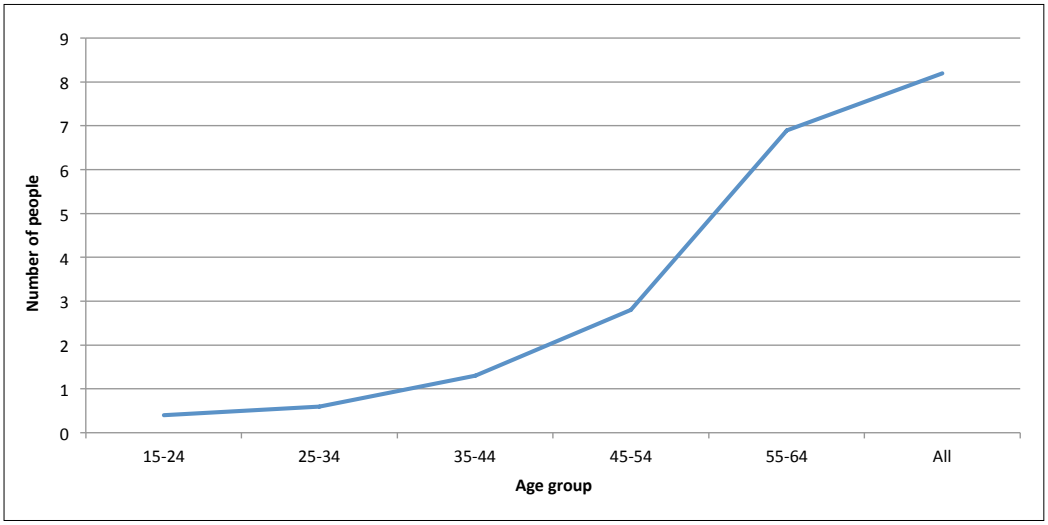


Figure 7: Breakdown of the gap between the most and least deprived females, by cause of death, 2008–10[14]



In 2013, deaths among adults aged 18–64 years accounted for around 18% (2,639) of the total deaths in Northern Ireland.[16] Nearly 90% of these deaths occurred in the older half of the adult population – those aged between 40–64 years. As expected, death rates increase as adults age, as shown in Figure 8. Potential years of life lost (PYLL) is an indicator of premature mortality, measured as the number of years of life 'lost' when a person dies before the age of 75 (including those aged one year and above). Deaths to adults aged 18–64 years accounted for 78% of the 77,692 PYLL in 2013.[16]

Figure 8: Death rates per 1,000 people, by age group



Source: NISRA[17]

Causes of death in adults aged 20–64 years are largely similar to those for the population overall, but there are some important differences. Cancer, respiratory disease and cardiovascular disease are the main causes of death for the whole population and constitute over two thirds (69%) of all deaths. In adults aged 20–64 years, they account for a smaller proportion (62%) of all deaths, and deaths from disease of the digestive system is the third most common cause rather than respiratory disease.

Deaths due to external causes such as accidents constitute 5% of deaths in the whole population, but among adults this proportion is higher at 7%. The proportion of deaths by suicide among adults is five times higher than that for the whole population – 10% for adults and 2% overall.[18]

Life satisfaction of adults in Northern Ireland

The Northern Ireland Life & Times survey asked a sample of adults in Northern Ireland some questions about their level of happiness. In 2013, 33% of respondents reported being very happy and a further 60% were fairly happy. Those who were most happy (highest proportion of very happy or fairly happy) were 45–64 year olds and the least happy were 18–24 year olds. A higher proportion of women than men reported being either very happy or fairly happy.

Reported happiness in most age groups declined slightly between 2007–2010, after which it generally increased again. This increase has been highest among older adults aged 35–64 years, with younger adults' reported happiness staying more static.[19]

Lifestyle choices of adults in Northern Ireland

Lifestyle choices can play a significant role in maintaining physical and mental health. Approximately one fifth of the population (22%) still smoke, a 4% reduction over the last 10 years. Differences in rates of smoking contribute significantly to the differences in health seen between the most and least deprived groups in the population. This is reflected in smoking-related diseases – for example, the lung cancer rate among the most deprived individuals is more than double that seen among the least deprived.[15]

The difference in smoking rates by deprivation is considerable – 22% higher in the most deprived sections of the population than the least deprived. In addition, people who are more deprived are less likely to have tried to quit smoking. A higher proportion of men than women smoke, but smoking among both sexes has fallen.

Smoking is highest among adults aged 35–44 years at 27%.[20] In 2013/14, 15.2% of expectant mothers smoked during their pregnancy (down from 16.3% the previous year), with the rate much higher in the most deprived areas (27%).[21] A substantial proportion (33%) of recently quit smokers or those who were current smokers had used e-cigarettes.[20]

Becoming an adult brings additional legal rights and responsibilities such as the ability to purchase alcohol. Alcohol misuse has significant negative impacts, not only on health, but also on social status and functioning. There are more than 200 alcohol-related deaths each year in Northern Ireland, with the highest number among 45–54 year olds.[22] The most deprived in the region are more than five times as likely as the least deprived to have an alcohol-related admission.[15] Three quarters of adults report drinking alcohol, but encouragingly, the proportion drinking above sensible weekly limits has fallen from 19% in 2011/12 to 16% in 2013/14. The age group most likely to drink above sensible weekly limits are 18–24 year olds.

Prevalence of drinking alcohol also varies with deprivation. Those in the least deprived areas are more likely to report drinking alcohol than those in the most deprived areas.[20] Exceeding the recommended daily limits is more common among males, but decreases with age among both sexes. Binge drinking is more common among young adults aged 18–29 years than older adults aged 60–75 years. Drinking at home has become more common over time and drinking in a pub less so, especially for females.[23]

Drug-related deaths have more than doubled over the past 10 years, from 52 in 2003 to 115 in 2013. Two thirds of drug-related deaths in that decade occurred among 25–54 year olds.[24] The drug-related death rate among the most deprived was almost four times the rate among the least deprived, and twice the Northern Ireland average.[15] Drug misuse services saw 2,574 new clients in 2013/14, which was

9% lower than in 2012/13. More than three quarters of these clients were male. Among males, 73% of clients were aged 18–39 years, whereas among females, just 51% were aged 18–39 years, and 44% were aged over 40 years (44%). One quarter of all clients were in prison. Hypnotic drugs are the most commonly used type, with reported use by 83% of male and 77% of female clients. Use of hypnotics fell slightly between 2012/13 and 2013/14 from 84% to 82% of clients, while use of cannabis increased from 58% in 2012/13 to 62% in 2013/14.[25]

There has been an increase in notified sexually transmitted infections (STIs). HIV diagnoses are on the increase among adults, especially males aged 25–44 years, with sexual transmission the most common route. Among females, rates are highest in 25–34 year olds.[26] Other STIs such as gonorrhoea and chlamydia have been increasing over the last decade, particularly among those aged 16–34 years.[27]

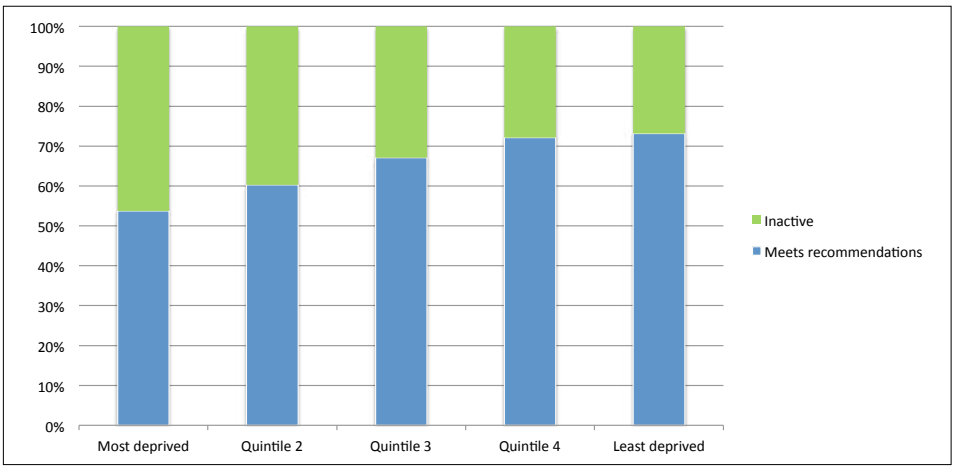
Adults aged 16–55 years were asked about their sexual health in a recent survey. Women were more likely than men to seek advice from a family planning or health clinic, while men were more likely to seek help from the internet. The major barriers to seeking advice on STIs were concerns about confidentiality or that staff may know them. Two thirds of respondents said they would prefer to see their GP about treatment for an STI.[20]

Obesity has become a major health issue in the last two decades, with a considerable impact on the health of individuals. In 2012/13, almost two out of every three adults (61%) were overweight or obese, an increase from 56% in 1997. The highest proportion of overweight or obese adults were aged 55–64 years.[20] In 2013/14, almost half of all mothers were pre-obese or obese at the time of booking. Older mothers had higher levels of obesity. Mothers from the most deprived areas had a 5% higher rate of obesity than mothers from the least deprived areas.[21]

The majority of adults are aware of the guidance on consumption of fruit and vegetables; however, only around a third of adults actually eat the recommended amount. A quarter of adults in the most deprived areas met the recommendations compared with nearly two fifths (38%) in the least deprived areas. Seven per cent of adults reported that they had not eaten a substantial meal in the last fortnight due to a lack of money.[20]

Physical activity is important for both mental and physical health, and inactivity can have serious health consequences. Inactivity shows a clear link with deprivation as shown in Figure 9. Adults from the least deprived areas are more likely than those from the most deprived areas to meet physical activity recommendations.[20]

Figure 9: Physical activity in adults, by level of deprivation



Source: Department of Health, Social Services and Public Safety (DHSSPS)[20]

The PHA is working with partner organisations on specific programmes to enable adults to reduce their weight and increase their activity with the aim of improving their health and wellbeing. The PHA recognises the centrality of good nutrition to health, and supports a number of programmes including cooking skills training and allotment projects. It also leads the implementation of the Tobacco Strategy and works with Health and Social Care Trusts (HSCTs), GPs and pharmacy services to help people stop smoking. The Health Protection team within the PHA provides a 24/7 service to protect the population from threats of communicable disease, including STIs.

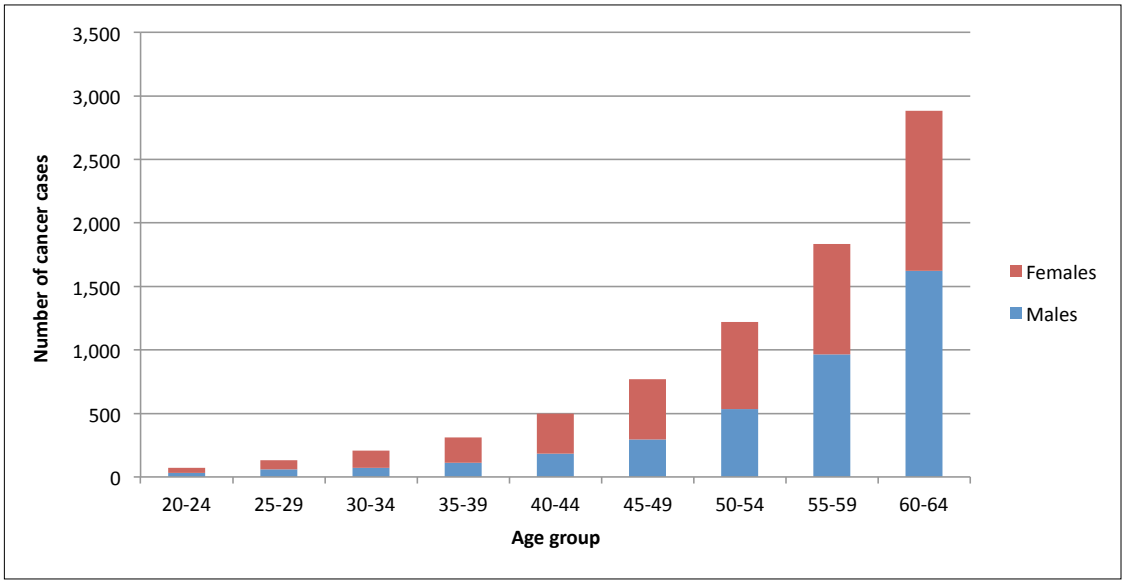
The health of adults in Northern Ireland

Almost three quarters of adults in Northern Ireland report their health as 'good' or 'very good'. Young people tend to report better health than older people, with 46% of those aged 16–44 years reporting 'very good' health compared with 25% of those aged 55–64 years. Self-reported health also varies by level of deprivation, with those in the most deprived areas more than three times as likely to report having bad health as those in the least deprived areas. The presence of a limiting longstanding illness also increases with age and with increased deprivation.[20] Approximately one quarter of respondents in 2010 reported a longstanding illness, disability or infirmity, with the proportion highest among those aged 55–64 years at 34%.[28]

In Northern Ireland (excluding a less serious and common form of skin cancer) each year there are, on average, almost 3,300 new cases of cancer diagnosed among adults aged 20–64 years, and almost 1,000 deaths due to cancer in this age group. As shown in Figure 10, cancer incidence among adults increases with age. Cancer diagnoses are more common among women than men up to the age of 54 years, after which the pattern reverses.[29]

Cancer incidence also varies by level of deprivation, with those who are most deprived having rates significantly higher than the Northern Ireland average, whereas people in the least deprived areas have significantly lower rates than the Northern Ireland average.[15]

Figure 10: Cancer incidence per 100,000 people in Northern Ireland, 2009–2013, by age and gender



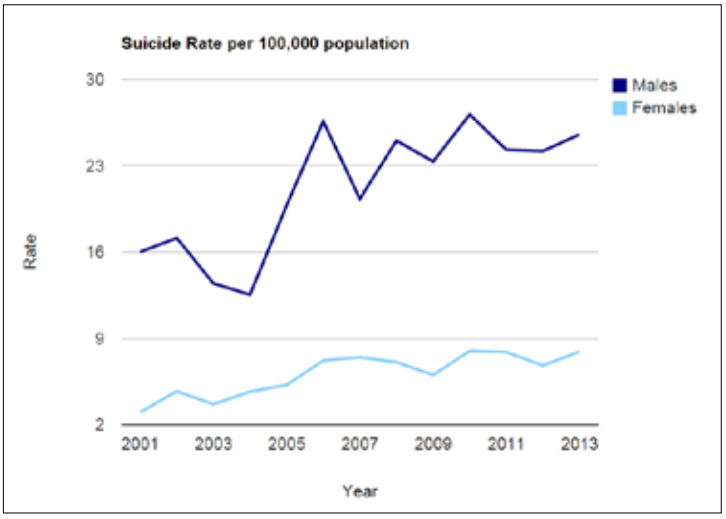
Source: Northern Ireland Cancer Registry (NICR)[29]

A recent survey suggests that around one fifth of adults showed signs of a possible mental health problem. This varied by gender and level of deprivation, with females and more deprived people having higher levels of mental health problems. There was also a strong correlation between level of activity and mental health, with inactive adults twice as likely to score highly on the screening tool.[20]

Self-harm is more common among young adults than older adults, with the highest number of episodes occurring among 20–24 year olds. The highest rates are found in the Belfast HSCT area. Alcohol was involved in 51% of all self-harm episodes in 2012/13. Rates of self-harm in Northern Ireland are over 50% higher than those in the Republic of Ireland.[30]

2013 saw the second highest number of suicides on record at 303. Suicide particularly affects men, as shown in Figure 11.[31] Mental health problems can have serious impacts on physical health and standards of living. The PHA supports a range of interventions to help individuals access their financial entitlements, improve their emotional and mental wellbeing, and prevent self-harm.

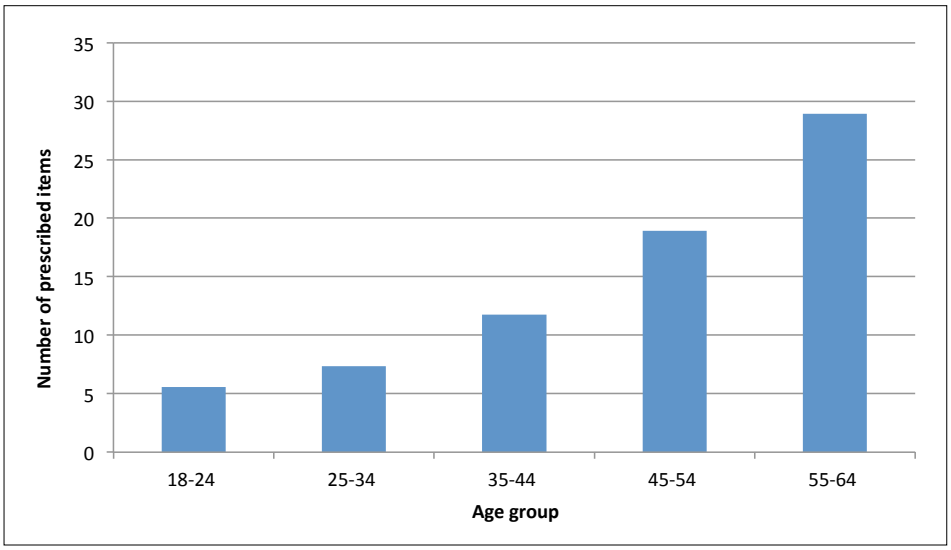
Figure 11: Suicide rate per 100,000 of the population in Northern Ireland



Source: NISRA[31]

In 2014, there were 39.8 million prescription items dispensed in Northern Ireland, 51% of them to adults aged 18–64 years. These were not distributed uniformly across age groups and, as would be expected, the number of items dispensed per person increased with age, as shown in Figure 12.[32]

Figure 12: Prescription items dispensed to adults, 2014

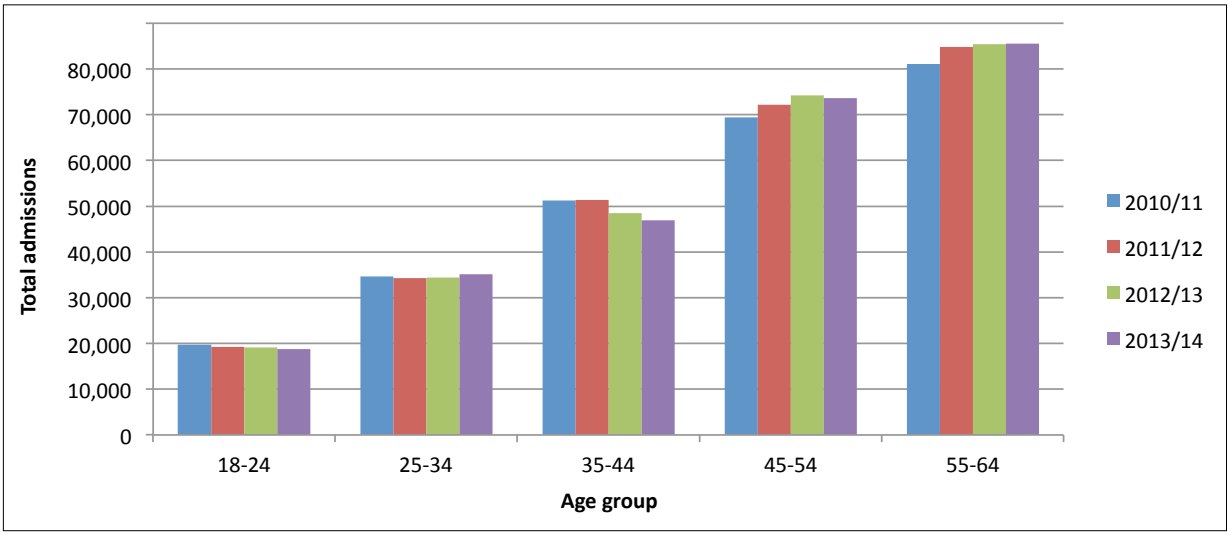


Source: BSO prescribing data[32]

The total number of acute hospital admissions (day case, elective, non-elective) by age group from 2010/11 to 2013/14 is shown in Figure 13. Older people have higher numbers of acute admissions, with a small increase during the years shown. Younger adults in the 35–44 and 18–24 years age groups have seen a decrease in admissions over time. The increase among older adults is mainly due to an increase in day case and non-elective admissions. The decrease in total admissions among 35–44 year olds is due to a decrease in day case and elective admissions, as non-elective admissions are reasonably steady.[33] The number of emergency hospital admissions varies with level of deprivation – the most deprived members of the population have 30% more admissions than the Northern Ireland average and almost 70% more than the least deprived in the population. The gap is not as pronounced for other types of planned admissions.[15]

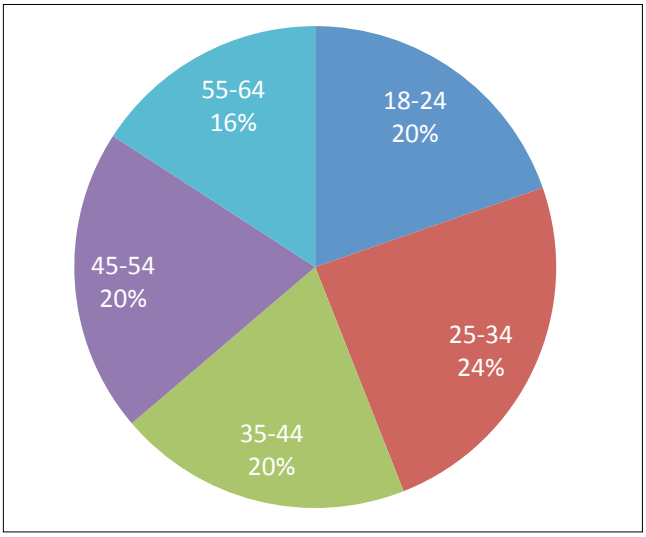
Just over half (53%) of all new and unplanned review Emergency Department (ED) attendances in 2012/13 were by adults aged 18–64 years. The highest number was among 25–34 year olds and the lowest number among 55–64 year olds.[33]

Figure 13: Total acute hospital admissions, by age and year



Source: DHSSPS Information Directorate[33]

Figure 14: Proportion of new and unplanned review ED attendances, by age group, 2013/14



Source: DHSSPS Information Directorate[33]

The PHA works with other organisations to develop, improve and assure the quality of screening and health services used by the population of Northern Ireland. This also includes raising awareness of common health problems such as cancer and heart disease.

Employment and working life of adults in Northern Ireland

In the year up to April 2014, median gross weekly earnings for all employees in Northern Ireland decreased by 2.2%, compared with an increase of 0.6% in the UK. The number of employee jobs in Northern Ireland increased by 2.1%, with public sector jobs falling by 1.7% and private sector jobs rising by 3.8%. By April 2014, the gender gap in earnings had narrowed slightly, with female median hourly earnings at 91% of male earnings. However, gross annual earnings still show a gender gap, with males earning 50% more than females, partly reflecting differences in the amount of hours worked per week. Earnings in Northern Ireland are lower than in the UK.[34]

Data from November 2014 show that 28% of the Northern Ireland population aged 16–64 years is economically inactive. This compares with 22.4% of the UK population as a whole. The figure includes people who are students, looking after families, not working due to ill-health or retired. Of the population aged 16–64 years who are economically active, approximately two thirds (67.8%) are in employment.[35]

In December 2014, there were approximately 50,000 people in Northern Ireland claiming Job Seekers Allowance (JSA), 4.1% of the population aged 16–64 years. This varied by age group:

- 6.7% of the population aged 18–24 years;
- 4.3% of the population aged 25–49 years;
- 3.1% of the population aged 50–64 years.

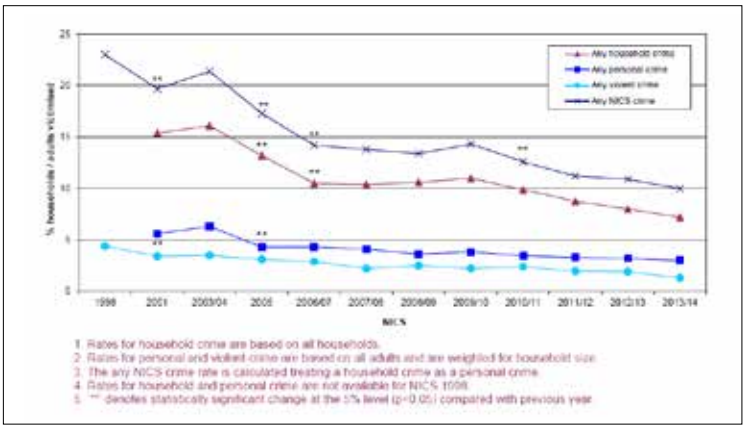
Within each age group, the proportion claiming JSA was higher than the UK overall figure.[35]

The living wage is a key indicator of low pay. It is the hourly rate that would provide a full-time worker with a basic, but acceptable, standard of living. In Northern Ireland, the living wage rate is currently £7.65. In 2012, there were an estimated 173,000 employees in Northern Ireland earning an hourly wage below this, which equates to approximately 23% of all employees. This was more common among female employees, part-time workers and young adults in employment, with over 80% of employees aged 18–21 years earning below the living wage. The industry with the highest proportion of people working for less than the living wage was accommodation and food service activities (74% of employees), followed by agriculture, forestry and fishing (56% of employees).[36]

In 2013, 64% of people in Northern Ireland felt their household's income had fallen behind prices. The age group most likely to report this was 45–54 year olds.[37]

There were 102,746 crimes recorded by the police in Northern Ireland in 2013/14. As Figure 15 shows, there has been a general downward trend in crime over the last decade.[38] Results from the 2013/14 *Northern Ireland Crime Survey* show that 10% of all households and their adult occupants were victims of at least one crime during the 12 months prior to interview, which is the lowest rate since the measure was first introduced in 1998. The risk of being a victim of crime in Northern Ireland remains lower than in England and Wales.[39]

Figure 15: Household/adult victims of crime once or more in Northern Ireland



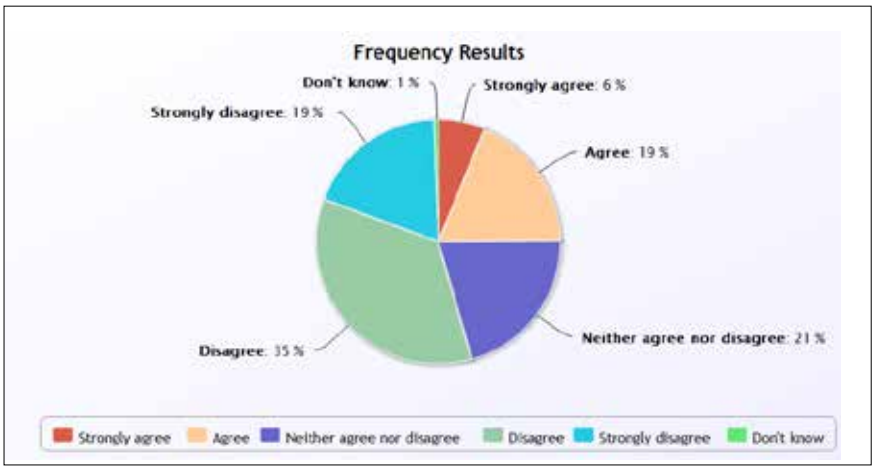
Young people and those who perceived their area to have a high level of antisocial behaviour were more likely to have been victims of a violent crime.[39]

The average prison population has been increasing steadily since 2003, apart from a levelling off between 2007–2010. By September 2013, the imprisonment rate was 101 per 100,000 of the population and, at any one time, there were approximately 1,700 people in prisons across Northern Ireland. The imprisonment rate was lower than England, Wales and Scotland, but higher than the Republic of Ireland.[40] Over 90% of the prisoner population are male and, in general, those in prison represent the more deprived groups in the population, with higher levels of dental decay, smoking and prescription drug use.[41]

Social attitudes of adults in Northern Ireland

Northern Ireland has seen significant changes, both demographically and socially, and there is evidence of some change in social attitudes. In 2013, one quarter of people strongly agreed or agreed with the statement that they prefer to 'stick with people of their own kind' with regard to colour and ethnicity, down from 27% in 2005 (see Figure 16). There was not much variation by age. Prejudice against Travellers is higher than other minorities. Acceptance of ethnic minority residents in a local area has fallen over the past five years, from 89% in 2008 to 79% in 2013. Also in 2013, 27% of people described themselves as very prejudiced or a little prejudiced, a decrease from 32% in 2008. Both of these descriptions increased slightly with older age.[42]

Figure 16: Level of agreement with the statement 'In relation to colour and ethnicity, I prefer to stick with people of my own kind'



Source: ARK 2013

More than three quarters of people in 2013 were not prejudiced at all against gay men and women, an increase from 2012. The proportion of people in favour of same-sex marriage has increased slightly since 2012, with the highest proportion among adults aged 18–34 years at 72%. There was also a religious split, with the highest proportion of people in support of same-sex marriage being those of no religion.[43]

Adults helping others in Northern Ireland

Nearly 44,000 adults aged 25–64 years were claiming Carers Allowance in August 2014, with the highest number of claimants aged 45–49 years.[44] However, many carers provide unpaid care for family and relatives. In 2011, 15.6% of the adult population provided unpaid care, which was higher than the proportion of the population as a whole at 12%.[45] In 2012/13, the age group reporting the highest level of informal care provision were 45–54 year old adults, followed by 55–64 year olds. The health needs of carers can sometimes be overlooked and those people who cared for someone informally for more than 20 hours per week were less likely to describe their own health as very good or good, compared with those who did not have caring responsibilities.[46]

Giving to others is an effective way to improve wellbeing.[47] The omnibus survey of people aged over 16 years in September 2012 showed that approximately one third of respondents had volunteered within the past year. Those without a disability, in paid employment and in more professional jobs were more likely to volunteer. The most common volunteering activity was fundraising, followed by a church/religious organisation.[48] The most recent widespread figures on volunteering in Northern Ireland were collected in 2007. These figures showed that 21% of the population had been involved in formal volunteering and a further 35% in informal volunteering. Those most likely to volunteer were aged 16–24 years and 35–49 years, but in different areas – younger people were more likely to be involved in sports or exercise-based activities whereas 35–49 year olds were more likely to volunteer in relation to schools.[49]

The aim of public health programmes

Public health programmes aim to:

- prevent ill health;
- address health inequalities;
- detect and treat diseases early;
- improve the health and wellbeing of the whole population.

The PHA's challenge is to:

- embed preventative action at regional and local level to improve the health of the population;
- provide opportunities for adults to improve their health;
- reduce inequalities in health;
- lead on the actions necessary to improve health outcomes.

Public health programmes in Northern Ireland are based on scientific and economic evidence where it exists, or on innovative practice if evidence is limited. This report highlights some examples from our range of public health programmes, particularly those that have led to significant improvements in the health and wellbeing of the adult population in Northern Ireland.

Further information

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Improving health and reducing inequalities

Overview

Improving the outcomes from diabetes in pregnancy

Weight loss referral scheme piloted in primary care

'Weigh to a Healthy Pregnancy' programme

Healthwise provides physical activity opportunities

Promoting physical activity through partnerships

Workplaces pilot '£ for lb' weight loss programme

FareShare tackling food poverty in vulnerable groups

Early intervention to support children's development

Action plan addresses Kilcooley health inequalities

Advice 4 Health expands northern support services

Community networks central to suicide prevention

Building mental health awareness through sport

Support project improves young men's resilience

'Breastfeeding Welcome Here' scheme grows further

Overview

Improving health and reducing inequalities requires coordinated action across Health and Social Care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors.

The DHSSPS published *Making Life Better* in 2014, a systematic strategic framework for public health that sets out key actions to address the determinants of health.

In Northern Ireland, there is a strong pattern of health and wellbeing inequalities at a geographic level, which has been persistent over time. Nevertheless, significant progress is being made in improving the public's health:

- A further 2% reduction in smoking levels among the adult population – from 24% to 22%, with a quit rate of 59% at four weeks across all socioeconomic groups, which represents higher levels of success than any other region of the UK.
- A further reduction in teenage pregnancy rates, down from 17.1/1,000 in 2002 to 13.8/1,000 in 2012 in the 13–19 years age group.
- An increase in the proportion of the population eating five pieces of fruit and vegetables per day – from 27% in 2005/6 to 35% in 2013/14.
- Improved quality standards in areas such as:
  - UNICEF Baby Friendly Breastfeeding Standards, which increased from 54% in 2012/13 to 93% in 2014/15;
  - mental health and emotional wellbeing standards to guide the development of services across multiple providers;
  - smoking cessation standards in pharmacies;
  - the implementation of guidelines such as those to support the needs of lesbian, gay, bisexual and/or transgender (LGB&/T) older people in nursing, residential and day care settings.
- New service developments such as evidence-based early years intervention programmes.

Throughout the year, the PHA has continued to focus on four key building blocks:

1) Give every child and young person the best start in life.
2) Ensure a decent standard of living for all.
3) Build sustainable communities.
4) Make healthy choices easier.

The following articles are illustrative of work underway to improve the public's health and form an important contribution to the implementation of *Making Life Better*.

Further information

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Improving the outcomes from diabetes in pregnancy

Public health challenge

There are four types of diabetes that can complicate pregnancy: type 1, type 2, gestational diabetes (GDM), and diabetes related to other conditions, eg cystic fibrosis. Type 1 diabetes cannot be prevented, whereas in many cases type 2 and GDM can be prevented.

Pregnancies complicated by diabetes are high-risk pregnancies with risks to the mother and infant. These risks include miscarriage, stillbirth, pre-eclampsia, pre-term labour and worsening retinopathy for the mother.

The additional risks for the infant include congenital malformations, birth injury as a result of macrosomia (birth weight greater than 4.5kgs), higher perinatal mortality rate and post-natal adaptation issues, eg hypoglycaemia (low blood sugar).

The number of diabetic pregnancies in Northern Ireland is increasing. There were 1,251 diabetic pregnancies and 1,270 infants born to diabetic mothers in Northern Ireland in 2013/14. This represents 5.2% of all pregnancies.

This contrasts with the 100 diabetic pregnancies reported in the 2001 CREST report on management of diabetes in pregnancy.[50] The 12-fold increase in diabetic pregnancies since 2001 can be explained by:

- rising levels of obesity, which is associated with type 2 diabetes and GDM;
- changes to diagnostic thresholds for GDM;
- having babies at an older age (above 35 years old) as diabetes is more common in older age groups.

Actions

To improve pregnancy outcomes for mothers and babies, women with diabetes should be advised to prepare for pregnancy and attend pre-pregnancy clinics, which are available in the five HSCTs, and attend more frequently for antenatal care when they are pregnant.

Pre-pregnancy care

To support women in achieving good glycaemic control before they become pregnant, pre-pregnancy clinics have been established in all five HSCTs in Northern Ireland. The aim of pre-pregnancy care is to support women with diabetes to plan their pregnancy, optimise blood glucose control prior to becoming pregnant, and ensure they are taking a high dose (5mg) of folic acid, which is available only by prescription, for at least six months before conception.

An online pre-pregnancy counselling resource for women with diabetes, and an educational resource for professionals, have been developed by Queen's University Belfast to assist women in planning and preparing for pregnancy.[51]

Antenatal care

Women with diabetes attend clinics jointly staffed by obstetric and diabetes teams. These women need to book early (by 10 weeks of pregnancy) and be seen more frequently in the antenatal period compared to women without diabetes.

Pre-pregnancy care client Emma Finnegan (centre) and her baby daughter Annabel, pictured with Cooperation and Working Together (CAWT)/ Southern Trust pre-pregnancy care clinic staff at Craigavon Hospital. Emma, from Newry, has diabetes and had a successful pregnancy with the support of the staff. Also pictured are (standing): Alison Barbour, Diabetes Specialist Dietitian and Joanne Dodds, Healthcare Assistant; (front row): Emma Meneely, Project Manager, CAWT Diabetes Project and Claire Black, Diabetes Specialist Nurse.

Post-natal care

All women with diabetes (type 1, type 2 and GDM) should be advised of the need to attend pre-pregnancy clinics when planning their next pregnancy and be directed to the resources on the 'Women with diabetes' website: www.womenwithdiabetes.net [51]

Women with GDM are advised of the increased risk of developing type 2 diabetes following pregnancy, and the importance of making lifestyle changes to reduce the risk of this occurring.

Impact

Establishing good glycaemic control before conception and continuing this throughout pregnancy will reduce, but not eliminate, the risk of miscarriage, congenital malformation, stillbirth and neonatal death.

Key facts

- Diabetes affects 5% of pregnancies in Northern Ireland.
- Women with diabetes should book for antenatal care by 10 weeks of pregnancy.
- 20% of women with GDM will develop type 2 diabetes within nine years following pregnancy.[52] Lifestyle modification in this group of patients (reduced weight, healthy diet and increased exercise) is key to preventing diabetes.

Further information

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The aforementioned changes in the organisation of diabetes care in the pre-pregnancy, antenatal and post-natal periods should facilitate better outcomes for diabetic mothers and their infants.

Next steps

Additional investment in antenatal diabetes care in Northern Ireland is planned for 2015/16 to deal with the additional number of women with diabetes attending antenatal clinics.

Clinical information systems should routinely report on pregnancy outcomes for diabetic mothers and their infants.

We will continue to raise awareness among women with diabetes or a past history of GDM of the need to plan pregnancy and ensure optimal glycaemic control before they become pregnant.

Weight loss referral scheme piloted in primary care

Public health challenge

In Northern Ireland, 61% of the adult population are overweight or obese.[53] Being overweight or obese increases the risk of developing a number of serious health conditions including diabetes, heart disease and certain cancers.

Actions

The Health and Social Care Board (HSCB) funded a pilot scheme that allowed GPs to refer non-pregnant, obese patients aged over 18 and with an obesity-related health issue for free sessions with a commercial weight loss provider.

Participating providers were Weight Watchers Ireland, Slimming World UK, Rosemary Conley Health and Fitness Clubs, LifeCounts and Unislim. Referrals were made over eight months from November 2012 to July 2013.

Impacts

Patients referred

There were a total of 6,227 referrals to the scheme from across Northern Ireland. Most people referred were female. Three quarters of people referred were aged 18–60 years.

Referral rates were highest in areas with the highest levels of deprivation. An intervention like this should be accessible to patients living in more deprived areas, as poor health and obesity rates are higher among more deprived communities.

Almost one quarter of people referred lived in areas ranked among the 20% most deprived in Northern Ireland (measured by the Northern Ireland Multiple Deprivation Measure). Twelve per cent of people referred lived in the 20% most affluent areas.

Participation in the scheme

Thirty percent of those referred by their GP did not participate in the scheme. Men were more likely not to participate. Only 55% of men referred returned a consent form and participated in at least one class compared with 75% of women referred.

Males living in the most deprived areas were the group least likely to participate after referral – 57% of this group did not participate even though they had been referred by their GP.

Weight loss results

As the loss of 5% total body weight can have significant health benefits, the National Institute for Health and Care Excellence (NICE) concludes that only schemes that result in at least 30% of participants losing 5% body weight or more should be funded.[54]

In this scheme, 38% of those who returned a consent form and participated lost at least 5% of their initial body weight. NICE also recommend that schemes being offered should result in average weight loss of more than 3%. In this scheme, the average weight loss was 4.1%.

Weight loss and deprivation

In total, 33% of participants from the most deprived areas achieved 5% weight loss, compared with 45% of those from more affluent areas.

Weight loss and gender

While females were significantly more likely to be referred and participate in the scheme, the males who did participate were more likely to achieve 5% weight loss – 46% of male participants achieved 5% weight loss or more, compared with 36% of female participants.

Next steps

Further work will be carried out to evaluate the long-term impact of this scheme on those who took part.

The HSCB and PHA will consider whether this sort of scheme should be provided in Northern Ireland in the future. Part of this consideration will be how such a scheme could target those at greatest risk in order to increase participation among certain groups – particularly males from the most deprived areas.

Key facts

- Four times more women than men were referred by their GP.
- The youngest person referred was aged 18 years and the oldest aged 80 years.
- 70% of those referred participated in the scheme.
- Referral rates were higher in more deprived areas but participation rates and weight loss were lower compared with more affluent areas.

Further information

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'Weigh to a Healthy Pregnancy' programme

Public health challenge

As the levels of population obesity have increased in recent years, maternity services have seen an increase in the number of pregnant women who are obese. Obese women have an increased risk of complications during pregnancy and childbirth. These include gestational diabetes, miscarriage, pre-eclampsia and maternal death.[55]

An obese woman is more likely to have an induced or longer labour, instrumental delivery, caesarean section and postpartum haemorrhage.[56] Obesity can also result in women experiencing reduced choices, with restrictions on home births, the use of birthing pools and types of pain relief.

Babies born to obese women are at higher risk of fetal death, stillbirth, congenital abnormality, shoulder dystocia and subsequent obesity.[57]

Guidelines in the USA state that obese women (body mass index (BMI) greater than 30kg/m2) should limit the weight they gain during pregnancy to between five and nine kilogrammes, as this will improve maternal and infant outcomes when compared to gaining more or less weight.[58,59]

Actions

The 'Weigh to a Healthy Pregnancy' programme was developed as a regional pilot aimed at limiting weight gain in pregnant women with a BMI of 40kg/m2 or above. It takes account of guidelines issued by NICE.[60]

The programme promotes healthier eating, physical activity and behaviour change through the provision of additional information and support to women and their families, and regularly monitoring weight gain during pregnancy. The evidence-based model is led by a multi-disciplinary management group and delivered by teams consisting of midwifery, dietetics and physiotherapy staff in each HSCT. The programme has a number of elements:

- written information;
- goal-setting in a one-to-one session with a dietician;
- offer of group sessions;
- follow-up by text or telephone calls;
- monitoring of weekly weight gain using telehealth methods.

The programme supports women throughout their pregnancy and into the first few weeks after delivery when they can be signposted to other existing initiatives. The secondary aims of the programme are to encourage women to sustain the healthy lifestyle changes in the longer term and increase breastfeeding rates among obese women.

Impacts

All HSCTs have engaged in the project and, from March 2015, are offering the programme to pregnant women aged 18 and over with a BMI of 40kg/m2 or above at booking. Staff involved in delivering the programme were offered specialist training to gain additional knowledge and skills in this area, and expertise in Solution Focused Brief Therapy.

Commissioning Plan targets have been set for the project – all eligible pregnant women, aged 18 and over, with a BMI of 40kg/m2 or more at booking are offered the programme with an uptake of at least 65% of those invited. Preliminary figures show that 581 women were offered the programme in 2014, with 397 (68% of those offered) participating.

Next steps

A weekly Roma clinic with input from a consultant paediatrician is provided for Roma families. The clinic is targeted at children aged up to five years and facilitates the commencement of family health assessments and growth parameters.

The Northern Ireland New Entrant Service (NINES) facilitates registration with GPs for those who are eligible. These clients can now obtain a medical card to allow registration with dentists and opticians.

Blood testing for hepatitis B and C, and HIV, commenced in July 2012. Clients who test positive are referred to hepatology/Genito Urinary Medicine (GUM).

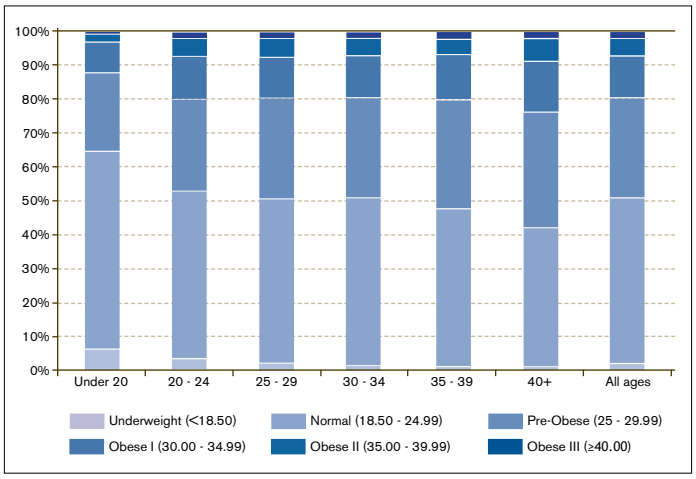
Next steps

An independent evaluation of the programme is being undertaken by the University of Ulster. This will report on:

- uptake of the programme;
- the impact it has had on lifestyle and behaviour;
- the outcomes in relation to weight gain during pregnancy and weight loss in the post-natal period.

The findings will inform future decisions about delivering weight management programmes in pregnancy.

Figure 17: Northern Ireland: BMI at time of booking of mothers who gave birth, by age of mother, 2013/14



Key facts

- 19.3% of all mothers who gave birth in Northern Ireland in 2012/13 were recorded as being obese at the time of booking.
- 560 pregnant women (2.4% of all pregnancies in 2012/13) were considered morbidly obese with a BMI of 40kg/m2 or over.

Further information

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Healthwise provides physical activity opportunities

Public health challenge

In Northern Ireland, 28% of adults do less than 30 minutes of physical activity per week.[61] In some minority communities, this falls to only 1 in 10 adults. Physical inactivity is the fourth biggest cause of mortality worldwide, making it as dangerous as smoking.[62]

There are clear and significant health and social inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability. Inactivity not only has consequences for the health of individuals, but also places a substantial cost burden on health services through the treatment of long-term conditions such as obesity, coronary heart disease, stroke, diabetes and cancer.[63]

Actions

The PHA, working in partnership across statutory, community and voluntary sectors, provides greater access to physical activity programmes and a better range of opportunities for people.

The Healthwise scheme is jointly funded by Belfast City Council, Belfast Local Commissioning Group (LCG) and Sport NI, and has improved links with healthcare professionals, resulting in an increased number of people being referred to programmes.

A group of patients who participated in the Falls prevention pilot programme, pictured with staff. From left to right are: Siobhan Weir, Elma Greer, Barbara Walker, Elizabeth MacKay, Sean McQuade, Eileen Gilbert, Ruby Glass, Sheila McMaster, Jenny Lockett, Paul McCrudden, Elizabeth McKay and Gail McMillan.

A number of pilot programmes were delivered to test the integration of physical activity into treatment pathways for long-term conditions including cancer and respiratory disease, and also for patients who have suffered a fall.

The development of a physical activity care pathway has ensured a more patient-centred approach to encouraging long-term behaviour change and promoting an active lifestyle. Continued investment in staff training has enhanced skills and improved service delivery for patients.

Impacts

More patients had access to programmes in a greater number of communities than ever before. A Social Return of Investment evaluation showed significant improvements in people's physical and mental wellbeing as a result of getting active through the Healthwise physical activity referral scheme.[64]

Evidence from the pilot programmes has shown significant benefits for people, including enhanced ability to manage their condition and reduced side-effects of treatment. These programmes have also raised standards of care, enabled greater choice and helped address many of the issues in supporting people with long-term conditions.[65]

Next steps

A new patient-centred physical activity referral scheme will be implemented across Northern Ireland. This will expand the number of programmes to support people with long-term conditions, increasing the integration of physical activity into care pathways and patient management.

Key facts

- More than 2,500 people participated in the Healthwise physical activity referral scheme.
- Social Return on Investment evaluation of the programme showed for every £1 invested, it gives a return of £7 socially and economically.[64]
- Respondents indicated an 82% improvement in physical wellbeing and an 84% increase in physical activity, illustrative of the low baseline levels of activity and health conditions for many of the participants.[64]
- Respondents also indicated that along with a 71% improvement in confidence levels, they improved their level of social interaction by 58%. Respondents also recorded an 82% improvement in their overall life as a result of the programme.[64]

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Promoting physical activity through partnerships

Public health challenge

Physical activity is essential for good health. Regular physical activity prevents and helps to manage conditions such as coronary heart disease, type 2 diabetes, stroke, mental health problems, musculoskeletal conditions and some cancers.[66]

All adults should be moderately active for 150 minutes per week, preferably at some stage every day.[66] It is also important to spend less time sitting and more time standing and moving. Almost half of Northern Ireland adults are not active to the recommended levels.[67] Physical activity levels vary according to income, gender, age, ethnicity and disability.[66]

Those who currently engage in the least physical activity benefit most from becoming active.[66] The challenge is to get everyone moving more and this can only be done with partnership working.

Gail Malmo, PHA (second from the right) with Councillor Stephen McIlveen (far right), former Mayor of Newtownards, and other eager runners, launch the first ever Ards Park Run in Comber on 31 May 2014. Also taking part in the inaugural event were more than 30 graduates of the Newtownards 'Couch to 5k' for whom it was their first official 5km run.

Actions

The PHA supports many programmes across Northern Ireland that encourage adults to become more active. These include:

- work with local councils, eg Healthy Towns in five council areas in the Western area.
- initiatives with the community and voluntary sectors, eg Western Green Gym led by The Conservation Volunteers, Comber Couch to 5K, and Parkrun and the Resurgam Healthy Living Project in Lisburn.
- programmes with local HSCTs, eg the regional Walking for Health programme.

Impacts

- 2,899 people participated in a range of programmes offered through Healthy Towns in the Western area.
- Participation in the Western Green Gym has brought about a sustained increase in physical activity levels – 84% of participants have increased their physical activity levels beyond their time in the Green Gym, 68% have lost weight and 53% eat four or more portions of fruit and vegetables per day following six months of Green Gym activities.[68] The Green Gym programme supports and sustains a strong network of partnership working.
- More than 500 participants have completed Couch to 5K across the Comber, Newtownards, Newcastle and Downpatrick areas. In addition, 501 people have registered with Comber Parkrun, with approximately 60 participating each week.
- 264 people have joined the Resurgam Community Gym and 58 regularly attend. In September, 180 people participated in a 3K fun run. The route is now the official 'Way to Health' route.
- 2,040 walk leaders are registered and have been trained to lead walks across Northern Ireland.

Next steps

The PHA will continue to work with key stakeholders to raise awareness of the benefits of physical activity and develop and promote innovative opportunities to engage adults in appropriate activities.

The PHA will further develop its means of evaluating the impact of programmes and partnership working.

Key facts

- Physical inactivity is the fourth largest cause of disease and disability in the UK.[69]
- The Health Survey for NI 2012/13 highlighted that 53% of respondents met the new CMO guidelines.[67]
- 28% of respondents reported they did less than 30 minutes of physical activity per week.[67]

Further information

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Workplaces pilot '£ for lb' weight loss programme

Public health challenge

Being overweight or obese increases the risk of developing serious health problems including type 2 diabetes, heart disease, stroke and some cancers. In Northern Ireland, 37% of adults are overweight and a further 24% are obese, with rates higher among men than women.[70]

The problem is greatest among older working age people with those aged 55–64 years being most likely to be overweight (46%) or obese (30%).[71] Obesity also contributes to health inequalities as those who live in the most deprived areas are more frequently overweight.[71]

Lifestyle weight management programmes that include a change in eating habits (including calorie restriction), behavioural therapy and physical activity have been shown to achieve weight loss.[72] The NHS Choices weight loss guide *Losing weight – Getting started* is a freely-available, self-directed 12 week programme based on these principles.[73] Business in the Community (BITC), a national corporate responsibility charity, proposed a workplace-based initiative to the PHA based on the NHS guide and we were delighted to work with them in 2014 to pilot the innovative '£ for lb Programme'.

Actions

BITC recruited 20 organisations that pledged to donate £1 to charity for every 1lb in weight lost by one of their participating employees (participants contributed the money in public sector organisations). The number of employees taking part in the participating organisations varied from 6 to 135.

The intervention used nominated workplace champions from the participating organisations to support delivery of the programme. Champions were trained by professionals from Belfast HSCT on:

- principles of safe and sustainable weight loss;
- healthy eating;
- physical activity;
- how to measure participants' weight and height accurately.

Participants followed the NHS guide over the 12 week period, supported by weekly weigh-ins at their workplace and ongoing encouragement and support from their champion.

Participants were asked to provide information at the beginning and end of the programme about their weight, eating habits, physical activity and general wellbeing. We compared the information before and after the intervention to learn how effective it was at changing behaviour and achieving weight loss.

Impacts

A total of 734 people who were overweight (49%) or obese (51%) returned the pre-intervention questionnaire, and 282 (38%) also completed a follow-up questionnaire. Half of the participants were male and half were female.

On average, people who finished the programme lost 5.1kg, which compares favourably to other behavioural weight management programmes available to the public. More than half (51%) of those

who completed the programme lost more than 5% of their starting bodyweight. This accounts for 21% of all those who returned a pre-intervention questionnaire.

The programme was especially effective for men, who were as likely as women to start and complete it. At the outset, men weighed on average almost 20kg more than women, but they narrowed this gap by losing an average of 3kg more than women over the 12 weeks.

By the end of the programme, participants were much less likely to eat unhealthy foods frequently and the proportion of participants who met the Chief Medical Officer's recommended physical activity target (150 minutes each week) increased from 40% to 70%. Participants also reported better wellbeing at the end of the programme compared to the start.

Next steps

BITC and the PHA are working together to bring the programme to more organisations in 2015 and are considering how this type of workplace intervention can be further extended in the future. We are improving the information collection so we can better understand the reach and effectiveness of the programme on adults in Northern Ireland.

Pictured at the '£ for lb Programme' celebration event in May 2014 at the Long Gallery in Stormont are (l-r): Graham Moore, Chairman of Westfield Health; Tanya Kennedy, Director, Workplace Campaign, Business in the Community Northern Ireland; Mary Black, Assistant Director of Public Health (Health and Social Wellbeing Improvement), Public Health Agency; Dr Michael McBride, Chief Medical Officer, DHSSPS.

Key facts

- Men lost an average of 6.4kg.
- Women lost an average of 3.6kg.
- 151 people lost more than 5% of their bodyweight.
- A total of 1,555kg in weight was lost among the participants.
- The direct cost to the PHA was £3.20 for every 1kg that participants lost.

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FareShare tackling food poverty in vulnerable groups

Public health challenge

Food poverty is the inability of individuals and households to obtain an adequate and nutritious diet, often because they cannot afford healthy food or there are a lack of shops in their area that are easy to reach. Food poverty can also be about an overabundance of 'junk' food as well as a lack of healthy food.[74]

Homeless people are particularly at risk and, along with other people on low incomes, have the lowest intake of fruit and vegetables. They are also far more likely to suffer from diet-related diseases such as cancer, diabetes, obesity and coronary heart disease.[74]

Research carried out by the Food Standards Agency (FSA) in Northern Ireland found that the key barriers to eating a balanced diet are:

- financial situation and education/cooking skills;
- depression/stress, alcohol and drug abuse contributing to a lack of appetite;
- a perception that food is not always seen as a priority.[75]

Actions

FareShare tackles food poverty in Northern Ireland by collecting surplus food from industry retailers and producers, and redistributing it to charities that provide meals to vulnerable and disadvantaged groups including low income families, senior citizens, people with disabilities, victims of domestic violence, at-risk children, young people and homeless people.

FareShare was started by the Council for the Homeless Northern Ireland (CHNI) in 2011, and is supported by the FSA in Northern Ireland, the PHA, the Esmée Fairbairn Foundation, and WRAP Rethink Waste.

Fareshare currently provides food on a weekly basis to more than 60 Community Food Members, 23 of whom use this food to provide hot, nutritious meals in hostels, shelters and other support centres for people who are homeless.

Impacts

FareShare aims to:

- improve the dietary choices of vulnerable groups through the provision of a wide range of fit-for-purpose surplus food;
- work with Community Food Members to ensure the most vulnerable people have access to food;
- partner with the food industry to source a wide range of surplus food or redistribution, while also creating a positive environmental impact;
- ensure 'no good food should be wasted' among the general public.

FareShare won the 2014 'Promoting Health Equity Award' at the World Health Organization's Belfast Healthy City Awards.

During 2013/14, the following outputs were achieved:

- 138 tonnes of surplus food diverted from landfill;
- 330,000 meals provided to disadvantaged people in their community;
- 580 tonnes of CO_2 emissions prevented;
- improved dietary options for approximately 4,000 service users.

During 2013/14, FareShare's achievements and commitment to tackling food poverty and reducing waste were recognised through a number of prestigious awards, including:

- UTV Eye Business Awards – winner of Waste Reduction Project of the Year Award;
- World Health Organization's (WHO) Belfast Healthy City Awards – winner of Promoting Health Equity Award;
- Brighter Belfast Awards – winner of the Judges Special Award for its contribution to a brighter, cleaner and greener environment.

The Northern Ireland FareShare programme was also showcased at the European Public Health Conference in Glasgow in November 2014 and profiled in the *European Journal of Public Health* in the same period.

Belfast Lord Mayor Cllr Nicola Mallon with staff and volunteers at the FareShare regional food redistribution depot in Belfast.

Next steps

The next steps for FareShare in Northern Ireland include:

- obtaining secure funding to maintain and expand the programme;
- opening a second food distribution depot;
- increasing the number of individuals benefitting from redistributed food;
- increasing the supply of food from producers;
- continuing to measure the impact and outcomes of the programme.

Key facts

- Currently, there is no measure of food poverty on the island of Ireland and such an indicator would allow for a quantifiable assessment of the extent of the problem in order to inform practice and policy.[75]
- It is anticipated that a food poverty indicator will be launched in 2015.

Further information

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Early intervention to support children's development

Public health challenge

The PHA has worked with Resurgam Community Trust to develop Early Intervention Lisburn (EIL), a cross-sectoral partnership aimed at securing a better understanding of the needs of children, young people and families.

Dr Roger Courtney's *The best for every child* report highlighted:

- what was needed across these communities;
- what outcomes we should strive for;
- how taking action early (early intervention) produces the best results.[76]

The report predicted continued poor outcomes for children, young people and families despite the best efforts of various organisations. The most striking message is that early intervention works and it can help families give their children a secure and loving space in which to grow.

Actions

An EIL project board has been established and consists of key statutory, community, voluntary and political representatives with significant experience in early intervention work.

The project has created opportunities for organisations to work together and research indicates collective responses result in better outcomes. An example of this approach is the implementation of the 'Incredible Years' programme designed to help children, parents and teachers develop strategies that will:

- manage emotion;
- reduce behaviour problems;
- increase problem solving.

Sure Start, Homestart, playgroups, nurseries and primary school staff deliver this programme together, giving parents better options within their community.

Impacts

- A motivated project board that is determined to improve outcomes for children, young people and families in Lisburn.
- The establishment of a collective action plan that has created a partnership approach in meeting the needs of the local population.
- Implementation of the evidence-based 'Incredible Years' programme in all primary schools in Lisburn, with local Early Years providers working in partnership to deliver it.

Parents and carers in Lisburn have been asked for their views on how best to develop services for children aged up to three years in their area. The PHA is one of the lead partners in the Resurgam Community Development Trust's EIL project, which held a one-day event in Lagan Valley Leisureplex to listen to the views of people from the communities of Hillhall, Tonagh, Old Warren, Knockmore and Hilden.

- Three parents who attended this programme are now delivering it in their local area. One parent with young children is now a volunteer with Resurgam Trust youth service and is using the strategies learnt in the training to influence behaviour change in young people.
- Department of Education (DE) funding has initiated two programmes delivered by Resurgam Trust and YMCA to support young people at risk of expulsion to remain in education.

Next steps

To make a lasting difference, EIL recognises that a long-term collective response is required. EIL project board members are committed to this project for the next 10–15 years.

EIL has reached stage two of the Big Lottery Supporting Families Fund. If the bid is successful, over the next five years local communities will see an innovative early years service, promoting good infant mental health by focusing on respond, cuddle, relax, play and talk.

This model of early intervention will help identify those who require further support at an earlier point. South Eastern HSCT and Bryson Charitable Group will also provide a home-school link project that will support parents and children in primary school who are experiencing emotional, behavioural and educational difficulties.

Resurgam Community Trust, in partnership with the EIL Project Manager, Bryson Charitable Group and South Eastern HSCT, is designing a social enterprise opportunity for affordable childcare in response to feedback from parents wishing to return to education or employment. This will provide employment, volunteering and student placement opportunities.

Largymore Primary School in Lisburn celebrated the first graduation for both parents and children involved in the 'Incredible Years' programme. The programme is designed to help children manage their emotions, reduce behaviour problems and increase problem–solving skills. It includes a dinosaur school with friendly child-sized puppets for younger children and a parenting programme focused on strengthening parenting skills and promoting parent involvement in children's school experiences.

Key facts

In Lisburn:

- 74% of young people leave the post-primary sector without five or more A-C grade GCSEs (excluding two grammar schools).[77]
- 22% of young people go on to higher education, compared to the Northern Ireland average of 43%.[77]
- 32% of children entering primary school were identified as requiring intervention for mild speech sound and/or language difficulties.[78]

Further information

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Action plan addresses Kilcooley health inequalities

Public health challenge

Reducing health inequalities experienced by people living in disadvantaged areas is a key public health priority.

Designated a neighbourhood renewal area, the Kilcooley estate in Bangor is in the top 10% of most deprived areas in Northern Ireland.

Action

The Kilcooley community identified health and social wellbeing improvement as a key area for development within the area. With financial support from the PHA, community leaders committed to developing a three year action plan to address the most pressing health inequalities faced by those living in the estate. The plan was informed primarily by the residents themselves through a community health survey.

The community's objectives were to:

- improve the overall health and social wellbeing of their residents;
- enable them to develop the skills and attitudes required to make healthier choices;
- improve their mental and emotional wellbeing;
- improve community access to health and social wellbeing services.

A wide range of health and social wellbeing improvement initiatives were subsequently delivered to address the needs of all residents, from the very young to the elderly.

Programmes in 2014 included:

- a community garden with 18 plots and a Healthy Living Centre with additional plots, poly-tunnels and training facilities;
- initiatives addressing healthy weight and nutrition, ('Weigh to Health' and 'Mood and Food'), physical activity (walking groups, yoga, circuit training), cancer awareness and prevention, relationship and sexual health education, and mental health and suicide prevention ('Positive Steps', 'Living Life to the Full', 'Safe Talk');
- community health fairs;
- arts and health programmes.

Impact

Community participation in health and social wellbeing activities has risen dramatically within the estate since the initiative began. Interest in the allotment programme was particularly high, with all available plots in use from the outset.

In 2014 alone, 100 residents enrolled in physical activity programmes and 22 participated in a weight management support group. In addition to the 18 garden plot holders, 130 residents participated in a range of other gardening programmes such as wreath-making and spring basket design.

Some of the participants in the 18 week seasonal gardening programme showing off their work.

Participants in these health and social wellbeing activities cited numerous benefits, including:

- the acquisition of new skills;
- increased motivation to attend further programmes;
- the formation of new friendships.

Several residents said they were able to return to employment as a result of new skills and increased confidence.

Next steps

The Kilcooley community is working hard to transform the horticultural project into a social economy venture. The prospects for this are promising, with a number of organisations having already availed of the horticultural therapy programme.

The Kilcooley Health Task Force, which oversees the plan, will continue to meet to monitor progress and measure impact, while the PHA will continue to support the overall implementation of the community's health and social wellbeing improvement plan.

Key facts

- Males in the top 20% most deprived areas can expect to live 4.3 years less than the Northern Ireland average, and 7.3 years less than those in the top 20% least deprived areas.[79]
- Female life expectancy in the most deprived areas is 2.6 years less than the regional average and 4.3 years less than that in the least deprived areas.[79]
- Those living in the least deprived areas can expect to live in good health for 13 years longer than those in the most deprived areas.[79]

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Advice 4 Health expands northern support services

Public health challenge

In 2011/12, there were almost 213,000 adults of working age (20%) in relative poverty in Northern Ireland (defined by household income less than 60% of UK median after housing costs) and almost 235,000 (22%) in absolute poverty (before housing costs).[80]

Insufficient income is associated with worse outcomes across virtually all domains of health. The negative effects can be caused by material and/or psychosocial factors.

While overall life expectancy has been increasing, a substantial gap remains between people living in the top 20% most deprived areas and those in the least deprived areas.

Actions

Advice 4 Health (A4H) was developed in the Northern HSCT area in 2005 to complement existing advice services and reduce poverty and tackle disadvantage by maximising benefit uptake in the community, with a particular focus on the most vulnerable.

Since 2011, the programme expanded to provide specific benefit support, advice and guidance for clients experiencing poor emotional and mental health impacted by drugs and alcohol.

Paolo Margari

The programme is a partnership between the PHA, local Citizens Advice Bureaus (CAB), local HSC organisations, and voluntary and community organisations, working across a range of settings such as community rehabilitation centres, GP surgeries and inpatient mental health units.

The programme targets people who would not avail of core CAB services by providing dedicated support for those with mental health or addictions issues, including outreach based advice and support.

Impacts

During 2013/14, the following support was given through the programme to clients with identified mental health or addiction issues:

- strong referral relationships established with more than 30 voluntary and community organisations, a range of professionals within HSC, the Social Security Agency and the housing sector;
- almost 5,000 client enquires were processed;
- benefits advice and support was given to more than 700 individuals, resulting in additional benefits of over £1,300,000.

Anita (pictured) was referred to the addiction outreach service. She was living on very little money and was unable to go out alone or communicate with people. She was supported to access the benefits she was entitled to, empowered to join a support group and now volunteers for a charity. She thanked the programme for getting her life back.

Next steps

The programme continues to be supported in the Northern area, has been implemented in the Southern area (in Newry and Dungannon) since 2011 and will be piloted in Belfast.

Advice 4 Health helped Anita access the benefits she was entitled to and encouraged her to join a local support group. Having previously been referred for addiction problems, she now volunteers for a charity.

Key facts

In Northern Ireland:

- people in the most deprived areas are almost six times more likely to die of an alcohol-related cause than those in the least deprived areas, and nearly five times more likely to die from drug-related causes (2007–11);[81]
- 15% of people are being dispensed drugs for mood and anxiety disorders, and this increases to 21% in our most deprived areas (provisional data 2011);[81]
- in 2013 (provisional data) the rate of suicide per 100,000 of the population in the most deprived quintile is nearly twice the Northern Ireland average and almost five times that in the least deprived areas;[81]
- there is a noticeable difference in the death rates from potentially avoidable causes between those in the most deprived quintile and those in the least deprived quintile.[82]

Further information

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Community networks central to suicide prevention

Public health challenge

In 2007, the PHA began engagement with community networks in the Northern HSCT area for delivery of activities to support implementation of *Protect life – A shared vision: The Northern Ireland suicide prevention strategy 2012–March 2014* and the 'Promoting Mental Health Strategy'.[83]

The community networks are:

- Causeway Rural and Urban Network (CRUN);
- Cookstown and Western Shores Area Network (CWSAN);
- North Antrim Community Network (NACN);
- South Antrim Community Network (SACN).

There are two key areas of activity delivered by the community networks – an annual, community-focused 'Promoting Mental Health and Suicide Prevention' small grants programme, and the establishment of three Suicide Prevention Development Officer (SPDO) roles. The two areas were subject to an independent evaluation in 2012.[84]

Actions

The small grants programme is the engagement of local community organisations and groups in taking forward small scale initiatives that:

- encourage greater awareness of the issues surrounding mental health problems, positive emotional health and suicide prevention;
- encourage communities to take a more proactive role;
- promote awareness of sources of support and encourage help-seeking behaviours;
- help establish resilient communities.

The key objectives of the SPDO roles are:

- raising awareness and education:
  - providing guidance to local communities;
  - signposting communities to support services and initiatives;
- building capacity and resilience:
  - empowering communities to get involved;
  - providing or signposting to training;
  - supporting communities to develop suicide prevention initiatives;
  - promoting and encouraging communities to apply to the 'Promoting Mental Health and Suicide Prevention' small grants scheme;
- partnership working – identifying and working with local stakeholders;
- information management:
  - contributing to new research/evidence;
  - sharing and updating local information and developments.

Impacts

The active involvement of community networks has led to successful local engagement and the building of significant social and community capital within local areas.

The benefits of having the community networks model in place include:

- increased awareness within Northern HSCT communities of mental and emotional health, related issues, and how these can be supported;
- increased awareness of suicide and what communities can do to help reduce the risk and prevalence of suicidal behaviour;
- new and enhanced knowledge and skills in this area among a wide variety of people;
- making mental health issues and suicide easier to discuss, while also increasing understanding and reducing stigma;
- improved quality of practice and approaches;
- a platform for continuing development;
- regular examples of people accessing further help after a community-based event (some events had happened as a result of a suicide in the community);
- end beneficiaries – eg pupils, programme participants, event attendees – feeling better equipped to help themselves and support others;
- big impacts with small amounts of funding – small size of grant is important.

PHA representatives and community network staff at a joint showcasing event on 26 February 2014. Pictured are (l-r): Ann McNickle (CRUN), Denise Doherty (CWSAN), Gabrielle Nellis (PHA), Amanda Elliot (NACN), Sandy Wilson (NACN), Wendy Kerr (SACN) and Janine Gaston (SACN).

Next steps

The PHA is currently working on a regionally consistent approach to support capacity building within communities for future work. The proposed key elements of the model are:

- awareness raising and education;
- capacity building and resilience;
- partnership working;
- information management.

Key facts

- The community network model covers 10 local council areas.
- Three SPDOs are currently in post.
- 933 small grants have been awarded – more than £780,000 in total – averaging just under £850 per grant.
- There have been more than 10,200 beneficiaries and 37,000 volunteer hours.
- Cost through PHA funding per beneficiary is approximately £14.

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Building mental health awareness through sport

Public health challenge

A reduction of the Northern Ireland suicide rate remains a PHA priority. It is important to note the range of broad social, economic and environmental factors that have an influence on suicide. It is essential not to rely solely on a suicide reduction target as the only gauge of the impact of *Protect life – A shared vision: The Northern Ireland suicide prevention strategy 2012–March 2014*.

The stigma attached to mental disorders and suicide means that many people feel unable to seek help. Social, psychological, cultural and other factors can interact to lead a person to suicidal behaviour. It is important to acknowledge the role sport and physical activity plays in combating stress and promoting wellbeing.

Sport supports healthy lifestyles by promoting good physical and mental health. Mental health and wellbeing is a key factor for many health problems and behaviours. People with lower mental health and wellbeing are more likely to:

- smoke;
- drink above recommended limits;
- be overweight;
- engage in lower levels of physical activity;
- eat unhealthily.

All of these contribute to lower life expectancy.

Actions

Sport NI

The PHA is working with Sport NI to:

- raise awareness of mental health issues;
- break down the barriers and stigma within sport towards mental and emotional wellbeing;
- build resilience in local clubs and communities.

Irish Football Association (IFA)

The PHA is working with the IFA to use football as a means of promoting health and wellbeing.

Gaelic Athletic Association (GAA)

The PHA is working with Ulster GAA to support the six new county health and wellbeing committees in developing programmes based on needs identified locally.

Irish Rugby Football Union (IRFU) (Ulster Branch)

The PHA is working with the IRFU on the development of the organisation's first health and wellbeing strategy, which was completed in April 2015.

Western HSCT Area Sports Club Programme

Clubs from the Western HSCT area have been taking part in a sports club programme, through the CLEAR project. These clubs deliver activities that meet the needs of local communities and support the

five steps to emotional wellbeing, which are: connect, be active, take notice, keep learning, and give.

Impacts

Sport NI

More than 100 clubs from various sports received a 'Mental Health Awareness Toolkit' in the form of a large sports bag containing equipment promoting the 'Minding your head' website and self-help literature.

More than 200 people from approximately 30 different sports clubs have received mental health awareness training.

Players from Antrim Rugby Club (above) and Carryduff GAC (below) receiving their Mental Health Awareness Toolkits as part of the Sport NI programme.

IFA

200 participants, including coaches, players and parents from local clubs, attended two conferences. In total, 44 seminars were held across Northern Ireland, providing practical information on mental health and nutrition. The PHA also provided support during the production of a health booklet that was distributed at the seminars.

GAA

The PHA supported the first Ulster GAA health and wellbeing conference in November 2014, where more than 200 delegates from Ulster attended and provided positive feedback. The PHA is also represented on the first All-Ireland GAA Health and Wellbeing Committee.

Western HSCT Area Sports Club Programme

Twenty clubs from various sports in the Western HSCT area sent approximately 110 members to complete SafeTALK and Mental Health First Aid (MHFA) training.

Next steps

The PHA will continue to work with Sport NI and other local sports governing bodies to promote positive mental and emotional wellbeing in local clubs and communities.

Key facts

- In 2013, 303 deaths by suicide were provisionally registered in Northern Ireland: 229 males and 74 females.[85]

Further information

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Support project improves young men's resilience

Public health challenge

During 2009 the PHA commissioned a scoping study to gather information on emotional wellbeing work with young men in the Northern area. The study identified a need for focused work within the locality to build resilience among vulnerable young men.

The Young Men's Support Project (YMSP) is funded by the PHA in the Northern area and managed by the North Eastern Education and Library Board Youth Service.

Actions

The young men who participate in the project are between 16–25 years of age, although exceptions are made to include some 15 year olds due to their peer group connections. This initiative focuses on building the resilience and coping skills of young men.

The YMSP contains the following elements:

- Outreach (personal development work) with young men focusing on enhancing 'protective factors', ie resilience-based work, help-seeking strategies, signposting to appropriate services/support if needed. The outreach work targets vulnerable, hard to reach young men.
- Minimum of 100 young men engaged per year by each worker (two workers).
- Between six and eight group work programmes delivered per year by each worker (each programme to last six to eight weeks, with a minimum of eight participants).
- Evidence of impact through pre- and post-programme evaluation methods and record outcomes/outputs.

Impacts

Approximately 400 young men have participated in the project since its inception in 2010. They present with a wide range of issues and needs:

- low self-esteem;
- identity issues;
- self-harm;
- suicidal thoughts;
- recovering from attempted suicide;
- coping with the loss of a loved one.

The project supports young men to:

- develop coping skills and resilience;
- break down the barriers and stigma attached to mental health issues;
- seek help and support when needed.

Referrals to the project have come from a number of different agencies and individuals, and demand is increasing. It is encouraging that several young men who have participated have then referred friends to the project. This is evidence that young men are becoming more aware and confident in relation to mental health and emotional wellbeing, and are encouraging peers to do the same.

Young men who attended the suicide prevention Motivation and Evaluation Day in March 2014.

There have been instances where signposting to other services was necessary for more focused and appropriate professional help.

Workers are now trained in several interventions including Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA), and all hold a professional qualification in youth work.

Next steps

The project continues to implement appropriate personal development programmes for young males, both as individuals and as part of a group.

A similar support programme for young women is an emerging requirement and this will be considered in future plans.

Key facts

- In 2013, 303 deaths by suicide were provisionally registered in Northern Ireland – 229 males and 74 females.[86]
- The male suicide rate is three times greater than that for females (25.1 per 100,000 for males and 7.5 per 100,000 for females in 2010–2012).[86]
- The highest rate of suicide among males (2010–2012) was in the 25–29 years age group (46.4 per 100,000) followed by the 20–24 years age group (45.3 per 100,000).[86]
- The highest rate of suicide among females (2010–2012) was in the 50–54 years age group (12.9 per 100,000) followed by the 45–49 years age group (12 per 100,000).[86]

Further information

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'Breastfeeding Welcome Here' scheme grows further

Public health challenge

Scientific evidence confirms that babies who are breastfed are generally at lower risk of infections, allergies, obesity, diabetes and cot death. Women who breastfeed can also have a reduced risk of developing breast cancer, ovarian cancer and osteoporosis.[87, 88]

The longer a mother breastfeeds, the more significant the health benefits to both mother and baby, which is why it is recommended that infants are exclusively breastfed for the first six months, with continued breastfeeding into the second year of life and beyond.[89]

According to the UK *Infant feeding survey*, those least likely to breastfeed include young mothers and women who have never worked.[90] The reasons why women decide not to breastfeed include:

- they don't like the idea of breastfeeding (20%);
- it suits their lifestyle not to breastfeed (19%);
- other people can feed the baby (17%).

Embarrassment is a concern, particularly for young mothers (20%), and feedback from mothers here suggests they are not comfortable with breastfeeding in public.[90, 91]

Promoting the 'Breastfeeding Welcome Here' scheme are (l-r): Belfast Lord Mayor Nichola Mallon, Lynn Gallagher and baby Sadhbh, and Mary Black, Assistant Director of Public Health, Health & Social Wellbeing Improvement, PHA.

Actions

The PHA is the lead organisation supporting implementation of *Breastfeeding – A Great Start: A strategy for Northern Ireland 2013–2023*.[92] The strategy aims to improve the health and wellbeing of mothers and babies through increased breastfeeding rates and outlines the strategic direction to protect, promote, support and normalise breastfeeding in Northern Ireland.

The strategy sets four strategic outcomes:

1. Supportive environments for breastfeeding exist throughout Northern Ireland.
2. HSC has the necessary knowledge, skills and leadership to effectively protect, promote, support and normalise breastfeeding.
3. High quality information systems in place that underpin the development of policy and programmes, and which support strategy delivery.
4. An informed and supportive public.

The PHA is prioritising action to address each of the four outcomes through a Breastfeeding Strategy Implementation Steering Group.

Outcome 1 has seen significant progress in 2014 through the 'Breastfeeding Welcome Here' scheme. This PHA initiative provides an opportunity to highlight the importance of breastfeeding to the health and wellbeing of mothers and babies. The scheme works with businesses and local government to signpost breastfeeding families to places where they are welcome to breastfeed their baby. There are currently 401 members of this PHA scheme and a full list of the participating businesses and facilities can be seen at www.breastfedbabies.org

Scheme members are asked to display a heart-shaped sticker and a certificate that lets mothers know they are welcome to breastfeed in all public areas. Recent new members include Belfast City Council and Parliament Buildings.

Impacts

In 2014, the 'Breastfeeding Welcome Here' scheme registered 66 new members, an increase of 19.7% on 2013 (335 members).

Engagement with businesses, local government and Parliament Buildings sends out a strong message of support to breastfeeding mothers and their families.

Next steps

The PHA continues to promote the 'Breastfeeding Welcome Here' scheme and is seeking increased membership, particularly in areas with low uptake of the scheme.

The Breastfeeding Strategy Implementation Steering Group is working on a proposal that could introduce legislation in Northern Ireland by 2018 aimed of protecting breastfeeding in public.

Key facts

- In 2010, Northern Ireland had the lowest breastfeeding initiation rate in the UK at 64%, compared to England (83%), Scotland (74%) and Wales (71%).[90]
- Data from the Child Health System suggest that breastfeeding rates on discharge from hospital may be gradually increasing from 40% in 2004 to 45% in 2013.[93]
- Breastfeeding rates beyond the first few weeks and months are particularly low in Northern Ireland, with only 16% of infants being breastfed at six months compared to 36% in England.[90]

Further information

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Improving health through early detection

Overview

Treating people with familial hypercholesterolaemia

Breast screening programme embraces digital future

New cancer campaign promotes public awareness

HPV test streamlines cervical screening programme

Changing lifestyles with 'Healthy Hearts in the West'

Overview

Early detection of disease often produces better outcomes for patients because at an earlier stage, treatment may be more effective, reduce ill-health and, in some cases, reduce premature death.

Population screening programmes have a key role in the early detection of disease. A range of screening programmes are available to the public in Northern Ireland and the PHA has responsibility for commissioning, coordinating and quality assuring them.

Screening is not suitable for every condition. Organised screening programmes are established on the advice of the UK National Screening Committee and according to the best evidence available.

There are a number of programmes that invite adults to participate in screening. These include the screening programmes for bowel, breast and cervical cancer. There are also two other screening programmes for adults – the diabetic retinopathy screening programme and the abdominal aortic aneurysm (AAA) screening programme for men.

This section looks in more detail at:

- the introduction of digital mammography to the breast cancer screening programme;
- the screening for cervical cancers;
- the 'Be Cancer Aware' campaign, which aims to improve knowledge and awareness of the signs and symptoms of cancer;
- the 'Healthy Hearts in the West' initiative;
- detecting people who have a genetic predisposition to high cholesterol;
- improving eye health through the development of an integrated care pathway for glaucoma.

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Treating people with familial hypercholesterolaemia

Public health challenge

Approximately 1 person in every 500 has a very high cholesterol concentration in their blood which is due to an inherited genetic defect; known as familial hypercholesterolaemia (FH). This means we would expect around 3,700 people in Northern Ireland to have this disorder. Only around 800 had been identified before April 2014.

Most people don't know they have FH until it causes early onset heart disease. The challenge is to actively identify, and treat as many people as possible who have FH. Treatment has been shown to reduce the risk of heart disease and premature death in people with this disorder.

Actions

The PHA, in a partnership arrangement with the HSCB and Northern Ireland Chest Heart and Stroke (NICHS), introduced a new service to identify people with FH in 2014.

This new service uses a system known as cascade testing to detect undiagnosed cases. The process begins when blood cholesterol measurement and DNA tests are carried out on someone with heart disease who is suspected as having FH.

If a genetic mutation is found, tests can then be carried out on their first degree relatives and subsequently other relatives. In this way, the testing is cascaded through the wider family circle in an effort to identify all those who have the disorder.

Impacts

The development of this service should result in an additional 1,000 people with FH being diagnosed and treated over the first four years of the programme. This will prevent around 170 premature cardiovascular deaths.

Launching the new FH cascade testing programme are (l-r): Andrew Dougal, NICHS; FH patient Frances Willey; FH nurse Moyra Cather; and Dr Adrian Mairs, PHA.

Northern Ireland is one of only a small number of countries that have an organised system for identifying people with FH. Our aim is to identify as many people as possible with this genetic disorder so they can get the advice and treatment they need to prevent the early development of cardiovascular disease and avoid premature death.

Diagnosis of FH is also crucial to the patient's family. Any child of an FH sufferer has a 50% chance of inheriting the disease. Once one family member is identified as having it, on average another five will be diagnosed through cascade testing.

Next steps

The PHA will be monitoring the impact of this new service using the following performance indicators:

- percentage of the expected number of people with FH in Northern Ireland who have been identified;
- percentage of adult FH patients achieving a greater than 50% reduction in (low density lipoprotein) cholesterol concentration.

Key facts

- 50% of men with undiagnosed and untreated FH will develop heart disease by the age of 50.
- 30% of women with undiagnosed and untreated FH will develop heart disease by the age of 60.
- It is estimated that cascade testing will result in the identification and appropriate treatment of at least 50% of people with FH.

Further information

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Breast screening programme embraces digital future

Public health challenge

Breast screening in Northern Ireland is routinely offered to women between the ages of 50 and 70 years. This population is projected to rise by 16% by 2021. The service also has a high uptake – 77% of invited women attended in 2013/14.

Women aged over 70 years are encouraged to self-refer for screening, which will lead to a further increase in demand for the service.

The challenges facing the Northern Ireland Breast Screening Programme (BSP) were to:

- replace the existing analogue mammography machines with state-of-the-art digital equipment, and ensure that the programme continued to provide a high quality service to women during the transition;
- upgrade the mobile screening units and static units at Altnagelvin Area Hospital and Linenhall Street in Belfast in order to improve the experience of breast screening for women;
- further promote uptake of the service by improving access in rural areas.

Actions

During 2014, the PHA, in association with the HSCTs, replaced all the analogue mammography units in the BSP with new digital equipment. Digital mammograms are easier to read and can be stored electronically (unlike the older x-ray films, which require physical storage space), so these images will be stored on the Northern Ireland Picture Archive and Communications System (PACS) where they will be easily available.

An objective of the programme is to ensure the needs of all participating women are met, as far as possible, in terms of location and the screening environment. This was achieved by commissioning seven new mobile screening units to replace the five existing units, and by providing mobile units at new screening locations in some rural areas. In addition, the new mobiles have disability access and are all fitted with a hearing loop system.

The fixed sites at Altnagelvin Area Hospital, Belfast City Hospital and Linenhall Street in Belfast were also refurbished and new digital mammography equipment was installed.

The Health Minister visited one of the new mobile breast screening units at Lurgan Hospital in January 2015. From the left are: Margaret Holland (Southern HSCT), Nicola Kelly (PHA), Jim Wells, Gillian Sandford (Southern HSCT) and Dr Adrian Mairs (PHA).

Impacts

Programmes elsewhere that have moved to digital-only screening have reported:

- a reliable and sustainable service, with improved turnaround times;
- a reduced number of recalls due to poor images;
- an increase in breast cancer detection rates;
- improved quality and access to images for use in treatment;
- improved user experience, with increased satisfaction among women attending for mammography;
- a reduction in administrative time due to ease of storage and retrieval of breast images;
- increased physical storage space for clinical use (by eliminating the dependence on conventional film technology);
- improved health and safety, and a better working environment for staff (by removing exposure to hazardous chemicals and reducing manual handling activities).

We expect to see similar impacts in Northern Ireland. In addition, women with mobility problems can now access the service at the mobile units. Women with breast implants can also attend for breast screening at the mobile units, as digital equipment allows staff to see immediately if they have obtained good images. Previously, these groups of women had to attend hospital sites for screening.

Next steps

- Monitor and report on quality improvements in the service.
- Explore ways of streamlining the service further.
- Identify and develop further sites for mobile units to visit.
- Undertake customer satisfaction surveys post-improvement.
- Continue with exercises to encourage uptake of screening among the population.

Key facts

- Mammography in the Northern Ireland BSP has been completely digital since October 2014.
- Approximately 1,300 lives are saved each year in the UK as a result of breast screening programmes.
- 230,000 women are due to be invited for screening across Northern Ireland over the next three years.
- The seven new mobile units will visit each of the 24 sites across Northern Ireland many times over that three year period.
- The PHA has published an online video to show women what to expect when attending for breast screening. It can be viewed at: www.cancerscreening.hscni.net/Breast%20Screening%20video.htm

Further information

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New cancer campaign promotes public awareness

Public health challenge

The PHA is currently running a cancer awareness programme to improve the public's knowledge of the signs and symptoms of cancer. The rationale for the campaign is that people with cancer will have significantly better outcomes if they are diagnosed and treated as early as possible. It is therefore important that people know and understand what to look out for as possible early symptoms of cancer.

Actions

Campaign planning has included the compilation of a comprehensive evidence review, including epidemiological analysis of cancer incidence and mortality in Northern Ireland. There has also been an appraisal of major European studies on factors associated with cancer survival and an evaluation of European strategies for raising public awareness of cancer symptoms.

In addition, the PHA has completed a baseline quantitative research study exploring the attitudes, knowledge and awareness of cancer, including signs and symptoms, of the Northern Ireland public.

The PHA has worked closely with key stakeholders in planning the campaign. Two stakeholder engagement sessions were held and attended by a broad range of individuals from HSC, voluntary and/or community groups, and the charities sector. The sessions explored the evidence and rationale for developing a public information campaign and confirmed that widespread support existed for contributing to implementation of the programme.

Impacts

The key findings from the quantitative research on public attitudes, knowledge and awareness of cancer reinforced many of the results of a recent international cancer benchmarking study in which Northern Ireland participated:

- Unprompted awareness of cancer signs and symptoms is relatively low in Northern Ireland. The warning signs most commonly mentioned included:
  - a change in the appearance of a mole (38%);
  - a lump/swelling (33%);
  - being generally unwell (27%).[94]
- A cough or hoarseness was only mentioned by 16% of the survey population.[94]

- Barriers to seeking help need to be addressed –49% of respondents said they would put off going to a doctor because of worry about what the doctor might find (if they had a sign or symptom they thought might be serious) and 42% said they would put off making an appointment due to embarrassment. There is strong evidence that barriers to seeking help will, if left unchecked, continue to prevent early diagnosis.[94]
- Awareness of cancer survival rates was generally poor – the majority of individuals failed to identify life expectancy levels for common cancers.[94]

Next steps

The findings and learning from the initial work and stakeholder engagement have been used to inform the cancer awareness campaign strategy, 'Be Cancer Aware', which was launched earlier this year.

The PHA will continue to engage on the proposed campaign strategy and enable stakeholders to contribute to delivery of the campaign programme as it progresses.

Although the programme plans include a focus on a number of prioritised major cancer tumours, they will also incorporate information relating to a wide range of cancers and promote better awareness and early detection of these.

The website www.becancerawareni.info was launched in February this year and is a key aspect of the campaign. It provides information about cancer signs and symptoms, explains what to do when possible signs or symptoms appear, and signposts people to recommended sources of support or further information.

Key facts

- In 2013, 4,200 people in Northern Ireland died of cancer.[94]
- The most common sites for cancer deaths across both genders were the trachea, bronchus and lung, with 969 deaths or 23% of all cancer deaths. These were followed by prostate cancer for males (272 deaths) and breast cancer for females (320 deaths).[95]
- In 2012, there were 9,034 new cases of cancer in Northern Ireland (excluding non-melanoma skin cancer NMSC).[95]
- An estimated 51,000 people in Northern Ireland are living with cancer.[96]
- The most recent cancer survival rates (for those diagnosed between 2003 and 2007) show that more than half of those diagnosed were still alive after five years.[96]

Further information

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HPV test streamlines cervical screening programme

Public health challenge

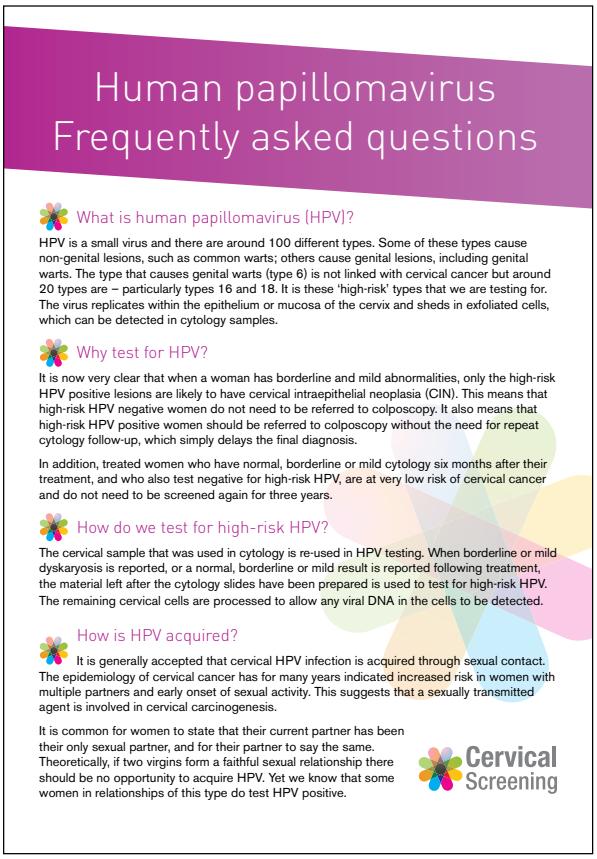
Over recent years, the link between human papillomavirus (HPV) and cervical cancer has become clearer. Thirteen types of HPV are deemed 'high risk' (HR-HPV) and are found in over 99% of diagnosed cervical cancers. This means that women who do not have HR-HPV infection are extremely unlikely to develop cervical cancer in the short to medium term.

Most people who become infected with HPV do not have symptoms and do not even know they have it. HPV is spread by close skin to skin contact. Infection with HPV is very common, but in most cases the infection is cleared naturally by the body's immune system. It is only when the virus persists that a woman is at increased risk of cervical abnormalities and cancer.

Screening for cervical cancer is offered to women aged 25–64 years. Because the screening test (smear test) looks for early changes in the cells lining the cervix, the aim is to prevent future cancers by treating these changes early.

Although over 90% of smears are reported as negative, the rest show some degree of abnormality. This ranges from low grade changes (mild or borderline) to an obvious cancer. Many low grade changes will resolve themselves and only 15–20% of women with a low grade result will have an abnormality that needs treatment.

The challenge is to improve how we identify those women with low grade changes who need treatment and ensure they receive this without undue delay. It is also important that women don't have treatments or repeat smears they don't need.



Human papillomavirus
Frequently asked questions

What is human papillomavirus (HPV)?

HPV is a small virus and there are around 100 different types. Some of these types cause non-genital lesions, such as common warts; others cause genital lesions, including genital warts. The type that causes genital warts (type 6) is not linked with cervical cancer but around 20 types are – particularly types 16 and 18. It is these 'high-risk' types that we are testing for. The virus replicates within the epithelium or mucosa of the cervix and sheds in exfoliated cells, which can be detected in cytology samples.

Why test for HPV?

It is now very clear that when a woman has borderline and mild abnormalities, only the high-risk HPV positive lesions are likely to have cervical intraepithelial neoplasia (CIN). This means that high-risk HPV negative women do not need to be referred to colposcopy. It also means that high-risk HPV positive women should be referred to colposcopy without the need for repeat cytology follow-up, which simply delays the final diagnosis.

In addition, treated women who have normal, borderline or mild cytology six months after their treatment, and who also test negative for high-risk HPV, are at very low risk of cervical cancer and do not need to be screened again for three years.

How do we test for high-risk HPV?

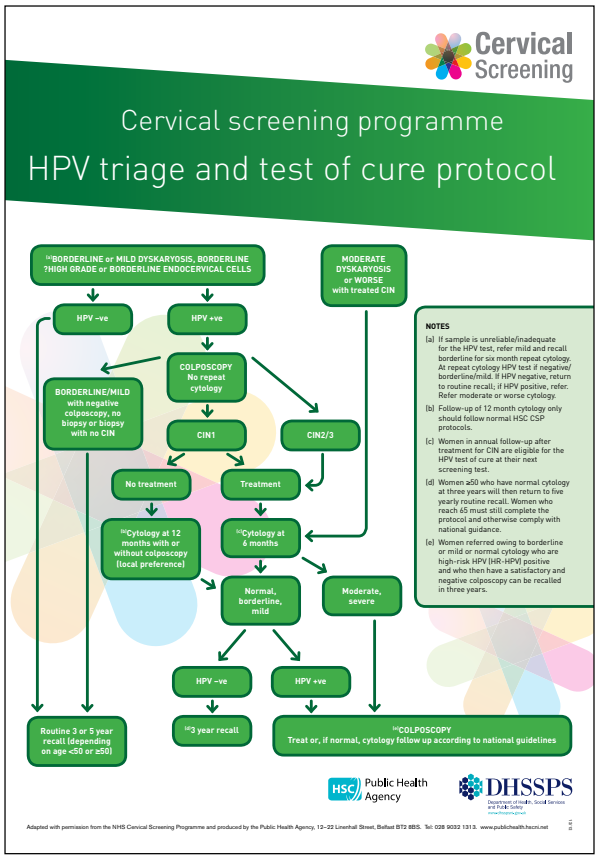
The cervical sample that was used in cytology is re-used in HPV testing. When borderline or mild dyskaryosis is reported, or a normal, borderline or mild result is reported following treatment, the material left after the cytology slides have been prepared is used to test for high-risk HPV. The remaining cervical cells are processed to allow any viral DNA in the cells to be detected.

How is HPV acquired?

It is generally accepted that cervical HPV infection is acquired through sexual contact. The epidemiology of cervical cancer has for many years indicated increased risk in women with multiple partners and early onset of sexual activity. This suggests that a sexually transmitted agent is involved in cervical carcinogenesis.

It is common for women to state that their current partner has been their only sexual partner, and for their partner to say the same. Theoretically, if two virgins form a faithful sexual relationship there should be no opportunity to acquire HPV. Yet we know that some women in relationships of this type do test HPV positive.

Cervical Screening



Actions

Testing for HR-HPV was introduced to the cervical screening programme in Northern Ireland in January 2013 to help identify which women are most likely to need treatment. HR-HPV testing is carried out on smear samples that are reported as low grade. If HR-HPV is found in the sample, the woman is referred to colposcopy without the need for further smears. If there is no HR-HPV present, the woman can safely be followed up in three to five years' time for her next smear.

Women who have already had treatment for cervical abnormalities may also be tested for HR-HPV at their follow-up smear six months after treatment. This allows many women with no HR-HPV infection to return to a schedule of one smear test every three years, rather than having these on an annual basis.

Impacts

HR-HPV testing was carried out on 9,587 samples with a low grade result in 2013/14. HR-HPV was present in 49.5% of these samples.

HR-HPV testing has improved the pathway for women with low grade changes who don't need treatment. Up to 4,840 women with a low grade smear in 2013/14 were safely returned to routine recall within the screening programme as a result of a negative HR-HPV test. Previously, these women would have been offered repeat tests or referral to colposcopy.

Testing has also ensured that women who may need treatment are referred to colposcopy in a more streamlined way. The 4,747 women with a positive HR-HPV test result were referred to colposcopy without the need for repeat smears.

Next steps

Further research suggests that HR-HPV testing may be an appropriate and effective first line screening test. Pilot studies are underway in England to explore the feasibility of changing the screening pathway. The Northern Ireland programme will watch these developments closely and consider the findings of the pilot when they are published.

In the meantime, the PHA continues to encourage uptake of the HPV vaccine for teenage girls as a means of protecting against cervical cancer. The PHA also promotes informed choice in relation to screening. Further information is available on our website: www.cancerscreening.hscni.net

Key facts

- 134,705 smears were reported in Northern Ireland in 2013/14.
- 77.3% of eligible women had a smear test in the five years up to the end of March 2014.
- Up to 80% of the population will have HPV infection during their lifetime.

Further information

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Changing lifestyles with 'Healthy Hearts in the West'

Public health challenge

Premature death rates for cardiovascular disease (CVD) in west Belfast are 50% higher than the Northern Ireland average.[97] The Healthy Hearts in the West (HHW) Initiative uses a community assets-based approach to change this.

Led by the West Belfast Partnership Board, it involves collaboration between Belfast HSCT, the HSCB, the PHA and Belfast City Council.

Established in 2012, it raises people's awareness of CVD risk factors and helps change individual lifestyles. It improves the use of existing resources and adds value by connecting service providers from statutory, community, voluntary and private sectors through partnership working.

The Belfast Taxis Community Interest Company Health Event took place on 15 February 2013 and was attended by more than 200 people, predominantly taxi drivers working for the company. The event was planned to coincide with the anniversary of the launch of the Healthy Hearts in the West Initiative and the unveiling of the Healthy Hearts taxi painted with the HHW logo. Pictured are (l-r): Geraldine McAteer, CEO WBPB, Dr Eddie Rooney, CEO Public Health Agency, and Harry, Healthy Hearts taxi driver

The initiative has been robustly evaluated, with support from the PHA and UK Clinical Research Collaboration (UKCRC) Centre of Excellence for Public Health at Queen's University Belfast, to demonstrate its potential to generate sustainable health improvement and reduce health inequalities.

Actions

HHW has supported delivery of services and programmes, piloted new interventions and added heart health awareness into existing activities by:

- working with services and groups to set up community-wide programmes, activities and events;
- delivering workplace interventions in a training centre, a call centre, a local taxi company, and with staff in a post-primary school;
- piloting cardiovascular risk assessment and weight management programmes in 10 local pharmacies;
- supporting provision of cardiac rehabilitation programmes in a community setting;
- promoting the weekly 5km Falls Park Run as part of a national movement.

Impacts

To date, more than 10,000 people have participated in programmes linked to HHW, including those that encourage people to stop smoking, be physically active, eat healthily, and watch their weight and alcohol intake. Approximately 750 people have engaged in workplace heart health events.

Following health days, lifestyle surveys and physical activity programmes, the training centre, supported by HHW, developed an organisation wide health strategy.

The participating taxi company supported the start-up of walking and physical activity groups for drivers.

Three months after the HHW post-primary school staff health day, 95% of staff (n=40) reported making lifestyle improvements. The school opened a small keep-fit suite for staff, their families and local residents.

More than 750 people accessed vascular risk assessments in community pharmacies. Over 20% were referred to their GPs because they were found to be at risk of CVD. Pharmacists also supported community events, at which more than 600 people had health checks. Over 25% were referred to HHW community pharmacy programmes.

Seventy six people completed the six month community pharmacy weight management programme. HHW in collaboration with one pharmacy and Belfast HSCT also delivered a 12 week weight management programme at a local women's centre. Eight of the 10 women who participated lost almost 25kg between them.

Cardiac rehabilitation uptake after the move to the community centre in 2012 was 42% which compared favourably against a Northern Ireland average of 38%, and patients accessed co-located supportive therapies and services. Encouragingly, the majority of cardiac rehabilitation participants continued programmes to maintain healthy lifestyles.

At the St Valentine's Day Park Run in Falls Park in February 2014, people of all ages and abilities were encouraged to walk, jog or run 1km–5km through the Falls Park and take part in fun activities designed to improve their heart health. Participants were also encouraged to learn more about how they can get involved with Healthy Hearts in the West and the weekly Park Run. Pictured are (l-r): Ciara McKay, Upper Springfield Healthy Living Centre, Janine Crawford, HHW, and Holly Burns, HHW.

The number of people registered with the Falls Park Run increased from 500 to more than 800.

Key facts

- In 2013, 3,917 people died from CVD in Northern Ireland. At 26% of all deaths, it was second only to cancer as a cause of death.[98]
- Although standardised death rates for CVD in people aged under 75 have declined (from 119 per 100,000 in 2004–08 to 93 per 100,000 in 2008–12), the difference between those who live in the least deprived areas (61 per 100,000 in 2008–12) and the most deprived areas (150 per 100,000) remains substantial.[99]
- CVD contributes two years of the 7.6 years difference in life expectancy between those living in the least and most deprived areas.[100]
- Those living in the most deprived areas are 10% more likely to be admitted to hospital and 14% more likely to be on antihypertensive prescriptions than those living in the most affluent areas.[101]

Next steps

HHW has recently completed a Belfast-wide scoping study of health improvement interventions in smoking cessation, physical activity, nutrition, and mental health improvement. Findings will inform the design of a city-wide community chronicdisease prevention and management model, taking account of lessons learnt in west Belfast.

Further information

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Improving health through high quality services

Overview

Providing high-quality maternity services for everyone

Radiotherapy centre developed at Altnagelvin

Improving quality and safety during the birth process

Care pathway to treat glaucoma in the community

Cook it! adapted for people with learning disabilities

Emergency PCI to reduce damage from heart attacks

Overview

High quality, safe services are very important to everyone. Although service use may be more common in the early years and later life, it's still crucial that services for adults are available when they need them.

This section covers some significant developments in available services including:

- the expansion of cardiac catheterisation capacity and the establishment of an immediate intervention for heart attacks called primary percutaneous coronary intervention;
- the development of a radiotherapy unit to be based at Altnagelvin Hospital;
- quality improvement for maternity services.

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Radiotherapy centre developed at Altnagelvin

Public health challenge

Radiotherapy is a treatment that many people with cancer receive. It can be used to cure many cancers, but is also used to control the spread of cancer and to manage cancer-related symptoms such as back pain.

Radiotherapy services are currently provided for Northern Ireland patients at the regional Cancer Centre at Belfast City Hospital, but it is anticipated that by 2016 the facilities at the Cancer Centre will be at full capacity because of the growing need for radiotherapy.

Following an announcement by the Health Minister in April 2008 that a new satellite radiotherapy centre would be established at Altnagelvin Hospital by 2016, the HSCB and PHA have worked closely with the Western HSCT on the establishment of a radiotherapy service at Altnagelvin. Construction is underway and the service will commence in the autumn of 2016.

Actions

The establishment of a radiotherapy service at Altnagelvin creates a unique opportunity for cross-border working with the Republic of Ireland as it will provide treatment for patients both north and south of the border.

There has been extensive collaborative work carried out with colleagues from the Republic on this matter and a memorandum of understanding (MOU) and service level agreement (SLA) have been agreed and signed between relevant parties.

Recent appointments have included consultant oncologists and the medical physics lead for the service.

Impacts

The new centre will increase radiotherapy capacity through the provision of services to people in the west and northwest of Northern Ireland. It will also offer services to a number of people from Donegal. The centre will greatly improve patient travelling times by providing more locally accessible services.

Radiotherapy treatment, both single and combination radiotherapy/chemotherapy, will be delivered at the Altnagelvin site for both palliative and curative purposes.

Care of patients with rare and/or complex cancers will continue to be provided at the specialist centres in Belfast or Dublin. Treatment and care will be delivered in line with current regional Northern Ireland Cancer Network (NICaN) protocols.

Next steps

The new centre will require a large number of staff from a variety of disciplines. The HSCB and PHA have worked closely with the Western HSCT to agree robust workforce plans and advanced recruitment for the required core disciplines is well underway.

Capital building works are also well advanced and all project plans are progressing in line with the anticipated opening of the unit in mid-2016.

The real value and importance of the new centre is that across Northern Ireland, radiotherapy provision will be much more geographically accessible. Almost all of the population will be within one hour's travel time of radiotherapy services.

As many patients attend for radiotherapy on a daily basis over a number of weeks, this improved accessibility will contribute to improved patient experience. Currently, people who live more than an hour's journey from Belfast often opt to stay at the overnight facilities at Belfast HSCT when undergoing treatment. Although this avoids lengthy travel on a daily basis, it also means people are away from home during a period of time when they may be unwell. With the addition of the Altnagelvin facility, very few people will need to remain in overnight accommodation close to either Belfast or Western HSCT radiotherapy facilities.

Key facts

- The Altnagelvin development will include three linear accelerators, housed in four bunkers.
- It will also include diagnostic facilities and 14 additional inpatient beds.
- Importantly, there will be additional staffing in the following specialty areas:
  - oncology;
  - therapeutic radiography;
  - medical physics;
  - nursing;
  - allied health professions (AHP) specialties;
  - admin/support staff.

Further information

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Improving quality and safety during the birth process

Public health challenge

The aim of the regional maternity strategy is to provide high-quality, safe, sustainable and appropriate maternity services in order to ensure the best outcome for all women and babies.[102]

Although total births in Northern Ireland are projected to decrease, there are growing challenges due to a relative increase in:

- the number of births to older mothers;
- multiple births;
- births to women who are significantly overweight or have a pre-existing chronic condition such as diabetes.

These factors increase the risk of complications during, or at the end of, pregnancy.

Overall, the rate of (clinical) intervention in labour and birth is higher in Northern Ireland than in other parts of the UK and shows significant variation across our maternity units. A focus on normalising birth and reducing unnecessary caesarean sections would result in better quality, safer care for mothers and their babies.

Actions

Recognising these challenges and the ambitions of the maternity strategy, the HSC Safety Forum established a maternity quality improvement 'breakthrough collaborative'. All HSCTs, commissioners and the DHSSPS actively contribute to the collaborative.

An advisory group, chaired by a frontline senior obstetrician, guides the strategy and direction of the collaborative. Three collaborative learning sessions were held during 2013/14. These are focused events at which frontline teams from all HSCTs share learning and best practice, and develop a plan for further actions focused on improving quality and safety for mothers and babies. Teams test and implement changes in their own settings and collect local data to measure whether or not there is improvement.

Impacts

Using the tools and techniques of improvement science, the maternity collaborative has focused on three key areas:

- promoting the normalisation of pregnancy and childbirth;
- effective communication, both between healthcare staff and with women and families;
- safe labour and delivery.

Regional outputs from the collaborative include the following:

- All HSCTs run, or are developing, 'birth choice' clinics. These enable women who have previously had a caesarean section or difficult birth to explore birth choices for the current pregnancy.
- A regional maternity quality improvement dashboard to which all HSCTs contribute data. This provides clinicians and managers with up-to-date information on clinical activity and outcomes, which assists decision-making and improves the quality of patient care.
- Integrated antenatal/post-natal obstetric early warning score. This provides a standardised approach to the documentation of clinical observations (such as heart rate and blood pressure) and the escalation of appropriate clinical concerns.
- Standardised evaluation stickers to assess a baby's heartbeat before and during labour.

Next steps

In 2015/16, the collaborative will consolidate their improvements to date and start two new areas of work:

- prevention and management of severe tears during vaginal delivery;
- a 'care bundle' to reduce the number of stillbirths (a care bundle is a set of interventions that, when used together, significantly improve outcomes).

Key facts

- In 2013, there were 24,387 births registered to mothers resident in Northern Ireland (24,277 live births and 110 stillbirths).[103]
- In 2012/13, 29.8% of births in Northern Ireland were by caesarean section. The rate by hospital ranged from 22.9%–35.8%.[104]
- Over the past 30 years, birth rates for women aged 20–24 years have more than halved and rates for women aged 25–29 years have fallen by a third. In contrast, birth rates for women aged 35–39 years increased by 34% between 1983 and 2013.[103]
- An audit of the Maternity Early Warning Score Chart showed that 86% of respondents were confident that the chart contributed to the management of women on the ward.

Further information

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Care pathway to treat glaucoma in the community

Public health challenge

Glaucoma is a common and potentially sight-threatening condition. It is usually asymptomatic until advanced, which means someone with glaucoma could be unaware there is a problem with their eyes until severe visual damage has occurred.

Regular eye tests are important for detecting eye conditions such as glaucoma. Once diagnosed, people with glaucoma or ocular hypertension need effective monitoring and treatment.

Developing eyecare partnerships, in line with *Transforming your care*, aims to improve the commissioning and provision of eyecare services over a five year period.[105,106]

The *Developing eyecare partnerships* strategy highlighted four aims:

1. Identify potential sight-threatening problems at a much earlier stage.
2. Contribute to the independence of adults and maintain them well in the community, for as long as possible, by improving access to current HSC treatment for acute and/or long-term eye conditions.
3. Contribute to the improvement of life chances for children, including those living with disabilities, through improving access to eyecare services and treatment for acute and long-term conditions.
4. Maximise use of HSC resources in both primary and secondary care services.[105]

Actions

One of the objectives being delivered by *Developing eyecare partnerships* is a regional approach to the development of integrated care pathways for a number of long-term eye conditions, including glaucoma.

Following publication of NICE guidelines on glaucoma, the HSCB, in partnership with stakeholders, redesigned the referral pathway for glaucoma.[107]

Service user John Perry with Clinical Nurse Specialist Alice Kennedy at the one-stop glaucoma clinic.

During 2013/14, a referral refinement service was launched. Community optometrists were supported to purchase state-of-the-art equipment and offered training to develop their skills. By increasing community optometrists' ability to make eye examinations more accurate, it is possible to reduce unnecessary anxiety and the need for patients to visit consultants in hospital.

For those diagnosed with glaucoma or ocular hypertension, a one-stop glaucoma clinic has been introduced in Shankill Health and Wellbeing Centre in Belfast. This allows patients to get all their tests and treatment in one place on the same day, without having to go to hospital.

Impacts

Referral refinement has resulted in fewer patients being referred to hospital ophthalmology clinics and more patients being managed closer to home as recommended in *Transforming your care*.[106]

The one-stop glaucoma clinic illustrates how primary and secondary care clinicians are working together to improve services for users. A consultant, community optometrists with a special interest and others are working together to provide a better patient-centred experience with improved outcomes.

John Perry, a service user, said: "It is great to get all my tests done and receive the results on the same day, and to know what treatment I require.

"Having everything done on the same day suits me as I don't have to travel all over the place to have tests carried out at different times and locations.

"I also don't have to take as much time off work and I'm receiving my treatment much quicker now."

Next steps

Developing eyecare partnerships is continuing work on integrated care pathways for other long-term eye conditions including cataracts and macular degeneration.

Key facts

- Approximately 10% of UK blindness registrations are attributed to glaucoma.[107]
- Around 2% of people aged over 40 years have glaucoma, rising to almost 10% in those aged over 75 years.[107]
- Glaucoma accounts for 15–19% of all referrals into hospital ophthalmology clinics and 25% of ophthalmology review appointments.
- 65% of patients who underwent referral refinement between December 2013 and July 2014 were managed without referral to hospital ophthalmology clinics.

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Cook it! adapted for people with learning disabilities

Public health challenge

Learning disability is defined as "a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development".[108]

People with learning disability experience more ill health and are at higher risk of premature death than the general population.[109] Unemployment, poverty and social exclusion are higher among the learning disabled and these contribute to significant health inequalities when compared with the general population.[110]

Research estimates that 50–90% of people with a learning disability have significant communication problems that make it difficult to read and understand written material, thereby creating barriers to accessing health information.[109]

The Northern Ireland *Learning Disability Service Framework* recommends that "people with a (learning) disability should be provided with healthy eating support and advice appropriate to their needs".[109]

Actions

The *Cook it!* programme is delivered by trained facilitators within local communities. It aims to increase people's knowledge and understanding of good nutrition and food hygiene, and help people develop the skills and confidence to cook healthy meals and snacks using inexpensive and readily available ingredients and equipment.

In recognition of the challenges experienced by people with learning disabilities and the need to provide them with health information in appropriate formats, an advisory group was established to guide the modification of the *Cook it!* programme. The group included service users, support workers, health professionals and Mencap NI.

Following results from an initial pilot, which informed further modification of the draft materials, a second pilot was undertaken by community dietitians and a dietetic student in the Western HSCT.

Materials for the new programme, called 'I can *Cook it!*', will be available from 2015/16. They include:

- a background manual for facilitators;
- full colour A1 posters with step-by-step photographic recipes for use in the weekly sessions;
- full colour recipe books for participants, featuring the pictorial recipes;
- certificates of achievement for participants that outline the key messages and skills developed during 'I can *Cook it!*' sessions.

Impacts

The new materials will be disseminated to support workers and others working with people with learning disabilities. This will be done through training provided by locally based *Cook it!* teams in the five HSCTs. Training will help support workers gain knowledge and skills to provide nutrition information and basic cooking skills sessions for their clients in an enjoyable, interactive and social environment.

People with learning disabilities will benefit from enhanced knowledge about healthier eating and good food hygiene, and will develop skills and confidence in cooking healthy meals and snacks.

By providing pictorial recipe books and certificates to record their achievements, it is anticipated that parents and carers will support and encourage individuals with learning disabilities to further develop their new skills in the home environment.

Ultimately, it is anticipated that the programme will have a positive impact on eating patterns and the health and wellbeing of people with learning disabilities.

Next steps

Evaluation of the programme will be undertaken to assess impacts among this vulnerable population group.

Key facts

- In Northern Ireland, the prevalence of learning disability is reported to be 9.7 people per 1,000 of the population.[111]
- Actual prevalence may be higher than this as a large proportion of individuals with learning disability do not present to services.[111]
- The Bamford Action Plan 2009–2011 estimated that there were 26,500 people with a learning disability in Northern Ireland. This was based on a prevalence of 1.5%.[112]

Further information

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Emergency PCI to reduce damage from heart attacks

Public health challenge

The *Programme for Government 2011–15* included a target to expand cardiac catheterisation capacity and develop a new primary percutaneous coronary intervention (pPCI) service model to reduce mortality and morbidity arising from myocardial infarction (heart attack).[113]

Approximately 40% of hospitalised heart attack patients have an ST-elevation myocardial infarction (STEMI). This type of heart attack happens when the blood supply to one of the heart's arteries is cut off completely as a result of a blood clot.

Until recently, most STEMIs in Northern Ireland were treated by giving patients a clot-busting drug (thrombolysis) followed by transfer a few days later to a catheterisation laboratory (cath lab) for a procedure called percutaneous coronary intervention (PCI). In PCI, a cardiologist uses a small balloon to inflate a narrowed coronary artery. The balloon compresses the blockage allowing the blood to flow more easily. A metal stent is then inserted to hold open the narrowed blood vessel.

Evidence has shown that if an emergency PCI can be given as the first (primary) treatment instead of receiving thrombolysis, then the risk of death, stroke and a further heart attack within the next 30 days is significantly reduced.[114]

Actions

A PHA/HSCB team brought together a group of lead cardiologists and service managers from the five HSCTs providing cardiology services, along with the Northern Ireland Ambulance Service (NIAS).

The group:

- reached a consensus on geographical and population catchments to deliver two pPCI centres at the Royal Victoria and Altnagelvin Hospitals;
- developed clinical protocols for NIAS crews and Emergency Department staff;
- developed systems for rapid return (repatriation) of patients to their local hospitals.

In tandem, additional daytime cath lab sessions were commissioned, resulting in lower waiting times, both for urgent in-patients and elective cases.

Former Health Minister Edwin Poots with staff from the Western HSCT at the opening of a new cardiac cath lab at Altnagelvin Hospital in September 2014.

Impacts

From September 2014, all patients in Northern Ireland who have a STEMI heart attack are taken directly by ambulance to either the Royal Victoria or Altnagelvin Hospital where they receive pPCI from skilled teams and, after six hours and once stable, can be transferred back to their local coronary care unit for recovery and rehabilitation.

Patient and relative feedback has been very positive. In the past, most patients with STEMI would have required a daytime PCI at some point during their stay. In the new emergency service, patients are treated at whatever time they first present, so two thirds are outside normal working hours. This has released daytime cath lab capacity to treat more patients from planned waiting lists.

Next steps

All hospitals in Northern Ireland are now contributing data to the Myocardial Infarction National Audit Project (MINAP). This will allow comparison of the pPCI service in Northern Ireland with similar units elsewhere. Examples of the features measured are 'call to balloon' time, 'door to balloon' time, and the extent to which evidence-based drug treatments are used to prevent recurrence. These results will be discussed with the Cardiac Network to ensure standards are achieved and maintained.

At the launch of pPCI for the east of Northern Ireland at the RVH in September 2013 are (l-r): Dr Tony Stephens, formerly Belfast HSCT; Veronica Gillen, HSCB; Dean Sullivan, HSCB; Lynne Charlton, HSCB; Dr Diane Corrigan, PHA; Colm Donaghy, HSCB; Dr Niall Herity, Belfast HSCT, and former Health Minister Edwin Poots.

Key facts

- There are approximately 950 STEMIs each year in Northern Ireland.
- When compared with thrombolytic therapy, pPCI reduces 30 day mortality from STEMI from 9% to 7%, non-fatal reinfarction from 7% to 3%, and stroke from 2% to 1%.[114]
- Catchments of the two pPCI centres have been agreed to minimise travel times for patients. The Royal Victoria Hospital (RVH) centre covers 75% of the population in the east and south-east of Northern Ireland, while Altnagelvin serves the western area stretching from Fermanagh to Ballycastle.

Further information

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Improving health through research

Overview

'Brain Manual' to tackle stroke risk and rehabilitation

Social networks play role in driving behaviour change

LAMP sheds light on children's meningococcal infection

Each Step Counts for people at risk of type 2 diabetes

Overview

The PHA continues to support HSC research in its widest sense. The research funded may be commissioned in response to specific needs or may be supported in response to a proposal put forward by a research team. The overriding aim is to fund research that can secure lasting improvements in the health and wellbeing of the entire Northern Ireland population.

By including representatives of service users and the public in the evaluation of research proposals, the HSC Research and Development (R&D) Division aims to ensure that the research involves these stakeholders in a meaningful and appropriate way at every stage – from design and evaluation through to dissemination of the results.

The Northern Ireland Public Health Research Network (NIPHRN) has continued to flourish during 2014 and has demonstrated success in securing external funding through collaboration with diverse stakeholders. The network draws together research development groups (RDGs), which create research proposals to secure funding for studies that address key public health priorities.

The HSC R&D Division continues to support the HSC research community in the acquisition of funds from the National Institute for Health Research (NIHR) Evaluation, Trials and Studies (NETS) research programmes. Northern Ireland- based researchers are increasingly benefitting from DHSSPS investment in NETS programmes by successfully leading studies across all programmes. During 2014/15, funding commitments have been secured for a further three Northern Ireland-led studies worth approximately £3.34 million. This income is supplemented through involvement in other studies as co-investigators. Research led by Northern Ireland researchers, worth a total of £2.17 million, has been funded through the Public Health Research Programme.

The HSC R&D Division often works in partnership with other funders to help bring additional research funding into Northern Ireland. During 2014, the HSC R&D Division commissioned seven research projects in dementia care in partnership with The Atlantic Philanthropies, with a total budget of over £2m. A commissioned schools-based research study in partnership with Cancer Focus NI is examining a smoking prevention intervention. In addition, a joint investment with Prostate Cancer UK is supporting the Movember Centre of Excellence at Queen's University Belfast, which is focused on enhancing prostate cancer treatment through radiotherapy clinical trials.

Further information

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'Brain Manual' to tackle stroke risk and rehabilitation

Public health challenge

Cerebrovascular disease is common, with 152,000 strokes occurring every year in the UK. One quarter of all strokes occur in people aged under 65 years. In Northern Ireland, 2% of males and 1% of females have had a stroke.

Stroke is the leading cause of adult disability. More than half of all stroke survivors are dependent on others for everyday activities. However, strokes are preventable events. In the 90 days before a stroke many people experience transient ischaemic attacks (TIAs), which are warning signals that a stroke may occur. Treating TIAs urgently and tackling risk factors are crucial, as these actions can reduce the risk of a stroke by approximately 80%.

Strokes and heart attacks share common underlying risk factors and both can potentially be avoided through lifestyle changes such as stopping smoking, or through medication to treat high blood pressure for example.

Cardiac rehabilitation is an effective form of prevention following a heart attack and halves the chances of a further heart attack. The *Heart Manual* is a validated home-based cardiac rehabilitation programme supported by NICE.[115]

However, people who have had a TIA or stroke are not currently offered cardiac rehabilitation programmes. The importance of determining how best to help prevent stroke is increasing.

Actions

Our research team plans to develop a novel home-based rehabilitation programme for patients who have just suffered their first TIA or minor stroke. It will do this by adapting the *Heart Manual*.

To test the feasibility of delivering a randomised controlled trial of the novel 'Brain Manual', a 12 week pilot study will compare the programme's effectiveness to standard care in improving physical fitness after a first TIA or minor stroke.

Finally, we want to explore how acceptable the 'Brain Manual' is among patients and health professionals for tackling stroke risk.

Impacts

It is anticipated the 'Brain Manual' will help support patients with TIA or minor stroke in relation to changing their lifestyle behaviour and working with health professionals during their ongoing treatment.

It is also hoped the programme will be acceptable to patients and the pilot study will show that its effectiveness could be tested in a large-scale trial.

In addition to promoting high quality care and self-management to the patients involved in this pilot project, the 'Brain Manual' also has the potential benefit of reducing their subsequent risk of stroke and all vascular events.

Next steps

Following the development of the 'Brain Manual' and completion of this pilot project, the next stage will be to conduct a large-scale trial to test its effectiveness in preventing further vascular events in people who have just suffered a TIA or minor stroke.

The protocol and intervention will be described clearly using recommended checklists.[116, 117] If found to be effective through the large trial, the next step will be to incorporate the 'Brain Manual' into routine clinical practice, while continuing to assess its impact on patients and the HSC system.

Our final aim will be to explore the use of the 'Brain Manual' in other countries as we try to improve people's health internationally.

Key facts

- A stroke occurs every three and-a-half minutes in the UK.
- 22% of stroke survivors are left with a severe or very severe disability.
- Strokes can be prevented by taking action following a TIA or mild stroke, but there is a need to improve prevention in everyday practice.

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Social networks play role in driving behaviour change

Public health challenge

Physical inactivity is responsible for 6–10% of all deaths from chronic diseases, at a cost to the NHS of £1.06 billion per year, and so the potential public health dividend of increasing physical activity in the population is substantial.[118-120] Previous initiatives have had only modest effects, with long-term changes in physical activity behaviour proving difficult to achieve. We therefore need to re-think our approach to public health interventions.

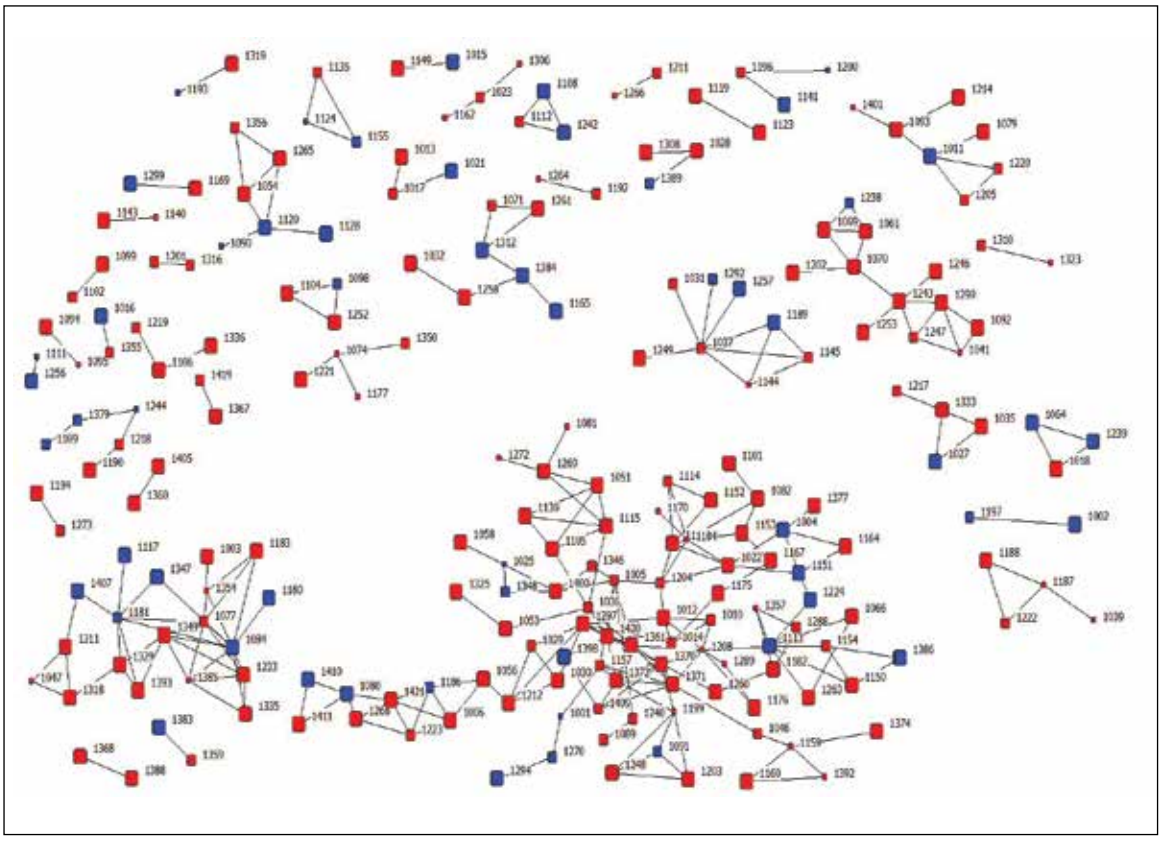
We know that social networks (connections to friends/family/colleagues) have a significant impact on health and behaviours. However, we know little about how to use social networks for behaviour change. Such interventions, if proven effective, could have significant potential for public health.

Actions

We conducted a study to investigate if social networks were evident in a physical activity behaviour change intervention, and if so, to investigate the structure and characteristics of the networks and how they change over time.[121]

Social network and physical activity data were collected over 12 weeks from a financial incentive intervention that involved sensors being placed along footpaths in the workplace environment.[122] Employees scanned a card at the sensors when undertaking physical activity such as walking, and this logged their activity. Social networks were assumed if participants swiped their card on the same day, at the same sensor (at three or more co-occurrences) and within 30 seconds of each other.

Figure 18: Network graph showing the derived social networks aggregated over the 12 week intervention period and their relation to achieved level of physical activity.



Node size = physical activity level, where the size of the node indicates the categories of 'none' (small node, 0 minutes per week), 'some' (medium node, 1–149 minutes per week) and 'sufficient' (large node, 150 minutes or more per week).

Blue node = male
Red node = female

Note: The mean degree centrality is 1.4 (SD 1.8) and ranges from 0 to a maximum of 10, meaning that the average participant (from all 406 participants) engaged in physical activity with 1.4 others.

Impacts

Results from the study provide evidence of social networks in a physical activity intervention and illustrate how networks evolve over short time periods and impact on behaviour.

Findings demonstrate that those who exercised in pairs or groups maintained higher levels of physical activity than those who did not. Therefore, harnessing and using such networks could help promote and maintain behaviour change.

To our knowledge, this is the first study to provide explicit evidence of social networks' role in behaviour change interventions. We argue that these networks have typically been overlooked, unobserved and subsequently underused in behaviour change interventions.

The collection of such data is relatively straightforward and could (and should) be incorporated into future interventions for a range of behaviours including physical activity, diet, alcohol and smoking.

Key facts

- Of the 406 participants in the study, 225 engaged in physical activity involving social interactions with at least one other participant (as opposed to those doing physical activity alone or not at all);
- 5,578 social interactions were inferred over the 12 week intervention, with 282 distinct pairings of participants;
- Figure 18 illustrates that certain participants formed clear physical activity clusters, including pairs (19 groups) and groups of three people (nine groups);
- The social network structure evolved over time. Dyadic (two people) and triadic (three people) structures were evident at each time point (weeks 1, 6 and 12), illustrating a sustained pattern of participants walking with the same people.
- Results suggest that those engaged in physical activity with others maintained higher activity levels (ie 150 minutes per week) throughout the intervention, reflected by the larger node size.

Next steps

Such interventions present various methodological and implementation challenges, which have yet to be explored.

Dr Ruth Hunter has been awarded a prestigious NIHR Career Development Fellowship to undertake development work prior to large-scale trials. This fellowship aims to do the pilot testing necessary to adequately design and evaluate novel social network-enabled interventions. This work will involve:

- reviewing previous research;
- analysing social networks for workplace physical activity;
- simulation of network factors to design an optimal intervention;
- pilot-testing the intervention.

This fellowship will address important knowledge gaps and build skills, capacity and evidence for social network-enabled interventions for physical activity behaviour.

Further information

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LAMP sheds light on children's meningococcal infection

Public health challenge

Meningococcal meningitis and septicaemia are serious and much feared infections that can rapidly progress to circulatory shock and death.

Early diagnosis is essential but very difficult because the early features are notoriously non-specific, especially in young children. Most patients initially report symptoms like those of an ordinary cold or flu-like illness, and up to half of all cases are falsely reassured by a doctor the day before they become seriously ill.

The current hospital laboratory tests can take 48 hours, so they cannot help doctors diagnose the infection. Many children who do not have the disease are also admitted to hospital and treated with antibiotics as a precaution while doctors wait for test results.

We need a rapid and accurate diagnostic test that can be used to identify and treat children with meningococcal disease early, and to avoid overtreatment of children who do not have the disease.

Actions

With HSC research funding, Drs James McKenna and Tom Bourke developed a novel 'near patient test' for diagnosis of meningococcal disease. The new test uses a method called LAMP, and was validated in the laboratory before being transferred to the Emergency Department of the Children's Hospital in Belfast.

The test was then evaluated to determine whether it could be used by a doctor or nurse, and most importantly, whether it could quickly and accurately diagnose meningococcal disease in children.

Impacts

The study confirmed that meningococcal LAMP testing:

- could be used in a clinical setting by staff without specialist laboratory training;
- could quickly deliver useful results to the clinical team (ie within one hour);
- could be used on different specimen types (blood and nose / throat swabs were tested);
- was very accurate (sensitive and specific) for diagnosis of meningococcal infection.

http://babycharlotte.co.nz

Charlotte Cleverley-Bisman, who survived amputations of all four limbs after being diagnosed with meningitis and became 'the face' of New Zealand's meningococcal meningitis vaccination campaign. Charlotte is now 11 years old and a huge inspiration to meningitis survivors around the world.

In a previous study, we showed the non-specific symptoms of early meningococcal disease were due to meningococcus infecting the nose and throat. This study confirmed that testing of nose / throat swabs can help with diagnosis of this serious infection, especially in very young children. This is important because a longer-term goal is to develop a cheap and simple test using a nose / throat swab or blood spot for children.

The LAMP test used in this study is now patented and being used routinely in the Belfast HSCT laboratory as a confirmatory test for meningococcal disease. Smaller hospital laboratories without specialist molecular diagnostic equipment could use the LAMP test as a frontline laboratory test for meningococcal disease.

Next steps

The LAMP test is being developed into a kit that could be used in any hospital, and possibly also in Emergency Departments, pharmacies or even GP practices.

We are developing a similar LAMP test for Group B streptococcus (GBS), which causes serious infections in newborn babies. We believe LAMP could be used in the labour ward, where a rapid GBS test result would allow targeted preventative treatment with antibiotics during delivery where needed, and we are seeking research funding to evaluate this.

We also believe LAMP tests could be useful in developing countries where there are often no laboratories. We have secured an initial research grant from the McClay Foundation (Northern Ireland) to develop tests to diagnose serious infections in Malawi, and work to field trial these tests in Africa is planned.

Findings from this study have been published in the Lancet Infectious Disease journal. We believe that this may help influence future NICE recommendations on meningococcal diagnosis.

Key facts

- Meningococcal meningitis and septicaemia are notifiable diseases in Northern Ireland.
- In 2013, there were 57 cases of suspected and confirmed meningococcal disease in Northern Ireland reported to the PHA.[123]

Further information

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Each Step Counts for people at risk of type 2 diabetes

Public health challenge

Type 2 diabetes is one of the most prevalent non-communicable diseases and is characterised by an inability to regulate blood glucose levels adequately. It is typically preceded by an intermediate or 'at risk' stage, often referred to as pre-diabetes.[124,125]

Group-based educational programmes that promote self-management and provide follow-up are recognised as an appropriate method of support to help prevent or delay onset of diabetes.[126]

Current recommendations are that those at risk of developing type 2 diabetes should aim to undertake moderate-intensity physical activities (such as brisk walking) for at least 150 minutes per week and maintain a healthy BMI.[127] However, little is known about how to successfully implement these recommendations in everyday practice.[128]

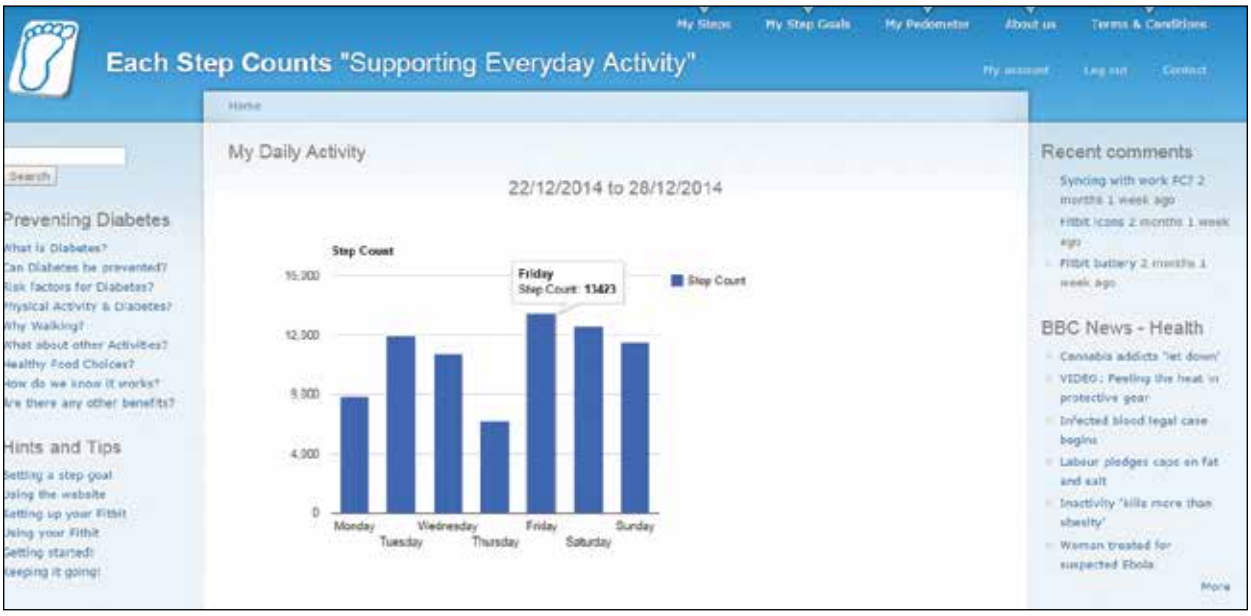
Actions

In 2014, the HSC R&D Division funded a knowledge exchange project to develop an online physical activity tool for people at risk of diabetes: www.eachstepcounts.co.uk

This is a collaborative project between South Eastern HSCT and the UKCRC Centre of Excellence for Public Health at Queen's University Belfast. The website has been developed to complement the existing community-based group intervention based on the 'Walking Away from Diabetes' programme.[129]

Existing evidence has been reviewed to identify components of previous programmes and examine the quality and content of online resources promoting activity in people with, or at risk of, type 2 diabetes. Goal-setting and self-monitoring have been identified as commonly used techniques.

Version 1.0 of the website has been completed and tested. Individuals attending the group programme can choose to use a pedometer (Fitbit Zip) to record their physical activity and upload this information to the website for review and goal-setting.[130]



Website screenshot showing individual step data uploaded for one week.

Impacts

The website provides information and advice on physical activity and its role in preventing diabetes, complementing information provided in the group-based programme. It also provides a tool by which individuals can monitor their own step data and has information on key local resources, including walking groups. The programme has successfully engaged with more than 60 people (since September 2014) who have attended the sessions across a range of locations.

The current web platform, which integrates automated uploading of physical activity data with goal-setting tasks, could easily be modified and developed further for use in this or other populations. Overall, the project provides valuable information relating to the effective integration of an online physical activity promotion tool into a community group-based intervention.

Next steps

Semi-structured telephone interviews are currently being carried out, asking people for their thoughts and experiences of using the pedometer and website to respond to the health promotion messages delivered in the group-based programme. These interviews will explore the level of user engagement with the website and how this could be improved.

Although active strategies have been put in place, additional technical support is needed for users to be able to use the Fitbit pedometer and website more effectively within the community. We therefore intend to further improve the usability of the website with the intention that it will be offered to all future participants in the South Eastern HSCT pre-diabetes prevention programme.

Some of the resources used in the group meeting to show fat and sugar content of different types of food.

Key facts

- Website analytics for www.eachstepcounts.co.uk show high visibility and access (more than 2,500 hits per month).
- Those who chose to use a Fitbit pedometer accessed the website on average 2.5 times per week during the first four weeks.
- This group showed a high level of self-efficacy for exercise (SEE = 82/90), good physical health (SF-8 = 52.2) and above average mental wellbeing (WEMWBS = 58).

SEE (Self-Efficacy for Exercise Scale)
SF-8 (Short Form 8 Health Survey)
WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)

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Protecting health

Overview

PHA leads Ebola preparedness across Northern Ireland

Coordinated action to reduce hepatitis C diagnoses

Raising public awareness key to treatment of tuberculosis

SSI surveillance improving safety of caesarean sections

Overview

The Health Protection Service within the Public Health Directorate of the PHA provides a high quality service to protect the population of Northern Ireland from threats posed by communicable diseases and environmental hazards.

These efforts are directed at all sections and age groups of the population. In the articles in this year's report, you will see how the Health Protection Service undertakes work to protect all adults in the community from infectious diseases.

Ebola preparedness has featured heavily in the work programme of the Health Protection Service. Ebola was declared a global public health emergency by WHO in August 2014. All countries, including Northern Ireland, were required to actively prepare for cases of Ebola Virus Disease (EVD). An active programme has been underway with the DHSSPS, HSCTs, primary care and others to ensure that Northern Ireland is prepared in the event that we see an Ebola case here. This includes the development of care pathways for patients who may present with EVD.

Tuberculosis (TB) infection continues to challenge us and we are seeing a change in the epidemiology of this infection. Notably, we are seeing an increased number of infections and we have seen some cases of multi-drug resistance TB in Northern Ireland. It is imperative that we raise public awareness of TB and the risk factors for transmission, and also ensure that arrangements are in place for early diagnosis and treatment.

Surveillance of communicable diseases is a key function of the Health Protection Service. This report highlights two infections of particular relevance to adults in the community – hepatitis C and surgical site infections (SSIs) post-caesarean section. It is important that we keep these diseases under surveillance to ensure that we can determine appropriate interventions. For example, in the case of caesarean section infections, the antibiotic prophylaxis guidance has been updated and an audit was undertaken during 2014.

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PHA leads Ebola preparedness across Northern Ireland

Public health challenge

Ebola virus disease (EVD) is a serious illness with a high mortality rate, which originated in Africa. The current outbreak in West Africa (Guinea, Sierra Leone and Liberia) is one of the most challenging global public health threats in recent times.

The incubation period (the time between catching an infection and developing symptoms) is 2 to 21 days and the likelihood of contracting EVD is extremely low unless the person has come into contact with body fluids (eg blood, vomit, diarrhoea, semen) of a symptomatic person. People with EVD do not become infectious until they have developed symptoms, such as a fever.

An infected person will typically develop a fever, headache, joint and muscle pain, sore throat, and intense muscle weakness.

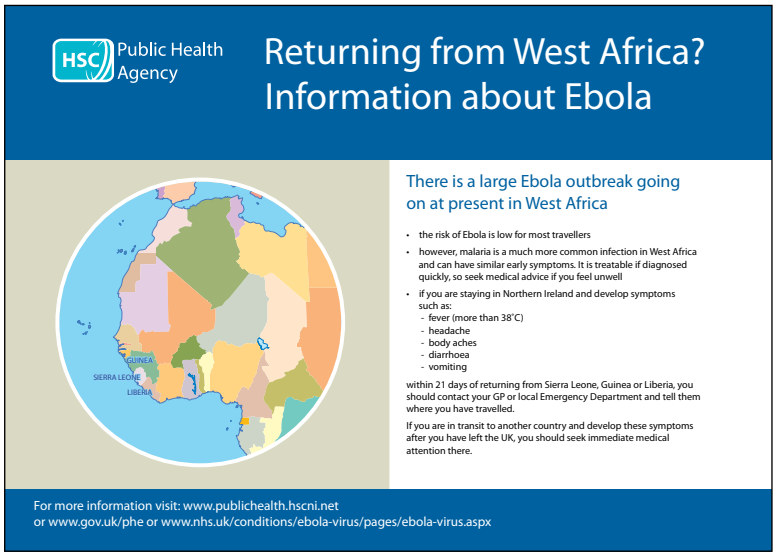
Ebola has had a major impact on the affected countries and on those providing care for infected patients. High attack rates and death rates have devastated communities, caused fear and anxiety, and affected cultural burial arrangements. Healthcare workers from Africa and the multiple aid agencies in the field have struggled to contain the outbreak given local living conditions, customs and the standard of health facilities.

Action has been taken to halt the course of the outbreak in the affected countries and the international effort, including some input from Northern Ireland as part of the UK response, is beginning to produce positive results.

Although the direct risk to Northern Ireland remains low, our health services must be prepared for the possibility of a person who has arrived from an affected country becoming ill when in Northern Ireland. During 2014, the challenge for health protection was to lead and ensure preparedness across all health services.

Actions

The PHA has been working with HSCTs and others to strengthen and test our preparedness to respond to a case of EVD. We also work closely with our health protection colleagues in Public Health England, sharing plans for response and undertaking surveillance of healthcare and other workers returning from the affected areas.


HSC Public Health Agency

Returning from West Africa?
Information about Ebola

There is a large Ebola outbreak going on at present in West Africa

- the risk of Ebola is low for most travellers
- however, malaria is a much more common infection in West Africa and can have similar early symptoms. It is treatable if diagnosed quickly, so seek medical advice if you feel unwell
- if you are staying in Northern Ireland and develop symptoms such as:
  - fever (more than 38˚C)
  - headache
  - body aches
  - diarrhoea
  - vomiting

within 21 days of returning from Sierra Leone, Guinea or Liberia, you should contact your GP or local Emergency Department and tell them where you have travelled.

If you are in transit to another country and develop these symptoms after you have left the UK, you should seek immediate medical attention there.

For more information visit: www.publichealth.hscni.net
or www.gov.uk/phe or www.nhs.uk/conditions/ebola-virus/pages/ebola-virus.aspx

In October 2014, we led a comprehensive exercise to prepare for the possible importation of suspected cases of EVD to Northern Ireland. Exercise Gueckedou (named after the area in Guinea where the first case in the current outbreak was diagnosed) was a half-day multi-agency exercise aimed at testing local and regional

preparedness for a suspected Ebola case in Northern Ireland. This exercise was jointly organised by the DHSSPS and the Health Protection Service of the PHA to provide organisations with an opportunity to discuss their local plans and regional coordination arrangements.

The plans cover the specific actions to be taken in the event of suspected or confirmed EVD cases in Northern Ireland. This also covers the vital public health action of monitoring contacts of confirmed cases including, where necessary, monitoring returning healthcare workers and other travellers from the affected countries.

Impacts

The planning process has involved all HSCTs and has required a significant amount of work, in particular for the Regional Virus Laboratory and the Regional Infectious Disease Service at Belfast HSCT.

Although the overall risk to the population of Northern Ireland remains low, planning, training and exercising will ensure that a case of EVD presenting in Northern Ireland will be rapidly identified, isolated and treated.

Clear patient pathways for diagnosis and care have been developed and are being used by HSCTs and primary care. This is important, not only for the individual, but to prevent others in close contact also becoming infected.

Next steps

The PHA and health services in Northern Ireland will continue to plan in accordance with the emerging evidence around EVD and strategies for containing this outbreak.

Key facts

- In early 2015, there were more than 21,000 confirmed or suspected cases associated with this EVD outbreak, and more than 8,000 deaths.
- A small number of confirmed cases have occurred outside West Africa, either in returned travellers from the affected countries or healthcare workers who treated those infected. This includes the first case diagnosed in the UK.

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Coordinated action to reduce hepatitis C diagnoses

Public health challenge

Hepatitis C is a viral disease that mainly affects the liver. Infected people can have no symptoms for 10–20 years but infection can lead to end-stage liver disease, cirrhosis and liver cancer. It is a worldwide problem and places with the highest rates of infection include some countries in Africa, Asia and South America.

The virus is mainly spread through contact with infected blood, so risks include injecting drug use, tattoos, and medical treatment and blood transfusions in high-risk countries. Diagnoses of hepatitis C in Northern Ireland have increased significantly to about 120 new cases each year, with the majority of these in the 15–64 years age group.

Actions

Actions to reduce hepatitis C infection fall into four main categories:

- prevention of new infections;
- raising awareness;
- increasing testing and diagnosis;
- improving treatment and care.

Current actions in Northern Ireland include:

- the Northern Ireland Hepatitis B & C Managed Clinical Network coordinates activities related to hepatitis C across the province;
- needle exchange sites in 17 locations across Northern Ireland to prevent new infections and reduce the spread of hepatitis C among people who inject drugs;
- raising awareness (through press releases, leaflets distributed to GPs and translated materials) of hepatitis C in the general population to encourage people who may have put themselves at risk in the past to seek testing;
- raising awareness among GPs (through GP education sessions) of the importance of offering testing for hepatitis C;
- a pilot education and testing session with the Chinese community in Belfast where 55 people were tested for hepatitis B and C;
- the Northern Ireland Hepatitis B & C Managed Clinical Network coordinator ensures all new diagnoses of hepatitis C are referred to hepatology services for assessment and treatment.

Impacts

- Northern Ireland needle exchange programmes issued 28,284 needle packs during 2013/14 to people who inject drugs, including an increase in needles for injecting performance and image enhancing drugs.[131]
- Approximately 200 GPs and practice nurses received training on hepatitis C in 2014, with sessions continuing in 2015.
- Before 2009, around 25% of people newly diagnosed with hepatitis C were not referred to specialist services. With the follow-up programme by the Northern Ireland Hepatitis B & C Managed Clinical Network, only 5% of people newly diagnosed with hepatitis C are not now referred to specialist services. This work received a commended award at the Quality in Care Hepatitis C Awards 2014.

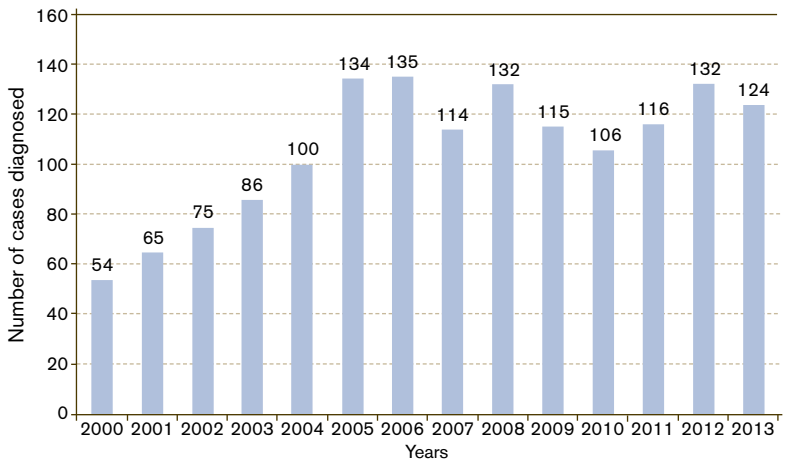
Next steps

We will continue to raise awareness of hepatitis C and the importance of early testing among healthcare workers and other groups who work with those at greatest risk.

We will also work with drug and alcohol services to increase testing of clients, including the introduction of dried blood spot testing.

As new treatments for hepatitis C become available, work will continue across the health service to ensure the maximum number of patients can be treated to reduce the risk of chronic liver disease and transmission of hepatitis C to others.

Figure 19: Laboratory-confirmed cases of hepatitis C in Northern Ireland, 2000–2013



Data source: NI Regional Virology Laboratory

hepBC

Northern Ireland Hepatitis B & C Managed Clinical Network

www.hepbandcni.net

Key facts

- Hepatitis C is a global health problem, with an estimated 150 million people chronically infected worldwide.[132]
- WHO estimates that more than 350,000 people will die each year from hepatitis C-related liver diseases.[132]
- Death rates from liver disease are increasing in the UK and most liver disease is due to alcohol, obesity and viral hepatitis.
- Around 214,000 people in the UK have long-term hepatitis C infection, and hepatitis C-related end-stage liver disease is rising.[132]
- The number of confirmed cases of hepatitis C in Northern Ireland has more than doubled in the past 13 years.

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Raising public awareness key to treatment of tuberculosis

Public health challenge

Tuberculosis (TB) is an infection caused by bacteria and usually affects the lungs, but can affect other parts of the body when the TB infection becomes active. It is spread from person to person when someone who has active TB of the lungs coughs or sneezes.

Incidence of active TB has increased in Northern Ireland in recent years, especially among younger people. This reflects the greater proportion of cases among people born outside the UK, who tend to be younger than locally-born cases. The increasing incidence of active TB among people aged 15–44 years and 45–64 years is shown in Figure 20, represented by the upward trend in green and red lines.

Actions

Public health measures to control TB depend on public awareness (especially among high-risk groups), enabling early diagnosis and treatment of active TB.

It is also possible to offer TB screening to people at high risk, eg people from high incidence countries, to detect TB infection before the disease becomes active (latent TB infection).[133]

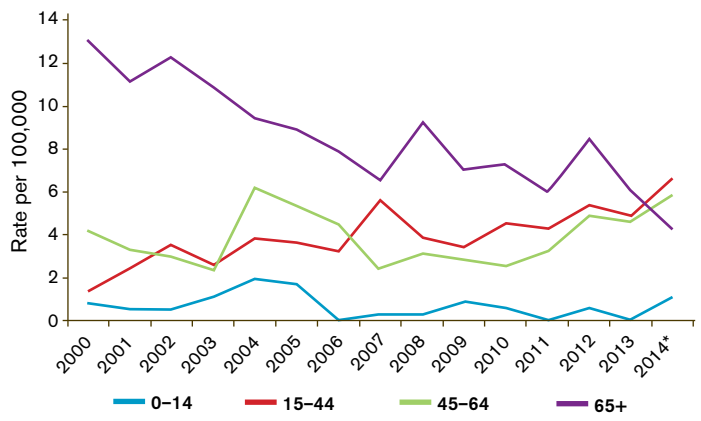
BCG vaccination is not recommended for everyone but is recommended for young babies and children who:

- have one or more parents or grandparents born in a high incidence country;
- will be living in a high incidence country for more than three months;
- have a member of their household or family circle who has TB, is suspected of having TB, or has had TB in the past five years.

Impacts

TB is usually curable with a six-month course of antibiotics but can be fatal if not treated. Prompt treatment is important to allow the person to recover quickly and also to prevent onward spread of the infection. TB treatment is free for patients in the UK.

Figure 20: Age-specific rates of TB in Northern Ireland



Note. * 2014 data provisional

By detecting and treating TB infection before the disease becomes active, it is possible to reduce a person's risk of developing active TB. Studies on the effectiveness of BCG vaccination have given varying results. However, BCG has been shown to be 70–80% effective against the most severe forms of the disease, such as TB meningitis in children.

BCG vaccination for those in the recommended groups, and the detection and treatment of latent TB infection in those at increased risk, including new entrants from high incidence countries, are essential for the prevention and control of TB in Northern Ireland.

Next steps

Any of the following signs and symptoms may suggest active TB and may require further specialist investigation:

- fever and night sweats;
- persistent cough;
- losing weight;
- blood in your sputum (phlegm or spit) at any time.

All suspected cases of TB should be referred for urgent assessment by the designated physicians within each HSCT.

TB is a notifiable disease. Clinicians are required to report all confirmed or suspected cases to the PHA Duty Room to enable appropriate public health measures.

Key facts

- There were 97 cases of active TB reported in Northern Ireland in 2014 (provisional figure).
- 55% of the people diagnosed with active TB in Northern Ireland in 2014 were born outside the UK.*
- TB cases born outside the UK tend to be younger than UK-born cases, with an average age of 36 years compared with 54 years.*

* Does not include four cases for whom UK born status is currently unknown.

Further information

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SSI surveillance improving safety of caesarean sections

Public health challenge

More than a quarter (29%) of all births in Northern Ireland are by caesarean section – a larger proportion than that recorded in other parts of the UK and Republic of Ireland.

The PHA coordinates a programme of surgical site infection (SSI) surveillance following caesarean section. SSI may occur following a surgical procedure and range in severity from infections involving the skin and tissue under the skin, to infections of the muscles or surrounding organs. SSIs represent a significant burden in terms of patient morbidity, mortality and cost to health services.

SSIs are relatively rare. The likelihood of developing an SSI depends on factors related to both the patient and the surgical procedure. Targeting modifiable risk factors, such as those related to the patient (eg appropriate hair removal, obesity and diabetes) and the healthcare setting (eg hand hygiene, wound dressing and prophylactic antibiotics) are crucial in minimising the risk of SSI following surgery.

Routine surveillance of SSIs, with feedback of appropriate data to healthcare staff and providers, is an important component of strategies to reduce SSI risk.[134-137]

Actions

Surveillance of SSI following caesarean section is mandatory in Northern Ireland. Data from this programme are analysed by the PHA and reported back to programme participants, to enable them to monitor and implement actions that reduce the risk and occurrence of post-operative SSI.

Women who deliver by caesarean section are reviewed during their inpatient stay. Most SSIs will not become apparent until after discharge from hospital, so community midwives follow up all women who deliver by caesarean section for up to 30 days post-delivery.

A key aim of this SSI surveillance programme is to improve the safety and quality of patient care. Programme outputs provide participating hospitals with robust infection rates to inform service planning and delivery, and to facilitate comparison and benchmarking with other similar services. Feedback of risk-adjusted SSI rates can inform many steps taken to minimise the risk of post-operative infection, and can help communicate the risks to patients.

Each quarter, the PHA provides participants with a summary of SSI infection rates relating to their caesarean section procedures. Data are presented by hospital and HSCT. Rates of infection are related to risk factors including BMI, nature of procedure (planned/elective), duration of procedure, and antimicrobial prophylaxis (agent and timing of administration).

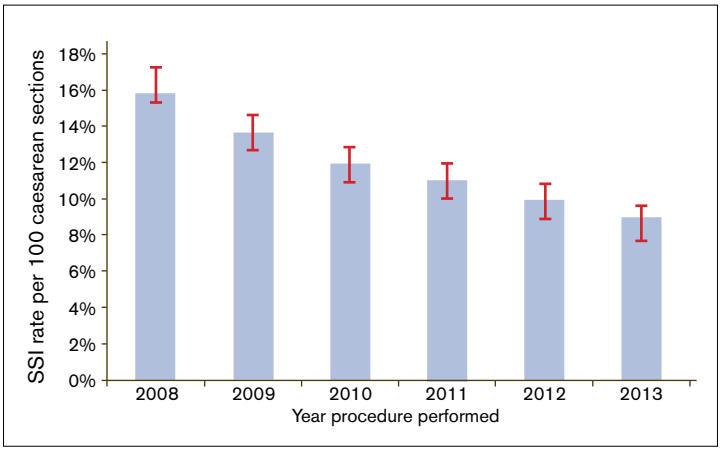
Impacts

This SSI surveillance programme was introduced in 2008 and continues to provide timely feedback to assist clinical teams in minimising the occurrence of SSI following caesarean section. In 2013, the PHA received information on over 80% of caesarean section procedures performed (with some providers achieving 100% compliance).

SSI rates following caesarean section surgery have declined year-on-year since the programme was established (Figure 21). The rate of infection has almost halved over the past six years, from 1 in 6 women developing an SSI in 2008 to 1 in 11 women in 2013.

HSCTs and clinical teams have used surveillance results to improve their practices. SSI surveillance programme outputs have also been used to assist and monitor the implementation of NICE Clinical Guideline 132 on caesarean section.[138]

Figure 21: Caesarean section SSI rate 2008–2013 (95% confidence interval)



Next steps

All hospitals and clinical teams are encouraged to develop a clear strategy for actively disseminating information and learning that emerges through the caesarean section SSI surveillance programme, particularly information relating to their own service.

The PHA will continue to focus on translating evidence into practice, working with clinical teams to further reduce SSIs following caesarean section. The overall aim is to use SSI data, linked with quality improvement methodologies, to reduce post-operative SSIs and to share best practice and lessons learned.

The PHA will continue to investigate the use of electronic data (from existing information sources) combined with web-based reporting of infection-related information to develop this SSI surveillance programme.

Key facts

In 2013:

- 510 women developed SSIs following caesarean section surgery. This represents 9% of all women who had a caesarean section.
- 95% of these SSIs were identified following discharge from hospital.
- 29% of women who had a caesarean section had a BMI of 30 or more, which is considered obese. Obese women were twice as likely to develop an SSI as women with a BMI less than 30.
- 90% of these SSIs involved the skin and/or tissue under the skin. The other 10% were more serious infections, involving deep tissue and muscle or surrounding organs.
- 34 women were re-admitted to hospital for treatment of an SSI, adding an average of four days in hospital for each woman.

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2. Northern Ireland Statistics and Research Agency. Home Population by sex & single year of age 1961 to 2013. NISRA. 26 June 2014. Available at: www.nisra.gov.uk/demography/default.asp17.htm Accessed 25 March 2015.

3. Northern Ireland Statistics and Research Agency. Census 2011: Ethnicity, Identity, Language and Religion. Economic Activity by Ethnic Group by Age by Sex_DC2601NI. NISRA. Available at: www.ninis2.nisra.gov.uk/public/Theme.aspx?themeNumber=136&themeName=Census+2011 Accessed 25 March 2015.

4. Northern Ireland Statistics and Research Agency. Statistics Press Notice. Census 2011: Detailed Characteristics for Northern Ireland on Ethnicity, Country of Birth and Language. NISRA. Available at: www.nisra.gov.uk/census/detailedcharacteristics_press_release_2_2011.pdf Accessed 25 March 2015.

5. Northern Ireland Life & Times. 2003 Background: Religion. NILT. Available at: www.ark.ac.uk/nilt/2003/Background/RELIGION.html Accessed 25 March 2015.

6. Northern Ireland Statistics and Research Agency. Long-term International Migration Estimates for Northern Ireland. NISRA. Available at: www.nisra.gov.uk/archive/demography/population/migration/Mig_Report11_12.pdf Accessed 25 March 2015.

7. Northern Ireland Statistics and Research Agency. Marriages by sex and age, 1948 to 2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp11.htm Accessed 25 March 2015.

8. Northern Ireland Statistics and Research Agency. Marriages, Divorces and Civil Partnerships Reports. NISRA. Available at: www.nisra.gov.uk/demography/default.asp25.htm Accessed 25 March 2015.

9. Northern Ireland Statistics and Research Agency. Census 2011: Key statistics for Northern Ireland, December 2012. NISRA. Available at: www.nisra.gov.uk/Census/key_report_2011.pdf Accessed 21 April 2015.

10. Northern Ireland Statistics and Research Agency. Census 2001: Key Statistics Tables. NISRA. Available at: www.nisra.gov.uk/archive/census/2001/key%20statistics/Key%20Statistics%20ReportTables.pdf Accessed 21 April 2015.

11. Northern Ireland Statistics and Research Agency. Interactive Content: Population. Families. Marriages, Divorces and Civil Partnerships. NISRA. Available at: www.ninis2.nisra.gov.uk/public/InteractiveMapTheme.aspx?themeNumber=74&themeName=Population Accessed 25 March 2015.

12. Northern Ireland Statistics and Research Agency. Statistical Bulletin: Births in Northern Ireland 2013. NISRA. 27 May 2014. Available at: www.nisra.gov.uk/archive/demography/publications/births_deaths/Births_2013.pdf Accessed 25 March 2015.

13. Northern Ireland Statistics and Research Agency. Life Tables / Life Expectancy. NISRA. Available at: www.nisra.gov.uk/demography/default.asp130.htm Accessed 25 March 2015.

14. Stewart B, Lyness C, Bell C. NI Health & Social Care Inequalities Monitoring System: Life Expectancy Decomposition. Belfast: DHSSPS, 2012. Available at: www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2013.pdf Accessed 25 March 2015.

15. Department of Health, Social Services and Public Safety. Regional Health Inequalities. DHSSPS. Available at: www.dhsspsni.gov.uk/index/statistics/health-inequalities/regional-health-inequalities.htm Accessed 25 March 2015.

16. Northern Ireland Statistics and Research Agency. Deaths by single year of age, 1955 to 2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp10.htm Accessed 25 March 2015.

17. Northern Ireland Statistics and Research Agency. Death rates by sex and age, 1971 to 2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp10.htm Accessed 25 March 2015.

18. Northern Ireland Statistics and Research Agency. Births and Deaths Reports: Microdata for Deaths in Northern Ireland, 2001–2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp23.htm Accessed 25 March 2015.

19. Northern Ireland Life & Times. 2013 Background: Happiness. NILT. Available at: www.ark.ac.uk/nilt/2013/Background/RUHAPPY.html Accessed 25 March 2015.

20. Walker H, Scarlett M, Williams B. Health Survey Northern Ireland: First Results 2013/14. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/index/statistics/hsni-first-results-13-14.pdf Accessed 25 March 2015.

21. Public Health Agency. Children's Health in Northern Ireland: A statistical profile of births using data drawn from the NI Child Health System, NI Maternity System and NISRA. Belfast: PHA, 2015.

22. Northern Ireland Statistics and Research Agency. Alcohol and Drug Deaths: Alcohol Related Deaths Registered in Northern Ireland 2003–2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp30.htm Accessed 25 March 2015.

23. Information Analysis Directorate. Department of Health, Social Services and Public Safety. Adult Drinking Patterns in Northern Ireland 2013. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/index/statistics/lscb-adps-2013.pdf Accessed 25 March 2015.

24. Northern Ireland Statistics and Research Agency. Alcohol and Drug Deaths: Tables for Drug Related Deaths and Deaths due to Drug Misuse Registered in Northern Ireland 2003–2013. NISRA. Available at: www.nisra.gov.uk/demography/default.asp30.htm Accessed 25 March 2015.

25. Public Health Information & Research Branch. Department of Health, Social Services and Public Safety. Statistics from the Northern Ireland Drug Misuse Database: 1 April 2013 – 31 March 2014. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/index/statistics/dmd-2013-14.pdf Accessed 25 March 2015.

26. Public Health Agency. HIV Surveillance in Northern Ireland 2014: An analysis of data for the calendar year 2013. Belfast: PHA, 2014. Available at: www.publichealth.hscni.net/sites/default/files/HIV_surveillance_report_2014.pdf Accessed 25 March 2015.

27. Public Health Agency. Sexually Transmitted Infection surveillance in Northern Ireland 2014: An analysis of data for the calendar year 2013. Belfast: PHA, 2014. Available at: www.publichealth.hscni.net/sites/default/files/directorates/files/STI%20surveillance%20report%202014.pdf Accessed 25 March 2015.

28. Northern Ireland Life & Times. 2010 Background: Disability. NILT. Available at: www.ark.ac.uk/nilt/2010/Background/DISAB1.html Accessed 25 March 2015.

29. Northern Ireland Cancer Registry. All Cancers Exc NMS. Queen's University Belfast. Available at: www.qub.ac.uk/research-centres/nicr/CancerStatistics/OnlineStatistics/AllCancersExcNMS/ Accessed 25 March 2015.

30. Public Health Agency. Northern Ireland Registry of Self-Harm Annual Report 2013/14. Belfast: PHA, 2015. Available at: www.publichealth.hscni.net/sites/default/files/Annual%202013%2014%20Report%20NIRSH_0.pdf Accessed 25 March 2015.

31. Northern Ireland Statistics and Research Agency. Suicide Deaths. NISRA. Available at: www.nisra.gov.uk/demography/default.asp31.htm Accessed 25 March 2015.

32. Business Services Organisation. Counts and Costs of Prescriptions. (Unpublished)

33. Department of Health, Social Services and Public Safety. Admissions Data by Age. (Unpublished)

34. Northern Ireland Statistics and Research Agency. Labour Market Statistics Bulletin: Northern Ireland Annual Survey of Hours and Earnings 2014. Belfast: NISRA, 2014. Available at: www.detini.gov.uk/ni_ashe_2014_bulletin-2.pdf?rev=0 Accessed 25 March 2015.

35. Nomis. Labour Market Profile – Northern Ireland. Nomis Official Labour Market Statistics. Available at: www.nomisweb.co.uk/reports/lmp/gor/2013265932/report.aspx?#tabnrhi Accessed 25 March 2015.

36. Oxford Economics. An Economic Analysis of the Living Wage in Northern Ireland: A Report for NICVA. Belfast: NICVA, 2014. Available at: www.nicva.org/sites/default/files/d7content/attachments-resources/nicva_living_wage_2014_0.pdf Accessed 25 March 2015.

37. Northern Ireland Life & Times. 2013 Background: Household Income. NILT. Available at: www.ark.ac.uk/nilt/2013/Background/HINCPAST.html Accessed 25 March 2015.

38. Department of Justice. Headline Statistics: Northern Ireland Criminal Justice System. DOJ. 30 December 2014. Available at: www.dojni.gov.uk/index/statistics-research/stats-research-publications/headline-statistics.htm Accessed 25 March 2015.

39. Campbell P. Experience of Crime: Findings from the 2013/14 Northern Ireland Crime Survey. Research and Statistical Bulletin 1/2015. Belfast: DOJ, 2015. Available at: www.dojni.gov.uk/index/statistics-research/stats-research-publications/northern-ireland-crime-survey-s-r/260215-nics-2013-14-experience-bulletin.pdf Accessed 25 March 2015.

40. Crone E. The Northern Ireland Prison Population 2013. Research and Statistical Bulletin 15/2014. Belfast: DOJ, 2014. Available at: www.dojni.gov.uk/index/statistics-research/stats-research-publications/prison-population/northern-ireland-prison-population-2013.pdf Accessed 25 March 2015.

41. Public Health Agency. Prisoner Health Needs Assessment. 2014. (Unpublished)

42. Northern Ireland Life & Times. 2013 Minority Ethnic People. NILT. Available at: www.ark.ac.uk/nilt/2013/Minority_Ethnic_People/RACOWNKD.html Accessed 25 March 2015.

43. Northern Ireland Life & Times. Lesbian, Gay, Bisexual and Transgender (LGBT) Issues. NILT. Available at: www.ark.ac.uk/nilt/results/lgbt.html Accessed 25 March 2015.

44. Department for Social Development. Benefits Statistics Summary: Carer's Allowance November 2014. DSD. Available at: www.dsdni.gov.uk/index/stats_and_research/benefit_publications.htm Accessed 25 March 2015.

45. Northern Ireland Statistics and Research Agency. Census 2011: General Health by Provision of Unpaid Care by Age by Sex_DC3301NI. NISRA. Available at: www.ninis2.nisra.gov.uk/public/Theme.aspx?themeNumber=136&themeName=Census+2011 Accessed 25 March 2015.

46. Department of Health, Social Services and Public Safety. Health Survey Northern Ireland – 2012/13. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/index/statistics/publications-statistics.htm?SelThemes=THLCB&SelTopic=TP&Year=2014 Accessed 25 March 2015.

47. Aked J, Marks N, Cordon C, Thompson S. Five Ways to Wellbeing. New Economics Foundation, 2008. Available at: http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf Accessed 25 March 2015.

48. Northern Ireland Statistics and Research Agency. NI Omnibus Survey: Voluntary and Community Unit (VCU) Module Report. Belfast: DSD, 2013. Available at: www.dsdni.gov.uk/volunteering-omnibus-survey-results.pdf Accessed 25 March 2015.

49. Volunteer Development Agency. It's all about time: Volunteering in Northern Ireland 2007. Full Report. Belfast: Volunteer Development Agency, 2007. Available at: www.volunteernow.co.uk/fs/doc/publications/itsallabouttimefullreport2007.pdf Accessed 25 March 2015.

50. Clinical Resource Efficiency Support Team. Management of diabetes in pregnancy. Belfast: CREST, 2001. Available at: www.gain-ni.org/images/Uploads/Guidelines/diabetes_main_doc.pdf Accessed 10 January 2015.

51. Queen's University Belfast. Women with diabetes. Available at www.womenwithdiabetes.net/ Accessed 20 January 2015.

52. Feig Denice S et al. Risk of development of diabetes mellitus after diagnosis of gestational diabetes. CMAJ 2008; 179(3): 229–234.

53. Walker H, Scarlett M, Williams B. Health Survey Northern Ireland: First results 2013/14. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/hsni-first-results-13-14.pdf Accessed 16 February 2015.

54. National Institute for Health and Care Excellence. NICE guidelines PH53: Managing overweight and obesity in adults – lifestyle weight management services. London: NICE, 2014. Available at: www.nice.org.uk/guidance/ph53 Accessed 12 February 2015.

55. Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists. CMACE/RCOG Joint Guideline – Management of women with obesity in pregnancy. London: CMACE and the Royal College of Obstetricians and Gynaecologists, 2010. Available at: www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/15.-March-2010-Management-of-Women-with-Obesity-in-Pregnancy-Guidance.pdf Accessed 29 January 2015.

56. Yu CKU, Teoh TG, Robinson S. Obesity in pregnancy. British Journal of Obstetrics and Gynaecology 2006; 113: 1117–25.

57. Ramachandran J, Bradford J, McLean M. Maternal obesity and pregnancy complications: a review. Australian and New Zealand Journal of Obstetrics and Gynaecology 2008; 48: 228–35.

58. Rasmussen KM, Yaktine AL (Editors), Committee to Reexamine IOM Pregnancy Weight Guidelines. Weight gain during pregnancy: Re-examining the guidelines. Washington DC: Institute of Medicine and National Research Council of the National Academies, 2009.

59. Siega-Riz AM, Viswanathan M, Moos MK et al. A systematic review of outcomes of maternal weight gain according to the Institute of Medicine recommendations: birth weight, fetal growth, and postpartum weight retention. American Journal of Obstetrics and Gynecology 2009; 201: 339 e1–14.

60. National Institute for Health and Care Excellence. Weight management before, during and after pregnancy: NICE public health guidance 27. Manchester: NICE, 2010.

61. Department of Health, Social Services and Public Safety. Health Survey Northern Ireland 2012/2013. Belfast: DHSSPS, 2014.

62. Public Health England. Everybody Active, Every Day: An evidence-based approach to physical activity. London: PHE, 2014.

63. Department of Health. Start active, stay active: A report on physical activity from the four home countries' Chief Medical Officers. London: Department of Health, 2011.

64. Gauge NI, Community Evaluation NI. Report on capturing and quantifying social and economic outcomes for Belfast commissioned health and social wellbeing programmes. 2014. (Unpublished)

65. Gauge NI. Evaluation of the Cancer Rehabilitation Pilot Programme: Small steady steps. 2014. (Unpublished)

66. Department of Health. Start active, stay active: A report on physical activity from the four home countries' Chief Medical Officers. London: DH, 2011. Available at: www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers Accessed 4 January 2015.

67. Department of Health Social Services and Public Safety. Health Survey Northern Ireland – 2012/13. Belfast: DHSSPS, 2014. Available at: www.google.co.uk/url?url=http://www.dhsspsni.gov.uk/health_survey_northern_ireland_2012-13.docx&rct=j&frm=1&q=&esrc=s&sa=U&ei=wo7wVLj9CsLy7Aaq84HQCQ&ved=0CBQQFjAA&usg=AFQjCNG4HvoMYbL-jWjHS21alnDzhzr18w Accessed 9 February 2015.

68. The Conservation Volunteers (TCV). Western Green Gym Year 2 Project Evaluation. April 2014. (Unpublished)

69. World Health Organisation. Global Recommendations on Physical Activity for Health. Geneva: WHO, 2010. Available at: http://whqlibdoc.who.int/publications/2010/9789241599979_eng.pdf Accessed 9 February 2015.

70. Department of Health, Social Services and Public Safety. Northern Ireland Health Survey First Results 2013/14. Belfast: DHSSPS, 2014.

71. Department of Health, Social Services and Public Safety. Health Survey Northern Ireland 2012/13. Belfast: DHSSPS, 2014.

72. National Institute for Health and Care Excellence. Managing overweight and obesity in adults – lifestyle weight management services: NICE public health guidance 53. London: NICE, 2014. Available at: www.nice.org.uk/guidance/PH53 Accessed 2 December 2014.

73. NHS and The British Dietetic Association. Losing weight – Getting started. NHS Choices. 10 January 2013. Available at: www.nhs.uk/Tools/Pages/Losing-weight.aspx Accessed 2 December 2014.

74. Food Access Network. What is food poverty? Sustain. 30 October 2013. Available at: www.sustainweb.org/foodaccess/what_is_food_poverty/ Accessed 6 January 2015.

75. Food Standards Agency in Northern Ireland. Food poverty. Food Standards Agency. Available at: www.food.gov.uk/northern-ireland/nutritionni/ninutritionhomeless Accessed 6 January 2015.

76. Courtney R. The best for every child. Belfast: PHA, 2012. Available at: www.publichealth.hscni.net/publications/best-every-child Accessed 30 January 2015.

77. Department of Education. School leavers. Department of Education. Available at: www.deni.gov.uk/32_statistics_on_education-school_leavers_pg.htm Accessed 30 January 2015.

78. Queens University Belfast, South Eastern Health and Social Care Trust. Prevalence of speech and language delay in primary one children in Lisburn areas. June 2014. (Unpublished)

79. Robinson A, Laverty C, Bell C. Health Inequalities: NI Health & Social Care Inequalities Monitoring System – Regional 2014. Belfast: DHSSPS, 2014.

80. Department for Social Development. Northern Ireland Poverty Bulletin 2011/12. Belfast: DSD, 2013. Available at: www.dsdni.gov.uk/poverty_bulletin.htm Accessed 3 February 2015.

81. Rodgers H, Stewart B, Keys L. NI Health and Social Care Inequalities Monitoring System: Fourth update bulletin 2012. Belfast: DHSSPS, 2012. Available at: www.dhsspsni.gov.uk/inequalities_monitoring_update4-2.pdf Accessed 3 February 2015.

82. Public Health Agency. Core tables to the 2013 Director of Public Health Annual Report. Belfast: PHA, 2014. Available at: www.publichealth.hscni.net/publications/director-public-health-annual-report-2013-and-additional-core-tables-recognising-divers Accessed 11 February 2015.

83. Department of Health, Social Services and Public Safety. Protect life – A shared vision: The Northern Ireland suicide prevention strategy 2012–March 2014. Belfast: DHSSPS, 2012. Available at: www.dhsspsni.gov.uk/suicide_strategy.pdf Accessed 15 January 2015.

84. McCready Donnelly Lowry Ltd. Evaluation of the impact of the work of the Community Networks in promoting mental health and suicide prevention in the Northern Area (to May 2012). Belfast: PHA, 2012. Available at: www.lighthouseireland.org/wordpress/wp-content/uploads/2012/05/FULL-EVALUATION-REPORT-Community-Networks-PMH-SP-JUNE-2012.pdf Accessed 15 January 2015.

85. Northern Ireland Statistics and Research Agency. Suicide Deaths: Key Statistics 2013. Belfast: NISRA, 2013. Available at www.nisra.gov.uk/demography/default.asp31.htm Accessed 16 January 2015.

86. Public Health Agency. Suicide in Northern Ireland – June 2014 Health Intelligence briefing. (Unpublished)

87. Ip S, Chung M, Raman G et al. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries: Evidence Report/Technology Assessment Number 153. Rockville, MD: Agency for Healthcare Research and Quality, 2007. Available at: www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf Accessed 15 January 2015.

88. World Health Organization .Global Strategy for Infant and Young Child Feeding: Evidence of the long term effects of breastfeeding, systematic reviews and meta-analysis. Geneva: WHO, 2007.

89. World Health Organization. Nutrition: Exclusive breastfeeding. WHO. Available at: www.who.int/nutrition/topics/exclusive_breastfeeding/en/ Accessed 28 January 2015.

90. McAndrew F, Thompson J, Fellows L, Large A, Speed M, Renfrew MJ. Infant Feeding Survey 2010: Summary. London: Health and Social Care Information Centre, 2012. Available at: www.hscic.gov.uk/catalogue/PUB08694/ifs-uk-2010-sum.pdf Accessed 28 January 2015.

91. Gossrau-Breen D, Gilmore G, MacDonald L. A review of the Northern Ireland breastfeeding strategy. Belfast: Public Health Agency, 2010. Available at: www.publichealth.hscni.net/sites/default/files/breastfeeding%20strategy%20review_3.pdf Accessed 28 January 2015.

92. Department of Health, Social Services and Public Safety. Breastfeeding – A Great Start: A strategy for Northern Ireland 2013–2023. Belfast: DHSSPS, 2013. Available at: www.dhsspsni.gov.uk/breastfeeding-strategy-2013.htm Accessed 28 January 2015.

93. Public Health Agency. Health intelligence briefing: Breastfeeding in Northern Ireland. Belfast: PHA. November 2014. (Unpublished)

94. Public Health Agency. Baseline Survey of Northern Ireland Public Awareness of Cancer Signs and Symptoms. Belfast: PHA, 2014. Available at: www.publichealth.hscni.net/publications/baseline-survey-northern-ireland-public-awareness-cancer-signs-and-symptoms Accessed 18 February 2015.

95. Northern Ireland Statistics and Research Agency. Statistical Bulletin: Deaths in Northern Ireland 2013. Belfast: NISRA, 2014. Available at: www.nisra.gov.uk/archive/demography/publications/births_deaths/deaths_2013.pdf Accessed 18 February 2015.

96. Northern Ireland Cancer Registry. All Cancers Exc NMS. Queen's University Belfast. Available at: www.qub.ac.uk/research-centres/nicr/CancerStatistics/OnlineStatistics/AllCancersExcNMS/ Accessed 18 February 2015.

97. Unpublished analysis by the Public Health Agency comparing deaths between 2001–2010 in West Belfast among men aged 40–64 and women aged 40–59 with Northern Ireland averages for those age groups.

98. Northern Ireland Statistics and Research Agency. Deaths Statistical Bulletin. Belfast: NISRA, 2013. Available at: www.nisra.gov.uk/archive/demography/publications/births_deaths/deaths_2013.pdf Accessed 18 February 2105.

99. Department of Health, Social Services and Public Safety. NI Health and Social Care Inequalities Monitoring System Regional 2014 Bulletin. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/index/statistics/health-inequalities/regional-health-inequalities.htm Accessed 18 February 2015.

100. Stewart B, Lyness C, Bell C. Life Expectancy Decomposition: An overview of changes in Northern Ireland life expectancy 2001–03 to 2008–10. Belfast, DHSSPS, 2012. Available at: www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2013.pdf Accessed 18 February 2015.

101. Robinson A, Laverty C, Bell C. Health Inequalities: NI Health & Social Care Inequalities Monitoring System – Regional 2014. Belfast: DHSSPS, 2014. Available at: www.dhsspsni.gov.uk/hscims-2014-bulletin.pdf Accessed 18 February 2015.

102. Department of Health, Social Services and Public Safety. A strategy for maternity care in Northern Ireland 2012–2018. Belfast: DHSSPS, 2012. Available at: www.dhsspsni.gov.uk/maternitystrategy.pdf Accessed 10 February 2015.

103. Northern Ireland Statistics and Research Agency. Registrar General Northern Ireland Annual Report 2013. Belfast: NISRA, 2014.

104. Northern Ireland Audit Office. Safer births: Using information to improve quality. Belfast: NIAO, 2014. Available at: www.niauditoffice.gov.uk/a-to-z.htm/safer_births__using_information_to_improve_quality Accessed 10 February 2015.

105. Department of Health, Social Services and Public Safety. Developing eyecare partnerships: Improving the commissioning and provision of eyecare services in Northern Ireland. Belfast: DHSSPS, 2012. Available at www.dhsspsni.gov.uk/eyecarestrategy2012.pdf Accessed 20 January 2015.

106. Department of Health, Social Services and Public Safety. Transforming your care: A review of Health and Social Care in Northern Ireland. Belfast: DHSSPS, 2011. Available at www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf Accessed 20 January 2015.

107. National Institute for Health and Care Excellence. Glaucoma: Diagnosis and management of chronic open angle glaucoma and ocular hypertension. NICE clinical guideline 85. Manchester: NICE, 2009. Available at: www.nice.org.uk/guidance/cg85/resources/guidance-glaucoma-pdf Accessed 20 January 2015.

108. Department of Health. Valuing People Now: a new three-year strategy for people with learning disabilities. London: DH, 2009. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf Accessed 19 January 2015.

109. Department of Health, Social Services and Public Safety. Learning disability service framework. Belfast: DHSSPS, 2011. www.dhsspsni.gov.uk/learning_disability_service_framework.pdf Accessed 19 January 2015.

110. Emerson E, Baines S, Allerton L, Welch V. Health inequalities & people with learning disabilities in the UK: 2011. Available at: www.improvinghealthandlives.org.uk/publications/978/Health_Inequalities_&_People_with_Learning_Disabilities_in_the_UK:_2011 Accessed 19 January 2015.

111. Slevin E, Taggart L, McConkey R, Cousins W, Truesdale-Kennedy M, Dowling L. A rapid review of literature relating to support for people with intellectual disabilities and their family carers when the person has behaviours that challenge and/or mental health problems. Belfast: University of Ulster, 2011. Available at: www.publichealth.hscni.net/sites/default/files/Intellectual%20Disability.pdf Accessed 19 January 2015.

112. Murphy E. Research and Information Service Briefing Paper: Statistics on People with Learning Disabilities in Northern Ireland. Northern Ireland Assembly. 6 May 2014. Available at: www.niassembly.gov.uk/globalassets/documents/raise/publications/2014/employment_learning/5014.pdf Accessed 18 February 2015.

113. Office of the First Minister and Deputy First Minister. Programme for Government 2011–15. Belfast: Northern Ireland Executive, 2012.

114. Keeley EC, Boura J, Grines CL. Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: A quantitative review of 23 randomised trials. Lancet 2003; 361: 13–20.

115. NHA Lothian. The Heart Manual. Edinburgh: NHS Lothian, 2014. Available at: www.theheartmanual.com/About/Documents/Leaflet.pdf Accessed 10 February 2015.

116. Chan AW, Tetzlaff JM, Altman DG et al. SPIRIT 2013 Statement: Defining Standard Protocol Items for Clinical Trials. Ann Intern Med. 2013; 158(3): 200–7.

117. Hoffmann TC, Glasziou PP, Boutron I et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ 2014; 348: g1687.

118. Kohl 3rd HW, Craig CL, Lambert EV et al. The pandemic of physical inactivity: global action for public health. Lancet 2012; 380: 294–305.

119. Lee I-M, Shiroma EJ, Lobelo F et al. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. Lancet 2012; 380: 219–29.

120. Allender S, Foster C, Scarborough P, Rayner M. The burden of physical activity-related ill health in the UK. J Epidemiol Community Health 2007; 61: 344–8.

121. Hunter RF, McAneney H, Davis M, Tully MA, Valente TW, Kee F. "Hidden" social networks in behavior change interventions. Am J Public Health. 2015; 105(3): 513-6. doi: 10.2105/AJPH.2014.302399.

122. Hunter RF, Tully MA, Davis M, Stevenson M, Kee F. Physical activity loyalty cards for behaviour change. Am J Prev Med 2013; 45(1): 56–63.

123. Public Health Agency. Surveillance of Meningococcal Disease. Public Health Agency. Available at: www.publichealth.hscni.net/sites/default/files/directorates/files/EpiYear-cases-serogroup.pdf Accessed 16 March 2015.

124. Hex N, Bartlett C, Wright D et al. Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabet Med 2012; 29(7): 855–62. Available at: www.ncbi.nlm.nih.gov/pubmed/22537247 Accessed 12 February 2015.

125. Ferrannini E. Definition of intervention points in prediabetes. Lancet Diabetes Endocrinol 2014; 2(8): 667–75. Available at: www.ncbi.nlm.nih.gov/pubmed/24731662 Accessed 12 February 2015.

126. Perreault L, Pan Q, Mather KJ et al. Regression from Pre-diabetes to Normal Glucose Regulation is Associated with Long-term Reduction in Diabetes Risk: Results from the Diabetes Prevention Program Outcomes Study. Lancet 2012; 379(9833): 2243–51. Available at: www.ncbi.nlm.nih.gov/pubmed/22683134 Accessed 12 February 2015.

127. American Diabetes Association. Executive summary: Standards of medical care in diabetes – 2014. Diabetes Care 2014; 37 Suppl 1: S5-13. Available at: http://care.diabetesjournals.org/content/37/Supplement_1/S5.long Accessed 12 February 2015.

128. Shah M, Kaselitz E, Heisler M et al. The role of community health workers in diabetes: update on current literature. Curr Diab Rep 2013; 13: 163–71. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3929361/ Accessed 12 February 2015.

129. Yates T, Davies MJ, Henson J et al. Walking away from type 2 diabetes: trial protocol of a cluster randomised controlled trial evaluating a structured education programme in those at high risk of developing type 2 diabetes. BMC Fam Pract 2012; 13: 46. Available at: www.biomedcentral.com/1471-2296/13/46 Accessed 12 February 2015.

130. Tully MA, McBride C, Heron L, Hunter RF. The validation of Fibit ZipTM physical activity monitor as a measure of free-living physical activity. BMC Res Notes 2014; 7(1): 952. Available at: www.biomedcentral.com/1756-0500/7/952 Accessed 12 February 2015.

131. Public Health Agency. Annual Report of the Needle & Syringe Exchange Scheme for the period 1st April 2013 to 31st March 2014. (Unpublished). Available at: www.publichealth.hscni.net/publications/annual-report-needle-syringe-exchange-scheme-period-1st-april-2013-31st-march-2014 Accessed 12 January 2015.

132. Costella A, Goldberg D, Harris H et al. Hepatitis C in the UK: 2014 Report. London: Public Health England, 2014. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/337115/HCV_in_the_UK_2014_24_July.pdf Accessed 12 January 2015.

133. National Institute for Health and Care Excellence. Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control: NICE clinical guideline 117. Manchester: NICE, 2011. Available at: www.nice.org.uk/guidance/cg117/resources/guidance-tuberculosis-pdf Accessed 14 January 2015.

134. Condon RE, Schulte WJ, Malangoni MA, Anderson-Teschendorf M. Effectiveness of a surgical wound surveillance program. Arch Surg. 1983; 118(3): 303–7.

135. The Society for Hospital Epidemiology of America; The Association for Practitioners in Infection Control; The Centers for Disease Control; The Surgical Infection Society. Consensus paper on the surveillance of surgical wound infections. Infection Control Hospital Epidemiology 1992; 13(10): 599–605.

136. Haley RW et al. The efficacy of infection surveillance and control programs in preventing nosocomial infections in US hospitals. American Journal of Epidemiology 1985; 121(2): 182–205.

137. Mangram AJ et al. Guideline for prevention of surgical site infection, 1999. Hospital Infection Control Practices Advisory Committee. Infection Control Hospital Epidemiology 1999; 20(4): 250–78.

138. National Institute for Health and Care Excellence. Caesarean section (update): Clinical Guideline 132. Manchester: NICE, 2011. Available at: www.nice.org.uk/guidance/CG132 Accessed 13 January.

Abbreviations and acronyms

A

A4H	Advice 4 Health
AAA	Abdominal aortic aneurysm
AHP	Allied health professions
AIDS	Acquired immunodeficiency syndrome
ASIST	Applied Suicide Intervention Skills Training
ASMR	Age-specific mortality rate

B

BITC	Business in the Community
BMI	Body mass index
BSO	Business Services Organisation
BSP	Breast Screening Programme

C

CAB	Citizens Advice Bureau
CAWT	Cooperation and Working Together
CHNI	Council for the Homeless NI
CRUN	Causeway Rural and Urban Network
CVD	Cardiovascular disease
CWSAN	Cookstown and Western Shores Area Network

D

DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
DPH	Director of Public Health

E

ED	Emergency department
EIL	Early Intervention Lisburn
EVD	Ebola Virus Disease

F

FH	Familial hypercholesterolaemia
FSA	Food Standards Agency

G

GAA	Gaelic Athletic Association
GBS	Group B streptococcus
GDM	Gestational diabetes
GP	General practitioner
GUM	Genito Urinary Medicine

H

HHW	Healthy Hearts in the West
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCIMS	Health and Social Care Inequalities Monitoring System
HSCT	Health and Social Care Trust

I

IFA	Irish Football Association
IRFU	Irish Rugby Football Union

J

JSA	Job Seekers Allowance

L

LCG	Local Commissioning Group
LGB	Lesbian, gay or bisexual
LGB&/T	Lesbian, gay, bisexual and/or transgender

M

MHFA	Mental Health First Aid
MINAP	Myocardial Infarction National Audit Project
MOU	Memorandum of Understanding

N

NACN	North Antrim Community Network
NETS	NIHR Evaluation, Trials and Studies
NHS	National Health Service
NI	Northern Ireland
NIAS	Northern Ireland Ambulance Service
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health and Care Excellence
NICEM	Northern Ireland Council of Ethnic Minorities
NICHS	Northern Ireland Chest Heart and Stroke
NICR	Northern Ireland Cancer Registry
NIHR	National Institute for Health Research
NINES	Northern Ireland New Entrant Service
NIPHRN	Northern Ireland Public Health Research Network
NISRA	Northern Ireland Statistics and Research Agency
NMSC	Non-melanoma skin cancer

P

PACS	Picture Archive and Communications System
PCI	Percutaneous coronary intervention
PDF	Portable document format
PHA	Public Health Agency
PHE	Public Health England
pPCI	Primary percutaneous coronary intervention
PYLL	Potential years of life lost

R

R&D	Research and Development
RDG	Research development group
ROI	Republic of Ireland
RSU	Research Support Unit
RVH	Royal Victoria Hospital

S

SACN	South Antrim Community Network
SEE	Self-Efficacy for Exercise
SF-8	Short Form 8
SLA	Service Level Agreement
SPDO	Suicide Prevention Development Officer
SSI	Surgical site infection
STEMI	ST-elevation myocardial infarction
STI	Sexually transmitted infection

T

TB	Tuberculosis
TIA	Transient ischaemic attack

U

UK	United Kingdom
UKCRC	UK Clinical Research Collaboration

W

WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World Health Organization

Y

YMSP	Young Men's Support Project

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05/15

PHA Social Care Procurement Plan 2014/15 - 2018/19 (Revised April 2015) Appendix 2

Tender	12/13	13/14				14/15				15/16				16/17				17/18				18/19				Estimated Value Per Annum	Current number of Conracts
	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	Apr May June **Qtr 1**	July Aug Sep **Qtr 2**	Oct Nov Dec **Qtr 3**	Jan Feb Mar **Qtr4**	**£(M)**	
Drugs and Alcohol (including Hidden Harm) (8 specs)																										£4.1m	60
Suicide Prevention and Mental Health (3 specs) Phase I																										2.4m (all 3 phases)	70 -80
Suicide Prevention and Mental Health Phase II (includes befriending, counselling, complementary therapies and mentoring)																										To be run in conjunction with lifeline Contract not yet known how mnay specs	
Lifeline																										3m	1
Suicide Prevention and Mental Health Phase III (includes community capacity, no. of specs unknown) - Madeline																											
Relationship and Sexual Education																										£0.25m	15
Teen Preg /SH Training																										£0.35m	TBC
Teen Preg / SH - Services																										£0.3m	TBC
Advice4Health / benefit maximisation																										£0.3 - £0.5 (est)	
One Stop Shop																										£0.7 - £0.9m	6-8
Obesity (inc Phy Activity and Nutrition) phase 1																										0.5m	5-8
Obesity (inc Phy Activity and Nutrition) phase 2 ??																										1.0m	TBC
Stop Smoking Services - Training Services																										TBC	TBC
Stop Smoking Services - Cessation Services																											

PHA Social Care Procurement Plan 2014/15 - 2018/19 (Revised April 2015) Appendix 2

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Healthy Living Centres																										1.3m	19
Green Gym / Allotment programmes																										£0.3m - 0.5m	5 -10
Health Promoting Homes (West)																										£0.07m	5
Community Development Infrastructure																										£1.5m (est)	15 - 20
Work Place Health																										£0.1m	TBC
Early Intervention Transformation Programme																										£8.0m (est)	08-Dec
Reading Groups for Prisioners																										£0.05m	1
Active Travel																											
Strengthening Families Programme																										TBC	1
Horticulture Therapy																										£0.1m	1
Active Travel																										£0.2m	
Keep warm Keep Well																										TBC	0
Cancer Focus (skin cancer)																											

Key:

Completed Tenders

Tender Preparation

Tender Process

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	Update on PHA Procurement Plan
Agenda Item	15
Reference	PHA/09/05/15

Summary

This paper provides an update for PHA board on progress that has been made during 2014/15 in implementing the PHA Social Care Procurement Plan.

During 2014/15, significant progress has been made in taking forward Tenders in areas such as Drug and Alcohol services and Mental Health promotion. In total, 12 tenders have been progressed with an overall annual value of circa £6.0m.

In progressing the Procurement Plan in 2015/16, account will need to taken of new EU Regulations on Procurement and capacity constraints.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This update was approved by AMT on 12 May 2015.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	13 May 2015

Update on PHA Procurement Plan 2014/15 – 2018/19

This paper provides an update for Members on progress that has been made during 2014/15 in implementing the PHA Social Care Procurement Plan. It also identifies issues that will impact on the continued implementation of the Plan during 2015/16.

During 2014/15, significant progress has been made in taking forward tenders in areas such as Drug and Alcohol services and Mental Health promotion. In total, 12 tenders have been progressed with an overall annual value of circa £6.0m. A detailed breakdown of these tenders is provided in appendix 1attached. In reviewing the experience gained to date a number of key themes have emerged that will inform future work in this area:

- Management of the tender process is complex and requires specialist knowledge and skills to be undertaken effectively;
- Early engagement with service users and providers is important to meaningfully inform strategic plans and priorities;
- The Business case is critical to addressing key issues such as the importance of social benefits; identifying the preferred service model; value for money; and scale of provision in terms of quantity and number of contracts to be awarded;
- Development of a clear specification and evaluation criteria is critical to achieving the outcomes desired; and
- On–going engagement with providers regarding service quality and capacity is important to ensure future changes required to meet needs are planned effectively.

The number of tenders that are now included on the Procurement Plan has continued to increase as budget leads review existing programme areas. In addition, new areas of work have also emerged where tenders need to be developed, such as under the Early Years Transformation Programme. A copy of the Procurement Plan is attached as appendix 2.

During 2015/16 the main focus will be on progressing Tenders in the following areas:

- Suicide prevention services including the Lifeline service;
- Early years intervention services; and,
- Obesity.

In progressing the Plan account will be taken of the following issues:

(1) In February 2015, new EU Regulations on Procurement were adopted by UK Parliament. Key changes under the new regulations are:
    - removal of exemptions that existed for some health and social care services regarding procurement;

- establishment of a new financial threshold of circa £625,000, under which the full Regulations do not apply; and
- introduction of the concept of a ‘light touch’ approach that can be applied to social care procurements that are over threshold.

PHA will work closely with colleagues in BSO procurement and legal teams to assess what impact the new Regulations will have on existing processes and ensure that future processes remain fit for purpose and proportionate.

(2) In addition PHA will need to review its capacity to meet the proposed timelines for all tenders included in the Procurement Plan, given the constraints on the overall management and administration budget.

Members are asked to **NOTE** this paper.

Appendix 1

Summary of Tenders Progressed in 2014/15

Tender no	Title	Annual Contract Value	Date of Advert	Closing Date	Current Status
001	Relationship and Sexuality Education (RSE) in the community across Northern Ireland	£ 275,500	29/09/2014	10/10/1204	**Tender process completed and Contracts Awarded**
002	Awareness Programmes to support Mental and Emotional Health and Wellbeing- Tier 1 Programmes	£ 44,000	12/12/2014	27/02/2015	**Tender process completed and Contracts Awarded**
003	Services to support the mental and emotional wellbeing of Lesbian and Bisexual Women, Gay and Bisexual Men and Transgender individuals and their families	£ 50,000	06/01/2015	20/02/2015	**Tender process completed and Contracts Awarded**
006	Community Based Psychological Intervention and Support Services for People who Self-Harm including provision of Family/Carer services	£ 719,000	30/01/2015	20/03/2015	**Tender closed. Evaluation and award process being completed**
008	Service to raise awareness and promote informed choice for the Cancer Screening Programmes	£ 180,000	12/12/2014	27/02/2015 (original 06/02/2015)	**Tender closed. Evaluation and award process being completed**
PHA2014/DAS/ 001	Therapeutic services for children, young people and families affected by parental substance misuse	£ 816,777	24/10/2014	15/12/2014	**Tender process completed and Contracts Awarded**
PHA2014/DAS/ 002	Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services)	£ 910,000	24/10/2014	23/01/2015 (original 15/12/2014)	**Tender process completed and Contracts Awarded**
PHA2014/DAS/ 003	Community based intervention services for adults and family members affected by substance misuse	£ 551,208	24/10/2014	15/12/2014	**Tender process completed and Contracts Awarded**
PHA2014/DAS/ 004	Community based services for young people who are identified as having substance misuse difficulties	£ 924,274	24/10/2014	09/01/2015 (original 15/12/2014)	**Tender process completed and Contracts Awarded**
PHA2014/DAS/ 005	Community Alcohol and Drugs Information Network Services	£ 600,000	30/01/2015	23/03/2015	**Tender closed. Evaluation and award process being completed**
PHA2014/DAS/ 006	Targeted Prevention for young people and parents / carers	£ 692,859	25/02/2015	20/04/2015	**Tender closed. Evaluation and award process being completed**
PHA2014/DAS/ 007	Workforce Development Programmes	£ 172,000	25/02/2015	20/04/2015	**Tender closed. Evaluation and award process being completed**

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	21 May 2015
Title of Paper	Child Development Programme Board Update
Agenda Item	16
Reference	PHA/10/05/15

Summary

The Child Development Board was established in June 2010, reflecting the PHA's Corporate Strategy focus on Giving Every Child the Best Start in Life. The remit of the Board is to develop an integrated pathway from conception to 18 years of age which includes proven programmes in early child and youth development. The role of this group has become increasingly important as the PHA has become involved in driving forward new inter-sectoral initiatives on children's health and well-being.

The CDPB has 9 key work strand teams which provide quarterly progress reports to the Board.

The PHA is conducting the consultation on the Draft Infant Mental Health Framework and Plan. Consultation closes on 29 May 2015 and PHA will then consider all responses which will inform the development of the Regional Infant Mental Health Framework and Action Plan. With regard to IMH training activity, 318 Early Years and HSC professionals have been trained at December 2014, an increase from 272 in October. This training enables professionals working with vulnerable families to enhance their skills, knowledge and support in the challenges of ensuring optimum development for newborns and infants.

An updated version of the "Off to a Good Start" book on breastfeeding was published in March 2015. PHA supports the "Breastfeeding Welcome Here" scheme and the number of participating organisations has increased by 20%.

The Public Health Agency was awarded funding in 2013 through the Delivering Social Change (DSC) Framework to develop and deliver a suite of evidence based parenting programmes. Incredible Years, Infant Mental Health Training, Strengthening Families and Parenting your Teen programmes have all been progressed successfully, despite some uncertainties over committed income from OFMDFM within 2014/15 which was resolved at a late stage of the financial year.

The Early Intervention Transformation Programme (EITP) is being delivered as part of the Delivering Social Change Programme (DSC) and will be implemented between April 2014 and March 2018.

Equality Screening / Equality Impact Assessment	N/A

Audit Trail	This update was considered by AMT at its meeting on 28 April 2015.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Public Health
Date	28 April 2015

CHILD DEVELOPMENT PROJECT BOARD

Friday 20 March 2015 9.30-11.30am

CR3&4 Linenhall Street

MINUTES

Present: Carolyn Harper, PHA (chair)
Finola McAlarney, PHA
Brid Farrell, PHA
Maurice Meehan, PHA
Ruth Carroll, PHA
Nicola Armstrong, PHA
Una Turbitt, PHA
Celine McStravick, NCB
Carol Diffin, BHSCT
Maurice Leeson, HSCB
Julie McConville, SHSCT
Joy Poots, South Belfast Surestart
Ann McDuff, WHSCT (via telecon)
Kate Keeling, WHSCT (via telecon)
Susan Gault NHSCT (via telecon)

Apologies: Mary Black, PHA
Miriam Karp, PHA
Denise Boulter, PHA
Fionnuala McAndrew, HSCB
Kieran Downey, WHSCT
David Douglas, SHSC
Sharon Beattie, Safeguarding Board
Billy Ashe, PHA (non Exec)
Sheena Funston, WHSCT
Fionnuala McKinney, WHSCT
Dr Carolyn Mason, RCN
Dr Paul Connolly, QUB

1. **Minutes of last meeting**
   The Minutes of 12 December 2014 meeting were approved.

2. **Infant Mental Health Training and Perinatal Mental Health Update**

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The PHA is consulting on the Infant Mental Health Framework and Plan. Consultation closes on 29 May 2015. In relation to training activity, by December 2014, 318 Early Years and HSC professionals have been trained (an increase from 272 in October). The Workstrand is working with the Clinical Education Centre regarding provision of Solihull training. In relation to beneficiaries from the training, as well as direct benefit to clients, there is also an indirect benefit in terms of support to other staff. It was agreed that a sustainability plan is required, linking in with Workstream 1 of the EITP project. The sustainability plan should quantify the type of staff, numbers of staff, and type of training to be provided. It should show the "back-logs" and the maintenance capacity required. It should also show how that training would be embedded within existing line management, appraisal and personal development processes. It should also set out the need for a provider who provides multiagency, group, multidisciplinary training.

In relation to infant mental health training for midwives, members considered a summary from Denise Boulter which set out the undergraduate and postgraduate arrangements. Overall, while there are some areas of good practice, the provision and uptake of substantial training is patchy. Members highlighted the need for a more systemic approach and it was agreed that Una Turbitt and Maurice Meehan would discuss with Denise the opportunity for a learning event to share practice between Trusts, particularly, to learn from those who have made more substantial progress.

Action: Maurice Meehan and Una Turbitt to develop the sustainability plan for training and to consider the learning event outlined above with Denise Boulter.

In relation to perinatal mental health, Stephen Bergin and Maurice Meehan are working with colleagues to refresh the perinatal pathway taking account of the recent NICE Guidance.

3. Parenting Programmes

The programmes are progressing well. A sustainability plan will be developed through Workstream 2 of the EITP project. The initial goal will be to sustain existing capacity, with expanded capacity funded in future years.

4. Family Nurse Partnership

PHA is still awaiting confirmation from DHSSPS regarding the 2015/16 Financial Plan which includes investment for the 2 additional FNP teams. The teams cannot proceed until confirmation is received. Staff are trained and ready to commence once approval is given. The Workstream is otherwise on progress in the existing 3 teams although it was noted that they are at capacity and unable to take further referrals. This is leading to some teenage mothers not receiving the service.

5. **Roots of Empathy**
   An event has been held with school principals across Belfast which was very positive and the Workstrand expect that the numbers in Belfast will return to usual levels later this year. In relation to the randomised control trial, results are expected for publication from April/May 2015.

6. **Breastfeeding**
   Members noted the significant achievements through the Breastfeeding Action Plan. Specifically, the percentage of babies born in baby friendly hospitals has now increased to 93% and the number of organisations participating in Breastfeeding Welcome Here has increased by 20%. In addition, the Workstream is developing a pathway for management of tongue-tie.

7. **Research**
   The Workstrand held a session for researchers and practitioners in relation to the EITP programme. While funding is limited, the initiative was received positively.

   A recent BMJ article concluded that more robust trials are required on Triple P before any conclusions can be drawn on its effectiveness. This affirms the decision to put the introduction of Triple P on hold. In relation to Family Functional Therapy, QUB are undertaking a trial with Croydon Council in relation to their FFT service. Action For Children Northern Ireland are providing FFT here and it was agreed that Dawn Shaw would be invited to present on that work at a future meeting.

Action: Finola to liaise with Dawn Shaw as above.

8. **Communication**

It was noted that the videos for the OFMDFM event are not available for sharing at this point. Otherwise, stakeholder engagement

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continues and opportunities sought to promote the work on child development.

9. Healthy Child Healthy Future

No update report was available. However, it was agreed that for future meetings, members would receive graphs showing the trend in percentage achievement of required health visitor visits, by Trust. The data for these is currently being validated. The overall sense is that achievement levels have not improved, certainly not significantly. The expansion of the health visiting workforce is included in the 2015/16 financial plan, but is subject to DHSSPS/Ministerial approval.

10. Early Intervention Transformation Programme

Update reports were received for Workstream 1 and 2. Both are making substantial progress, including development of sustainability plans. A specification for the procurement of the early intervention service is being developed and under Workstream 1, there has been significant engagement with education including on the role of school nurses.

11. Building Great Britons – Conception to Age 2 Report and The First 1001 Days

Maurice Meehan developed a summary of the report and members considered the gaps in current approaches in Northern Ireland. A change in culture and move to a culture along the lines of the Scandinavian approaches, was identified as a key gap. Members also thought there would be benefit in developing a strategic operational vision for child development as this would help to create a consistent direction and make it more visible and transparent.

Action: Maurice and Celine to consider.

12. Any Other Business

Dr Farrell reported that the Child Health System Report for 2013 will be available for members shortly. Key messages will be shared at the next meeting.

13. Dates of future meetings

Friday 26 June 2015, 9.30-11.30am, 5th Floor Meeting Room
Friday 18 September 2015, 9.30-11.30am, 5th Floor Meeting Room
Friday 18 December 2015, 9.30-11.30am, 5th Floor Meetings Room
Friday 11 March 2016, 9.30-11.30am, 5th Floor Meetings Room

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Friday 24 June 2016, 9.30-11.30am, 5th Floor Meetings Room
Friday 16 September, 9.30-11.30am, 5th Floor Meetings Room
Friday 2 December, 9.30-11.30am, 5th Floor Meetings Room

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